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CRITICAL REFLECTIONS ON THE STRATEGY OF HEALTH FOR ALL BY 2000 A.D.

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It is well over a decade after the famous Alma-Ata conference in 1978 in which Governments from different countries all over the world decided upon the goal of "Health for all by 2000 A. D." The approach to attain this goal was to be primary Health-care. Since the Alma-Ata declaration, the slogan of "Health for all by 2000 A. D." and the "Primary Health Care approach" have almost become catchwords in public health circles. Every body seems to have accepted and glorified these two things uncritically. In MFC also, Primary Health-care approach has been the accepted approach. After the experience of more than a decade, it is high time that these concepts, strategies, programmes as evaluated to identify the genuine progress, the blind-spots, deficiencies and distortions in the primary health care approach and the programme of "Health for all by 2000 A. D." In this note, an attempt would be made to do the same in the spirit of taking stock of the situation. The aim here, is not to establish the viewpoint expressed with empirical support but to put forward a framework, a view point, for discussion. Perhaps this viewpoint summarizes the consensus that exists in M.F.C. on this issue.

1) Health for all and Primary Health Care:

Let us first be clear as to what is the 'Health for All by 2000 A. D.' strategy. The Alma Ata conference declared -

"Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisation and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain that every stage of their development in the spirit of self -reliance and self - determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary Health Care includes at least : education concerning prevailing health problems and the methods preventing and controlling them, promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs."

2) Positive Features:

These declarations are impressive enough; and there is some genuine conceptual advantage in these declarations compared to the dominant pattern of privatized, commercial health-care that existed then and even continues today. The dominant pattern of health - care was described by the Alma Ata Conference as follows :-

"Health resources are allocated mainly to sophisticated medical institutions in urban areas. Quite apart from the dubious social premise on which this is based, the concentration of complex and costly technology on limited segments of the population does not even have the advantage of improving health. Indeed, the improvement of health is being equated with the provision of medical care dispensed by growing numbers of specialists, using narrow medical technologies for the benefit of the privileged few. People have become cases without personalities and contact has been lost between those providing medical care and those receiving it."

The 'Primary Health Care Approach' is radically better than this dominant approach. There were certain features in the PHC

- approach which were new and positive. The commitment to 'socially acceptable methods and technology,' to community participation, to the principle of 'cost community and country can afford', to self-reliance and self-determination ..... these features imply a health care delivery model quite different from the one dominated by blind acceptance of : 'high-technology' from Western countries. Secondly, the approach of Community Diagnosis is of course a rational one.

The Bhore - Committee had recommended the formation of Citizens' Committees of 5-7 voluntary workers in each village. Each member was to be trained in health - activity - initiation of voluntary preventive activities, dispensing of simple drugs, collection of vital statistics ... But such committees became defunct. Later on, the evolution of voluntary Health Workers in innovative health projects in the NGO-sector and the adoption of this concept by Alma-Ata Declaration is one of the most important positive steps in the organization of health-care. Though the experience during last decade has removed the romanticism about CHW's role, on the one had, and on the other hand, the vulgarized from in which the scheme was implemented in the Government sector has much maligned it, there is a golden mean that can and has been achieved in different places. A much better trained, better equipped, better supported CHW has an important role to play in providing good quality medical care and health-education and in fostering preventive, promotive activities in rural areas. But perhaps the powers that be are not interested in its full-potential and look upon the CHW-Scheme as a cheap device of providing a token of health-care to rural areas.

Includtion of provision of nutrition, water, sanitation in Primary Health Care is also a step ahead of a purely medical model of provision of medical services. Unfortunately, this demedicalitation inclusion of the non-medical aspects, is the most neglected and failed part of the PHC as has been practised in India.

3) Blindspots, deficiencies, distortions :

While analysing the negative side of the HFA-strategy and the PHC-approach, it would be better to distinguish betwen the blindspots, deficiencies and disttactions in this strategy.

By blindspots I mean those deficiencies which occur because of the very nature of the limited conceptual framework of the strategy, which prevents it from looking at important problems. For example, as would be argued later, there is no National Programme for women's Health in spite of high prevalence of gynaecological disorders. This is because women are looked upon only as mothers and there is thus only Maternal and Child Health Programme.

By deficiency is meant the inadequate performance of an essentially correct programme, for exmple, inadequate coverage of the population in need of a health-care service. When the deficiency is so gross or the quality of implementation is so bad that it hardly reflects the original aim of the programme, we would call it as distortion. Foe example, in the Government set up, the extremely low quality of training to Community Health Workers and the extreme neglect of this programme of VHW has resulted in a picture that hardly reflects the original aim and potential of this programme.

By way of example, let us take a few important aspects of the HFA strategy to analyse the blindspots, deficiencies and distortions in them. Let us first critically look at the goal of HFA itself.

3.1 The Goal of HFA by 2000 A. D.

3.10 Who has defined health as "not merely the absence of disease", but as "a state of complete physical, mental and social well-being", and has regarded "The enjoyment of the highest attainable standard of health", as "one of the fundamental rights of every human-being". But the Alma-Ata Declaration aims at : "a level of Health that will permit people to lead socially and economically productive life." This subtle shift to a limited goal should be noted. There is nothing wrong in setting up limited goals in a time-bound programme, so long as we are aware that the goal is in fact a limited one. It is important to point out the limitations when an aura has been created around HFA. It is true that even this limited goal was a difficult one to achieve-when it was announced in 1978. Moreover, now it looks impossible to achieve, given the performance so far. Yet the conceptual shift has to be noted. Secondly, in today's market economy, what is 'productive' is decided by its value in the market place. That is why the work and hence the health of house-wives, marginalised workers, old people have been neglected. The nature of the limited goal for the time-bound programme of HFA-200 AD, has thus been decided by the blindspot of the socio-economic system and not directly by the health needs of the people.

3.11 : As for deficiencies, in the fulfilment of the goal of HFA-200 AD, the accompanying table gives the grossly deficient progress made in India, in the first ten years after Alma-Ata. With this pace of progress, even the limited targets of HFA-2000 AD sem impossible to achieve in time. It will be seen from the table, that the People's Republic of China and Shri Lanka have already fulfilled some of these targets.

Table No. 2

Progress towards some HFA-Targets.

Sr. No.	Indicator	Status in 1978	Progress till 1987	Progress in China by 1987	Progress in Sri-Lanka by 1987	Target for 2000 A.D.
	(1)	(2)	(3)	(4)	(5)	(6)
1)	Infant Mortality rate	125	99	32	33	below 60
2)	Crude Death-rate	11	11	7	6	9
3)	Crude Birthrate	35	32	21	23	below 21
4)	Material Mortality rate per lac births	500	N.A.	44 (1980)	90 (1980)	below 200
5)	Life expectancy at birth for males	52.6	58	68	64	64
6)	Life expectancy at birth for females	51.6	58	71	73	64
7)	Babies with low birthweight	30%	30% (1985)	6%	28%	10%

(Table No. 2 Continued)

	Indicator	Status in 1978	Progress in 1987	Progress in China by 1987	Progress in Sri Lanka by 1987	Target for 2000 A.D.
	(1)	(2)	(3)	(4)	(5)	(6)
(i)	Deliveries by trained birth attendant	30%	30% (1985)	N.A.	8%	100%
(ii)	Immunization :					
	(a) T.T. for pregnant women	20%	30%	-	-	100%
	(b) DPT for children	25%	64%	-	-	85%
	(c) Polio	5%	58%	-	-	85%

3.1.3 : The WHO has evolved a set of indicators for monitoring progress towards HFA-by the year 2000-AD. (3) The Government of India, has however, deleted the non-medical indicators from its reports of progress towards HFA by 2000 AD. In their view, HFA is thus a purely medical enterprise. The non-medical determinants of health such as extent of provision of safe drinking-water, adequate sanitary facilities, integrated development etc. have been mentioned in the "National Health Policy" declaration of the Government of India. But since they are not included in the monitoring of progress towards HFA, these declarations can not be taken as genuine. This absence of integration of medical and non-medical aspects of health amounts to a distortion of the declared strategy of HFA by 2000-AD.

The actual performance on the economic social front is abysmal. In the context of rising prices, unemployment, pollution, the talk of HFA by 2000 A. D. has become an empty rthetoric.

3.1.4 : Even amongst the health-indicators, one sensitive, important indicator has been deleted in the evaluation parameters in India. The WHO has specified that by the year 2000 A. D. "Atleast 90 % of children have a weight for age that corresponds to the reference-values." (4) This is a difficult task to be achieved compared to the task of say reduction in infant mortality rate. It is precisely this indicator which is missing in the Government of India's evaluation-parameters.

3.1.5 : Even if we take only health-interventions, they are grossly inadequate; an important reason being lack of adequate funds. The WHO has specified that 5 % of the Gross National Product be spent on Health-care. But in India, however, it had increased to only 1.17 % by 1988 (5). Moreover, the share of Health and Family- Welfare (Read population-control) as percentage of total plan outlay has declined from 3.3 % in the first plan to 2.9 % in the sixth plan (6).

3.2 : Primary Health Care approach

According to the Alma Ata declaration, the method of attaining the goal of HFA is that of tackling the health-problems with the Primary Health-care approach. As remarked earlier, this approach is much better than the dominant privatized, commercialized approach. But the PHC-approach has its blindspots, limitations.

3.2.1 : Neglect of Curative Services :

The minimum list of activities quoted above which must be included in Primary Health Care are heavily biased in favour of preventive and promotive measures. "Appropriate treatment of common diseases and injuries; and provision of essential drugs" comes at the end of this list. In practice also, medical treatment is the last priority of the governmental health-system. It is true that diseases can be eradicated primarily through preventive and promotive measures. But that does not mean that curative/ symptomatic care be neglected. The need for such care is acute and many times crucial in alleviating intense suffering or preventing death or preventing a disability. But it is precisely this need that has been by the large neglected by the Government set up. People therefore, suffer or die silently or go to private practitioners, many of whom in rural area are simply quacks. There is tremendous exploitation of the rural people by these third rate practitioners. Since the Government service is grossly deficient in curative care, in the eyes of the people the credibility and popularity of this service is also low.

The emphasis on preventive, promotive measures is a convenient alibi to neglect curative health-services and thereby to reduce Government's expenditure on Health Services. What is needed is adequate emphasis on both prevention and cure. One need not be emphasized at the expense of the other.

3.2.2. : Narrow Coverage :

In terms of coverage of population for health - care, the PHC - approach is a step backward compared to the recommendation of the Bhore Committee in 1946. The Bhore Committee's recommendations were to be the basis of the restructuring of health - services after Independence. The Bhore-Committee had recommended "Comprehensive Health - Service" having the following criteria:

(a) provide adequate preventive, curative and promotive health service.

(b) be as close to the beneficiaries as possible.

(c) has the widest cooperation between the people, the service and the profession.

(d) is available to all irrespective of their ability to pay for it.

(e) look after more specifically the vulnerable and weaker section of the community

(f) create and maintain a healthy environment both in homes as well as working places. . . . (7)

"To the individual patient, comprehensive health - care means that he can get whatever kind of care is required by the diseases to which he may be subject. " Primary Health Care is however, selective. It includes : 'maternal & child health,' " locally endemic diseases, common diseases & injuries," as problems to be tackled. (Incidentally there is no mention of control of communicable disease - probably a slip of pen ?) Secondly, PHC does not include occupational health - hazards, which are now becoming increasingly common even in rural areas.

Material and child Health is hailed as an important example of community - approach to health - problems. What is forgotten

is that the real reason for choosing this programme is the interest the state has, in having a healthy adult population which can contribute to "National Wealth". Children are the future 'pillars of the nation' and hence the interest of the State in their health and thereby in the health of the mothers. Women are thus looked upon only as mothers and their other health-problems are being neglected. The 'scientific rationale advanced in support of the MCH programme is the biological vulnerability of mothers and children, the universal nature of health problems associated with motherhood and childhood, and its preventability. There is of course some truth in this argument. But this rationale is only a half truth. Old people are also biologically vulnerable. But there is no National Geriatric Health Programme. If prevalence is a criterion, gynaecological problems in women would require a National Programme.

A community based survey found that as much as 92 % of women in a rural area had some gynaecological disease or the other, a very high proportion of these were due to vaginitis, cervicitis. (3) This finding is probably representative. In spite of such a high degree of prevalence of gynaecological disorders, there is no national health programme to tackle them. If neglected, many of these gynaecological problems turn into serious crippling illness, or even death. Chronic cervicitis which remains untreated in Indian women for years, can predispose women to cancer of the cervix of the uterus, a killer disease. Many of these diseases are easily preventable and easily treatable in the early stages. It is therefore clear that epidemiological characteristics are not enough to make any health - problem worthy of a national programme in PHC. The interests of the ruling elite decide the final selection. Many people who glorify the PHC-approach' gloss over this fact of the step-down from Comprehensive Health services (recommended by the Bhore-Committee) to Primary Health Care and are unaware of the politics of selection of health - problems in PHC.

Why this step-down ?

This step-down was necessitated by the fact that most of the recommendations of the Bhore-committee remained largely unfulfilled; and with increasing financial constraints due to economic crisis, it was pretty clear that there was no chance of making 'Comprehensive Health Care' a reality. Table No. 1 gives the performance of the health - care system in India, as compared to the recommendations by the Bhore - Committee.

Table No. 1

THE COMPARISON OF HEALTH MAN - POWER AND INFRASTRUCTURE IN 1981 WITH BHORE - COMMITTEE RECOMMENDATIONS 1971

POPULATION	1971 Recommended ..(1)	1981 685 Million ..(2)			
		Projection as required by Bhore - Committee	Actuals	Shortfalls	shortfall in percentage ..
PRIMARY HEALTH CENTRES	1 : 20,000	34,250	5,740 (2)	28,510	83 %
DOCTORS	1 : 2,000	3,42,500	2,68,712 (3)	73,788	21.5 %
NURSES	1 : 300	22,83,333	1,50,399 (2)	21,32,934	93 %
HEALTH VISITORS	1 : 5,000	1,37,000	@ 19,033 (2)	1,17,967	86 %
MIDWIVES	1/100 births:	2,31,000	@ 23,200 (2)	2,08,330	90 %
DENTISTS	1 : 4,000	1,70,500	8,648	1,61,852	94 %

@ Trained upto 1981

SOURCE : (1) Bhore Committee Recommendation report
(2) Health Atlas of India, 1986
(3) Health Information of India, 1987

This abysmal performance is an a way the source of the new selective approach. Some kind of cheaper health-service had to be offered to the rural areas to avoid discontent. PHC-approach was seen to be such a solution.

3.2.3 : Poor-training :

Poor quality of training of VHWs means a marginal ability to treat even minor aliments, to establish credibility to do health-education. There is also no continuing education of VHW. Perhaps the doctors do not believe in the philosophy of the important role of VHWs; nor are they themselves trained to appropriately train this cadre of health workers.

The doctors themselves are not appropriately trained to work in a rural, peripheral set up, and to act as team - leaders.

3.2.4 : Assumed resource-constraint

The powers that be, have in fact reduced the already subminimal percentage of plan-expenditure on health (family planning excluded.) The medical experts have meekly adjusted themselves to this neglect of the health sector and under meassumed resource-constraint, devised suboptimal strategies. Thus in TB-control programme, sputum negative, x-ray positive patients are given an inferior drug-regiment. Though they are epidemiologically not a threat to the community, that does not mean that their disease or suffering is less dangerous or less troublesome to them than those who are sputum positive. (10) The step-motherly treatment to these patients is based on the assumption that we do not have enough resources to treat all TB-patients equally well.

The same assumption is responsible for inadequate dose of iron to pregnant women in the MCH-programme ... (11) or lack of calcium-supplementation to pregnant, lactating women from the poorer community.

3.2.5 : Domination of Family Planning Programme

This point needs some elaboration :

3.2.5.1 : To begin with, Family Planning is a misnomer, a euphimism for population control since it is aimed at only planning for a small family. Other aspects of family-education, rearing-up, employment etc. are not planned. Similarly, Family Welfare is also a misnomer. The Maternal and Child Health are only a miniscule part of the F. W. Programme. In the 5th plan, expenditure on MCH services constituted only 1.4 % of the Family Welfare expenditure, and was underspent by 15 %. In the 6th plan, this expenditure was raised to 13 % (that too because of the incorporation of the Expanded programme of Immunization) but it was again grossly underspent by 27 % (12) Thus F. W. Programme is in fact, Primarily the F. P. Programme.

3.2.5.2 : When other programmes are starved of financial support, funds for family planning programmes increased astronomically. For example, in Gujrath, F. P. expenses on per eligible couple increased from Rs. 0.68 during 1966-69 to Rs. 309.93 during 1985-90; whereas the per capita expenses on all other health-programmes together increased from Rs. 3.51 to Rs. 39.91 during the same period. (13) Allocation for Health Plan excluding F. P. declined during the same period from 4.1 % to 3.5 % of the total plan outlay. (14)

3.2.5.3 : Even within the F. P. Programme, those undergoing tubectomy are increasing as compared to those undergoing vasectomy, even though the latter is of course, for convenient, simple, safer, cheaper method. The medical establishment thus has meekly joined hands with the patriarchal system which is the root cause of the preference for tubectomies. What is indeed shocking, is that more than 50 % of the sterilization operations are done on individuals who are beyond thirty years of age or have four or more living children. (15) Thus more than half the operations are done after the couples have completed their family; and hence are by and large wasteful. These trends of excessive emphasis on population control, on tubectomies, and late-sterilizations are not simple deficiencies, but constitute distortions of the PHC-approach.

3..2.6 : Lack of community participation

By and large, the community is even unaware of the various health-programmes. The Village Health Workers are recommended by the Gram Panchayat, but after that the Gram-Panchayat does not have any control over the VHW, nor over any other health-functionary. The VHW or the health-bureaucracy is not able to involve the community in the planning and implementation of Primary Health Care. Nor are the social political leaders interested in Primary Health Care; they are by and large unaware of its existence. Much innovative thinking and work is needed to foster community participation. The experiments in the voluntary sector need to be evaluated and integrated in the national planning.

3.27 Neglect of non-allopathic systems

In the Alma-Ata Declaration there is no mention of the role of non-allopathic systems of medicine. Role of indigenous systems of medicine is important in the context of "Self- reliance" as one of the features of the PHC-approach. In the National Health Policy statement of the Govt. of India, this aspect has been covered. But it has neither been included in monitoring of the progress nor in the section on medical research. Grass root level operational research, as well as laboratory research, is crucial in defining and fostering the role of indigenous systems of medicine. In absence of such research mere inclusion of a few non-allopathic drugs in the VHW-kit hardly does justice to the subject.

3.28 : Selective Primary Health Care and Vertical Programmes:

Since the Government is not willing to spend enough money and other resources on even the limited programme of Primary Health Care, there is now a talk about selective Primary Health Care. Human beings and their health-Problems in totality are going more and more into the background, and a limited number of targets are being chased with the help of technocratic managerial interventions; whatever may be the scientific jargon that may be used to camouflage the real motive. This new upcoming strategy of selective PHC with the help of vertical programmes is at variance with the basic tenets of Primary Health Care - essential health care, community participation, self-reliance, demedicalization of health. That is why it has been very severely criticized by those who steadfastedly adhere to the basic philosophy of PHC, for example, ACHAN. (16)

3.29 Privatization -

In recent years, in different places, aspects of public health services are being handed over to private sector and there is a trend towards "fee for service" approach in the public health sector. This trend vitiates the basic tenets of Primary Health Care Approach, which includes universal accessibility of Primary Health Care services. "Fee for service" means a denial of health services for those who can not afford these. It is one thing to collect token contribution in a collective health insurance scheme, as a measure to enhance people's participation and control. But the upcoming trendl is not aimed at this, but is aimed at essentially reducing the Governmental expenditure on health care. Like selective PHC, this trend also constitutes a distortion of the PHC - approach.

We would not go into all the problems of the PHC-approach, as it is practised in India in the government sector. (The NGO sector also shares some of these problems.) It would be clear from the discussion so far that the PHC-approach in theory and in practice is far too short of what is neded and what is possible. It is, therefore, necessary to conceptually broaden and deepen the scope of PHC, and to take up steps to avoid the mistakes in planning and implementation for a strategy for health For All. The role of the NGO sector could be important to show how this can be done. (This is a revised version of my earlier note: "Critical reflections on the Strategy of Health For All by 2000 A.D." submitted for the Seminar on "Science and Technology Policy in India" at Kolhapur, Maharashtra in February, 1990)

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The Targets : 'HEALTH FOR ALL'

Primary Health Care is to be the approach and Health For All is to be the strategy of achieving quantified targets by 200 AD. An impression is created that the health-ministry through this very well formulated programme is going to improve the health of the people. In reality, health-status can not be 'delivered,' nor can health-services be the primary determinant of improving health-status of the people. In the absence of proper socio-economic development, today health-services cannot play even the catalytic, supplementary role, they ought to play. There is no wonder, therefore, that in the period of hurgeoning price-rise, unemployment, drought, socio-political instability HFA-strategy is a mere cry in the wilderness. It is bound to fail even in the limited goals it has set for itself. A word about the limited goal. HFA aims at: 1a level of Health that will permit people to lead a socially and economically productive life.' In today's market-economy, what is productive is decided by its value in the market-place. That's why the work and hence the health of the old people, house-wives, marginalized workers have been neglected.

Secondly, though the Alme Ata Declaration gives a set of twelve health and non-health indicators to evaluate the progress of HFA-strategy, the Government of India has deleted the non-health-indicators from its reports of progress towards HFA by 200 A.D. Health has become a purely medicalized enterprise.

Thirdly, though Alma Ata Declaration specified that 5 % of the GNP (Gross National Product) be spent on health-care, in India, however, it had increased to only 1.17 % by 1988. (5) Moreover, the share of Health and Family-Welfare (read population-contro) as per centage of total plan outlay has declined from 3.3 % in the First Plan to 2.9 % in the Sixth plan. (6)

Forthly, even amongst the health indicators, one important, sensitive indicator has been deleted in the Indian evaluation-parameters. The Alma Ata Declaration specifies that by the year 200 A. D. "Atleast 90 % of children have a weight for age that corresponds to the reference-values ....". This is a difficult task to be achieved, compared to the task of achieving reduction in maternal mortality or immunizing all children. It is precisely this indicator which is missing in the Govt. of India's evaluation - parameters.

The progress towards achieving even these limited goals is extremely tardy. This is reflected in table No. 2 With only ten years to go, it is quite clear that except for a couple of indicators, even the limited targets of Health for All by 2000 A.D. would not be achieved in India. The table shows that China and Sri Lanka have already s urpassed some of these targets.

Thus these targets are definitely achievable in backward countries. India has however failed miserably.

To conclude, health-status in primarily a function of socio-economic development, health-interventions can considerably accelerate this process, but can not substitute it. Health for All is, therefore, bound to fail in today's crisis-ridden socio-economic set up. Primary Health Care as an approach to health - problems has some positive features, but its blindspots have to be brought into focus, and the retreat form the aim of providing Comprehensive Health Care has to be criticized. By overcoming there blind-spots and by consistently applying the principle of community - diagnosis and Primary Health-Care, a programme of "Health-Care For All" can be successfully launched. An honest and consistently scientific approach would, however, require a different alignment of socio-political forces.

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Principles of a National Health Policy

[redacted]

1. Definition of Health

Health is not merely absence of disease but is a state of complete physical, mental and social well being. This definition of WHO has gained ground in both official and progressive circles and has served the purpose of obscuring the popular concept in such a way as to undermine the importance of medical care responsibilities of the state. Further, though this abstract definition is a step forward in the way of intellectual sophistication, it is beyond peoples' comprehension: as well being is not measurable. It is therefore, suggested that we should define health merely as absence of diseases., since it is comprehensible, clear and points towards a concrete objective; presence or absence of diseases is measurable.

2. Medical Health Care Vs Non-medical Health Care

Medical Health Care (MHC) involves measures which require medical intervention eg. treatment of illness, immunization, medical rehabilitation etc. Non Medical Health care (NMHC) comprises those basic non-medical needs which also act as determinant elements of health eg. food, shelter, drinking water, sanitation, clean environment, education, employment etc. The present (National Health Policy) declares that our failure on the health front is due to injudicious grafting of a western model of health care system which is curative-oriented, hospital centred and urban-biased, and thus only provided benefits to the upper crusts of society. The health care service, therefore, should be drastically revised to put emphasis on universal provision of primary health care and public health services, a time-bound programme be adopted to ensure adequate nutrition for all, potable water supply and basic sanitation facilities, protection of environment etc. This is also the policy direction so long advocated by the WHO. Since then it has been adopted almost as a truism among those concerned that priority should be given to NMHC and emphasis on MHC should be reduced.

The above principle, it appears, has developed out of ignorance or political motivation. There is no denying the fact that NMHC lays and maintains the proper foundation of health but there can not be any question of differential priority between curative care and preventive care; nor there is any conflict between the application of these two. Curative care is meant for ill persons whereas the recipients of preventive care are those who are not afflicted with illness. In other words, for the ailing person the curative care is a must, no amount of preventive care can relieve or cure him. Hence, it ought to be clear that we need both preventive and curative care or say, both NMHC and MHC, of necessary standard and adequate measure, and there cannot be any question of [redacted]

3. [redacted]

From the foregoing, it is obvious that in order to protect and maintain the health of an individual as well as the community, we should have medical care for all, food for all, shelter for all, i.e. water, sanitation, education, employment etc for all. Can the health administration be entrusted to achieve all these objectives? The answer obviously is, no. The job of health administration of the country should, therefore, be to prepare a scientific, people -oriented MHC policy and its implementation; NMHC should be left to other appropriate agencies to deal with.

4. Tasks of the policy on MHC

It should deal with all aspects of medical care in public and private sectors; production, marketing and consumption of drugs and equipment, medical and paramedical personnel and their education and training, immunization and control of communicable and other controllable diseases, health education, health legislation, health research and other related matters.

5. Basics of the policy on medical care

The objectives should be universal coverage by an acceptable and feasible standard of curative care and its equitable distribution. At present, the poor people get the inferior kind of free state medicare and buy, under compulsion, a cheap low quality market medicare; the affluents get the superior kind of free state medicare and costly high quality market medicare. Employed people in the organised sector additionally get another bounty of institutional medicare reserved for themselves.

In order to proceed towards and achieve equity, it is imperative that the entire state free medicare service be exclusively reserved for the poor people so that the affluent people may be confined to the market sector and the employed people to their own reserved institutional medicare. This should be the point of departure.

6. Task of the people's health movement

From the foregoing, it is quite apparent that the issues pertaining to the NMHC belong to the political forces to deal with. Activists and organisations of people's health movement should therefore, concentrate on the issues pertaining to MHC.

Guidelines for state health care delivery system
Suggestions from field experience of voluntary sector

Dr. U. R. JAJOO
[illegible]

Dear Medico Friends,

While preparing the note entitled - 'Guidelines for State Health Care Delivery System suggestions from field experiences of voluntary sector' the following assumptions were in my mind and those need to be considered.

- To provide at least primary health care services accessible to poor is an obligation that the state should fulfil. The tendancy of the state to shrug off this responsibility by encouraging privatisation must be opposed by pro-people voluntary sector.
- The pro-people voluntary sector should offer its constructive suggestions based on their field observations, to the state. While doing so, voluntary sector must put itself in the position of the 'Last man' and question itselves to spell out optimum minimum that he/she would like to have.

eg.
- Will I like to get my delivery conducted by a trained Dai/ ANM in the village home ?
- Will I like my child to be treated for pneumonia at the mercy of a village health worker ?
- In a situation where 2/3rd microscopically detectable cases of pulmonary tuberculosis are missed and are sent off with a prescription of cough mixtures, will I insist for radiological support to be available at reachable primary care hospital ?
- Will I like a well-equipped referral hospital to stand by for catering to common emergencies (e.g. obstructed labour, acute appendicitis, intestinal obstruction, bladder neck obstruction due to benign prostatic hypertrophy, head injury needing burr hole, fracture neck femur, mastoiditis, lens induced glaucoma, Gullianbarre with respiratory paralysis etc.) ?
- In matters of justice to the poor (providing minimum emergency care) the cost factor should not deter us. The onus of redistribution of misallocated funds rests with the state.

The field observations that heavily weighed in my mind while writing this note are -

- The distance of primary health care hospital should be such where emergencies requiring immediate attention (e. g. neuroparalytic snake bite, obstructed or complicated labour, organo-phosphorus poisoning, convulsing child, acute left ventricle failure etc.) can be transported within 1/2 hour (maximum).
- The distance of referal hospital should be such where a patient needing caesarian section can be transported from the cottage hospital within 1/2 hour (Maximum).
- To reduce unpredictable maternal & child mortality (disorders like uterine inertia with foetal distress, retained placenta with post-partum haemorrhage), institutional delivery should be accessible to every mother.
- The cottage hospital (PHC) should be so equipped that it caters to all emergencies which either can not be transported due to gravity of illness or do not offer enough time to transport patient to referral hospital.
- The quality of skilled manpower availability at the cottage hospital should be such that the abovesaid emergencies can be dealt with confidence.
- Barring sophisticated and superspeciality services, all other demands (e.g. Intensive care unit, neonatology, general medicine, general surgery, ophthalmology, ENT, radiology, including ultrasonography, clinical pathology, microbiology and clinical biochemistry) be met by the referral hospital.
- The cottage hospital (PHC) which provides curative services should extend preventive & promotive out-reach services.
- The responsibility of assuring availability of skilled manpower at peripheral hospital must rest with the state.
- For primary health care services, a common man should not be required to pay from his pocket at the time of need.
- By controlling finances and evaluating performance, the people can be empowered to command an efficient and qualitative health care delivery system. Since all demands of people (tonics/pricks) may not be professionally justified, there is a limit to which the control can be decentralised. An obligatory golden mean will have to be worked out from time to time.
- The village is not a homogeneous community. There may be strong party affiliations which do reflect in Gram Panchayat. The people's mandate must be sought in forum no less than GramSabha. Realising the culture-that majority is silent, decisions in Gram-Sabha should be made by overwhelming majority (say 75%). For a genuine protest to be lodged (e.g. performance evaluation) with higher health system hierarchy, less than majority (say 35%) should suffice.
- The financial control by the people should be routed through voluntary prepayment (insurance contribution)
- The private sector should be allowed to compete with the state services. If private sector is ready to provide services through prepayment schemes, the state should offer equal support (financial) to them as is given to state run hospitals.

Guidelines

1. Aim :- To provide health care services equitably accessible to poor.
2. Structure :-

For each village/ward of a city - Door-step services through village/community health worker and Dai.

For a cluster of Villages/City - Cottage hospital services of primary health care.

At district level - Referral hospital preferably attached to the Medical college (If available)

At state level - Superspeciality hospital accessible strictly on referral basis.

3. How far the cottage hospital should be ?

Ideally about 1/2 hour's reachable distance from the village by the fastest available transport (on foot, by bullock cart, by Jeep). The pliable approach roads and quick communication system (Phone) is requisite minimum if ambulance of cottage hospital is supposed to cater to emergencies. With ready ambulance service and good roads one expects to cater to 25 k.m. radius area around.

4. How far should the referal hospital be ?

Preferably within 1/2 an hour's distance by ambulance of cottage hospital. The referral hospital is thus expected to cater to 50 k.m. radius area.

5. How much the cottage hospital be equipped ?

The minimum that cottage hospital should cater to is -

5.1 Curative care

5.1.1 Indoor emergency care for the problems where patient is not transportable to referral hospital e.g. Forceps/ Ventouse delivery, breech delivery, PPH, incomplete abortion (OB & Gyn). Resuscitation of newborn, dehydration, lower respiratory tract infections, convulsing child, PEM with complications, Kerosene/Datura poisoning, Diphtheria (Paed), Snake bite, Tetanus, insecticide poisoning, severe hypertension, acute LVF, COAD (General Medicine), Epistaxis, tracheostomy, colic (Surgery)

5.1.2 Curative services for illness which need not come to referral hospital.

e.g. Common Ailments attending Gyn/Paed/Medicine O.P.D. (including T.B. & Leprosy), Extraction of loose tooth, Acute otitis media, wax in ear, otomycosis, safe CSOM, Maggots, Minor burns, abscesses, suturing, dressing, splints, Conjunctivitis, Normal delivery

5.2 Preventive and promotive services at door-step by out-reach programme organised from cottage hospital

5.3 What should be minimum humanpower requirement of a cottage hospital :

- A postgraduate in paediatrics
- A postgraduate in OB & GYN
- A postgraduate in community medicine

(A special inservice training of all these doctors in elementary anaesthesias, orthopaedics, dentistry, ENT, ophthalmology will have to be undertaken to equip them for good medicine efficiently.)

- Two ANMS for hospital
- Two ANMS for outreach health services
- Two social workers for outreach programme
- A dresser cum dispenser cum registration clerk
- Two attendants for hospital
- Two attendants for outreach programme
- A driver for ambulance
- A dhobi on contract basis for the hospital,

5.4 Learnings from Sevagram experiment :-

Expected indoor load - 1 per 11 people

Expected average hospital stay - 7.5 days

Expected bed requirement - 2 beds per 1000 population with 100% bed occupancy

Expected indoor recurring cost (1989 figures)

(Salary, drug, food, Mentainance all inclusive) -

68 Rs. /day/bed, 510 Rs./admission, 46 Rs./per capita/per year

Expected out-reach recurring expenditure (1989 figures) -

3.5 Rs./Capita/Year for village drug kit and for hiring mobile health team

2 Rs./capita/year for VHW + Dai Remuneration

Expected outdoor attendance - 1 per person/per year

5.5) Blind lanes -

- What can be the average outdoor expenditure of running O.P.D. Service ?
- What should be the numerical relationship between total O.P.D. attendance/indoor admissions and number of doctors/ paramedical staff needed to run the cottage hospital ?

The abovementioned information will guide in deciding population that can be catered to and the catchment area for a cottage hospital in more concrete terms. The cost economic feasibility of skilled manpower at the cottage hospital can also then be calculated.

5.6 The strategy for outreach services -

Annual cluster (pulse) immunization strategy (4 visits/village/ year)

MCH services (3 visits/village/year)

Health education with Slide shows/community meetings

Supervisory role to be shouldered by postgraduate doctor in Community Medicine.

5.7 How to assure availability of skilled manpower ?

Mandatory 5 year internship on completing post graduation study before obtaining post graduate degree.

If a medical college is available nearby, the district referal hospital be obligatorily run by medical college staff.

6. The role of referral hospital :-

To provide all specialities (Care General surgery, General Medicine, General Paediatrics, Orthopedics, ENT, Ophthalmology, OB & Gyn, Dentistry & Community medicine) strictly on referal basis either from private sector or from cottage hospital.

- Documentation of local events
- Appropriate research
- Teaching students, if the referral is attached to a medical college :

7. How can privatisation be checked ?

Free and good quality of accessible health service from government sector can check privatisation. All government employees must join state health insurance scheme and no reimbursement be allowed for hospital care obtained from private sector.

8. How to incorporate people's participation and their control?

For state health services to be responsible to people's need, empowering people by promoting their participation and by controlling at least a part of financial resources is obligatory. The decentralisation process must be initiated. In the present situation, the control cannot be totally decentralised as professional wisdom

is not necessarily identical to felt demands of the people e.g. the demand of tonic bottles and pricks can not be justified by professional wisdom. There must be scope in the system for professional wisdom to be assertive enough when required. As it is important that health professionals are not required to dance to the tune of people's minds, it is also imperative that people be empowered to the extent that they can command an efficient and quality health care delivery system.

The following strategy is suggested - The state should extend health services through **health insurance scheme.** The smallest participatory unit would be a village or a ward of a town (depending on population) The population size of the participating community can be around 1000. The area to be catered by district level referal hospital and cottage hospitals would be predefined. The decision to participate in the state health insurance scheme will be taken by Gram Sabha with at least 75% majority, that means health insurance scheme would be voluntary.

The people's participation in management services would occur by co-opting a representative from each participating unit. The management body so formed with the hospital/state co-ordinators would enjoy maximum autonomy in local planning, budgeting, and implementation.

Out of expected recurring expenditure, state would handover, say, 75% amount in advance with district hospital and 25% balance amount would be distributed to participating unit according to per capita calculations. This earmarked amount will thus be deposited with Gram-panchayat/Municipality/Corporation and would go back to hospital in form of health insurance contribution, provided beneficiaries by atleast 75 % majority approve it. In the event of non-participation in state health insurance scheme, the money would go back to the state.

The financial control will serve three objectives :-

a The professional and management body of the health system would be **responsive** to people's demand in terms of efficiency, outreach and quality since they seek 25 % budgetary allocation from the people.

b Since 75% of the funds are assured, the professional and management staff would not be that insecure so as to compromise on misdirected people's demand.

c The autonomy in planning, budgetary allocation and implementation would pave way for **creative involvement** of managerial staff and the people.

The superspeciality health care will be provided by state run hospital **strictly on referal basis.**

For a purposeful link between people and health service delivery staff, it is essential that village based and village level staff is controlled more intensely by the people. I suggest the following strategy -

The village based staff (VHW & Dai) would be paid honorarium by Gram Sabha. The earmarked amount would be made available with Gram-Panchayat by the state (2 Rs. per capita per year) The powers to hire (by 75% majority) or fire (by atleast 35% beneficiary) village based functionary will rest with Gram-Sabha.

To get satisfactory performance report from Gram-Sabha would be requisite minimum for doctors/ANM/Social workers before they entitle for increments or promotions. The obligatory minimum for unsatisfactory performance would be protest lodged by at least, 35% of beneficiary population.

It is believed that direct control on village based staff and indirect control on village level staff will pay its dividends in increasing reopensiveness to the people.

9. What is the proposed financial layout ?

(based on Sevagram experience)

- Money with the State for

Health delivery system expenditure - 80 Rs.per capita per year (1989 figure)

- Allocation of the District Hospital System - 36 Rs. per capita (75 % of 48 Rs.)

- Allocation to Gram Panchayat for VHW remuneration- 2 Rs. / per capita

- Allocation to Gram Panchayat for health insurance contribution 12 Rs. / per capita (25 % of 48 Rs.)

Balance money with state government for : running superspeciality hospital - 30 Rs./Capita

- To meet non-recurring expenses of cottage & district hospitals - 30 Rs. Capita

For state sponsored scheme - 30 Rs. Capita

10. The role of Voluntary Sector : -

- Appropriate training of paramedics (Supportive role)
- Operational Research.
- An obligatory participant in evaluation of health system performance (Watch dog)
- Search for alternatives (Reformist/revolutionary role)

11. Village based workers :

David Werner in "VHW, lackey or liberator" has brought out comparison of doctor and village health worker. The appropriate future role of a doctor, according to the author is on a tap (not on top), as an auxiliary to the VHW, helping to teach him/her more medical skills and of attending referals at the VHW's request for 2-3% of cases that are beyond VHW's limit. VHW has been recognised as the key member of the health team, is the doctor's equal and one who assumes leadership of health care activities in the village, but relies on advice, support and referal assistance from the doctor when he/she need it.

Sevagram Field experience distillate the following :-

11.1 The Role :-

VHW can not be doctor's equal in curative services (The felt need of the people) because VHW can not command faith of an expert healer. Though people do approach VHW for symptom relief of common self limiting illnesses because of easy accessibility, the credibility that VHW enjoys depends on efficiency and quality of the supporting hospital system. VHW is regarded as a' link between system and the people. The power equation-VHW for poor villagers and superspeciality hospitals for urban elites-is seen by rural poor as double standards and glaring discrimination.

To be instrumental in development activities and conscientisation process. VHW has wide scope. In pro people milieu their leadership skills can be nurtured. One does not expect government system to provide such milieu, the hopes lie with voluntary sector.

Looking at the hard realities, in the present government health system, VHW can be a lackey and not the liberator.

11.2 The Selection :-

For VHW to be answerable to the community, it is often quoted that VHW should be selected by the community. However, precise structure of 'community' is never realised. In a Gram Sabha, few

local affluents dominate the platform whose opinion can not be considered vox populi. All members of a village (community) never turn up for meetings. The partisan nature of selection can not be considered to be the consent of the silent majority.

Apart from answerability to the community, VHW has to meet the minimum quality expected by the health system from him/her to function as an efficient link. The directions of where and how to go is known better to the professional wisdom in technical matters.

To meet both requirements, Sevagram experience suggests the following strategy -

Let the maximum number of candidates be suggested by Gram Sabha by at least 75 % majority. Suitable person would be selected from among them by the mobile health team members on the basis of following guide-lines -

a) The VHW should preferably come from a family which is not desperate in meeting two ends. The poor class remains engrossed in earning one's bread and hardly can think beyond.
b) The VHW be preferably acceptable to all fractions of the community.
c) The scope for developing leadership qualities in VHW should always be kept in the mind.
d) It is obligatory that VHW can read and write in local language.
e) The selected candidate should be likely to stay permanently in the village.

In the Sevagram experience, it was not easy to get voluntary offers for VHW's responsibility in sufficient numbers. Quite often the health team had to persuade a person in whom leadership qualities been observed. The occasions where non-performing VHW was to be dropped, were not infrequent.

11.3 Male or Female :-

The choice depends on the kind of job expected and the availability. A lady VHW is preferable if she meets the minimum quality expectations. We found it difficult to get appropriate lady candidates who fulfilled technical expectations and also perform socially with competence.

11.4) The incentive :-

The incentive of putting one's soul in an endeavour can be money, material, prestige, power and enjoyment of creativity. The first two become the major concern of a poor & low caste VHW who is struggling to find out his/her identity. The prestige and power attract those whose minimal basic necessities are satisfied. The creativity factor satisfies only few already conscientious individuals.

By selecting VHW from middle class one tries to tap a candidate who may not be attracted merely by monetary consideration. By effective implementation of health programme the credibility of the health system can be transmitted to this vital link. By nurturing leadership skills through informal participatory education one hopes that the creativity incentive will supervene.

11.5 The Control :

VHW has to be responsive to people's need at the same time be guided by village health team. The twin control can be established by providing financial support through Gram Sabha and performance evaluation by the health team.

The Bazar doctor - A harsh reality !

Sham Ashtekar

Rural India - that is Bharat - presents a strange and pathetic health services scenario. It is a peculiar mix of unpardonably poor state health infrastructure and a thriving 'underworld' of bazar medical services. The ills of this heritage are manifold and multifaceted; and given the existing situation and its projections; the 21st century also shall be no different despite all that is said and done about HFA.

A alarming peculiarity about rural health services is that there is a convenient division of preventive/promotive from the curative. The state services peddling a caricature of preventive programs (largly F. P.) and the private medical sector rushing up on the curative.

There is enough said and discussed on what and how the state services should be (even in this issue); but hardly anything on the private sector. There is a tendancy to ignore it as a non-essential (?) exploitative (yes !) sector that has no place in the scheme of things to come. No clearcut policy perspective or even pointers are available on how to deal with this large and politicaly strong section of the rural elite; serving the rural masses-whatever the quality - much more than what the state seems to offer as a curativve componant. (3/4 th of the rural sick seek private medical services). Even if there is a full scale nationalisation of health services, there has to be some way of dealing with this sector except when one is proposing to do away with this sector with some method not known today.

Till then, the rural people - poor as well as rich or not so rich - are going to suffer at the hands of the private medical practitioner. True, there are a lot of undersirable things that come with his being a 'private' practioner; but there are many ills attached to his 'medical' status also; and it is to this latter aspect that I am addressing to in this article.

First of all let us examine the fibre of these 'medical' services' In rural areas - or 'periphery' to be more true to professional medical jargon - most doctors are non-allopathic. It is surely so in Maharashtra and should not be far from the truth for other states also. The numbers of medical practitioners in the rural areas are directly in proportion to the general cash-flow level in the area, the population, proximity to big cities etc. In Junnar block near Pune - this is what I have heard - there are about 150 medical practitioners; while in my own block there are about fifty. These include about 5 % of allopaths (graduate, post - graduates) and then Ayurvedics, homepaths, electropaths (?) R. M. P. s etc. Their knowlege about allopathic science is obviously very poor and largly comes from observation of senior pravite practitioners with whom they had chanced to work after graduation and from the medical representatives. This, plus their own perceptions in practice make a strange 'masala' of general practice offered to the hapless rural masses. Large and easy everyday earnings make this masala all the more fixed. There could be some exception to this kind of practice but this is what generally prevails here. Absence of clinical diagnosis is made good by using

aggressive medication/prescriptions without any heed to science or ethics of medicine. In Maharashtra atleast, use of remedies from the respective science of healing (that the practitioner belongs to) is hardly ever seen.

Thus the situation can be summed up as - most of them non-allpaths; but all of them using mordern medicene without any rationale.

Can we imagine the result of this revolting situation ? I see that simple malarias continue to get antibiotics for weeks & weeks, fungal infections of groin branded as STDs and patients bled for money, uterine irritability in pregnancy given methergin injections, children with bladder-stones given large infusions to expel the 'obstruction'; acute meningitis cases being given fast infusions causing deaths, meningitis cases being treated without any diagnosis, diarrhoeas geting all kinds of antibiotics, gastro cases with renal shutdown not getting so much as a lassix injection (Rs 2) to save the kidneys, PEM babies being given all kinds of things except correct nutritional advice, Tuberculosis cases being treated with cough mixtures and so on and so on. Add to this the woes of our village women who don't even see anyone around to tell about their Gyneac complaints. There is little if anything by way of clinical diagnosis and the management of illnesses is often less than what a better trained ANM/VHW should be able to offer.

So is it not only exploitation of poor rurals but injury too, and it is not profit-motive alone that operates this but a mighty ignorance of medical science on the part of the rural medical practitioners coupled with an abysmal illiteracy in the rural community about matters related to health and medicine.

For those who choose to ignore this sector under the cover of 'private enterprise' and its profit motive, the answer is a simple ban on all this. But having worked both as a medical officer staffing a govt. health center myself and as a medical practitioner in the 'periphery'; I see a simple - if partial and limited - measure of orientition & training of this sector in the basics of modern medicine, its strengths & limitations, as a necessary step. I am aware of the criticism this attracts - that this rationalises malpractices etc. - but insist that all the ills of rural medical sector are not because of privatisation alone. Ignorance is also an important factor coupled with inactive & apathetic state medical apparuts that has little to do with anything more than F.P. and 'vertical programms'.

In fact such courses are no doubt essential for many allopaths is another point. But a short term crash course - a compulsory one - with a well worked out detailed programme shall serve as an important step to evolve mechanisms to regulate this anarchic sector. This will benefit rural patients much more than the practitioners themselves. Further, there can (and has to be) a consensus list of drugs & procedures that these practitioners can employ. Prescriptions/purchases beyond this list should be treated as transgressions. If these two measures - training courses coupled with regulating use of drugs etc. - are effectively employed, the rural community shall be at least partially relieved of the prevailing malpractices. I do feel that not all 'other' practitioners are tendentiously reckless or compulsive antisocials, and many of them shall welcome such trainings and facilities; at least the new-comers shall surely do. Effective legislation & regulation should iron out many things. What remains is the privatisation factor which needs discussion that is beyond this article.

A tangent, not wholely out of the context, is the retraining of allopathic practitioners. In the day to day general practice, some of us increasingly feel the limitations of modern medical science in various situations and the need to resort to alternative therapies. Without elaborating on this, I would like to add that allopaths - general practitioners - also need some measure of 'alternatives' training. It is possible to institutionalise this in the same fashion as above.

Lastly, in conclustion, I would like to restate that in the absence of any long term policy perspective on the rural private medical sector (nationalisation etc.) it would be a folley to ignore and wish away this sector when we think of rural health services. It is necessary to take a pragmatic - if short term - position on a sector that is far bigger and important as compared to the state sector in the eyes of the rural community.

Dear Friends,

This is infact the last minute version & the bulletin issues that were due for sometimes. From Jan 91, the publication printing and all the business of the bulletin is with us at Nasik. Pending some formalities the regular bulletin issue could not be finalised. This mail carries the background papers prepared for the Annual Meet (Jan 91). From the next month— i. e. Feb. 91, you shall be receiving the bulletin regularly.

Wishing you all a Happy Year.

(Editors)

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Jan 7th, 91

The Declaration of Alma-Ata

Primary Health Care is the key to health for all

In a world in which four-fifths of the population has no access to any permanent form of health care, and in which millions more are disenchanted with the service provided by conventional health systems, primary health care is the key to achieving an acceptable level of health for all. The International Conference on Primary Health Care, held at Alma-Ata in the USSR from 6 to 12 September 1978, drew up the fundamental principles of this far-seeing concept and embodied them in The Declaration of Alma-Ata. Urgent national and international action is needed now to translate these principles into dynamic, practical programmes.

WORLD HEALTH ORGANIZATION • UNITED NATIONS CHILDREN'S FUND

Declaration of Alma-Ata

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

Jointly sponsored by WHO and UNICEF, the International Conference approved the Declaration in the V.I. Lenin Palace at Alma-Ata, in Soviet Kazakhstan. (Photo WHO)

I

The conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic condition and socio-cultural and political characteristics of the country and its communities, and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

* *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration. ■

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THE NEW ORIENTATION OF HEALTH SERVICES, WITH RESPECT TO PRIMARY HEALTH CARE WORK

The booklet entitled "Health Work for Human Development" contains the conclusions reached by a Working Group set up by the Pontifical Council COR UNUM in 1976 in order to examine Primary Health Care.

A second group was convened in Rome from 31 March to 2 April 1977, to examine the new orientation of health services to fit in with this Primary Health Care policy.

Experts drawn from many different areas of the medical and health care profession put forward their viewpoints based on their own experience and research in a very useful series of discussions. They looked at Christians' responsibilities and those of the religious congregations in the light of the new orientations. Being all too aware of the way in which situations can vary one from another, and of the complexity of the problems, they rejected the idea of prescribing formulae or methods to be used. Any comments made regarding structures at whatever level were only attempts to summarize the problems in order to be able to search for the most suitable solutions.

I. THE CHRISTIAN APPROACH

1.1. The attitudes taken by Christ

Christ took pity on people and came to their aid, whether they were spiritually ill as a result of sin or physically sick. His attention was given to the sick person with whom he frequently talked, showing his preference for the poor, but without excluding anyone in need who appealed to him. Accounts of his mira-

she have been recorded where he restored people to health, teaching us that we also, with whatever means we have, must be concerned for those who suffer sickness, and do what we can to comfort and heal them.

1.2. *Populorum Progressio*

Jesus considered suffering and sickness as forming part of the "less human" situations which the Encyclical "Populorum Progressio" asks us to endeavour to make "more human" (cf. *Populorum Progressio*, 20). If we wish to be faithful to Christ and take up his attitudes with regard to our fellow-men, we must work for the overall development of each man, and focus on the sick person more than on his sickness. Since development also means solidarity, we must necessarily turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village. This means we must practise community medicine.

The "quality of life" of his environment is important to ensure that the sick person will be restored to physical and psychological health, so that with the aid of his human community he can duly take charge of his own evolution towards a more human state, thereby becoming the craftsman of his own development.

The grassroots community responsibility for Primary Health Care work has the advantage of following the principle of subsidiarity. Health-care personnel, following this principle, serve, at the same time, their own personal development.

Mastering their impatience, they listen and learn before they organize. They are more concerned with fostering action than undertaking it themselves.

1.3. *Evangelii Nuntiandi*

As Christians, we are evangelizers, as the apostolic exhortation "Evangelii Nuntiandi" reminds us. We are bearers the Good News, of the whole and jointly responsible salvation of men in Christ. We proclaim this Good News through the witness of

our lives, and by taking up the caring attitudes manifested by Christ towards each person, his environment and his traditions. Through us the Church evangelizes man and their communities. Through us and our commitment to health-care work, the Church proclaims evangelical liberation to the millions of human beings whose physical and spiritual health is affected.

1.4. *The need for conversion*

The mission that we have been given is a call for a true conversion of our hearts and also of our methods. Secularization is spreading in people's hearts from the industrialized and technological world to the developing world countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work, will discover the love of Christ. The rapid development in the field of health service technology has often meant installing expensive equipment in the hospitals, requiring a large number of staff for a relatively low number of patients, while in many of the same countries in the world, up to 80% of the population are still without health-care services. Since Christians are the leaven, we must reach out towards the masses by providing simple, accessible and promotional health care according to our own possibilities, modest as they are, or in collaboration with the public services, where this is allowed.

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. Community health care is therefore part of the comprehensive pastoral work of the Church.

2. PRIMARY HEALTH CARE IN THE LOCAL COMMUNITY

2.1 *National health service policy*

Any primary health-care organization in local communities must take account of the health service policies laid down by the authorities of the country in charge of the general running of health services.

2.2. *The basic principles of W.H.O.*

The organization of primary health care services must help each individual person in his own community. The true needs of this community must be taken into consideration and it must be encouraged and helped into contributing to its own development. Primary health care brings health services to the patient and is concerned with prevention of disease as well as early treatment where this is needed. In this respect, we follow the basic principles laid down by the Executive Council of the World Health Organization at the January 1975 meeting in Geneva, ratified subsequently by the various governments concerned:

1. Primary health care should be shaped around the life pattern of the population it should serve.

2. The local population should be actively involved in the formulation of health care activities, so that health care can be brought into line with local needs and priorities.

3. Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are often present.

4. Primary health care should be an integrated approach of preventive, curative and promotive services for both the community and the individual.

5. All health interventions should be undertaken, at the most peripheral practicable level of the health services by the worker most simply trained for this activity.

6. Other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervision and referral support.

7. Primary helath care services should be fully integrated with the services of the other sectors involved in community development (agriculture, education, public works, housing and communication.)

2.3. *The local community*

It is vitally important to be aware of the sociological situation of the community. This includes the composition and growth trend of the local population, its traditions and customary laws, the various social and economic problems and all the conditions on which the overall and balanced development of the community depends, including its health—an integrating factor which cannot be neglected.

The members of the community must be helped, where necessary, *to become aware of their own problems* and to express them so that, here again, they become the craftsmen of their own development. They alone are in a position, for example, to explain why they are afraid of the hospital, why they seek medical care late in the day, why the womenfolk prefer to give birth at home, what dying with dignity means to them, surrounded by their family, etc.

2.4. *The community health worker*

These profoundly human factors make it possible to share out the responsibilities for organizing primary health care. There is a wide variety of different things to be done, and some of them were brought to the attention of the Working Group. In the examples which follow, there is no desire to impose a specific pattern or model for the programmes which are to be implemented. They are simply a way of illustrating what a primary health care service in a local community can be. In some countries, a grassroot *Community Health Committee* is formed whose members are chosen by the community. They may be dignitaries in the community, government officers, etc., or simply persons whose personality or capability makes them suitable for such a task. This Committee makes known the health care needs of the people they represent and appoints the *community health Worker*. Whatever be the title given to this person, and this varies in different countries, he or she is the one selected by the community. He (or she) is given the basic training to be able to provide primary health care, usually on a part-time basis, while still continuing his/her normal daily work.

The health worker's tasks depend upon local conditions, but in general they may be summed up in the words of the WHO in "The Primary Health Worker" (Experimental edition, 1977, pp 4-5).

"1. care for the health of the inhabitants and look after community hygiene;

2. give care and advice, in accordance with the instructions written down in the guide or given by his supervisor, to anyone who consults him;

3. send patients to the nearest health centre or hospital in any case in which the guide instructs him to do so (evacuation or referral) and in any case not covered by the guide. The PHW should therefore confine his care and treatment to those cases, conditions and situations described in the guide;

4. with authorization from the local authorities, visit all dwellings and give those living in them advice on how to prevent disease and foster good habits of hygiene;

5. make regular reports to the local authorities on the health of the people and on conditions of hygiene in the community. Get the local authorities and the people to give him the help and support he needs for his work;

6. keep in as close contact as possible with his supervisor so as to be able to give of his best in his work and to obtain the equipment and supplies he needs;

7. promote community development activities and play an active part in them."

The training required, which may be graded in complexity, should initially be given on the spot by slow and gradual training process, given while actually "on the job". Unless the individual concerned is so talented that the training is going to be followed up at a later stage to "professional" level, the training should not be so advanced that the individual is pushed beyond his capacity. Sometimes it is a good idea to train local healers or traditional

"doctors" to become community health workers, if they are willing.

Although each community is called upon to look after its own health care problems with its own means as far as it is able in accordance with the principle of subsidiarity, thereby enabling it to work out its own development, it should not be loaded with so many responsibilities that it finds it cannot cope with. The public authorities, who have drawn up an inventory of the *immediate resources* available (personnel, drugs and medical supplies etc.) must allocate them fairly for the benefit of the local communities as well.

3. QUALIFIED HEALTH SERVICE PERSONNEL

Each individual country has the task of determining *the type of personnel* required, and their respective role, in the light of the training to be given. A great many experiences and ventures undertaken in the past have shown that a unified *terminology* would be very helpful and in this, assistance of WHO would be appreciated.

We simply wish to mention certain constants that our own experiences and generally recognized requirements have shown to exist in the various types of personnel required, and their respective tasks. These constants will enable us to see in what directions we should be moving in order to play our part, especially since we are often numbered amongst the promoters.

3.1. *Health care auxiliaries*

One of the first levels of health service personnel is that of auxiliaries, whose responsibilities, recruitment, training and motivation need to be examined. These are people who should be able to undertake tasks on their own. They also have to assist the doctor in perform many tasks in preventive and curative medicine. They work both in medical centres and with the community health workers. The latter's training may be given by certain auxiliaries, whose supervision they will accept. This supervision not only gives them security but also provides them with on-going training, since it is not so much a question of

controlling them, as counselling them as they carry out their work. The auxiliaries are recruited both from those who apply for the work directly, or who are nominated by the local community, as well as from among those community health workers who show the right sort of ability and know their human environment sufficiently well. It must not be forgotten, however, that they do not always continue their work on a long-term basis, and this is a cause for concern.

Their training, which should be also given on an ongoing, continual basis including the period they are actually performing their health care work, can be at various different levels of skills and responsibilities. It should be provided by professional personnel such as the medical team that supervises them. The responsibilities which are entrusted to the auxiliaries under this new primary health care policy demand serious motivation. They must consider their function not so much as a form of personal development as a service to the community. It is a service which demands the highest moral conscience if dangerous deviations are to be averted. The auxiliaries must never lose sight of their own limitations in terms of medical skills, and of their need to be in continual training. Their professional conscientiousness must constantly keep their spirit of service alive in their minds.

3.2. *The nursing staff*

On account of their qualification and skills, nurses frequently have to aid the local people to grasp the fact that their health is in need of attention, and to encourage them to aspire to improved health and a changed way of living. Since they will give top priority to prevention and health education, they will also devote their efforts to training community health workers and auxiliaries. They can be helped by the qualified midwives who can undertake some of the same tasks, and they also assist the doctor in organizing primary health care services. This new role for nursing staff of both sexes, and of qualified midwives, demands the right training on a continuous basis, as well as deep motivation. This is a need of all the health care personnel.

3.3. *The doctor*

This new health care policy alters the role of the doctor, but does not make it any the less essential. The doctor needs not only new motivation, but a training that will enable him to respond to all the demands that will be made on him as a member of a health care team. He must be capable of coping both with challenges of sickness and those of under-development. He must learn to consider his vocation as a doctor as a call to be of service to the community rather than a means of personal development. The reluctance to go out and serve in rural areas, which is far too widespread, has to be overcome.

3.4. *The health care team*

Since the health care is entrusted with the task of promoting health in a context of true community development, and it is not merely a means for accomplishing routine work such as distributing medicine, there should be a genuine team spirit among them.

This health care team usually comprises the following *members* : the doctor, the nurses and the auxiliaries, and also the community health workers and traditional midwives. The fact that they have different educational background and training, different tasks to perform and different degrees of commitment to the service of the sick and their communities, sometimes inevitably leads to tensions or psychological conflict within the health team. It is the leader's responsibility to restore harmony, if he is unable to prevent them occurring in the first instance.

The responsibilities of this health care team include planning the various tasks the team has to carry out. The team must also provide medical treatment, nursing care, hygiene education and be sensitive to the psychological problems and comprehensive needs of their fellow-men. This shows how important it is for the members of the team to have a complementary training and background.

4. THE THINKING UNDERLYING THE CHURCH'S NEW APPROACH TO HEALTH CARE

The emphasis given to the new primary health care policy has shown the vital importance of a whole motivational approach

on the part of those who work in the health field or for health improvement. Unless this new approach on the part of the personnel is inculcated through special courses that need thorough planning and implementation by highly qualified staff, the new orientation to be followed by the various health services will simply not come about. The "Christian approach" outlined above looked at the motivation underlying the Church's particular interest in this new approach to health services for which the Church and its personnel take on direct responsibility.

4.1. *The health care centre*

The health care centre stands midway between the village and the hospital, and must have a dispensary with a few beds for emergency admissions. The number of emergency beds will depend on the population served by the centre and the distance from the nearest hospital. The team must look after a certain number of villages which will be using their services for more complicated cases; the centre is in charge of preventive, curative and development work.

The team must also help the community health workers in the various communities by providing them with continuous advice, supervision and supplies.

A team motivated and oriented in this way will really participate in the implementation of the new health care policy.

4.2. *The hospital*

The rural hospital is the point of reference for a number of health centres which refer the patients they cannot handle to it, or those in need of surgery.

The hospital team is most important. It must look after all the hospital's needs, as well as provide continuous training and supervision to its health care centres. It may be called upon to make up mobile health teams. Eventually these may be nucleus of a new health care centre.

Where the team includes a pharmacist, he or she can help in the training of personnel and, where appropriate, can help sta-

cate the local people in basic public health, hygiene and simple nutrition, though this latter is more usually done by a nutritionist.

The category of personnel known as health inspectors can be very valuable members of the team and provide aid both to the health centres and the community health workers.

To the hospital team falls the responsibility of handling the hospital administration problems. Where the hospital falls under the responsibility of a *Board of Governors or Directors*, a Management Board or a similar kind of body, the local communities must be represented on it.

The doctor and one paramedical staff representative are habitually ex officio members of such a board.

In a larger town there is usually a regional hospital to which the rural hospitals in its catchment area refer the patients whom they are unable to treat themselves. The medical team in these hospitals needs to be larger and more highly qualified to be able to meet all of its responsibilities. In order to avoid overburdening this hospital with the basic needs of the local population, it may have an annexed dispensary, either adjacent to it or even in another part of the town.

4.3. *Childbirth*

A new orientation could also be introduced in the case of maternity units which would only be used for the difficult births. Very serious difficulties would of course be referred to the hospital. Childbirth could normally be organized in the mother's home once the health care services really do cover the whole of the local population, particularly through careful training given to the traditional midwives. Maternity units can be independent units or wards attached to the health centre.

The maternity units also have the task of training the midwives. Part of their instruction should include the teaching methods by which they can help their patients toward responsible parenthood using natural methods for child spacing in the general context of the promotion of the family.

5. CHRISTIANS' RESPONSIBILITIES

5.1. *Evangelical motivation*

Christians are citizens just like anyone else, and must be committed to the struggle against under-development. The example and the teaching of Christ and the exhortations of the Popes shed light on this commitment and serve as a guide and encouragement to them in their work which they undertake for the love of God and their fellow-men. If they work in the field of medicine and nursing, the evangelical reflections mentioned at the beginning will lead them to ongoing conversion of heart to provide a better service on behalf of the suffering members of Christ and to awaken the communities of men to their responsibilities in this area.

5.2. *Relations with the government*

In the past, the laity or members of the religious congregations have often pioneered health care work in many countries. In some instances today, their work is being taken over by the government which sees health work as a part of its duty towards its citizens and for which it accepts responsibility. Far from feeling discouraged or useless as a result of this new state of affairs, they must see it as a golden opportunity to play an active part in the national endeavour to bring about integral and mutually responsible human development.

The religious congregations are called to reinforce their basic attitudes of cooperation with all organizations at whatever level, and in particular with the governments. This cooperation, respecting the specific role of all concerned (for example, the creation and constitution of the religious should always be offered with the one concern of attending to the true needs of the sick and their communities.

The hospitals and health care centres for which the congregations are responsible and where they provide a Christian spirit of service, are there for the benefit of the whole population without any racial or religious discrimination. They must be ready to provide their services in those areas out of reach of the public

health network, insofar as their personnel and financial resources permit.

Where they run schools for nursing or auxiliary staff, the training curriculum, animated by the Christian spirit, must conform to the requirements laid down by the government, so that the personnel trained there will have a state-recognized qualification and can, one day, join the public health service if they wish. Wherever religious personnel undertake tasks alongside professional people in the public sector, they must demonstrate their constant concern to be fully integrated into the medical teams running the areas in which they work.

5.3. *The current situation*

While this new primary health care policy is taking shape, members of the religious congregations must take a good hard look at the current conditions under which they are working in order—where necessary—to re-direct them. It sometimes happens that as a result of changes which not everyone is necessarily aware of, too many of their work in hospitals and health centres that have become too expensive for the majority of the population, and are only within reach of the pockets of a certain "elite" who can afford them. In this case the leaven is too far removed from the loaf.

5.4. *New orientation*

The religious congregations are by no means ill-equipped to take part in the necessary new orientation process. Although it may happen that in some cases some of their hospital workers are somewhat distant from the masses, so many others are working closely with local communities and are in close contact with the people in rural areas or poor urban areas.

Their experience can be profitably used by everyone, since they really know the true needs and deep-seated aspirations of the local people. Before they take part in this new health care policy, those in charge of religious congregations must see if they have the necessary means to do so, especially in terms of manpower, trained and suitable for the work, and with the right motivation.

Having *the right kind of training* for the personnel will be valuable to the country. Special care must be devoted to training foreign[1] personnel so that they have a good knowledge of the environment and the psychology of the people with whom they will work. Local and foreign[1] personnel must be spread over the various services in the local community and the hospital according to their skills and qualifications so that the population everywhere may have increasingly free access to health care services. They must never forget that they have the duty to aid everyone to develop wholly, bearing in mind that all development is a community matter, in a spirit of mutual respect and brotherhood.

Religious congregations, therefore, have a chance here to play a role of *promoters* and pioneers in the health field by educating some of their members for the important tasks in the primary health care field, such as public health specialists trained to implement this new health approach as well as skilled in planning and running staff training courses.

CONCLUSION

By setting up a hierachy of values and a policy regarding the means to be used on behalf of the sick people requiring care and the human communities needing to be helped to reach their full development, the Church has already provided a substantial contribution. It is ready to do even more in order to bring health to the sick and to awaken the conscienec of the people. Working on behalf of the very poorest, the Church is enabling them to know their essential needs and to undertake the responsibility for their own development in a healthier existence.

[1] *(The word "foreign" here refers to non-local personnel)*

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On the basis of the findings of the Group, the Secretariat of COR UNUM is producing the present pamphlet whose text was reviewed and approved by the Council's Plenary Assembly (3-6 November 1977).

HEALTH FOR ALL - ALL FOR HEALTH

KNOWLEDGE ON HEALTH IS EVERYONE'S RIGHT

INFORMATION KIT — MARCH 1988

MESSAGE FROM

DR S ED KD

Regional Director
World Health Organization
Regional Office for South-East Asia,
New Delhi

It is well known that with the lamp of knowledge the darkness of ignorance, superstition and disease are soon dispelled. Knowledge, therefore, has been long recognized not merely as an effective tool, but as a powerful weapon in the war against poverty and disease. Thus, it was only logical that the historic Declaration of Alma-Ata while defining the eight essential elements of primary health care gave pride of place to "education concerning prevailing health problems and the methods of preventing and controlling them."

As Member States of the World Health Organization strive to achieve the goal of Health for All by the Year 2000, it is becoming increasingly clear that concerted action is required by all to achieve the cherished goal. And this is where knowledge on health assumes a vital role. Since prevention is the cornerstone of effective health care, it is all the more important to equip people with the right information and knowledge to enable them to make the right choice with regard to adopting healthy behaviour and life-style. What is necessary to keep in mind is that the promotion and protection of health is not an expensive proposition. Staying healthy is within th reach of all, requiring simple measures that can be carried out by individuals, families and th community, using local resources.

A beginning has to be made by those concerned with health development to ensure that relev knowledge about health reaches the people, so that they can all become partners in achieving g health for themselves, the whole nation and therefore, the world.

WHO40/1988/March/1

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The WHO Constitution states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social situation. Since health is largely dependent on individual, family and community-action, dissemination of knowledge on health, mobilization of public opinion with community-based education for activities designed to protect and promote health assumes added significance.

HEALTH A HUMAN RIGHT : KNOWLEDGE A TOOL TO HEALTH

The experience of two world wars resulted in the widespread conviction that effective international protection of human rights was one of the essential conditions for international peace and progress. This conviction was elaborated in a number of statements, declarations and proposals made by the United Nations.

Paragraph 1 of Article 25 of the Universal Declaration of Human Rights proclaims: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

Under Article 12 of the international covenant on economic, social and cultural rights, states parties recognize the right of every one to the highest attainable standard of physical and mental health and agree to take steps to achieve the full realization of this right, including (a) the provision for the reduction of the still birth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions which would assure medical service to all and medical attention in the event of sickness.

HEALTH FOR ALL BY THE YEAR 2000

The role and function of health in development has been debated for sometime. It is now recognized that health programmes are necessary to meet human needs and are an essential component of economic development. Happily, two very important concepts relating to the human right to health have emerged in the Alma-Ata Declaration. (a) The social target of health for all by the year 2000 and (2) the primary health care strategy, which is essential for health. Among other things "health for all" embraces the following ideas:

1. Every one without exception, has the right to health care.

2. Every one without exception has the right of access to the different levels of complexity of the health system.

3. Every one without exception, has the right to live in a cultural, social, economic and physical environment inherently conductive to health.

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4. Every one without exception has the right and duty to be an active and decisive partner in looking after his or her own health and that of the community.

5. There must be a significant reduction in the enormous and disgraceful differences in the health levels of different population groups, both between countries and within countries.

6. There should be a significant reduction in the enormous and disgraceful differences in the way national societies allocate resources for the health care of their people.

7. To sum up, "health for all" is a concept that incorporates a way of implementing a human right - the right to health - within principles of universality, equity and social justice.

PRIMARY HEALTH CARE

The concept of primary health care based on the following essential components:

1. It is an approach that should enhance the entire health system of a country.

2. It is based on the active and responsible participation of the people - individually and collectively - at all levels of complexity of the health system and in all the processes that make the system work.

3. People's participation, real health needs, and the actual resource for the countries and their local communities should govern the type of technology to be used by the health system at its different levels. That is why appropriate technology is included in the concept of "primary health care".

4. The above elements indicate the absolute necessity of multi-sectoral action.

5. The above components also govern the absolute necessity of gradually delegating responsibilities for health activities.

6. Finally, "primary health care" must be a component of and never isolated from a national socio-economic development strategy.

KNOWLEDGE - A TOOL TO HEALTH

Since health is largely dependent on individual, family and community action, it is necessary to inform, stimulate and assist people to adopt and sustain healthful life practices in order to maintain and promote their health and to judiciously use the available health services. Knowledge and education for health should always be considered as tools to encourage behaviour changes to help reduce the incidence of specific diseases, create awareness about one's own life style and motivate the people to participate in a dynamic relationship with the health system and bring changes in the environment. This is the reason that the Declaration of Alma-Ata on primary health care mentioned education concerning prevailing health problems and the methods of preventing and controlling them as the first of the eight essential components of primary health care.

CONCLUSION

The 161 member countries of the World Health Organization by acting jointly and collectively through their Organization acknowledge in practice what is stated in the preamble to the Constitution "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

HEALTH FOR ALL – ALL FOR HEALTH

KNOWLEDGE ON HEALTH IS EVERYONE'S RIGHT

INFORMATION KIT — MARCH 1988

The art of transmitting information, ideas and attitudes differ from country to country on the basis of advances made in communication technology during the last few decades. However, the realities of third world call primarily for a radio system that reaches more people than any other medium. It also needs a blue print of planned health activities for the use of the media for community participation.

COMMUNICATION TECHNOLOGY FOR HEALTH

"Communication" is derived from the latin word "Communis" i.e. common. When we communicate we establish commonness with someone i.e. we try to share information, an idea or an attitude. In the context of primary health care, communication is a process that extends beyond the confines of an organizational structure and reaches the people as primary health care does. Media plays an important role in the dissemination of information and creating awareness if planned properly.

In the South-East Asia Region the usability, relevance and comprehensiveness of the health information which the health workers pass on to the people depends largely on the information about the programme which they receive from their superiors or during training. If the information passed on to the people through the mass media generates understanding or even raises doubts for which answers are sought and found with health workers, it can be assumed that there has been coordination and communication between media organizations and the department of health. This intra- and inter-organizational communication is crucial to the success of the scheme.

COMMUNITY INTERACTION WITH MEDIA

The media habits and communication characteristics of the people are important factors in awareness, perception, dissemination and use of information. Though the people may have access to media, a negative relation or habit towards it make the access useless. Utilization of the mass media is low except for the influence of radio on agriculture in some countries. Other printed matter such as newspapers, magazines and books are not of much use in the rural areas due to very low literacy. It seems that with the exception of radio, whose performance is very heartening, little adoption of practice has taken place because of mass media.

FILM SHOW

A 'film show' in the village is rare. Its screening is a festive occasion. The limitation is that a simple film show cannot be used to determine media habits.

NEWSPAPERS/MAGAZINES AND BOOKS

There are some people who would like to learn from newspapers, magazines or books, but their inability to read eliminate them from media usage. This gap can be bridged by electronic media like radio and television. Newspapers are read mostly for political news rather than information on health.

POSTERS, WALL PAINTINGS

This is the most widely known media but not much understood. This is mostly election, health and agriculture-related.

TELEVISION

Television is the "youngest" medium available for disseminating information. It has a marked advantage over other methods of "extension". However, its potential can only be realized when the quality of programmes and administration are linked with audience need, relevance of messages, timeliness etc. Television is not available in all the countries and wherever available it is confined to the urban population. The situation is redeemed by isolated appreciation of programmes on epidemics, nutrition, child rearing practices and family planning. The programmes dealing with methods of raising income are most popular. Among all the programmes agriculture figures most prominently while programmes on health and hygiene take low priority.

RADIO

Most countries in South-East Asia are passing through a "transistor revolution". The rich generally own sophisticated radio sets while others have the domestic products. Generally, familiarity with the equipment is so low that the manipulation of the transistor set itself is a great 'leap' in experience; many are unaware of how to switch to different channels.

A recent study of broadcasting revealed that a major problem faced by listeners was non-availability of dry cell batteries. Due to poor reception conditions the receiver had to be tuned to 'full power' which rapidly consumed the batteries. This led to an increase in costs which made even the 'low cost radio' too dear for many.

The expanding radio audience in Asia also creates a dilemma at the level of programming. While on one hand there is pressure on the broadcasting authorities to use this facility for "instructional broadcasting", on the other, there is a demand for entertainment and religious programmes. The problem is in finding the right balance.

DISTANCE TEACHING

Use of telecommunications to extend services to rural areas is an important development in the field of distance teaching. It encompasses correspondence education, adult education, higher education, educational technology, inservice training and nonformal education. It's utilization in the field of health, however, is not significant.

TRADITIONAL FORMS OF COMMUNICATION

The mass media were in a nascent stage when most of the developing countries were struggling for independence. It was through group discussions, mass meetings and the traditional media that the leaders of the movements established effective rapport with the masses. The theatre, art, folk media and other traditional forms of communication are very much accepted by the rural masses as is evidenced by their participation during important socio-cultural events. Traditional art forms have a great potential for establishing links with the masses and getting their whole-hearted participation in the health care system.

HEALTH WORKERS

At present communication does not emerge as a planned activity either within the health care system or by extension, between primary health care activities and the people they are to serve. Middle level health workers tend to depend mostly on their own functionaries and the health infrastructure. In both cases, however, integration with formal media and communication agencies is very low.

As in the case of the media, the data on health programme activities indicate that provision of information does not always result in action. Practice of an idea is related to the source of its awareness. Agriculture is seen in every day life, and most often discussed with friends, relatives and neighbours since it is central to existence. Health is considered relatively less important to the rural economy and the sources of information are traditional healers or area health workers.

CONCLUSION

In order to ensure that communication truly fulfils its function, it is essential that the process is integrated with the health care system itself. Only when communication becomes a two-way channel can its potential as an agent of change be effectively tapped. And yet, in the process of information dissemination and creating awareness among the people what needs to be ensured is that these developments are matched, if not preceded by provision of adequate health facilities. There is nothing worse than creating an awareness or need which cannot be met in reality. Communication, therefore, can only aid, but never replace health care.

HEALTH FOR ALL – ALL FOR HEALTH

KNOWLEDGE ON HEALTH IS EVERYONE'S RIGHT

INFORMATION KIT

MARCH 1988

Knowledge on health is everyone's right, but it's dissemination alone does not change health behaviour. It is a complex process. At the macro and meso levels, the modern communication media may be effective in creating the necessary awareness among the masses, but at the grassroots and micro levels it is the trained health and health related workers who can effectively disseminate the required information through village leaders, social workers, existing social institutions and traditional media. They should also be equipped with necessary skills to support the community in the decision making process so that the people can participate effectively in their own health care system.

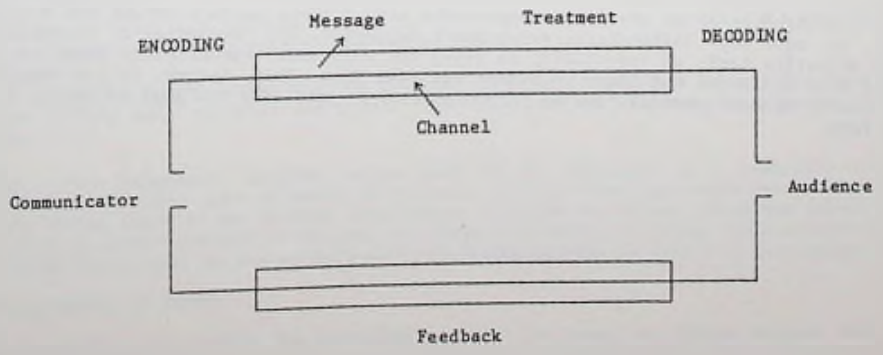
THE IMPACT OF NEW COMMUNICATION TECHNOLOGY ON HEALTH IN DEVELOPING COUNTRIES

Knowledge on health is everyone's right, but how this knowledge can be transmitted to the people so that they act on it to achieve some useful results depends on a variety of factors, including the process of communication. What channels and media are to be employed in the process? What approaches, techniques and strategies are most successful or most appropriate for a given situation? These are the questions a social engineer will have to answer.

KEY ELEMENTS OF COMMUNICATION

Successful communication requires a skillful communicator sending a useful, effectively treated message through proper channels to an appropriate audience that responds as desired. The communication task thus consists of skillful handling of the following elements.

KEY ELEMENTS OF COMMUNICATION



WHO40/1988/March/4

NEW COMMUNICATION TECHNOLOGY

Today we all are aware that satellite communications span tremendous distances. "Non-broadcast technologies" have increasingly become more accessible and less expensive as modes of information delivery in the industrialized world. During the 70's, the availability of commercial satellites, new cable systems offering 80 or more channels and high capacity computer networks hold promise for offering new communication systems for specialized needs at relatively reasonable cost. Technologies that seem most significant today were little more than laboratory developments or systems in their early experimental stages in the 60's.

IMPACT OF NEW COMMUNICATION TECHNOLOGY

If the people are to participate in their health care system, they must be "in the know" of things so that they can understand and plan for their own health care. This is more in the nature of education than simple publicity.

In turn, the response of the people to health care programmes must also be conveyed to the health authorities for their education and necessary modifications. Such a process ensures that the viewpoint of the community is always reflected in the health plan. This broad educational process which brings the planner to the people and vice versa for mutual learning and facilitates behavioural change both in individuals and the organisations is termed communication.

In the context of primary health care, communication is a process that extends beyond the confines of an organizational structure and reaches the people just as primary health care does.

RADIO NETWORK

Twenty years ago radio and television were heralded as the means to make the deserts bloom, eradicate diseases and promote literacy. They did not. In the 1980s there is talk of the "barefoot chip". But the realities in developing countries call primarily for utilizing the existing radio network that reaches more people than any other medium.

At the macro and meso levels, the modern mass media may be effective in creating the necessary awareness among the masses about the health situation and Health For All by the Year 2000 as a part of overall developmental strategy. But at the grassroot and micro levels, in a majority of cases it may not be possible to provide information support through the modern media except through radio to some extent. Thus health and health-related workers have to be trained in the technique of effectively disseminating the required information through village leaders, social workers, neighbours, friends, existing social institutions, developmental agencies and through the available traditional media.

CONCLUSION

The realities of the third world, our world, make it imperative that the communication revolution is viewed objectively. It is easier to communicate with someone halfway across the world through satellite, but much more difficult to reach one's neighbour. The revolution in communication can become an effective tool, an opportunity to reach out only when communicators learn to establish communion with audiences and learn to become one with them. That, indeed, is the challenge, and the opportunity to make communication an effective tool in achieving the goal of health for all by the year 2000.

HEALTH FOR ALL – ALL FOR HEALTH

KNOWLEDGE ON HEALTH IS EVERYONE'S RIGHT

INFORMATION KIT — MARCH 1988

With diseases that can be directly attributed to behavioural patterns the process leading to action is more complex and more difficult to define. Many obviously harmful practices have been a part of everyday life and need to be altered if not dropped altogether. There are many factors responsible for failure. In this context, there is urgent need for a free exchange of knowledge. People need health-related information on:

(a) What is the problem or where does the problem lie?
(b) Why did it occur and why does it persist?
(c) What are the best ways of solving the problem?

Once this is done, it will become easier for people to recognize how they can promote and preserve their own health and the health of the community.

MAKING HEALTHY BEHAVIOUR A WAY OF LIFE

There are many living things and non-living substances that are either good or dangerous to health. Natural events and man made environmental factors also have a close bearing on health. In addition, there is another factor why people stay healthy or, on the contrary, become ill. This is their own action or behaviour. If we are interested to help people promote and protect their health, it is necessary that we should also identify the behaviours that cause or prevent illness.

BEHAVIOUR

We have many kinds of thoughts and feelings about the world we live in. These are shaped by our knowledge, belief, attitudes and values, and they can help us decide whether to behave in one way or in another.

Knowledge comes from experience. Beliefs are usually derived from ancestors or respected people. We accept beliefs in faith, without trying to prove that they are true. They indicate what is acceptable and what is not. They may be helpful, harmful or neutral. Attitudes reflect our likes or dislikes. They often come from our experiences or those of people close to us. Attitudes are sometimes based on limited experiences. We may form an attitude also without proper comprehension. Values are the thoughts and feelings to which we attach the most worth, importance and desirability, as, for instance, the welfare of children.

The second behaviour moulding reason is the influence of the persons who are important and generally looked-up to, like parents, religious leaders, teachers etc.

The third underlying factor shaping peoples' behaviour is whether or not they have resources. Resources include man, material and money. Time, location of material or distance also play an important part.

The normal behaviour, beliefs, values and use of resources in a community constitute a pattern or way of life. This is known as culture. Cultures have developed over hundreds of years by people living together and sharing experiences. Cultures do change, sometimes slowly, sometimes quickly due to natural events or contact with people of other cultures. Each culture has its own way of doing things and its own beliefs about why things should be done in a particular way.

HOW PEOPLE DEFINE SICKNESS

Health is viewed differently by different people. In human societies beliefs and practices relating to ill health have been a central feature of the culture. Often these are linked to

beliefs about the origin of misfortune, of which ill health is only one form. In some societies supernatural forces are blamed for ill health. To understand how people react to illness, one has to understand the type of culture that they have acquired. It is also necessary to study the social organization of health and illness in that society, to understand how people define illness and present to 'healers'. Healers are found in different forms in every society. In developing countries traditional healers play important roles. Sometimes they are the agents of social control, helping to label and punish socially deviant behaviour.

We are also concerned with the provider system. The selection of particular methods and decisions concerning their application depend to a great extent on the conditions under which people come into contact with the health care system and economics for the operation.

NEW ERA IN HEALTH CARE SYSTEM

With the Alma-Ata Conference in 1978 and the commitment to Health For All By The Year 2000 (HFA/2000) through Primary Health Care (PHC), a new era in health dawned. Today, health is being shaped as a result of what occurs in our homes, our schools and our places of work. The achievements of the current era are a direct result of our attitudes, habits and behaviour. Our knowledge about the relationships between behaviour and health status is growing stronger. Research has shown that our own behaviour and our own choices are the cornerstones to good health. We are learning how to make important gains in our own health by adopting simple and positive health-promoting habits.

Up to now, a vast share of resources have been invested to improve the availability and quality of diagnosis, treatment and rehabilitative services. Now, however, a shift in emphasis is needed. Future advances in health status and quality of life should come from the efforts we make as individuals,families and communities to improve our present life styles, our own environment and by developing a dynamic relationship with the health care system.

There is need to concentrate our attention and energies on providing individuals and communities with the knowledge and skills necessary to help them assume maximum responsibility for their own health. They need information on socio cultural factors affecting health as well as information based on scientific knowledge on existing risks due to prevailing diseases and how they can be prevented. To reinforce their positive attitude they may be persuaded to get involved in the prevention and control measures.

The people who are at risk have already adopted certain behavioural patterns. Their participation in health promotion, disease prevention, control and rehabilitation activities is important to fulfil their roles. For this the people need to know about the risk involved, what action is required on their part and what the consequences would be if the action is not taken.

Empirical findings have shown that something more is required in addition to knowledge about the risks linked with illness.to successfully overcome them. This includes:

- Voluntary, cooperative participation in prevention and control measures by individuals and the community.
- Commitment to disseminate information and create favourable environment to participate in control measures.
- Viewing disease control as a continuing measures and as an integral part of PHC.
- Maintaining flow of information and ideas between the community and neighbours.
- Search for unreported cases and assistance in survey.
- Family and group support in diagnostic measures.
- Following the drug regimen.
- Supporting for side effects during the treatment.
- Facilities for the transport of patients.
- Use of preventive measures.
- Participation in general sanitation.
- Voluntary participation and training in diagnosis on the basis of early symptoms and refer the cases to health centres.

CONCLUSION

Illness is not only a physical or mental but also a social dysfunction. There are social causes of illnesses influenced by culture in interpreting norms related to health and disease. Patients may be reluctant to walk long distances for treatment. Facilities may not be available in the health centres. Moreover, patients may prefer to get treated by their spiritual or religious healers in whom they have more faith than the practitioners of modern medicine. A doctor with a team of a few health workers may not be able to prevent or control the disease. The entire community must have the necessary knowledge to understand the problem and participate from the beginning in planning and control activities as an integral part of the existing health care system.

HEALTH FOR ALL – ALL FOR HEALTH

KNOWLEDGE ON HEALTH IS EVERYONE'S RIGHT

INFORMATION KIT

MARCH 1988

In search of knowledge and truth man has made endless efforts to break the shackles of ignorance, fear and superstition. Ill health occupies the central feature of this spectrum, shrouded in the clouds of mystification. If the goal of Health for All By The Year 2000 (HFA/2000) based on self-care and self-reliance, is to be realized, there is a need to encourage health literacy and transfer health knowledge and capabilities to every body, from one generation to the next.

SELF-CARE, THE KEY TO HEALTH

Over the ages, through endless efforts made to satisfy his wants, his appetite and wishes, man slowly developed his brain. In the process, he was able to acquire the faculties of reasoning. Ignorance, fear, and mistakes, however, hindered his progress. He was threatened by natural disasters, crop failure and illness as he craved for knowledge and truth. The whole range of these misfortunes was attributed to supernatural forces, and ill health formed the central feature of the spectrum.

UNDERSTANDING ILL HEALTH

Ill health cannot be studied in isolation as it is a part of a wider culture and milieu. It is not possible to understand how people react to illness, death and other health related phenomenon without an understanding of the type of culture that they have grown up in. It is also necessary to examine the social organization of health and illness – which includes the ways that people are recognized as "ill", and the way that they present this illness to other people specially the healers, who are found in every society.

CARING AND CURING

In a lay society when people get sick, they have a number of options open to them. Among these are: self treatment or self medication; advice or treatment given by a relative, friend, neighbour or work mate; healing or health care activities in religious places, cult or self-help group; consultation with another lay person having a similar experience; or medical treatment. In most cases the main domain of health care is the family. The main providers of health care are women, usually mothers or grand mothers, who tend to diagnose common illnesses and treat them with the material at hand, tried and tested through generations.

In certain societies there are special beliefs about the maintenance of health. There are a series of guidelines in each cultural group that lay down behavioural norms for preventing ill health in the individual and in others. They include beliefs about the "healthy" way to eat, drink, sleep, dress, work, play and generally conduct one's life. In some societies, health is "protected" by the use of charms, amulets and religious medallions which are supposed to ward off bad luck, including unexpected illness and attract good luck and good health.

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In most rural areas of developing countries one can find certain individuals with specialized skills in healing. These practitioners of traditional or folk medicine are not part of the official medical system and occupy an intermediate position between the popular and professional sectors. These folk healers share the basic cultural values of the communities in which they live and work. These include beliefs about the origin, significance and treatment of ill health. In societies where ill health and other forms of misfortune are blamed on social causes like witch-craft, the "evil eye" or supernatural causes, folk healers are particularly common. They usually adopt a holistic approach, dealing with all aspects of a patient's life, environment, supernatural forces as well as physical and emotional symptoms. The etiological factors are attributed to immoral behavior, conflict within the family or failure to observe religious practices.

In agrarian societies ill people are usually a part of the therapeutic net work which are connected to all sectors of health care systems. Advice and treatment pass along the links in this network - beginning with advice from family, friends, neighbours, and then moving on to religious or folk healers or physicians. Patients make choices, not only between diagnosis and advice that make sense to them on the basis of knowledge and information they get from various sources.

TERMINOLOGY

When medical terms and jargon are used by the doctors, there is often a danger of mutual misunderstanding. The same term, for example, may have an entirely different meaning for doctors and patients. Blaming the victims for their sickness and mystification of medical treatment is another factor that creates a distance between the patient and the medical profession. Similarly, a patient's use of specialized folk terminology may also confuse the clinician. In order for the health care to be acceptable to the patient, it must 'make sense' to them.

TRANSMISSION OF KNOWLEDGE ON HEALTH

Attainment of the goal of HFA/2000 depends on the achievement of self-care and self-reliance as well as on the successful transfer of health knowledge and capabilities from one generation to the next. Message development to transfer health knowledge requires an in-depth understanding of peoples' beliefs about health and illness - one should keep in mind the audience experiences and modern health practices. Messages must promote awareness of issues and encourage people to act. Exact wordings of the messages used in folk media may be developed by folk artists as they know their art forms and their audiences well. It must attract the attention of and appeal to the target audience. It must be field tested before it is used on a large scale.

CONCLUSION

If health for all is to become a reality, it is essential to forcefully make each individual aware of the fact that the prime responsibility for health rests with him/her alone and hence knowledge on health is everyone's right.

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

INFORMATION KIT — MAY 1988

MESSAGE FROM

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As Member Countries of WHO march towards the goal of health for all by the year 2000, it is becoming increasingly clear that the target will only be achieved if the people become self-reliant in matters of health. This does not imply that every individual should acquire knowledge on medicine and surgery. But it certainly means that every individual should be made aware of the basics of health promotion and what can be done to preserve and protect health. This is at the level of the individual.

Self-reliance has another dimension. And that is when one looks at it from the level of the community. When a community achieves self-reliance in primary health care, then one is on the threshold of achieving HFA/2000. Because it is individuals and communities that eventually make up a nation. These communities, in turn, comprise many groups – health teams, governmental and nongovernmental organizations, youth, women and religious groups and a host of others who have a direct involvement with the health and health-related sectors. In this context it is important to remember the vital role that health professionals can play in providing technical guidance and support to the community. Self-reliance in health can be made more meaningful if it is supported in this manner.

As has been proved more than once, particularly in the developed nations, it is not the availability of resources alone that eventually determines the success of a development programme, but the extent to which it enabled people, the beneficiaries, to take care of their own needs. Self-reliance in health would mutually support the general socio-economic development. Self-reliance in primary health care, therefore, would be a vital pillar for the bridge to HFA/2000.

WHO40/1988/May/1

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

INFORMATION KIT MAY 1988

PRIMARY HEALTH CARE IN ACTION

PEOPLE – THE MOST IMPORTANT RESOURCE FOR PHC

Primary Health Care (PHC) is the key approach applied in the countries of WHO's South-East Asia Region to achieve HFA/2000. Being a social goal, HFA/2000 is intimately linked to the overall development efforts of these countries. In every country of SEAR development programmes and projects are aimed at alleviation of poverty and ignorance in the urban and rural under-served and deprived areas, where material resources are scarce. In such a milieu the PHC approach must of necessity be innovative, concentrating on making maximum use of all available resources of which people are potentially the most important.

Involvement of individuals, families and communities in promoting their own health is fundamental to the PHC approach. For PHC to succeed in any setting or environment, involvement of many groups – health teams, governmental and nongovernmental organizations, religious groups, political leaders – is essential. Cooperation, coordination and commitment is the basis for achieving HFA/2000.

Here are a few examples of PHC in action in the Region which may form springboards for action-oriented initiatives in all the countries in the twelve remaining years to 2000 AD.

SAFE WATER THROUGH BAMBOO "PIPES"

In many rural areas people, usually women and children, have to spend hours walking long distances to collect water. Providing pipe borne water to rural villages is both an expensive and long-term process. But knowing that it will take time for water to reach their own village, some villagers have joined together to improvise their own water schemes. What they used was freely available bamboo trees. The hollow trunks and branches joined together and laid along a gradient in consultation with the sanitarian in the health team soon brought water to the village. Until the government's schemes reached the village, the people on their own had obtained water for themselves. Innovation leading to self-reliance.

"RICE CLOCKS" FOR SAFE HOME DELIVERY

In remote rural areas of most countries in the Region, women still give birth at home attended by Traditional Birth Attendants (TBA). For this purpose, TBAs are trained, with particular reference to boiling of instruments. Instruments should be boiled for 20 minutes is the usual teaching. The effectiveness of any training programme depends on several factors, one being the availability of facilities to work as laid down in the training. For example, one such trained TBA did not have a watch to time the sterilization process. Neither were there clocks in the poor homes where she went to deliver babies. A young villager who attended school came up with an innovation. Once the water started to boil he suggested that a few grains of rice be put in the container with the instruments. When the rice was fully cooked, the instruments would have been in boiling water for over 20 minutes.

HOME-BASED MEASURING METHOD

Oral rehydration solution is now a scientifically accepted form of treatment for dehydration. It is saving the lives of thousands of children who suffer from diarrhoea. But as with all things scientific, the composition of the solution must be absolutely correct. The salt in the packet must be dissolved in one litre of water. Many poor homes do not have graduated measuring glasses. In the search for a solution, some communities in a particular country in the Region have come up with a novel method. Most homes, it was found, have at least one empty bottle of a popular brand of mineral water lying around. Health workers found that the quantity of liquid in the bottle when

filled to the cap of the "trade mark" is 500 ml. Therefore, teaching even an illiterate mother how to measure one litre using such a bottle was an easy task, that is, to use 2 bottles of water.

VILLAGE-BASED FEEDING

Malnutrition in children is a major cause of disease, disability and death in most countries of the Region. The problem in many developing villages is to augment the available shop-supplied food with good nutritious supplements. For example, rice, wheat or corn may be available through the state distribution system. But for growing children these alone are insufficient for healthy development.

In the rural schools of some countries, the health teams have obtained assistance of the school teachers, parents and the well-to-do people and initiated schemes to provide children with a nutritious "soup" daily. This "soup" is made of locally available nutritious green leaves supplied by parents or teachers, and rice, soyabean and other protein and calorie providing substances given by local philanthropists. This practice may be a part of the school lunch programme. In many schools, the kitchen garden activity also aids this practice.

MEDIA FOR COMMUNICATION

In many countries of the Region, it is difficult to put across health messages through the printed word due to low literacy levels, specially in the vulnerable groups such as mothers. The radio and television have yet to reach the hinterland of vast areas in many countries. At the village level, health teams and others involved in health development have deve- loped effective initiatives to communicate important health messages. The extensive use of stories, drama and folk songs are striking examples of such methods. With the help of local leaders, stories, dramas and songs are developed. These learning techniques use traditional knowledge and beliefs and move towards action which will help solve particular health problems. For the children, who usually are fond of toys and games, some innovative games such as snakes and ladders has proved beneficial. The number that has a ladder giving the player an advantage also has a health promoting message such as "brushing teeth every time after meals make them last long - advance 10 steps" while another number with the snake's mouth will have another message, "candy will decay teeth". By playing this, children gradually absorb the health message and remember it easily.

LOCAL MEDICINE FOR MINOR AILMENTS

Most countries now have community health workers. They have been trained to assist the people in the community with minor ailments. They are usually provided with essential drugs. The replenishment of the drugs is a big problem and a burden to the Government. In most countries, the Government asks the community to take care of the replenishments. Some of them come up with the practice that all the sick people that need the drug have to buy it which again is a big burden to the poor. Some communities place the drug kit at the monastery or other religious centre where people donate money to the drug chest or even the people who do not use it may contribute some money for this purpose. This is one way of keeping the drug chest replenished. Other communities may have a regulation to collect money from every family regardless whether they are sick or not like a health insurance premium and they can use the drugs free of charge when they need them. Other communities which have plenty of herbal plants use available herbs for their medicinal chest. All families are asked to plant and take care of some kind of herbs; the community health personnel are asked to advise them about the utilization of herbs for common available diseases.

PEOPLE'S TREATMENT CENTRES

In a certain district people had to go long distances for treatment of minor conditions such as cuts, wounds, headaches, etc. The villagers were discussing this problem and were overheard by the local rural development officer. He discussed this with the members of the health team and together with the villagers found a solution. They established small "health posts" in the remote areas of the district. These were manned by trained volunteers or retired health workers. No fees were charged, but a "fill" was kept at the entrance so that those who could afford it could drop their donations in the fill. The collection was used to arrange for the supply of simple drugs and dressings.

SELF-RELIANCE THROUGH PRIMARY HEALTH CARE

The foregoing are examples of innovations developed by primary health care workers, community leaders and the people themselves in providing some of the essential elements of PHC to individuals and families in developing communities. The striking feature in all of them is that they have evolved from the community itself. The importance of the team effort is also highlighted. In addition to members of the health team, teachers, members of nongovernmental organizations, the more affluent among the people and health volunteers have been involved. They are living examples of PHC in action.

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

INFORMATION KIT — MAY 1988

RESOURCE MOBILIZATION

A health system is made up of components from the health and other sectors whose inter-related actions contribute to health. The primary health care area is the hub of the health system. Around it are arrayed the other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuing basis. Primary health care development and delivery of health services require a lot of resources in various forms. Generally, only resources from the government cannot cope with the enormous demands for health for the community especially in developing countries. Self-reliance and social awareness are key factors in human development and these lead to resource mobilization for primary health care. There are many forms of resources to be utilized in primary health care and many ways in which they can be mobilized. Some examples are:

LOCAL HEALTH INSURANCE SCHEME

Health insurance schemes are well-known and widely practised in developed countries. The range of coverage for the service varies and the premium is generally high. Thailand has adapted this concept to the health card scheme. Based on the principle that the Government will provide most of the health service to the people, but according to the limited resources the Government needs some community participation. The health card system was launched by the Ministry of Public Health. Those who wish to be involved in this scheme have to pay a premium for this insurance scheme which is very low as the Government does not intend to make profit from this scheme. There are different rates of premium and those who pay receive a health card with different colours according to the rate of premium and which covers a range of services. All Government health facilities provide health services to the card holders.

VILLAGE HEALTH COOPERATIVES

In many societies people have a tradition of mutual help such as "gotong royong" in Indonesia where community participation is natural. They work together such as during harvesting to help their friends, who in turn will help them later. Within this principle, some communities have developed village health cooperatives to help each other, primarily to answer the problems of scarce essential drugs by collecting money (shares) from the people to purchase essential drugs to be made readily available in the village and sold to those in need at a marginal profit which is used for maintenance purposes. In many communities further development of these drug cooperatives has evolved in other health activities such as environmental sanitation development and nutrition activities such as school lunch programmes. Another such activity covers income-generating schemes.

REVOLVING FUND FOR HEALTH ACTIVITIES

This emanates from the idea to promote self-reliance especially for sustaining the availability of essential drugs. There are some villages where the community received some initial funds from donor agencies and they did not have to collect shares from the people. However, instead of using the entire fund from donors to purchase drugs directly, one portion of the fund is used for purchase of drugs (for sale to the needy, and the money is recycled into the purchase/sale of drugs). Another portion of the fund is set aside for investment in any form, with the interest from the fund being used to purchase drugs for those who cannot afford them. Both measures ensure the sustained availability of drugs for the villagers. It thus also keeps the revolving fund growing both in volume and quality of purpose. In many villages, the scope of the fund has been expanded to cover other health activities.

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MATCHING FUND

Community participation is the basic principle in primary health care. The form of participation may be seen in many forms, in the involvement of the planning and implementation of the health programme in expressing their health needs, in volunteering to assist the programme, or in the contribution to the programme which may be in cash or kind. Most health programmes have limited resources and also need community participation. One way to be sure if the programme proposed is the felt need of the community is to ask for their contribution. A matching fund approach is introduced to ensure the needs of the community. That is, for any project needed by the community such as a water system, drainage construction etc., the Government will allocate only a portion of the total budget while the rest has to come from the community in cash or kind as labour force or construction materials. This will ensure community participation, make the people have a sense of belonging and furthermore will relieve the burden on the Government and other services made available from limited resources.

COMMUNITY CONTRIBUTIONS

Resources for health are linked in general especially in the developing countries. Contributions from those who benefit from the health system or those who do not but who need to make good to mankind are needed. Some political parties, societies, associations, religious groups and NGOs are mostly willing to improve the standard of living and quality of life of mankind of which health is one important element. They can help the health system in many ways, in cash, materials, buildings, technical guidance, direct services, labour force etc. This is the major source to mobilize resources in health development. In Burma it is known that most of the health centres were constructed by donations from the communities or other donor agencies and not from the Government's budget. The Government will take over the running expenditure after construction. The people of Ayadaw township inside the township or those who move out and have a successful business outside the township but are willing to improve the development in their own home land have contributed a big sum of money to run the health programme in Ayadaw which received the Sasakawa Prize for developing primary health care. The key issue to attract more contributions is a well developed plan and good implementation. The community has to identify exactly what they need in terms of health and the approach should be possible, feasible, effective, economically and technically sound. After the planning period, community involvement in implementation of the plan is vital for success.

COMMUNITY HEALTH WORKERS

These workers not only provide resources that are scarce in most communities but also provide manpower which is also in short supply. Primary health care has to make full use of all available resources, and therefore has to mobilize the human potential of the entire community. As individuals and families accept greater responsibilities for their health, their active interest and participation in solving their own health problems are a clear indication of social awareness and self-reliance and also an important factor in ensuring the success of primary health care. In many developing countries, community health workers have proved to be a realistic means of attaining total population coverage with essential health care. Generally belonging to the community in which they live, they have back-up support from health professionals. In many countries, referral systems have been strengthened to ensure the best quality from the health workers including services from community health workers to hasten the march towards health for all.

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

INFORMATION KIT — MAY 1988

ALTERNATE TECHNOLOGIES IN HEALTH CARE DELIVERY

TRADITIONAL MEDICINE

Traditional medicine is intimately interwoven with the cultural, social, behavioural and religious practices of large sections of our people in this region. Most people have great faith in the efficacy and safety of traditional medicine and practices. Traditional medicine practitioners are respected in all societies and they have carved for themselves a definite place in the socio-cultural and behavioural patterns of communities. Traditional medicine practitioners have been playing an important role in dealing with health problems, particularly in rural areas over the centuries. Thus, this is a readily available and valuable manpower resource which could be gainfully utilized as an alternate technology for promotive and preventive aspects of health.

A number of countries in WHO's South-East Asia Region have thus recognized this role of traditional medicine and have utilized traditional practitioners in health care delivery particularly at the grassroots. Some countries, such as Bangladesh, Burma, India and Sri Lanka have instituted training programmes in traditional medicine and developed a parallel health infrastructure in Ayurvedic or other local systems of traditional medicine. A major emphasis of WHO's programme in this area, however, has been to promote utilization of traditional practitioners in primary health care activities.

Most traditional medicines are made from herbs and the traditional practitioners have learnt about the "art" of traditional medicine, generally through "inheritance". They therefore pursue their normal vocation in addition to dispensing traditional remedies. Thus, these medicines are brought almost to the door steps of the people and are therefore comparatively cheap and mostly safe. They are also probably efficacious though not as potent as modern drugs. People tend to prefer them because they do not produce toxic effects like some allopathic drugs.

In recent times, the training in traditional medicine has been institutionalized and several countries have established well structured training programmes and institutions of traditional medicine as in Bangladesh, Burma, India, Nepal and Sri Lanka. Traditional medicines are also now being prepared on a commercial scale utilizing modern pharmaceutical techniques. These are therefore available for distribution on a large scale.

Very often traditional medicines contain several ingredients. These could be derived from medicinal plants or be a mixture of minerals and medicinal herbs. It is very difficult to standardize such compound preparations. Some countries like Burma and India have initiated steps for standardization of such medicinal preparations utilizing modern botanical, phytochemical and pharmacological methods. It is believed that since most traditional medicines have been used for several centuries, they would be safe. But, there are often reports of harmful effects after use of such medicines. It may therefore be necessary to establish the safety of at least some commonly used medicinal preparations particularly if they contain metallic substances such as mercury, arsenic or lead. Another major constraint in the use of traditional medicine is the marked variation in active ingredients of the plants/materials particularly if these are collected in different seasons. All these facets have to be taken into account while standardizing traditional medicines.

Some countries have established a parallel health care system in Traditional Medicine. There may, however, be a case for integration of traditional medicine with modern medicine. China and DPR Korea have attempted such an integration at national levels. A common training programme for health personnel could be evolved aimed at incorporating the best in traditional medicine and modern medicine in the form of an integrated training module.

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All countries in the WHO South-East Asia Region have formulated strategies for achieving HFA/2000. While utilizing modern appropriate health technology has been the hallmark of these strategies, traditional medicine is no doubt being promoted as an important alternate strategy for achieving HFA/2000. WHO has collaborated with the governments in training traditional practitioners in promotive and preventive aspects of health, identifying simple traditional remedies which may be gainfully utilized in treating commonly encountered ailments, supporting activities for cultivation of medicinal plants, developing a methodology for standardization and quality control of commonly used traditional formulations and training of primary health care workers in the use of simple traditional medicines. WHO has also supported, as a priority area, research in several important aspects of traditional medicine such as the study of the behavioural pattern of the community, utilization of traditional medicine at the P.H.C. level, clinical evalua- tion of the efficacy of some of the widely used traditional remedies and strengthening research in pharmacognocy, phytochemistry and pharmacology of medicinal plants.

TRADITIONAL BIRTH ATTENDANTS (TBAs)

Traditional midwives or TBAs are an important part of community health systems in most countries. These indigenous practitioners are an especially important human resource for the formal system to tap in villages because they are already there and because they share the socio-cultural values of the community they serve.

The traditional birth attendant has played an important role in the health care of women in South-East Asia. It is estimated 75 to 90 per cent of the deliveries in some parts of the Region take place under the supervision of a TBA. The TBA not only helps to deliver babies but also provides prenatal and postnatal care, and also assumes responsibilities for household duties during the postnatal period, gives advice on birth control, nutrition, domestic problems, and minor illnesses.

The TBA is known as "let-the" in Burma: "foolhuma" in the Republic of Maldives; "dai" in India; "mohtamyae" in Thailand; "sudeni" in Nepal; and "dukun bersalin" in Indonesia.

The utilization of TBAs is helping to provide a solution to the question of how to reach remote areas unserved or underserved by organized health services. The health system supports them in terms of training for more safety, some supplies and equipment, and places them in the network of a referral system to ensure safety of the more difficult cases.

WHO and UNICEF have been giving special attention to the training of TBAs. In collaboration with UNICEF, UNFPA and other international organizations, WHO has, since 1974, provided technical support to those countries which have requested assistance for the training of TBAs. These training programmes are oriented in the context of primary health care with the emphasis on the utilization, monitoring and evaluation of the trained TBAs.

It is recognized and accepted that the services of TBAs have a direct effect on the health and well-being of the vast majority of mothers and children as well as the whole family. In the countries of WHO's South-East Asia Region, there is great concern to see that the efforts are producing the desired outcome in improving the health status of this vulnerable group as this would have an important bearing on achieving the goal of HFA/2000.

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

INFORMATION KIT — MAY 1988

COMMUNITY PARTICIPATION

THE CONCEPT

The 11 Member States of WHO's South-East Asia Region (SEAR) are utilizing primary health care to achieve the goal of HFA/2000. An important facet of the PHC concept is community participation. In the Alma-Ata declaration, community participation was described as "the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and to develop the capacity to contribute to their and the community's development."

During the decade since Alma-Ata, the countries of SEAR have given the highest priority to translate this concept of community participation into a working reality. However, the actual form of operationalizing community participation has been greatly influenced by the overall political structure and the social and economic situation in each country. In other words, community participation is interpreted differently in different countries and peoples involvement in improving their onw health depends largely on social, cultural, economic and political considerations within a country. Within such a flexible framework it will be useful to look at different examples of "community participation" so that this important aspect of PHC can be effectively used in the countries of SEAR and make PHC programmes more appropriate to local, cultural and socio-economic conditions, and therefore more effective.

PEOPLE'S CONTRIBUTION

A common example of what is considered as community participation in many countries is the mobilization of the peoples resources – money, labour and materials and for health programmes in the community which are either government-planned or government-controlled. Although some may view this as a misinterpretation of the concept the reality is that in many countries this form of activity is considered as an example of peoples' participation. However, such contributions are desirable and have helped in the implementation of health programmes in many countries.

There are several examples of members of the community donating land for construction of health centres. In some countries the people themselves build the health centre using local labour and materials, often with little or no contribution from the government or local authorities. Then again there are numerous instances where individuals or health volunteers in villages have given free accommodation for offices of village health committees and other voluntary bodies. This form of participation by the people in health activities is usually the first step towards community involvement in health development.

DIRECT HEALTH ACTIVITIES

Another form of activity which is interpreted as community participation is the involvement of individuals at community level in direct health activities. For example, in many countries, the village health volunteers assist members of primary health care teams to conduct clinics. They are trained by the PHC team members and take part in activities such as organizing the clinic, weighing of children, distribution of drugs etc. Volunteers also play an important role in disseminating health messages in the community. In some countries, volunteers also take responsibility for a defined number of households and monitor activities such as immunization, family planning, diarrhoeal diseases control etc. This form of participation can also lead to entire communities becoming involved in health programmes and actually becoming an integral part

of such programmes. The immunization programme in some countries is a good example of this. Whereas in the initial stages health teams and volunteers had to actively promote immunization programmes, now the community itself demands immunization. They have become involved in it. In the years ahead, when new health problems caused by improper life styles like drug abuse, AIDS and tobacco-related diseases increase in the countries of the Region, the involvement of committed volunteers and other members of the community will become very important.

In the countries of the Region, the importance of community participation is well recognized. Useful lessons can be learnt from country experiences and these experiences further developed so that community participation becomes a strong basis in the entire PHC strategy. Ultimately it is the health worker who has to learn from the community. Working in an atmosphere of community participation will enable health workers to see beyond the narrow limits of medicine to the political and socio-economic causes of hunger and ill health and enable them to respond more adequately to the needs of the community.

HEALTH FOR ALL – ALL FOR HEALTH

SELF-RELIANCE FOR PRIMARY HEALTH CARE

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TECHNICAL GUIDANCE AND SUPPORT FOR PHC

SELF-RELIANCE - A KEY FACET OF PHC

Primary Health Care (PHC) is the multifaceted approach adopted by all Member States of SEAR to achieve HFA/2000. Perhaps the fact that this social goal embodies mans inherent dream to enjoy a long and happy life in good health, was an important reason for its ready acceptance and adoption in the countries.

The PHC approach with its emphasis on overall development of communities at grassroots level fits in well with the development plans of all countries in the Region, which are targeted towards district, town and village. Key principles of PHC such as intersectoral action, appropriate use of technology, community involvement are integral to all such development programmes. Cutting across the framework of PHC is the need to develop self-reliance at community, family and individual levels for achieving the targets and goals in the march to HFA/2000.

BUILDING COMMUNITY SELF-RELIANCE - A CHALLENGE TO HEALTH WORKERS

Achievement of self-reliance and community involvement for developing and strengthening of PHC poses a big challenge to health workers, in the context of the socio-political, educational and cultural backgrounds of the countries of SEAR. In most countries of the Region, individuals, families and communities have been and continue to be nurtured in a tradition of strict hierarchical administrative structures. Conditioned as they have been to a system, where the "authorities" "provide" them with their basic needs, they are now expected to make a tremendous attitudinal change and become active partners in the development process. It is indeed difficult for such groups to grasp the value and benefits that will accrue from such behaviour in the long run.

Evaluation of progress in the implementation of HFA strategies has clearly shown that much still remains to be done in this area. From a situation where people "participated" in activities of the authorities, they are being asked to actually become involved in planning and working for their own health. Clearly this is a stupendous undertaking – but if achieved, it will be the vital breakthrough that health workers everywhere are striving for.

THE OBJECTIVE FOR THE HEALTH WORKERS/PROFESSIONALS

As stated in the Declaration of Alma-Ata, self-reliance implies the assumption of responsibility for their own health development by individuals, communities and the national authorities. As they become self-reliant, they are expected to adopt measures that are understood by them and acceptable to them. They should be able to identify their own strengths and resources and to use them effectively. They should know when and to what purpose to turn to others for support and cooperation.

Helping the people to achieve self-reliance in this manner will be the task of the trained health professional from the national to the village level. In doing so they should provide correct technical guidance at all levels. To achieve this objective the health workers must be adequately trained in this function.

HOW TO ACHIEVE THIS OBJECTIVE

Training of Health Professionals

Content related to the development of self-reliance should be developed and included appropriately in pre-service, basic or undergraduate training. Such curriculum development will necessarily have to be done by multi-disciplinary groups including social scientists, behavioural scientists,

communicable specialists, etc. In-service training programmes must be similarly developed to reorient the workers already in the field to equip them with the knowledge, skills and attitudes for assisting in building up self-reliance in the community. There is a close relationship between the MCH leadership development initiative and development of self-reliance for PHC. Other key principles of PHC such as intersectoral coordination, community involvement and appropriate use of health technology are also closely linked to the concept of self-reliance. Therefore in the training of health workers, this relationship must be emphasized in the curriculum.

During training it must be stressed upon students, both pre-service and in-service, that development of self-reliance cuts across the entire spectrum of PHC. Self-reliance applies equally to all eight elements of PHC. Be it an immunization programme, maintenance of the local MCH centre, planning and implementing a latrine construction programme, or a nutrition programme, the same principles of self-reliance apply.

Training of the People

Once they become skilled in operationalizing the concept of self-reliance health workers should go about their task by helping communities to develop self-reliance. The target groups will be community leaders at all levels, health volunteers, mothers groups, teachers and older school children, youth organizations in the community etc. by casting the net wide the numbers will increase and the target will be reached sooner.

Teaching Methods and Materials

The trained health worker should be able to select the most appropriate teaching method for the selected audience. These can be the use of lecture based training courses augmented with practical demonstration, group discussions, role play, etc. Such methods are suitable for small groups such as health volunteers, school teachers, etc. Seminars and workshops are also recommended. At all times the health worker must be conscious of the educational/literacy level of the target group. This will vary among countries and within countries. Intra-country study tours, whereby selected workers from one district visit and learn from another district, where self-reliance is better developed is also an important teaching/learning method.

In assisting the development of self-reliance in the communities where they work, health workers can draw upon examples from other countries in the Region and adapt them appropriately to the local scene. The Health Literature and Library Network now operational in all countries should be utilized maximally for this. The local point library and other participating libraries must be geared to disseminate useful information to the health workers.

MAINTAINING SELF-RELIANCE

Improvement in the health status of the people is a continuous process, and self-reliance in health is part and parcel of this. As individuals and communities achieve self-reliance, locally available resources will be used in a more enlightened manner. Smaller medical institutions which were ignored and bypassed will be increasingly utilized by the people. The advice of PHC workers will be listened to and followed. With the growth of self-reliance, the referral system which is now so difficult to establish and maintain will begin to work.

In other areas of PHC too, a more self-reliant population will show increasingly responsibility not only towards their own health, but also in looking after the local health facilities. But health workers must continually provide necessary support to the people in their activities. Not only should health workers support communities, they must promote and support the growth of self-reliance among their own kind too. Thus health professionals at secondary and tertiary levels of care must lend their full support to their co-workers at the primary level.

Self-reliance must not be misinterpreted in ways that ultimately people will assume full responsibility for their health and therefore health workers can move again withdraw from the scene. No, they must continue their interaction with communities and maintain their interdependent relationship. This applies equally to government working with communities in health-related sectors as well. The slogan "Partners in Health" must not remain a mere catch word.

Right now, the main concern is on giving proper guidance through education to assist people to take an active interest in promoting and protecting health. Once this is achieved, health workers must continue to remain in close contact with the people and give them correct guidance and support so that their morale and commitment continues to remain high.

Health Care For All

In the last few years, the number of medical colleges in India has increased by seven times. Some of them are comparable to the best in the world. But there has been no such progress in providing health-care for the masses.

Today we have nearly 3,30,000 hospital beds—a bed-to-population ratio of 0.5 per thousand against the desired norm of one bed for every thousand. The total number of qualified doctors in the modern allopathic system of medicine is about 162,000 giving an average of one doctor for every 4,000 people against the desired norm of one for every 3,500. The total number of trained nurses is about 1,00,000 giving a national average of one for every 6,000 against the desired norm of one for every 3,000. Our per capita expenditure on medical and public health is Rs 9.44 a year.

At present, the quality and quantity of medical care available is extremely variable—ranging from highly organised and advanced to most primitive. In large cities, there are several hospitals. Most of them are well equipped and staffed. In semi-urban areas, the hospital services are less adequate and in some really rural areas hospital facilities are almost non-existent.

There are about 4,500 primary health centres dispersed all over the country (one primary health centre for about 1,35,000 population). These health centres, initially meant for preventive and promotional medicine, now look after the curative aspect also. In addition, there are about 700 to 800 dispensaries run by the State Governments and a large number of sub-health centres manned by para-medical staff. Even so, the health services in rural areas are inadequate in every way.

The health care of about 12 per cent of the population (mostly in urban areas) in the organised sectors like Government services (including Defence), industrial workers under the Employees State Insurance Scheme and people working in large commercial and industrial establishments covered by insurance schemes, is fairly adequate. But the remaining 88 per cent of the population has nothing to claim as a matter of right from the Government in this regard. This great discrepancy reflects the general pattern in other areas like wages, housing, filtered water supply and education.

For the last 16 years, we have been adding over 10,000 doctors every year (presently 15,000 a year). Many of them have been absorbed in the new medical colleges and their associated hospitals, but a significant number of them have been migrating to other countries. This means an enormous loss to the Exchequer at whose expense they were trained (medical education is highly subsidised). Most others prefer to stay in urban or semi-urban areas. As a result, qualified medical practitioners are scarce in interior rural areas.

No doubt, many expert committees on health have been formed during the last 30 years and they have made very specific and useful suggestions but unfortunately not many of them have been implemented. To give an example, a committee appointed for Delhi made a specific recommendation to disallow existing hospitals from increasing their bed strength. But we all know that almost all Government hospitals have been increasing their number of beds. There are instances of giant hospitals situated on the two sides of the same road and charitable hospitals being charged commercial rates of electricity and water and with tax exemption to the tune of only 50 per cent.

Providing medical and surgical facility for the sick is at least as urgent and important as medical research. Even today, when further growth of medical colleges appears to have been nearly stopped by the Government, the prestigious multi-crore "research institutions" continue to spring up even in areas where health services are almost non-existent.

But let us not think that the Government alone is responsible for this unsatisfactory state although they must get a big share of the blame.

The attitude of the public, seen in their indifference to this problem or their criticism of the hospitals, has in my opinion, acted against voluntary participation in providing patient care. Unfortunately, the general feeling is that health care should be entirely the responsibility of the Government and be available free of charge to all. Everyone expects the best professional care, medicines, efficiency and devotion in return for nothing. One so often hears the criticism about charitable hospitals not providing free medicines, free medical investigations etc. But who is going to pay for all that? This attitude of the public is indeed surprising and is contrary to their attitude to food and shelter which, at any rate, are more important than health care.

Various Governmental agencies, civic bodies and voluntary organisations run their hospitals independently without any overall control. This has led to faulty geographical distribution of health services. In addition, each such organisation tends to run highly sophisticated centres resulting in great wastage of finances.

During the 30 years of Independence, there has been no significant voluntary participation in providing medical relief. This is due to many factors like lack of enough governmental recognition, lack of provision of total exemption from income-tax on donations to hospitals and many such other impediments.

Everyone should realise his responsibility towards the health coverage of the community. It is imperative that the community must agree to look after itself with necessary help and aid from the Government. The solution is in people's spontaneous and simultaneous participation. Every segment of the population can raise a hospital for itself if everyone donates even a small sum, say, 30 paise a day (the cost of perhaps a cup of tea) for a comprehensive health coverage including consultation, domiciliary treatment, preventive medicine, promotional medicine and hospitalisation.

Let it be accepted that no rural health care programme should ever be isolated from that of the urban population. The medical colleges and other large hospitals must accept the responsibility of fully participating in the delivery of a total health care programme and form the apex of the pyramid the base of which should be located in the rural areas.

* * *

I give an outline below of a model plan for health care, the essential features of which are.

(1) The Government should recognise that community effort is the only viable adjunct of a national health programme. (2) Every hospital in the city should accept the overall responsibility as the apex body for the region. (3) Beneficiaries of the plan should contribute 30 to 50 per cent of the capital and maintenance expenses. (4) All the doctors working under the plan will be required to provide free professional services for the poor and at reduced rates for the middle-income group but may charge full fees from the more affluent. This concept of practising doctors is at complete variance with the concept of whole-time doctors prevalent now. Only heads of departments in teaching institutions need to work on a full-time basis. This would considerably reduce the recurring expenses of the plan.

The details of the plan are discussed below.

Organisation

A national health authority should be appointed with adequate representation from the medical profession, industry, business, journalists, social workers and other prominent citizens, apart from representatives of Central and State Governments. The function of this authority would be to evolve a national policy on healthy care and monitor its effective implementation by the State health authorities.

The State Health Authority will be responsible not only for detailed planning of the health facilities under the broad guide-lines laid down by the National Health Authority but also for its effective implementation. Each State would have regional health authorities based on medical colleges and large hospitals above 500 beds. Each such authority would have a number of district health authorities. All the members of various health authorities will be working in an honorary capacity and only the secretarial staff would receive salaries.

The basic purpose of this organisational structure is to have a national policy but to decentralise the actual implementation, thus deriving both the benefits of planning at national level and making its beneficiaries participate in its execution.

The health set-up would be broadly divided into two categories:

1. **Preventive and promotional medicine:** This is the most important component of the health plan. It assumes even greater significance in rural areas. No amount of curative medicine is going to be of any use unless a very sincere and highly organised effort is made to educate people about good water supply, sanitation and personal hygiene. This job should be undertaken by people specially trained as public health workers under the guidance of specialists in preventive and social medicine.

2. **The out patients' services including domiciliary:** Every person will be required to be registered with a doctor in his area who will be generally in charge of his health care. The doctor would provide consultation and domiciliary treatment and if necessary send the patient to the specialists or a hospital. No patient would be admitted in any hospital except on his advice barring of course emergencies. This would prevent overcrowding in hospitals and ensure better utilisation of services there. Each such practitioner would register not more than 1,500 such patients.

To avoid duplication or underutilisation of hospital facilities (especially of the sophisticated type) a proper liaison should be maintained between various types of hospitals.

National Referral Centres:

Five such centres should be developed to serve the north, south, east, west and central zones of the country. They will be maintained by proportionate contribution from various States they serve and would be equipped with the most modern equipment For example, CAT SCAN in the department of radiology, facilities for open heart surgery, renal transplant, disciplines like endocrinology, nuclear medicine, most sophisticated laboratories and so on.

They will undertake only referral work and would form the highest level of medical institutions available in the country. Most eminent medical men in the country should be invited to serve in these institutions to give them a national standing.

Type I Hospitals:

The apex of the pyramid in this health programme should be formed by large Government hospitals (including those attached to medical colleges) with more than 500 beds. These hospitals would act as general hospitals for people in those areas. Only such specialised departments as are determined by the regional health authority would be categorised as regional referral centres for that particular speciality.

Efforts should be made not to locate all such centres in one hospital but allow a fairly uniform distribution in each State. The State referral centres will undertake not only the specialised type of work but also clinical research etc.

Type II hospitals (divisional level):

These hospitals along with the type III and type IV would on one hand admit patients directly and on the other hand act as referral hospitals for one type below it. Type II hospital would consist of 200 to 300 beds and would essentially be situated in the urban areas and would admit patients sent by the general practitioners and the type III or IV hospitals. These hospitals will have all general disciplines and also the specialised services which are not so sophisticated.

Type III hospitals (district level):

They will have about 100 beds each and will be situated on the outskirts of cities or in bigger towns with a population of at least one lakh people. Such hospitals will provide services in all general disciplines like medicine, surgery, Obst. Gynae, ENT etc. but not in the sub-specialities. The radiology and the pathology departments of these hospitals may have to be manned by technicians till trained and qualified hands are available. The department of radiology in such hospitals will have a number of Mobile X-Ray units which will be used for mass chest X-Rays (to detect tuberculosis) and on a weekly rota basis visit the type IV hospitals under their jurisdiction.

Type IV hospitals (cottage hospitals):

These are hospitals with 20 to 50 beds, situated in population pockets of about 40 to 50 thousand people. At present there are over 4,500 primary health centres with a sanctioned strength of two qualified doctors, several nurses and para-medical staff. All of them should be converted into cottage hospitals. In addition, another 5,000 cottage hospitals will have to be provided to make an average of one cottage hospital for every 50,000 people. The existing dispensaries numbering about 800 in the country should also be converted into cottage hospitals wherever feasible or else closed down and the staff transferred to the new cottage hospitals.

These health centres would primarily undertake preventive and promotional medicine and maternity and child welfare and manned by para medical staff. The existing sub-centrez will be adopted in this.

The capital outlay for this project would be met in three equal parts by contributions from beneficiaries of the scheme, donations, and aid from the Government. The Government would also be expected to give free land and concessions like tax exemptions.

The recurring expenses will be met entirely by contribution from the beneficiaries in the form of health insurance premia. On an average it will cost an individual Rs 25 per annum which should be made mandatory except in certain cases. This sum is well within the reach of most people. It works out to only about 10 paise per day.

While submitting this plan, I am fully aware that we may not be able to implement it in its entirety straightaway. The plea is for the Government to identify the areas with inadequate health facilities and hand them over to voluntary organisations willing to come forward and undertake the health care project. Such organisations should be duly recognised and assisted at all levels. At the end of a three-year period the efficiency and cost of this system may be evaluated and, if found superior to the present set-up, should replace all future effort in providing health care.

Outline of a Plan for People's Participation

by B. K. Vohra

evidence of this process available player makes a living and the those offered by public and pri-
no general lack of employment oppor- vate teaching organisations of