POSITION PAPER ON NATIONAL HEALTH POLICY

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The National Health Policy as planned may remain only a policy document unless all of us make a commitment to it, and try to implement it at all levels. Each of us must carefully analyse the health problems, keeping in mind the country's capacity to deal with them. The goals and priorities will be fixed accordingly. Strategies to achieve them need to be based on social justice and equity, intrasectoral linkage and self-reliance as far as possible.

The ill-conceived and inadequate health services currently provided to the vast majority of the population has created a feeling of social injustice and given many voluntary organisations the impetus to act as natural leaders of their communities. They have the responsibility to lead movements for the change. For this they need to identify the strategies to develop their full leadership potential. They should look beyond the traditional system of health care and develop a deeper understanding of the philosophy of primary health care and a commitment to achieve health for all by 2000 A.D.

1. PROVISION OF HEALTH SERVICES TO ALL

For those who live in remote areas and belong to the lower income groups, health care can be provided only through a system which creates a broad base of functionaries and provides health care to the maximum number of people. The training of new community health workers at the village level has only duplicated the existing system and has not proved very helpful in the long run. Wherever the traditional health functionaries have been involved, the infrastructure has become stronger. The health care system may continue to be lopsided, unless efforts are made to improve the training and supervision of CHW's and Dais.

2. REFERRAL SYSTEM AND PRIMARY HEALTH CARE : A STRATEGY

The bottlenecks that exist between the village and a health sub-centre are again a matter of concern. The health assistant is no better equipped with the skills and will to deal with certain health problems than a CHW. So unless there is a way to reach Primary Health Centres very little can be done at these levels.

Another important point is that the referral system does not allow for any planned way to go from one to another. There is no geographical or political boundary which one cannot cross. Unless the screening is done at all levels, the political and the social linkage is established between a specialist hospital to a Primary Health Centre of the block, from there to the village sub-centre and back from village to the specialist hospital; the congestion, duplication and the parallel system will continue to exist. The suggested change of effective links between primary health centres and medical colleges and hospitals in order to harness and provide specialised skills is no doubt progressive thinking for re-orientation of medical education and better health service, but its implementation has been held up due to many administrative difficulties. As a result, neither are the Block Administrators taking responsibility for the better functioning of these Primary Health Centres nor have the medical college hospitals established a proper linkage with them. Very few specialists from these hospitals like to go out to the Primary Health Centres. In fact the person who goes there is only a junior or senior resident working in those specialised units. Most of the time they treat these trips as holiday excursions. There is no continuity of ties nor any feedback from such hospitals to the Primary Health Centre doctor.

3. INFORMATION SUPPORT

To estalish a proper information support, there must be a well-defined referral system. General practitioners, indigenous practitioners and all others who are involved in any way with the health care system should become a part of the information support. The Epidemiological Cell in each State may not be essential but it should have a computerised system for collecting and processing information from different units. Without information, support evaluation and monitoring of any programme is not possible.

4. RE-ORIENTATION OF HEALTH PERSONNEL

To equip health personnel with appropriate and scientific techniques we must provide a system of continuous education. Inservice training programmes are essential to develop the skill to do the job better. Certain managerial skills which are never imparted to medical professionals in their undergraduate courses must become a part of the orientation training programmes. All courses could be so planned that NGO/Govt. officials attend the courses together and can interact with each other.

The voluntary organisations have a greater sense of dedication and commitment to social causes and are more open to change. This gives them an enormous advantage in the field. They provide care at all levels in all kinds of settings to the poorer section. They frequently act as links between the individuals, community and the rest of the health care system.

5. INTERSECTORAL COORDINATION

That various sectors have influence on health is well understood, but intra or intersectoral coordination remains most of the time only in the minds of people or as words on paper. Actual coordination at various levels is possible only if the planning of the two sectors are done at one place, and from bottom to top. The possibility of removing the bottlenecks is maximised if two sectors, well connected like water and sanitation, nutrition and education, are planned together. Again, regarding the educational status of woman and her acceptance of family planning, both must be worked out together, and receive the same importance. The administrative blocks also need attention. There is a need to define the job responsibility of various people at different levels, as well as a policy of delegation of authority at each level. If decision making is confined to the planners' level, the implementing functionaries find it very difficult to carry out their day-to-day duties.

6. ALTERNATIVE SYSTEMS OF MEDICINE

There is a need for integrating the training programmes of different personnel in different systems. The policy has recommended the use of indigenous systems of medicine like Ayurveda, Unani, Sidha and Homeopathy. It also emphasises introducing Yoga and Naturopathy into the overall Health Care Programme. But when it comes to putting this into practice, none of the Primary Health Centres or the dispensaries is equipped to give advice on any of the traditional systems of medicine.

Traditional systems of medicine have always had a place in our culture. They are both less expensive than modern medicine and more easily accessible to the majority of our population. To allow them to stagnate will only increase existing inequalities in the health care system. Therefore, ways of integrating the modern with traditional system of medicine must be thought of.

7. REGIONAL IMBALANCES OF THE HEALTH CARE SYSTEM

It is of vital importance to correct the regional imbalances that exist in health care systems today. The policy cannot be successfully implemented unless sustained political, social and administrative support is obtained from everyone concerned. Here the local communities play a very important role and it is our duty to make them aware of the facilities they are entitled to, so that they demand the care they need. The concept of preventive and promotive services is still lacking all through.

8. MEDICAL EDUCATION

We need not go into the details of formal medical education as we all know that it is not tailored to meet the requirements of the type of medical practitioners who work

in Primary Health Centres. If more clear and effective strategies could be specified, the wasted resources could be harnessed. The re-orientation of medical education has been talked about for the last several years but very little has been done to make education community-oriented and problem-based. Most of a medical graduate's time is spent in hospitals. The type of knowledge and skills that he/she acquires are the ones from the hospital itself, when almost 80% of the ailments are preventable and can be cured by simple remedies. But these cases never reach the hospital for their attention.

The National Health Policy is aimed at taking services to the doorstep of the people ensuring fuller participation of the community and improvement in the quality of their life. It is intended to restructure the health care services on the preventive, promotive and rehabilitative aspect rather than on cure only. Therefore to provide trained personnel with the right attitude and outlook is more important for proper functioning of the services talked of in the policy document.

9. MEDICAL RESEARCH

It is the opinion of various experts that today there is a lot of money being wasted on basic research which could be well shared by the developed world. The technical know-how can be easily obtained from them.

Special research on health care system, problem based medical education and need-based para-medical education at various levels, require a lot more attention than is being given in this country. In my opinion "behaviour problem" of the recipients of health services should form the priority for the research grant in India. There is also a need for a constant feedback on the new findings and advances in medical research and their application to health services. The dissemination of this information to the proper levels both upward and downward are equally important. Unless we keep informing our workers at the grassroots level of what is happening at the central level, the implementation of the programmes become difficult.

10. THE TARGETS

The National Health Policy paper gives the targets to be achieved according to the time frame. These targets are not comprehensive nor have they been worked out on any realistic terms. The exercise only tells what future achievements can be expected provided the base is known. No doubt it is better to work on some frame, to measure the milestone and progress being made but the baseline information is of crucial importance.

The target sets are based on certain information that was available at one point of time: perhaps as far as 1975 or 1976. Unless the relevant data is available from different states it is of no use setting up targets to reduce the incidence. A few studies

carried out by big institutions like the All India Institute of Medical Sciences or PGI Chandigarh tell us very little about the overall health status of our country. Lack of vigilance in reporting and collecting of information will hinder us from reaching our targets.

11. ROLE OF NGO's

The role of voluntary agencies has been very well spelt out by the Alma Ata Declaration. It includes:

1. Identification of the needs and problems of the people.
2. Development and innovative programmes for Primary Health Care, in the context of comprehensive human development.
3. Promotion of full participation by individuals and communities in the planning, implementation and control of these programmes.
4. Training of health workers, supervisors, administrators, planners and various agricultural and development workers, along with training schemes, build on the skills of traditional healers and midwives.
5. Creation of new and effective methods of health education.
6. Recognition of the essential role of women in health promotion and in the full range of community development concerns.
7. Contribution to the search for greater social justice.
8. Development of locally appropriate health technologies and use of resources.

Most of the voluntary organisations are working for both health and development. The standards of health cannot be improved unless there is an improvement in the general quality of life. The NGO's are more willing to go to the most difficult areas where nothing exists as far as the health system is concerned. Still they find it difficult to be recognised and get little or no help from the government system. It is time we all realised that to achieve health for all by 2000 AD, the involvement of the voluntary sector is essential.

THE DILEMMA—NATIONAL HEALTH PROGRAMME

Most of the time the doctor faces a very big dilemma in his day-to-day functioning. He is unable to find what to do and how to get started with diverse programmes like TB, Leprosy, Prevention of Blindness, Malaria control, Family Planning, Immunization, School Health, Nutrition and MCH, as well as to keep evaluating the programmes from time to time. Only if the planning process, information system, resources, supervision, coordination and training is adequate can the

doctor use his energy as a team leader to build up the team, organise the community, keep proper records, monitor the programmes and do a follow up review, as well as initiate certain changes in the programme when the need arises.

The bring about any change is a very complex task. The people who are striving to reach the goal of health for all must have a clear understanding of the National Health Policy, the critical issue required for its implementation and the broad principles involved in it.

In these three days let us together work out an action plan for our own areas keeping all the elements of the National Health Policy in mind and evolve our own strategies to reach the goal of health for all by 2000 AD.

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PROBLEMS IN PRIMARY HEALTH CARE

Based on the analyses of human resource development for primary health care offered in previous chapters, we may now attempt to summarize the major problems found in six study countries and the desk review. Not every problem, of course, is found in every country, but if a problem or issue has been identified in two or more countries it has been considered worth reporting. These observations will be presented in three groupings: health human resources development, primary health care delivery, and underlying issues. It should be clear that all problems are inter-related.

6.1 Development of Human Resources for Health

To avoid repetition and to sharpen this presentation, the problems of human resource development for health will be presented mainly under generalized concepts, rather than separately for each personnel category:

(1) Inadequate Numbers and Ratios of Conventional Personnel. Most developing countries have inadequate supplies of physicians, professional nurses, sanitarians, dentists, pharmacists, some types of technicians and other conventional categories of personnel to meet their health needs. While various adjustments - such as training many assistant nurses or community health workers (see below) - are necessary, a minimal supply of fully-trained physicians, sanitarians, and others is still essential for the effective operation of a health care system providing primary health care. In some countries, where the supply of doctors is adequate, relative shortages of nurses and other personnel result in the inefficient use of medical time.

(2) Inappropriate Training of Conventional Personnel. The education and training of physicians, nurses and other conventional personnel in developing countries are based largely on teaching models drawn from industrialized countries. The emphasis is on laboratory sciences, clinical specialisation and high technology. It is weak on the basic requirements of primary health care such as prevention - personal and environmental - and the psycho-social aspects of family health problems, so important in PHC. Some use may be made of field training in a community setting, but seldom enough and often none. Some medical schools are greatly overcrowded, reducing the quality of teaching, and teachers are technologically, rather than socially, oriented; this applies to the education of nurses and sanitarians as much as to physicians. Little if any use is made of social scientists in the educational programmes.

(3) Lack of Health Human Resource Planning. For health personnel trained in universities there is seldom communication with health authorities or national planning bodies on the needs. Even for personnel categories trained in a Ministry of Health, there may be poor communication between the branches responsible for training and those using the personnel. The lack of planning applies to both the numbers turned out and the content of their education. Nurses or assistant nurses trained in hospitals, for example, may be quite unprepared for functions they are later expected to perform in community health centres.

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(4) Lack of Community Health Workers. In response to many health human resource problems, new types of multi-purpose community health workers (CHW) have been produced, with varying levels of training. Some highly developed countries have also done this to meet health needs in rural areas, where doctors were lacking. In most developing countries, however, the numbers of these CHWs trained have to date been below the needs. There have been difficulties in finding suitable teachers, in developing appropriate teaching materials, and in recruiting qualified students. Moreover, the educational content in these programmes has sometimes been highly technical and clinical, rather than social and preventive. As a result, the later performance of CHWs may be largely confined to treating the sick rather than promoting community health and welfare.

(5) Inadequate Teamwork and Supervision. All of the countries reviewed in this study, and most developing countries generally, provide primary health care through teams of personnel working in organized frameworks. The effective functioning of such systems, however, requires an understanding of the meaning and practice of teamwork. It also requires that team leaders are capable of leadership and effective (not dictatorial) supervision. Such qualifications seem to be rare in the countries studied.

Basic education in medicine, nursing, pharmacy, etc. seldom has the time or resources to teach the requirements for teamwork and supervision. As a result this ordinarily becomes a task for in-service training and continuing education. Even such education, however, appears to be lacking or unsuccessful in the countries studied. Teamwork requires sensitivity to personal relationships and supervision requires organizational knowledge and skills; such matters are not easily taught in a classroom but are learned best in a field practice setting.

(6) Lack of Continuing Education. Effective teamwork and leadership are not the only subjects for which continuing education can be useful. For good performance of all health care functions, clinical as well as social, education should be a lifetime process. Systematic arrangements for periodic continuing education are important but seldom found in developing countries. Its lack may also help to explain the poor morale among many health workers.

(7) Lack of Job Descriptions. Problems in teamwork and general work performance are often due to lack of any clear explicit statement of the tasks expected from each member of the health team. Absence of job descriptions leads to confusion and uncertainty in the relationships among personnel in a health facility. It also contributes to inappropriate training. Both the teacher and the student require a clear understanding of future job functions. Such job descriptions should be prepared by health authorities responsible for programmes, and they should be updated periodically with experience.

(8) Absence of Relations with Traditional Healers. In most of the developing countries studied, traditional practitioners and traditional birth attendants (TBAs) play a large part in the primary health care of the people. Yet - with some exceptions for TBAs and in one country for general

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[illegible] the policy in the countries reviewed to ignore these personnel and hope that provision of modern health services will lead eventually to their disappearance. The soundest policy toward traditional healers may be subject to debate, but Ministries of Health that simply ignore their existence are missing an opportunity to exert influence on the nature of health services used by millions of people.

(8) Low Motivation of Personnel. Permeating many of the health manpower problems reviewed above are the attitudes and motivation of health personnel. These attributes may be initially acquired during basic training, but they are shaped by many subsequent experiences. All too often one encounters health professionals, particularly physicians, who rush to complete their tasks in a health centre in order to maximize the time they have for private practice. Others undertake post-graduate studies abroad and do not return to their home country; this "brain drain" means a serious loss of health manpower investment by many developing countries.

The issue of personnel motivation is, of course, complicated, and it is caused by many economic, social and psychological factors that are not easily influenced. No simple course of training can impart a socially responsible motivation in any doctor, pharmacist or nurse. But many policies may have an influence on motivation, as will be explored in the next chapter.

6.2 Problems in the Functioning of Primary Health Care

It is recognized that it is somewhat artificial to separate the considerations of health human resource development in the last section from the overall primary care system; however, this section will attempt to address the problems in the functioning of programmes on a somewhat broader basis.

(1) Poor Working and Living Conditions. The greatest need for primary health care programmes in developing countries is in rural areas, and life there offers few of the amenities to which staff trained in urban centres are accustomed. While most countries are devising strategies to make rural health work and rural life more attractive to such personnel, work in many rural health centres remains difficult; the physical structure is often deteriorated, and may lack properly functioning heat, water and electricity. When personal housing is provided for staff, it may be modest and in poor condition; schools for dependents of personnel from urban areas are usually below the standards to which they are accustomed. A particular need in most countries is housing for young unmarried female staff such as nurse-midwives whose posting to areas other than the home village may be culturally unacceptable without appropriate housing. These are, of course, problems inherent in rurality, but they must be recognized as requiring various compensatory measures.

(2) Inadequate Salaries and Incentives. Among the greatest obstacles to organizing adequate PHC programmes is the low level of salaries paid to all levels of staff. The typically low public service salaries are undoubtedly responsible for short periods of public employment and high turnover.

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Physician salaries are a particular problem, insofar as - unlike most other personnel - doctors have an alternative option to engage in private practice. There may sometimes be financial awards for meritorious service, but they are not very large.

Remuneration for community health workers presents special problems. Ordinarily, countries do not want to pay CHWs official salaries. They are sometimes regarded as "volunteers", and may receive only compensation for their work expenses. In reality, these small amounts may be the only monetary income of the CHW, and therefore are significant for their stability in the PHC work. Governments differ on this policy question and international agencies tend to be reluctant to finance such personnel expenditures, but experience has shown that reliance on "volunteerism" is unrealistic for sustained health activities (as against one-time compaigns in village clean-up, immunization, etc.).

(3) Weak Health System Management. The above problems concern the management of a health care system, but there are other more fundamental difficulties. In all the study countries, responsibilities in the Ministries of Health (and other ministries) are highly centralized. Even when MOH officials function at a provincial or district level, they have usually been appointed by central authorities and often must get approval from the top for almost anything involving the expenditure of money. This policy causes delays, inefficiencies and irritations. Proper management also requires a flow of information on the operation of health programmes - information on patients seen, services provided, problems encountered, etc. Seldom do such information systems function efficiently. Sometimes there are printed forms to be used, but they are not filled out. In some higher-level offices receiving such forms, they pile up and are not analysed.

Official personnel policies, another aspect of management, may be counter-productive. In one of the study-countries, any physician doing clinical work is paid more than a physician whose main duties are administrative. Thus a Provincial Health Officer receives a lower salary than a fresh young medical graduate treating patients. The problems of inadequate training in teamwork and supervision are further obstacles to good management, discussed above. Another impediment to supervision is simply the frequent inadequacy of communication (if telephones do not work) and transportation (if vehicles are not available). The isolated health worker is often left with little or no supervision or consultation.

(4) Problems with Equipment and Supplies. Operational equipment and adequate supplies can be crucial in a PHC programme, and yet they are often lacking in health facilities. The supply of drugs and vaccines is particularly important, but - depending often on imports from abroad - they may simply be unavailable. Even when available in a central depot, the logistical process of getting them out to rural units may break down, causing serious delays. Recurrent costs of drugs are a chronic problem. Vehicles may be available, but without fuel. Refrigerators, important for storing vaccines, may not work for lack of spare parts; personnel with the necessary skills may not be available to maintain equipment in working order.

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(5) Meagre Community Participation. One of the weakest aspects of the PHC programmes in the six study-countries relates to the involvement of the community. While a village or municipality may contribute land or money for establishing a health centre and even labour for its construction, local people rarely are involved in deciding priorities for health unit operation. In some countries local Health Councils are established to represent community people in programme administration, but - sometimes after initial enthusiasm - they seldom meet and do not function. Co-operative work by local people is essential in improvement of water supplies and sanitation, but this usually requires mobilization and guidance by sanitarians, which is often lacking. Campaigns against snails or other disease vectors can be carried out by community groups, with proper technical leadership and inter-sectoral co-operation, but this has not been observed in the country studies.

(6) Weak Intersectoral Co-operation. While it is widely recognized that health depends on far more than health services, implementation of this concept has proven difficult. At the local, provincial and central levels, health personnel are often overburdened with their own work. Opportunities to improve environmental sanitation through association with agricultural and public works personnel are not exploited. Seldom does the PHC nurse have the authority to gain access to children in the schools. Even within a Ministry of Health, theoretically committed to primary health care integration at the local level, local operation of specialized vertical programmes in such fields as malaria control or family planning often continues.

(7) Weak Preventive Orientation. While curative health services are an essential responsibility of health personnel, much too often preventive and health promotive activities are overlooked both in training personnel and in the functioning of the health post. Overworked staff, under pressure from the community to provide curative services, may have little time or energy to devote to prevention activities, even where their training has included it. Moreover, prevention is an overall orientation rather than a discrete set of activities which is needed at all levels, from CHWs to doctors.

(8) Low Utilization of Services. As a result of the many problems summarized above, both in health manpower development and in the functioning of PHC programmes, it is not surprising that many community people seem to have relatively low regard for the PHC services of health centres or other local health units. Analysis of utilization rates in countries studied shows them to be very low, by comparison with other programmes in the same country (such as health insurance schemes), with health care utilization rates in other countries, with the capacities of the health facility staffs, or with obvious evidence of health needs.

In spite of (or perhaps because of) the low rates of utilization of PHC services, the data suggest that hospital out-patient departments are heavily used and overcrowded. Clients with ailments which could be handled at the health post, by-pass it and go to a hospital where they are aware that they will see a Specialist rather than a general medical practitioner, non-medical community health worker (or perhaps neither of these types of personnel) at

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the health poor. In some countries there is evidence that physicians are offering private medical services, even in rural areas, for which individuals and families are paying personally. Alternatively, patients consult a traditional healer or a private physician.

(9) Disease and Waste. The ultimate cost of all the inefficiencies and other problems reviewed is persistent disease and death, excessive birth rates and unnecessary waste in the use of resources. Children and adults do not receive preventive and/or treatment services that could avert disease or cure it; instead they get seriously sick and may die. We see the evidence of this in the high infant mortality rates and the relatively low life expectancies of all six of the study-countries.

Waste is easy to demonstrate. The low utilization of PHC resources means that those resources are not fully utilized. In countries with serious shortages of personnel - according to widely accepted standards - one sees doctors, nurses, and others sitting around and waiting for patients who do not come. The money paid for their salaries is wasted and, more important, the capability of these personnel to serve people is squandered.

6.3 Underlying Issues

All of the problems in health manpower development and primary health care functions may, in a deeper sense, be regarded as symptoms of certain underlying issues. Exploration of these basic social issues in depth is impossible here, but they may be identified briefly.

(1) Inadequate Health Funds in the National Budget. Where total figures were available in the study countries, the funds allocated to the Ministry of Health have been only a very small percentage of the national government budget. They usually amount to less than 5 percent for both recurrent and capital costs, and in at least two of the six study-countries this figure has been declining in recent years. This reflects, of course, low government priorities.

(2) Low Regard for Primary Health Care. Comprehensive health services include a wide range of technical activities for the diagnosis, treatment, and rehabilitation of diseased persons, as well as for prevention and health promotion. The complex technologies found in hospitals have a dramatic quality not seen in the day-to-day tasks of health maintenance. Primary health care, therefore, tends to be appreciated by many people at much less than its true value. These attitudes are unfortunately reflected in the budgetary allotments of Ministries of Health.

There are, of course, health expenditures by ministries other than the Ministry of Health, but the MOH is the major source of public support for PHC furnished to the general population. Yet, analysis of MOH expenditures nearly always shows the lion's share of funds - usually over 50 percent - to go to the support of hospitals and reflect an urban emphasis rather than a rural one. Primary health care tends to occupy a very important place in the declared priorities of health authorities, but not in the way that the available funds are actually allocated and spent.

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(3) The Private Health Care Market. Private household expenditures for health services have not been quantified in many developing countries, but where they have been, they have usually been found to be large - larger indeed than overall government health expenditure. In one of the study countries where this question has been investigated, private health expenditures were found to account for some 60 percent of the total. A large share of these personal expenditures goes for primary health care, including private physicians, traditional healers and self-prescribed drugs. These expenditures result not only in serious inequities, but also in serious inefficiencies. They mean inequities because the services go to those with most money to spend, rather than to those in greatest need. They mean inefficiencies, because the lack of planning and organization in the private medical market is inevitably wasteful. Private incentives even mean that patients may be given services that are unjustified and unnecessary because they yield a fee to the provider.

(4) External Support for Health. In the next Chapter we will examine in more detail the process of external support for health. One fundamental question involved is the level of resources which developed countries are prepared to make available to developing countries; on a global level this is less than 0.5 percent and health expenditures are only a very small percentage of this. Even if the inefficiencies noted previously did not exist, the impact of external health support on the developing countries would be small. Inefficiencies and lack of co-ordination unfortunately make the impact even smaller.

(5) Political Commitment. Probably most fundamental of all the issues that lie beneath problems in HRD/PHC is the political will of each nation for the advancement of its people's health. Since WHO was founded in 1948 and especially since the Alma Ata Conference of 1978, declarations about health as a "basic human right" and about the goal of "health for all" have been made by health leaders in every country. But there is a vast difference between declarations and actions taken to implement them. The gap between these two is determined by the degree of political commitment to health in a country. This, in turn, is influenced by countless different forces in each national society.

6.4 Health Project Evaluation

The evaluation of projects in primary health care, as in any other cross-sectoral, multi-disciplinary field, is inherently difficult. As regards the problems outlined in this study, each problem has its explanations, and pointing a finger of blame at any one international or national organization does not usually serve to right the situation. By its nature, national development in health and every other sector is a complicated process, bound to involve delays. Perhaps the most important lesson is that, with very limited resources, goals must not be too ambitious, and time-schedules should anticipate the probability of delays. Otherwise both national and international staff can become frustrated and demoralized.

The ultimate evaluation of a health project must depend on its impacts on the health of the people. Is there evidence that the activities of the project have made them healthier? Is there a reduction of [illegible]

morbidity or an improvement in the capability of people to work and function in society? Is there evidence of improved nutritional status in children? Are there lower rates of parasitic infestation? These are, of course, very difficult to measure - even so straightforward an index as the infant mortality rate in a defined geographic area. Even if an objective improvement in some such measure can be demonstrated, it can seldom be concluded that the change has been due solely to the project under study, and not also to other related social and environmental circumstances. Moreover, the slightest real change in the health status of a population usually takes years to demonstrate.

Evaluation of activities in the field of human resource development is particularly difficult. One may assess what students have learned in a course, through examinations. But the crucial question is what effect does the course have on the graduates' subsequent performance. Determining this, in relation to other influences on performance, is not so easy.

In the face of such difficulties in evaluating health impacts or outcomes, most health and social scientists must be satisfied with more modest criteria for assessment. Is there improved "coverage" of a population, for example, with personnel providing primary health care? Are they accessible more equitably than in the past? Can it be shown that a project has resulted in a higher rate of utilization of certain services by the people? Such measurements of the "process" of health care are easier to make, and yet again there are difficulties. "Baseline data" on conditions before the project must be available, and often they are not. Also, one must still face the question of whether any changes identified can be attributed to the project. Perhaps the mere passage of time in a country brings changes in the health behaviour of people, with or without any specific intervention that an international project may provide. There are comparative research designs that can overcome these difficulties, but it is costly to carry them out and they must be carefully planned in advance.

It is small wonder, therefore, that many attempts at evaluation of health projects, international and national, continue to be too descriptive and impressionistic. One observes events and talks with the personnel involved. Are they satisfied with what has been happening? Is there evidence that people (patients) are pleased with the service? What problems - physical, behavioural, social - have been encountered? Have plans been frustrated and, if so, how much has been due to defects in the planning or to events beyond anyone's control? After a reasonable time has passed, to what extent do the realities of a programme correspond to the original plan?

Despite all the difficulties, evaluation of health projects must be attempted. Primary health care is especially difficult to evaluate, because it encompasses so many activities. In general, if the object of study can be narrowed down, successful evaluation is more likely. The performance of specified immunisations, the childbirths occurring under hygienic conditions, the households accessible to safe water, the proportion of school children with signs of malnutrition, the percentage of women of child-bearing age accepting family planning methods, the rate of malaria parasites detectable in blood smears - such measurements are much more feasible than "primary

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health ... ire" as a whole. Yet each of these specific criteria requires the collect ...n of information ...nd its recording. The findings must also be interpr... ...ed against a background of knowledge about the total health care system ...nd, indeed, the overall environment) in which an activity is being evaluat... ...l. In the long run, such efforts have always been necessary for the advance... ...nt of health sciences and health services.

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RECOMMENDATIONS FOR STRENGTHENING HUMAN RESOURCE DEVELOPMENT FOR PRIMARY HEALTH CARE THROUGH EXTERNAL SUPPORT

Solution of the problems or reduction of the difficulties reviewed in the last chapter obviously must depend on national actions and actions suitable to the conditions in each country. Externally-financed technical co-operation is obviously not appropriate for all problems. International agencies may help by supporting such actions or sometimes by suggesting strategies that have been effective in other countries. It must be emphasized that internationally-funded projects or activities are effective only insofar as they support national objectives.

In this chapter some recommendations are made on human resource development for health and the functioning of primary care systems. While they are presented in a roughly logical sequence, the rank order of the proposals, however, should not be interpreted as implying any recommended priorities. Decisions on first-level or second-level priorities will obviously vary in different countries, and at different times in the same country. Priority ratings for the development of primary health care necessarily depend on considerations of resources, deficiencies, historical experiences and political factors in each national health system.

7.1 Development of Human Resource for Health

Actions needed to improve health human resource development should correspond to the problems identified: recommendations here roughly parallel the problems identified in Chapter VI. However the most appropriate international strategy will vary with the category of health personnel and the country involved.

(1) Increasing the Supply of Health Personnel. In countries with a low supply of doctors, the training of "community health workers" deserves higher priority than the formation or expansion of medical schools. Still a certain minimum number of doctors are needed for the proper operation of a national health care system. Qualified women should be admitted to medical schools on the same basis as men. International agencies can provide consultants, fellowships, equipment, teaching materials, etc. to help establish or enlarge medical schools.

The training of nurses, midwives, pharmacists, sanitarians and other basic types of health personnel can usually be undertaken within the normal resources of hospitals but it is important to develop hospital-based training schools which make use of community settings for teaching students about the social and preventive aspects of PHC. The training of sanitarians in adequate numbers is especially urgent, but it is made difficult by the lack of qualified teachers. Because this work usually pays very low salaries, the most competent sanitarians often leave government for private employment or change to other occupations. External support can provide incentives (including salary supplementation) to teachers, effective teaching materials and housing for students. The schools may be multi-disciplinary institutions, where laboratory technicians, pharmacy assistants and others are taught - with common instruction in basic biology and chemistry.

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(2) Improving the Social Content and Methods of Health Training. The possible role of international agencies for improvement of the social and community content of health training is substantial. In all six study-countries, no deficiency in PHC personnel training is more general than the weak place of community field experience or social science instruction in the preparation of students. Education on the purely technical aspects of medicine, nursing, midwifery and sanitation may be very well provided, but the social, behavioural and environmental aspects of primary health care are almost ignored or, more often, taught only superficially and ineffectively.

In medical education, there are several ways by which the policies might be improved. Departments of Community Medicine (sometimes "preventive and social medicine") are typically small and weak. They require enlargement and further training of their faculties. Secondly, every medical student should have a social exposure to community health work in a rural as well as an urban area - experience at least equivalent in depth and breadth to that received in hospitals on surgery or other clinical subjects. Thirdly, all clinical faculty should be required to teach the social aspects of their subjects - e.g. teaching paediatricians the social aspects of child health, the social aspects of communicable disease, etc. (If faculty members in these clinical departments are incapable of teaching such subjects, they should either learn them or invite others to teach them.)

Teaching methods in most professional health schools have not caught up with modern pedagogical knowledge. Formal lectures are delivered on classical subjects, without regard to their impact on students' learning or understanding. Much education can be made more effective by teaching teachers how to teach, and helping teachers design courses that enable students to solve problems in the real world. (WHO offers a major advisory programme on this matter.)

Equivalent changes should be promoted in schools of nursing, sanitation, etc. In fact, the establishment of field training areas could well serve the training needs of all the PHC health disciplines. In several countries, such field training areas have been established, but they are inadequately staffed or used only by certain schools. The field training areas, in different parts of a country, should be subject to change, but should have the same importance as that now held by hospitals. As part of the field training, students could participate in household surveys on various health problems, which would contribute not only to their education, but also to research on medical/social/environmental problems.

(3) Encouragement of Health Human Resource Planning. Technical co-operation can serve as the catalyst to bring together Ministries of Health, Ministries of Education and universities to adjust training programmes to the needs of the health services. It can also give advice on how to quantify existing health human resources (often quite different from the names on official "registers") and to make reasonable estimates of future needs. Joint councils of health and educational authorities can be very useful for health human resource planning which should, of course, be carried out as part of the planning of overall health systems.

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(4) Effective Training of Community Health Workers. The training of new types of multi-purpose auxiliary health workers has helped to make PHC accessible to rural populations in many countries, but aspects of the concept remain to be clarified. Objective assessment of the situation by national and international experts can lead to sound policies for an effective schedule of training, training of trainers, proper teaching methods, scope of functions, relationships with other health personnel, proper supervision, continuing education, etc. Both women and men should become trained for this work, preferably themselves coming from rural communities; however, even these CHWs may lack community orientation in their work, and need additional training. Finally, very brief training of village "health communicators" or "health promoters" is needed to acquaint people with the availability of PHC units and advise on simple elements of hygiene.

(5) In-service and Continuing Education. The systematic provision of continuing education, according to a practical periodic schedule, is needed by all health personnel. This requires careful planning and administration, physical facilities where teaching can be done and participants housed, as well as proper teachers and teaching materials. The "field training areas" recommended above to enrich the community content of basic health personnel education, can serve also as the sites for continuing education. In-service training, often needed at the beginning of employment in a health post, is a good way for new health workers to learn about teamwork. Acquiring teamwork skills and attitudes can be facilitated by regular meetings of health centre staffs to discuss cases and general problems.

(6) Effective Relations with Traditional Healers. While some traditional healers are highly entrepreneurial and concerned with personal gain, others - probably more frequently among traditional birth attendants - welcome new knowledge about methods of treating and preventing disease. The formal health system, including external technical co-operation, can learn to collaborate with and teach traditional healers, so that they provide beneficial PHC services. Regular but short courses can be given to traditional healers for this purpose, a practice that has been most often done with TBAs.

7.2 Functioning of Primary Health Care

After health personnel are trained, conditions need to be created whereby their work can be well done and effective. Physical settings have an influence on the feelings and attitudes of both patients and health workers and attention should be given to the work setting and the social environment around it.

(1) Improved Working Conditions. To some extent, attractive working conditions are a matter of physical structure and its maintenance. The health post, examining room, laboratory, waiting areas, equipment, pharmacy and its essential drug supply, water and sanitation arrangements should all be as orderly and well maintained as possible. The same applies to personal housing provided for staff members. Technical co-operation can help on such matters, even though physical measures alone are never enough.

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(2) Better Salaries and Incentives. Salary levels in most countries have certain uniformities among different ministries, so that changing them in the Ministry of Health or any other single Ministry is usually difficult. It should be possible, however, within the boundaries of a MOH, to re-arrange the levels payable to different kinds of health personnel. If primary health care is to be truly accorded high priority, this should be reflected in higher salaries paid to its providers. Increments for continuing service and seniority should also be designed to encourage continuity.

Several countries among those studied have mandated periods of public service (usually rural) for all or most new medical graduates. In one country, students with higher scholastic records escape this obligation and may directly enter specialty training - an unfortunate policy since it makes those serving in rural posts feel 'punished" and "second class". Mandatory rural service is a way of the student's paying back society for a socially-financed professional education, and it should be required equally of all graduates. In fact, greater rewards and incentives should be built into these programmes, so that young doctors work at optimum levels. A system of periodic reporting and review should be feasible. It is also important to support the young graduate with proper supervision and to provide her or him with opportunities for consultation.

Incentives through rewards for meritorious service are also feasible for all health personnel. Financial increments can be combined with honour, recognition and opportunities for further training. If such rewards go to perhaps 10 per cent of health workers per year, the costs need not be very high. Financial support for such policies might even be explored by international agencies, as has been done by philanthropic foundations in the past, in order to test the value of an idea.

Regarding community health workers, although the prevailing policy in many countries is to pay them no salaries, this policy should be more flexible. When CHWs carry crucial responsibilities for PHC, both national and international agencies should not hesitate to pay them amounts beyond the compensation for their working expenses. Such expenditure would be only minor in the overall health sector budget and would go a long way toward alleviating the sense of disillusionment and high drop-out rate among CHWs.

Other strategies for elevating salaries are being tried. Small charges to patients for drugs can go into a "revolving fund" for purchase of further drugs, and paying small salary increments. Where community participation is mobilized, this can include the organization of a health co-operative, to which all local families contribute small periodic sums for supplementing staff salaries and improvements in the health facility. Where the financial benefit increases the diligence and devotion of health unit staff, the payoff to the community in better service is apparent.

(3) Efficient Health System Management. One of the most concrete and definite ways that PHC programmes can be improved is by strengthening the managerial process in national health care systems. Strengthening is needed at all levels, but especially at provincial and local levels.

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Providing supervision is essential, and this ability does not belong intuitively to every person in a supervisory capacity. For professional personnel, supervision, administration and planning -- the essentials of teamwork -- can be trained at graduate level such as a School of Public Health, as discussed more fully below.

Proper management includes mechanisms for producing, transmitting, organizing, and using information. Information systems are essential to programme evaluation as well as day-to-day management. Without a reliable flow of information on morbidity/mortality, use of human resources, and provision of services to people, evaluation essential for programme planning is very difficult to carry out. Other management essentials include logistics for assuring drugs and other supplies, maintenance of equipment and vehicles, and records on personnel schedules and on all financial matters. At the community level management has an important role to play in achieving effective integration of health programmes . As noted earlier, certain vertical activities (e.g. family planning) may persist in a country for historical reasons, but every effort should be made to integrate these with overall PHC programmes as soon and as efficiently as possible.

To do all these managerial tasks efficiently requires special training. A medical head of a health centre team should not be expected to carry all these responsibilities, in addition to community health and clinical duties. The training of "Health Care Managers" is a realistic solution, for which external support could be highly valuable. An appropriate locale for such training would be a School of Public Health.

(4) Active Community Involvement. Rarely is there a community in a developing country that spontaneously develops the initiative to launch a programme for primary care. A dramatic event, such as an epidemic, may stimulate action, but ordinarily action must be promoted by the health workers themselves. Chapter VI notes the typically limited performance of sanitarians, doctors, and nurses in this regard, and little should be expected unless modifications are made in their training.

In public health affairs, the personnel with training specifically oriented to community organization are "Health Educators". Their skills with posters and talks and audio-visual presentations are generally known, but much more important is their ability - when properly trained - to communicate with the natural leadership and understand the prevailing attitudes of local people, so as to mobilize community action. This concept of health education might be better described as "community health organization". All PHC programmes should have trained Health Educators of this type, not at every local facility, but at a district or provincial level from which every local area can be reached.

The work of the Health Educator should be of two types: first, to orient all health personnel in the PHC programme (especially field workers and their supervisors) on the concepts and methods of health education, and second, to work directly with community leaders and local people in the attempt to demonstrate the value of community participation. The training of Health Educators, like Health Care Managers, should be at a School of Public Health.

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(5) Strong Inter-sectoral Co-operation. Organizing health benefits achievable through schools, agriculture, and other sectors is a task mainly for PHC team leadership. This would include leadership at local health centres, as well as leadership at district and provincial levels. Obviously inter-ministerial health councils at the national level can be most helpful of all, but they are often more difficult to achieve and, if established, to keep active. Proper training and continuing education of PHC leaders is required for this objective.

7.3 Schools of Public Health or Health Development Institutes

References have been made above to the need for a School of Public Health available to each country for training PHC leaders, Health Care Managers, Health Educators, and others. In recent years, some countries have designated such schools as "Health Development Institutes". The terms "School of Public Health" and "Health Development Institute" are treated as synonymous in this section. In three of the six countries studied, some such school or institute existed, but for various historical reasons it was not playing its potential and appropriate role.

Almost every country has a school of medicine, or several of these, not only to train physicians but also to provide leadership role for medical science and service in the country. However schools of medicine, it must be recognized, are inevitably oriented to the treatment of disease in the individual patient. Their educational programmes are built on basic sciences of anatomy, pathology, biochemistry, physiology, etc. and their curricula culminate in internal medicine, surgery, paediatrics, obstetrics, gynecology, ophthalmology, neuro-psychiatry, etc. Aside from the classroom, their places of learning are the laboratory and the hospital ward.

The goals and methods of public health and of primary care, as now understood, are very different. Their orientation is not to individual patients but to communities and populations. Their tasks are mainly preventive, and curative only in an organizational sense. The basic sciences of public health are not anatomy, etc. but sociology, economics, political science, statistics, nutritional science, sanitary engineering, management, ecology, etc. The culmination of their curricula is in disciplines relevant to the population: epidemiology, community health education, public health planning, health care management, applied nutrition, environmental management, health information systems, and so on. Their major places of learning are in communities, rural and urban. In such settings, and in the study of such disciplines, requirements for good primary health care programmes - like teamwork, supervision, motivation, etc. - should be learned naturally without necessarily labelling them as such.

Health Development Institutes must be multi-disciplinary not only in the subjects they teach, but also in the students they admit and the personnel they turn out. The need for training Health Educators and Health Care Managers in such schools has been discussed earlier. In addition, teachers and leaders in nursing, midwifery, environmental sanitation, nutrition, health information (statistics), communicable disease control (epidemiology) and other fields should be trained. Perhaps most important, general Medical

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Officers of Health should study in the School or Institute for at least one year. With such education, one may expect that national, provincial and district leaders in public health and primary care will acquire not only the necessary technical knowledge, but also the motivation and inspiration to provide effective leadership to all other personnel.

Like a school of medicine, every country should have access to a national or regional Health Development Institute, not only to train urgently needed categories of personnel, but also to provide general status and inspiration to the whole field of advancing the health of populations. The average doctor and nurse should, of course, also have some appreciation of public health (or "community medicine", as it may be called, or perhaps "preventive and social medicine"), but departments teaching this field are invariably of very minor importance in medical schools - inevitably dominated by the laboratory sciences and clinical disciplines. Public health is usually regarded by both faculty and students as a diversion from the central purpose of medical education - the diagnosis and treatment of the individual patient. Countless attempts to strengthen departments of public health in medical schools have been unsuccessful. Other attempts to inject a "social point of view" in each of the clinical disciplines have had moderate success in a handful -- perhaps in one per cent -- of the world's medical schools.

The strategy, therefore, should be to develop firmly grounded Health Development Institutes accessible to or in all countries. They should be university-based, but as medical and nursing schools are linked to hospitals, these Institutes should be linked to Ministries of Health or major provincial Departments of Health. Academic degrees might be awarded for certain programmes of study, but not necessarily for all. The Institutes should not only train personnel, but should do research on the problems of the health care system, and provide consultation and leadership. Development of the faculty and resources for such institutions in developing countries would take time, but such development would be an extremely useful objective for external international support.

7.4 Co-ordination of External Technical Co-operation for Health

Co-ordination of international technical co-operation, both multilateral and bilateral, has been discussed in Chapter V. It was clear that co-ordination is necessary, not so much to prevent overlap in particular geographic areas, as to provide technical co-operation that corresponds to the priorities of the recipient country rather than to those of the external agencies. Almost any developing country welcomes financial support for any reasonable purpose; the needs are so great in every sector. But the most effective support is naturally that which co-incides with the overall planning strategy and priorities of the country. To achieve this, co-ordination should be improved on three levels.

(1) Within national governments, general planning units or similar bodies with overall responsibilities should co-ordinate technical co-operation activities for health from all sources. Likewise, Ministries of Health should contain a unit responsible for monitoring, co-ordinating and

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hopefully, peace. The second and less obvious, is that the health sector is, in fact, one of the most amenable of the many sectors of society requiring change for achieving speedier national development; unlike land ownership, housing, industrial production or foreign policy, it does not touch the deep roots of the basic power structure in a nation. Although some changes in health care may be subject to debate, they are not controversial in the sense of significant changes in other sectors. This is why so many developed countries have benefitted from major reforms in their health care systems, without social upheavals. Important reforms and improvements in health care systems, including PHC, can be made with relative ease politically, for a relatively small price economically, and with large payoffs. The benefit-cost ratio of improved health services is high, especially in developing countries where the main diseases are so readily preventable. The benefits can be high both economically and politically, because every family is concerned with disease and health every year or even every day.

Tackling the "underlying issues" that explain the problems of HRD/PHC, as summarized in Chapter VI, need not, therefore, be so weighty a task as might at first appear. The social forces that can lead to political commitment for health include all sorts of population groupings - farmer's associations, labour unions, women's leagues, religious groups - for whose members health usually has deep personal meaning. If the political commitment to work toward "health for all" can be achieved, the other strategies should be implementable without great difficulty. It is quite feasible to mobilize the large expenditures, already being made in the private sector, for the public sector of health. It has to a significant extent already been done in the many countries - developed and developing - with social security programmes for health service. If this can be done, an increase in the health sector's share of total governmental expenditures and in the PHC share of health expenditures, should be implementable in relatively short order.

Thus attainment of "health for all" in a country can demonstrate concretely and dramatically the benefits of planning, community efforts, and social change, for everyone to see. The primary health care orientation of an effective health care system brings benefits even closer to the field of observation of every family. Such achievements in health can encourage equivalent actions for social reform in the many other sectors contributing to national development.

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1. PROBLEM IDENTIFICATION

THE PRIMARY HEALTH CARE CONCEPT

Primary Health Care is not a new phenomenon. Since time memorial a patient has had a possibility to be cared for by a doctor or other health person in case of illness or infirmity. There has been a referral system - the doctor has referred the patient to secondary or tertiary health care level if need be. The service has largely been centered on the physician. Another typical feature has been the concentration, more or less entirely, on curative care. Still another feature has been the great concentration of this curative care to urban centres. Even this is not a new phenomenon. It was more natural to place the hospitals in areas with higher population density.

However, with increasing number of hospital beds and increased number of physicians and other health workers - all concentrated in urban areas - the inequalities became most disturbing in developing countries with poor resources and where 80 per cent or more of the population are living in rural areas.

During the early 1970s the international community became increasingly concerned about unequal and slow development. It should also be stressed that in quite a few developing countries the pattern of maldistribution of health services had been inherited from the previous colonial powers.

One of the most important meetings ever held in the field of health services was in 1978 in Alma Ata in the Soviet Union. On September 12, 1978 the international conference on Primary Health Care meeting in Alma Ata made a most important declaration expressing the need for urgent action by all governments, all health and development workers and the world community, to protect and promote health for all people of the world. The Conference strongly reaffirmed that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is a fundamental human right. The attainment of the highest possible level of health worldwide is a most important social goal, the realization of which requires the action of social and economic sectors in addition to health.

The conference underlined that the existing gross

inequalities 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, therefore, a concern to all countries.

Economic and social development 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 health of the people is essential to sustained economic and social development and contributes to a better quality of life.

The conference stressed that the people themselves had the right and the duty to participate individually and collectively in the planning and implementation of their health care, but also that governments have responsibility for the health of their people. The main social target of governments, international organizations and the whole world community should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to live a socially and economically productive life. It was stressed that PHC is the key to attaining this target as a part of development in the spirit of social justice.

Primary health care has been identified as essential health care based on practical, scientifically sound and socially acceptable methods and technology which is made universally accessible to individuals and families in the community through their full participation and at the cost that the community and the country can afford to maintain in the spirit of self-reliance and self-determination. The PHC should form an integral part both of a 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 should be 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 elements of a continuing health care process.

The declaration of Alma Ata further stresses that primary health care should reflect and evolve from the economic conditions and socio-cultural and political characteristics of the country and be based on the results of social, medical and health services research and public health experience.

It should address the main health problems in the community

providing promotive, preventive, curative and rehabilitative services accordingly.

It should include the following eight elements:

E ducation
L ocal disease control
E xpanded Programme of Immunization
M CH and family planning
E ssential drugs
N utrition and food supplies
T reatment and prevention
S afe water supply and sanitation

It should involve in addition to the health sector all related sectors and demand the co-ordinated efforts of all these sectors including agriculture, education, communication and so forth.

It should require the self-reliance and participation in the planning, organization and operation and control of PHC and making fullest use of local, national or other available resources.

It should be sustained by an integrated functional and mutually supportive referral system and lead to a progressive improvement of comprehensive health care for all, giving priority to those most in need.

Finally, it should rely both at the local and at the referral level 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.

The declaration further stresses that 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 co-ordination with other sectors. To this end it would be necessary to exercise a political will to mobilize the country's resources and to use available external resources rationally.

It is about five years since the famous PHC declaration was made. It is a short period when it comes to planning and implementation of a reorientation of national health systems. The PHC concept has been interpreted in many

different ways depending on the prerequisites in different countries. It has to do with the national resources, it has to do with the population density, it has to do with the value system and the way people are used to refer and turn to the health system.

It can be foreseen that between now and the year 2000 when there should be health, or at least health service for all, there will be an interesting development in this field.

PRIMARY HEALTH CARE IN SOMALIA

Following the Alma Ata declaration of 1978, the Somali Ministry of Health prepared a health development strategy, based on the PHC approach as outlined in the National Health Plan (1980-85). The Ministry has established a PHC Central Policy Committee, a Primary Health Care Co-ordinating Unit within the Ministry as well as a PHC National Office.

The PHC activities in Somalia were started in 1981. The international, bilateral and non-governmental agencies assisting the programme in different regions are listed below (Table 1):

TABLE 1. PHC activities in Somalia

REGION	AGENCY
Lower/Middle Shabelle and N/west	Unicef/WHO (1987)
Sanag	Community Aid Abroad (1982)
Gedo	Caritas, Germany (1992)
Mudug and L/Juba	USAID (1986)
Bay and Togdher	USAID (1984)
Hiran	Italy (1984)
Middle Juba	Swedish Church Relief (1984)

Infrastructure

The national PHC office in Mogadishu has to supervise and co-ordinate PHC activities at all levels: to plan, organize and develop standardized curricula and to give logistic support to the middle level and the periphery.

The regional PHC co-ordinator supervises the district PHC co-ordinator, who supervises the first level of health facilities: the [illegible] unit, which serves 5000-10000 persons and health posts that serve 3000-4000 persons.

The [illegible] Unit with its team (Nurse, Sanitarian and Midwife) supervises and trains Traditional Birth Attendants (TBAs) and community health workers (CHWs) [illegible] (health posts) and facilities and co-ordinates those activities with the work of other sectors [illegible] also keeps the contact with the village

CHAPTER 5

Population and Family Planning

Sex and self preservation are two major biological urges of the mankind. Sex results in procreation. Children provide emotional satisfaction to parents. In patriarchial societies, the girls move to another family after marriage. In traditional societies and in joint families, boys stay with their parents and look after them when they are old. In most developing coutries, the son provides social security to parents. Most families try to have at least two sons. If one child unfortunately dies, the other child could look after them in their old age. To get two living sons, the family generally needs to bear an average of 4 children. In families with experience of early childhood deaths, more children are born to compensate for these deaths. There has been a steady improvement in the health status of people. Illnesses and scourages of yester-years are disappearing. Smallpox has been eradicated from the world. There are fewer deaths due to malaria, Kala azar, tuberculosis and other communicable diseases. More people survive longer, but death rates among infants and young children have not declined as dramatically and substantially as in adults. Two out of 5 children die before they are 5 years old. Parents lose confidence and are afraid that their surviving children might die due to lack of good medical care.

We live in a finite world. The growing number of people need houses to live in for which there will always be limited space and increasing demand. It will be a stupendous task to provide adequate housing to all people in the years to come. Besides housing, there must be other community facilities such as roads, shopping centers, schools, playgrounds, safe

potable water supply and means of disposal of waste water of cities.

Factories installed to provide the increasig needs of the people encroach on the fast diminishing landmass available for agriculture and food production. Already many poorer countries of the world cannot produce all the food for providing minimum nutritional needs of the people and have to import food at huge cost.

Less and less money becomes available for other developmental activities, needed for raising the standard of living of people. Some scientists feel that with new improved seeds, biotechnology and better use of fertilisers, food yield could be increased many fold. With the current advances in science and technology, the world might be able to tide over the food crisis for a few more decades even if the population continues to increase at the present rate. But this cannot continue till infinity.

There is increasing demand for limited available goods. The industrial growth may satisfy the needs of people for several decades. The cost of energy for industrial use and transportation has increased several fold; the prices of commodities are rising beyond a reasonable level. Most people already find the inflation raising its ugly head all over the world, a crushing burden for survival.

Educational facilities are not increasing at the same rate as the population. It is a greater struggle for young people to get appropriate educational experiences. More and more young people are entering the job market without full educational preparation. They are chasing fewer and fewer jobs. Unemployment is a major social problem in all countries of the world, largely responsible for the social tension among urban underemployed frustrated youth who take to life of crime and find it easy to take refuge in large overcrowded cities.

The social strife due to rising population and diminishing opportunities is manifesting as conflicts between the rich and poor, different ethnic groups and among religious denominational groups.

The dreadful prospect of spiralling population and its impact on social, cultural and economic ethos are awesome for the world leaders, the rulers and the government officers,

who conduct the affairs of the country. But these are of little concern or at least are not well understood by an average man in the village. His little world is often limited to his immediate family. He is only obsessed with his own survival for today and possibly for tomorrow. It is of little concern to him, what will happen to the world in future, if he continues to beget too may children. He will be anxious only if a catastrophy falls on his family, his wife and children. The common man will be motivated to limit his family size, only if he comprehends the direct benefits of family planning to his little private world.

In the villages many girls are maried young. If they bear children before they are twenty years old, it affects their health badly. A 15 to 16 years old girl herself needs more food for her growth. If she gets a baby, she becomes more pale and undernourished. She is too small and fragile to bear the strain of pregnancy. In the child-bearing ages, many mother deaths are attributed to child bearing. More of these occur in mothers who are below the age of 20 or above the age of 35 years. Women should know that it is safer for them to bear children between the ages of 20 and 30, when they are healthy and strong. If the baby is born before the mother is 20 years old, there is a greater chance that the baby may die before delivery. It may be born before full term or may be so small in size that it may find it difficult to suck at breast or cope with the outside environment. It may die soon after birth. Some such small babies may survive the first few weeks of life, but they remain small for years and do not do as well in later life as compared with the babies of normal birth weight. They may not be mentally as alert and many do poorly at school.

There is a greater risk both to the mother and child if the mother's age is over 35 years. More older mothers die of repeated child births. They become severely pale, weak and ill during pregnancy.

It has been seen that a large proportion of babies of older mothers have birth-defects and mental retardation due to causes such as Down syndrome (which was erroneously called a Mongol child, because of a superficial resemblance to features of Mongol races). Another problem of having babies at late age is that when children reach a marriageable

age and require to be settled in life, parents have become too old to arrange for these and provide for their needs.

Mother should be told not to have pregnancy too soon after the birth of the first child. It is risky for her to suffer the pangs of second pregnancy, before she has recovered from the weakness caused by the first. There is a higher risk of maternal deaths and more serious complication of pregnancy.

Since the mother is not able to breast feed the earlier baby due to the onset of next pregnancy, health of the first child may suffer. The mother may be too tired to look after the first baby, who may suffer from infectious illnesses and is more vulnerable to die just because the second pregnancy occurred too soon. Mother may not have time to recoup her own health. She may become pale and malnourished. Therefore, her new baby may be born small and suffer from all the consequences of low birth weight described earlier.

Having too many children is not good for the mother and the family. Every new pregnancy exposes the life of mother to new risks. Looking after too many children is exhausting for her. She becomes tired and irritable. Her anger is reflected on the husband. They quarrel frequently and family life is disturbed. As the earning of the family is limited, each member gets less food and clothes as his or her share. Overworked mother cannot provide even the basic necessities of life to children. The older child has to be often removed from the school to help the mother look after the younger children.

Although it is not a general rule, mental functions and school achievement of the first two or three born children are better than those born subsequently.

Inspite of all the arguments advanced that family planning is good for the mother, the child and the family, the health worker may not always be able to convince the mother. She may shyly point out that decisions for the number of children rests with her husband and the mother-in-law. These arguments may have to be repeated with the latter.

Fortunately the conditions are changing. People are becoming more responsive to the need for family planning. In the villages, more people are aware of the need to limit the family size. Many have joined, police and army. They carry the message of family planning to their home. Most people accept the need. Some women are too shy and feel awakward if they are seen going to a family planning clinic. This obstacle has been overcome by integrating family planning with maternal and child-health clinics and by more frequent home visits by the family-planning staff.

After the family has agreed to limit the family size, what isthe best course to follow? Young couples should have a child and then delay the birth of second child by 2 years by using temporary methods such as condom or pills. Pills are relatively safe for young mothers. Intrauterine device is a good temporary method of birth control. Very rarely a pregnancy may occur inspite of it and some women may have pain and bleeding from vagina with the use of intrauterine contraceptive device (IUCD). Risk is small but not acceptable to some mothers. However most mothers find it quite convenient. Some mothers prefer to use hormonal contraceptive pills. These need to be taken regularly according to a prescribed schedule. Supplies should be made available by the family planning clinics regularly. Rarely these may cause unacceptable complications.

It is possible to stop all births by a minor operation on the father or the mother. The operation on the father (vasectomy) is safe. It takes a few minutes. Post operative period is short. Operation has absolutely no effect on the health or vitality of the father. Unfortunately fewer father go in for it. Tube which carries male sperms to the penis is blocked. If necessary, in some cases, it may be possible to rejoin the blocked and cut ends of the tubes later, if the couple wants to bear more children due to death of their earlier offspring. Most family planning operations are performed on the women. The fallopian tubes which bring female eggs from the ovary to the uterus are blocked and cut either by an abdominal operation or by a special apparatus called laparoscope by well trained doctors. It is generally desirable not to do permanent methods of birth control in very young couples, before they are 30 years old or before they had at least 2 children with the younger child being at least 5 years old and in good health, of good weight with no history of any significant congenital or acquired illnesses.

SYNOPSIS OF SOCIO-ECONOMIC AND PUBLIC HEALTH CONSEQUENCES OF OVER POPULATION

Table 5.1

SOCIO ECONOMIC CONSEQUENCES

1. Increased demand for housing, encroachment on available land mass needed for agriculture, high cost of construction, spiralling rents.
2. Increased demand for community services such as roads, shopping centers, schools, play grounds, safe potable water supply and means for disposal of garbage and sewage.
3. Increasing demand for food and diminishing land mass for agriculture. High cost of food; need to import; political implications.
4. Educational facilities are not able to keep pace with the needs of spiralling population. Higher cost and difficulties in securing admission in educational institutions.
5. Slowing of pace of economic development because of need to divert resources for social services.
6. Increasing unemployment of burgeoning labour force.
7. Inflation. Slow rise in production of goods and rapid rise in demand from increasing population causes inflation.
8. Increasing social tensions due to diminishing job opportunities, unemployment, high cost of living, economic disparities.
9. Rising crime rate due to rise in population of frustrated unemployed youth, who take refuge in large overcrowded cities.
10. Deteriorating quality of life due to overcrowding, poor sanitation and increasing pollution.

Table 5.2

HEALTH CONSEQUENCES OF LARGE FAMILIES

For the Mother

1. Higher incidence of anemia and malnutrition due to repeated pregnancies in the mother
2. Medical illnesses during pregnancy carry relatively poor prognosis.
3. Increase in maternal mortality rate due to inadequately supervised perinatal care or complications of pregnancy and delivery.
4. Higher incidence of handicaps in the mothers as a sequel of complications of pregnancy.

For the Baby

1. Higher perinatal mortality if the mother is too young at the time of delivery or is multiparous.
2. Higher incidence of preterm deliveries or birth of small-for-date infants if the mother is below 20 years old, interval between successive pregnancies is small or in multiparous mothers.
3. Growth and development of the fetus and infant are compromised. There is higher incidence of intrauterine growth retardation.
4. Higher incidence of minimal brain damage or learning disabilities.
5. Higher incidence of chromosomal disorders, if mother is over 35 years old at the time of conception.
6. Higher incidence of malnutrition in children if the interval between successive pregnancies is small.

FAMILY PLANNING METHODS

NATURAL METHODS

Coitus Interruptus. This is uncertain method but some persons are confident of their ability to interrupt coitus before ejaculation.

Safe Period. In women with regular menstrual cycle, coitus should be avoided between 8th to 19th day of the menstrual cycle. The safe or infertile period of menstrual cycle may be determined by reference to the date of the next menstrual period. During ovulation, the body temperature in the morning rises over the previous daily temperature. Cervical mucus increases and breasts may become slightly tender. This is not a reliable method of contraception.

MECHANICAL METHODS

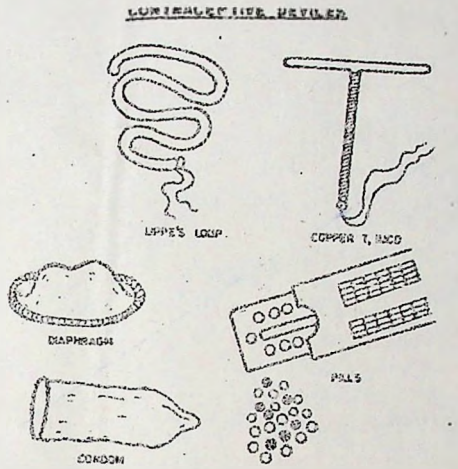
Condoms. The husband uses a rubber sheath over his penis during intercourse. It is used to prevent insemination but

it may tear and spermatozoa may move to the vagina resulting in pregnancy.

Spermacidal Jelly or Diaphragm. The wife is advised to use a spermicidal jelly or diaphragm during coitus to ensure protection from pregnancy.

Intrauterine Devices IUD. Several varieties such as Lippe's loop or copper T are being used. These are inserted into the uterus by a trained person preferably a physician. Lippe's loop is available in 4 sizes viz., 21.25, 27.5 and 30 mm. After through gynecological examination of the women in lithotomy position to rule out pelvic infection and after determining the position of uterus the loop in a speculum is inserted in the vagina. Anterior lip of the cervix is held with a single toothed spectulum forceps with full aseptic precautions. As the IUD introduced reaches the external os, the loop is pushed by the plunger into the uterine cavity from the introducer. The polyethylene filament attached to the loop hangs out of the cervix into the vagina. While it is not necessary to dilate the cervix before insertion, in case of parous women, it may be necessary to do so in nulliparous women. If it is inserted within 5-6 days after delivery or abortion, there is a high expulsion rate. IUD should not be inserted in cases with pelvic inflammation, erosion or ulceration of cervix, dysfunctional bleeding from uterus and in the presence of uterine tumors. In case of cervical erosion, patient should be referred to the hospital for excluding malignancy by PAP staining.

Complication of IUD include irregular and excessive menstrual bleeding, *pelvic inflammation*, *pains* and *perforation of uterus*. IUD may be *expelled* without the knowledge of the user woman. *Bleeding* generally stops within a month or two of insertion and is generally not severe. If bleeding persists for more than 3 months, the device should be removed. *Pelvic pain* is commoner in nulliparous than in parous women. If pain is severe it may become necessary to remove the IUD. *Perforation of uterus* is rare. It is generally asymptomatic and is often diagnosed only on radiography, when IUD is not seen on pelvic examination and there is no evidence of its expulsion.



Oral Contraception (Pill). This is an effective method of contraception. The pill is a mixture of estrogen and progesterone. It is taken every day for 21 days from d. 5 (or for 28 days in some cases). Pills may cause nausea, vomiting, headache, breakthrough bleeding, tenderness of breasts, vaginal discharge and increase in weight. These symptoms disappear after 3-4 menstrual cycles. In some cases, serious side effects such as venous thrombosis, pulmonary embolisation and cerebrovascular accidents have been reported.

The pill should be avoided in patients with prior history of such episodes, hypertension, diabetes, heart disease, jaundice, liver disease, malignancy and during lactation.

Post-partum Sterilisation: Optimum time for post-partum sterilisation is between 48 and 72 hours after delivery. After local anaesthesia, a 5 cm incision is made near the fundus of the uterus. Two fingers are put into the peritoneal cavity and fallopian tubes are hooked out after clear identification of tubes by looking at the fimbrial end. A loop of tube is picked with the forceps. Base of the loop is tied with plain catgut suture, passing through mesosalpinx avoiding the blood vessels. The loop of the fallopian tube so isolated is resected. The process is repeated on the other side.

Map No. 3 missing

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HEALTH CARE PROGRAMME FOR TRIBALS

Almas Ali

Concept paper prepared for the Workshop on role of Voluntary Organisation in the field of Health Care Delivery to be held at New Delhi - January, 4 - 5, 1988.

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HEALTH CARE PROGRAMME FOR TRIBALS

Almas Ali

India is a signatory to the Alma Ata Declaration of 1978 and it is committed to attaining the goal of "Health for All (HFA) by the year 2000 A.D. through the Primary Health Care Approach". The concept of Health for All is not so simple as we look at it but it is a continuous process which means that we have to pay equal attention to all strata of society (regardless of location, position or ability to pay) and justifiably much greater attention to the underprivileged and weaker sections like the Scheduled Tribes, majority of whom live below the poverty line. Moreover, the Government has expressed special concern for development of the Tribals, and one of the long term objectives of Tribal Development is improvement of the quality of life of the Tribal people. Thus, human resource development becomes the most important aspect for the conversion of the natural resource endowment into a ready economic asset.

The overall health status of the tribal community is the outcome of several interacting factors e.g. (a) effects of environment in which the tribals inhabit, (b) behavioural pattern and life styles of the tribals, (c) health care delivery service (in tribals areas / constraints in accepting modern health care), (d) heriditary and genetic determinants. All these sub-systems make up the totality of the health status of the tribals.

There is general agreement that the health status of the tribal people in our country is very poor. Different studies have tried to establish this with the help of morbidity and mortality statistics. Though the exact estimates on vital indices in tribal population of our country are not available/known, it appears that the IMR and MMR among these group of people is also comparatively greater than the non-tribal population. The widespreadv poverty, illiteracy, malnutrition, hostile environment,

absence of sanitary living conditions, ignorance of the causes of diseases, lack of health services or inability to seek and use them have been traced out in several studies as possible contributing factors for the deplorable health conditions prevailing among the tribal groups.

Extention of existing health system is being made during this plan period with the earnest hope that this will improve the deplorable health conditions of the tribal communities. The National Health Programme provides for greater inputs in terms of man, material and facilities. For tribal areas one primary Health Centre is open for every 30,000, population. Similarly for every 3,000 population two multi-purpose health workers (one female and one male) are provided. For the non-tribal areas these norms are 50,000 for Primary Health Centre and 5,000 for two MPWs. Inspite of these steps and expansion of health facilities in tribal areas, the situation is not improving much. The utilization of health services is reported to be very poor. There is no significant change in so far as important indices of health like IMR, MMR and incidence of communicable diseases are concerned. It has become undoubtedly clear that the optimal level of health among the tribal communities can not be achieved only through simple linear expansion of the existing system of health services.

Health problems and Health status of all Tribal groups is not of the same type and therefore any formula approach for health care delivery is not only unsuitable but unthinkable. Different tribal groups are characterised by their individual socio-cultural, socio-biological and socio-economic attribute and in a strict sense they are distinct biological isolates. The health of these tribal population is as such a function of the interaction between socio-cultural, and socio-bilogical practices, the genetic attributes and the environmental conditions. In order to understand the highly complex etiology of the health status among tribals and to develop appropriate health care strategies amidst variable conditions, it would be worthwhile to have a proper understanding about tribal demographics and the regions of tribal concentration in the wider context of tribal development.

Tribal Demography of India:

The tribal communities belong to different ethnolingual groups, profess diverse faith and are at varied levels of socio-economic development. Spread along the entire spectrum-ranging from hunters and gatherers of forest produce to the urbanised skilled or industrial wage earners - the tribal communities constitute very important segment of the Indian population.

The term 'Tribe' is nowhere defined in the Constitution and in fact, there is no satisfactory definition anywhere. No standard term has been accepted to denominate the people who are classified as of tribal origin. According to Article 342 of the Constitution, the Scheduled Tribes are the tribes or tribal communities which may be notified by the President. The Census enumerates only such tribal communities as are scheduled under the relevant constitutional order in force at the time of the Census.

According to the 1981 Census, in India the Scheduled Tribe population is 51,628,638 comprising 26,038,535 nakes and 25,590,103 females constituting 7.76 per cent of the total population. This figure of Scheduled Tribes excludes Assam where the 1981 Census enumeration did not take place. The statement at Annexure-I shows the distribution of Scheduled Tribe population in different States/UTs and their percentage with respect to (a) total tribal population of India and (b) total population of their respective States/UTs. It may be noticed therefrom that the population of Scheduled Tribes varied a good deal from one state to another. Their largest population is found in Madhya Pradesh (11,987,031). The second largest number of the tribals is enumerated in Orissa (5,915,067) immediately followed by Bihar (5,810,867) and Maharashtra (5,772,038). But their largest proportion to total population among all the states is found in Mizoram (93.55 per cent) followed by Nagaland (83.99 per cent) and Meghalaya (80.58 per cent). Among Union Territories, Lakshadweep (93.82) per cent) ranks first. The tribals in the 1981 census were enumerated throughout the country except in three States viz. Haryana, Jammu and Kashmir and Punjab and three Union Territories viz. Chandigarh,

Delhi and Pondicherry, where no Scheduled Tribes have been notified by the President of India.

Regions of Tribal Concentration:

The spatial distribution of the tribal communities, is, however characterised by a striking tendency to cluster in a few Pockets of diverse degree of isolation. Ecologically, the tribal homelands are far from homogeneous and as such display a diversity of a high order.

The areas of tribal concentration have been generally described as the forest and hilly areas of the country. No systematic classification of the tribal areas had been attempted until the beginning of the Fifth Plan period when a new strategy for tribal development was evolved and the areas of tribal concentration were systematically identified and demarcated on some objective criteria. A clear picture of the areas of tribal concentration in the national scene has emerged only thereafter. Now the tribal areas of India can be broadly divided into six regions viz.:

1) Central Tribal Region:
   a) South-Central Tribal Region
   b) North-Central Tribal Region
2. Western Tribal Region
3. North-Eastern Tribal Region
4. North-Western Tribal Region
5. Southern Tribal Pockets, and
6) Oceanic Groups.

Each region has some distinguishing characterstics of its own. They differ considerably amongst themselves in terms of the geo-climatic conditions, resource potential and demographic characterstics (vide Annexure - II & III).

Tribal Development:

In the recent years there has been increased emphasis on tribal development. It is well known that the strategy for integrated development led to the launching of the Tribal Sub-plan concept in the Fifth Plan period. Three basic parameters of the tribal situation in the country were recognised in the formulation of the concept. First, that there is variation in the social, political, economic and cultural millieu among the different scheduled tribe communities in the country. Second, that their demographic distribution reveals their concentration in parts of some States and dispersal in others. Further, that the primitive tribal communities live in scheduled regions. Hence, the broad approach to tribal development has to be related to their level of development and pattern of distribution. In predominant tribal regions, area approach with focus on development of tribal communities has been favoured, while for primitive groups community oriented programmes have been preferred.

This new strategy for tribal development can therefore be broadly divided into four parts to cover the entire tribal population of the country :-

(i) States/Union Territories having majority Scheduled Tribe population (more than 50 per cent) - Four States viz: Meghalaya, Nagaland, Mizoram and Arunachal Pradesh, and Two Union Territories: Dadra and Nagar Haveli, Lakshadweep;

(ii) Areas of tribal concentration;

(iii) Dispersed tribals; and

(iv) Primitive tribals.

Areas of tribal concentral in the country, i.e. areas where more than 50 per cent of the population is tribal have been identified and project approach has been adopted through

the formulation of Integrated Tribal Development Projects (I.T.D.Ps.). On the whole 181 I.T.D.Ps. have been established in 17 States and 2 Union Territories covering 27 districts fully and 97 districts partly and 633 blocks fully and 280 blocks partly. These programmes through I.T.D.Ps. are being implemented to bridge the gap of socio-economic disparities between the tribal and non-tribal people. Development of human resources of the tribal communities has been identified as a crucial element of such programmes. It has also been realised that improvement in the health and nutrition status in the tribal grpups is fundamental to any programme of human resources development in such communities. Such programmes for improving the health and nutrition status in tribal communities require a multi-disciplinary understanding and approach and need to take into consideration the cultural and economic aspiration of tribal communities.

Health and Nutrition Programmes for Tribals:

The project (I.T.D.P./I.T.D.A.) reports are supposed to subsume within it all aspects of development within the project area. The essence of I.T.D.P. approach or Sub-plan approach lies in the key-word "integration" - integration in planning in execution through a single individual i.e., the Project Administrator in financial arrangements at the State and the I.T.D.P. levels. For primitive tribal groups special Micro Projects are operating throughout the country. Therefore any health/nutrition programme whether of adhoc or long term nature, need to be fitted into the planning, implementational and financial frame work of the I.T.D.P. or the Micro Project. Monitoring and evaluation should also cover health and nutrition aspects.

Tribal Health Research:

Comprehensive research studies pertaining to health and nutritional status among different tribal groups of India are very few, very scanty and often completely lacking. Again, one feels ~~and often~~ that there is a lack of broad inter-disciplinary approach to study this problem. Clearly the time h

has come to take a fresh look at the priority health problems of the tribals, which have been neglected for a long time and therefore, this vital problem of health, nutrition and genetics of the tribals can be investigated and studied only by using a multi-disciplinary approach which should necessarily be based on an integration of such components as :-

(a) Assessment of the health status

(b) Study of dietary habit and assessment of nutritional status.

(c) Indepth study of genetic diseases and disorders (including chromosomal anomalies and haemoglobinopathics).

(d) Demographic studies (specially mortality and morbidity statistics).

(e) Basic assessment of the environment.

(f) Socio-economic assessment, and

(g) Study of health, culture and health related behaviours.

Recently the Indian Council of Medical Research (CMR) has also initiated a number of projects to study systematically various health problems of the tribal population and unique to hilly areas. The health and nutrition problems of the vast tribal population of India are as varied as the tribal groups themselves who present a bewildering diversity and variety in their race, language, culture and are at widely divergent stages of socio-psychological orientation and economic, cultural and educational development. Because of these striking differences in their levels of development, each group has a number of problems of its own closely allied to its socio-economic situation, eco-system, historical experience and patterns of political articulation. Thus the health, nutrition and medicogenetic

problems of most of the tribal groups are also unique and present a formidable challenge for which appropriate solutions have to be found by planning and evolving appropriate strategies which should be need based and problem solving in nature, i.e., identifying the problem, defining the factors causing the problem and generating alternative solutions to the problem.

Priority Areas in Tribal Health:

Recognising the inter-regional differences in the tribal situation in the country and recognising the differences in the problems of the tribal communities, it would seem that a different kind of effort for health care delivery in each case is called for. At the present juncture it might not be possible or desirable to study the health and nutrition problems of all the tribal groups of the country. Therefore, in tribal health, programmes for the primitive tribal communities deserve top priority. Primitive groups require sensitive and delicate handling, some of them are very small in size and often face the problem of bare survival. Therefore, in the case of primitive tribal communities indepth research studies on health, nutrition and genetics have to be given priority. The next item in the priority list should be health services operational research in tribal concentrated areas because transformation of the already existing knowledge/research findings into practice is woefully lacking. In the areas of tribal concentration since the I.T.D.P. appears to be the smallest administrative and operational unit at which the activities of different sectors are co-ordinated, it is this unit, which we suggest should be studied in the context of health services in order to find functional gaps in respect of various health/medical facilities in the I.T.D.P. area; and to achieve operational efficiency in the health care delivery programmes.

Conclusion:-

The problem of Tribal Health is not only a complex problem but is also profoundly human in nature. The urban classes in our country have been the fortunate receipient of uptodate and modern medical care facilities during the past four decades, and the rural masses, in general, have been coming in for some attention. The Tribals have been more or less on the periphery; the primitive Tribal groups have suffered from a total umbra. From the limited data we have, it appears that due to their isolation, endogamous marriages, and higher coefficient of inbreeding they represent a concentration of genetic and other specific disorders such as Sickle-Cell Haemoglobin, Glucose-6-Phosphate-Dehydrogenase(G-6-PD) deficiency etc. But the available information on these aspects among the primitive tribals is very meagre. This type of data is so crucially important that it may be the deciding factor between their survival or extinction. Thus, there is a danger that these groups might perish altogether. If they do, we shall be answerable at the bar of history. It is a challenge to the society, it is a chellenge to we one and all present here and we must respond to with earnestness and vigour.

The magnitude and gravity of the health problems of the tribals of India, compounded as they are by wide spread poverty, illiteracy, ignorance and lack of health education, are daunting. Nevertheless, much can be done to improve the health standard of the tribal people if location-specific and need-based health planning is done. Apart from Governmental bodies, Voluntary Organisations can play a notable part and can act as vital bridge-heads between tribal communities and governmental agencies. We should also make use of the genuine social organisations and leadership among the tribals. Finally, it will be really worthwhile if this Workshop attempts to evolve some practical guidelines in the field of health care delivery for the tribals.

ANNEXURE-I

SIZE AND DISTRIBUTION OF SCHEDULE TRIBE POPULATION IN DIFFERENT STATES / UNION TERRITORIES

State/ U.T.	Population	Percentage of tribal population with respect to	
		Total Tribal Population of India	Total population of their respectiv state
1. Andhra Pradesh	3,176,001	6.15	7.76
2. Bihar	5,810,867	11.26	8.31
3. Gujarat	4,848,586	9.39	14.22
4. Himachal Pradesh	197,263	0.38	4.61
5. Karnataka	1,825,203	3.54	4.91
6. Kerala	261,475	0.51	1.03
7. Madhya Pradesh	11,987,031	23.22	22.97
8. Maharashtra	5,772,038	11.18	9.19
9. Manipur	387,977	0.75	27.30
10. Meghalaya	1,076,345	2.09	80.58
11. Nagaland	650,885	1.26	83.99
12. Orissa	5,915,067	11.46	22.43
13. Rajasthan	4,183,124	8.10	12.21
14. Sikkim	73,623	0.14	23.27
15. Tamil Nadu	520,226	1.01	1.07
16. Tripura	583,920	1.13	28.44
17. Uttar Pradesh	232,705	0.45	0.21
18. West Bengal	3,070,672	5.95	5.63
19. Andaman & Nicobar Islands	222,361	0.04	11.85
20. Arunachal Pradesh	441,167	0.85	69.82
21. Dadra & Nagar Haveli	81,714	0.16	78.82
22. Goa, Daman & Diu	10,721	0.02	0.99
23. Lakshadweep	37,760	0.07	93.82
24. Mizoram	461,907	0.89	93.55
INDIA	51,628,638	100.00	7.76

Source: Census of India, 1981, Primary Census Abstract, Scheduled Tribes, Series 1. India, Part II-B(iii), pp.xix-xxiii.

ANNEXURE-II

THE TRIBAL POPULATION IN TRIBAL CONCENTRATED REGIONS OF INDIA

Sl. No.	Region	Tribal population in States/ Union Territories	Percent with respect to total population of State/UT	Percent with respect to Tribal population of India
1.	CENTRAL TRIBAL REGION:			
1.	Madhya Pradesh	11,987,031	22.97	
2.	Orissa	5,915,067	22.43	
3.	Bihar	5,810,867	8.31	
4.	Andhra Pradesh	3,176,001	5.93	
5.	West Bengal	3,070,672	5.63	(58.03)
		29,959,638	13.05	
2.	WESTERN TRIBAL REGION:			
6.	Maharashtra	5,772,038	9.19	
7.	Gujarat	4,848,586	14.22	
8.	Rajasthan	4,183,124	12.21	
9.	Dadra and Nagar Haveli	81,714	78.82	
10.	Goa, Daman and Diu	10,721	0.99	(28.85)
		14,896,183	22.09	
3.	NORTH-EASTERN TRIBAL REGION:			
11.	Meghalaya	1,076,345	80.58	
12.	Arunachal Pradesh	441,167	69.82	
13.	Nagaland	650,885	83.99	
14.	Manipur	387,977	27.30	
15.	Mizoram	461,907	93.55	
16.	Tripura	583,920	28.44	
17.	Sikkim	73,623	23.27	(7.12)
		3,675,824	58.14	
4.	NORTH-WESTERN TRIBAL REGION:			
18.	Himachal Pradesh	197,263	4.61	
19.	Uttarpradesh	232,705	0.21	(0.83)
		429,968	2.41	
5.	SOUTHERN TRIBAL POCKET:			
20.	Karnataka	1,825,203	4.91	
21.	Kerala	361,475	1.03	
22.	Tamil Nadu	520,226	1.07	(5.15)
		2,606,904	2.34	
6.	ISLAND REGION:(Oceanic Tribal Groups)			
23.	Andaman and Nicobar	22,361	11.85	
24.	Lakshadweep	37,760	93.82	(0.12)
		60,127	52.83	
	All India Total :-	51,628,638		100.00

ANNEXURE-III

REGIONS OF TRIBAL CONCENTRATION WITH SOME IMPORTANT CHARACTERISTICS

Sl. No.	Region	Components States/UTs	%age of Tribal population with respect to total Tribal population of India	Main Tribal Communities	Geo-climatic & characterstics of the Region	Major Diseases
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Central Tribal Region:		58.03			
	(a) South Central	Andhra Pradesh, South M.P., South Orissa		Gonds	Extensive forests with low pressure of population, Heavy soil erosion, Extensive shifting cultivation.	T.B., Malaria, Lepsory, Polio, Xaws, V.D./ Malnutrition.
	(b) North Central	Bihar, West Bengal, North Orissa, East M.P.		Santhal, Oraon, Munda, Kolho	High Population Pressure, Richest mineral belt/Industrial belt.	
2.	Western Tribal Region	Rajsthan, Gujarat, Maharashtra, Dadra Nagar Haveli, Goa, Daman and Diu	28.55	Bhills, Dhodia, Gamit, Warli	Arid/Semi arid region(Rajasthan) Heavy rainfall area (Western Ghats of Maharastra)	T.B., Skin diseases, urinary stone diseases, diseases of digestive tract.
3.	North Eastern Tribal Region	Meghalaya, Arunachal Pradesh, Nagaland, Manipur Mizoram, Tripura, Sikkim, Assam	7.02	Nagal, Khasi, Mizo, Miri, Tripuri	Highest rainfall area Shifting Cultivation.	T.B., V.D., Skin diseases, endemic Goitre.

contd...

(1) (2)	(3)	(4)	(5)	(6)	(7)
4. North-Western Tribal Region	Western U.P., Himachal Pradesh	0.83	Jaunsaries, Laholies, Kinnoras	Mountains and High Altitude Density of population very low.	V.D., Goitre, Leprosy
5. Southern Tribal Region	Karnatak, Kerala, Tamil Nadu	5.15	Malayali, Kurumba, Soluga	Heavy rainfall area and dense forest.	V.D., Leprosy, T.B., Malaria.
6. Island Region	Andaman and Nicobar and Lakshadweep	0.12	Onge, Great Andamanese, Sentendex, Jarwas, Nicobarese, Shompen.	Equatorial climate and rich vegetation, Economy based on Ford gathering from forest, hunting and fishing.	V.D, Malaria

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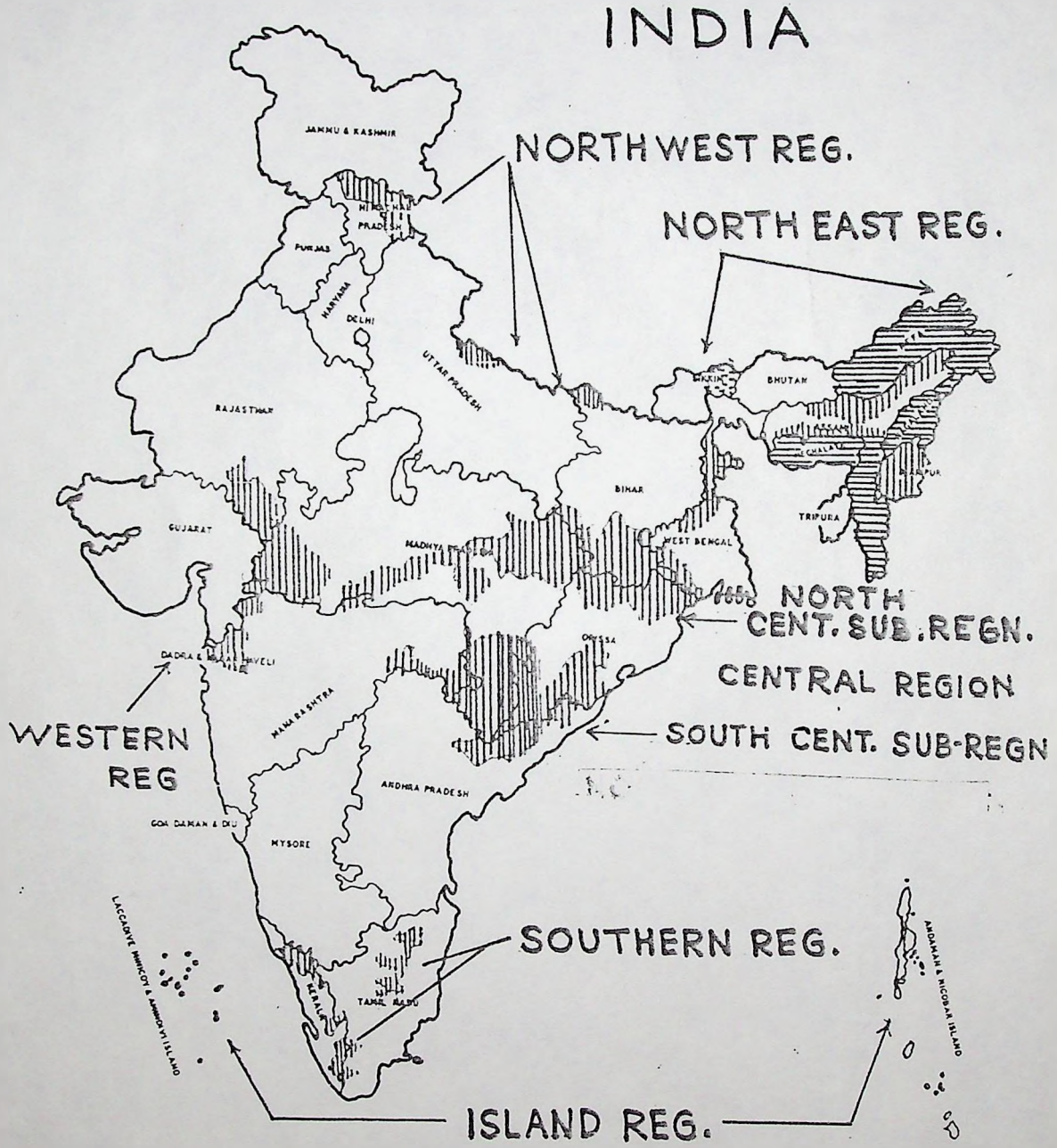
REGIONS OF TRIBAL CONCENTRATION IN INDIA



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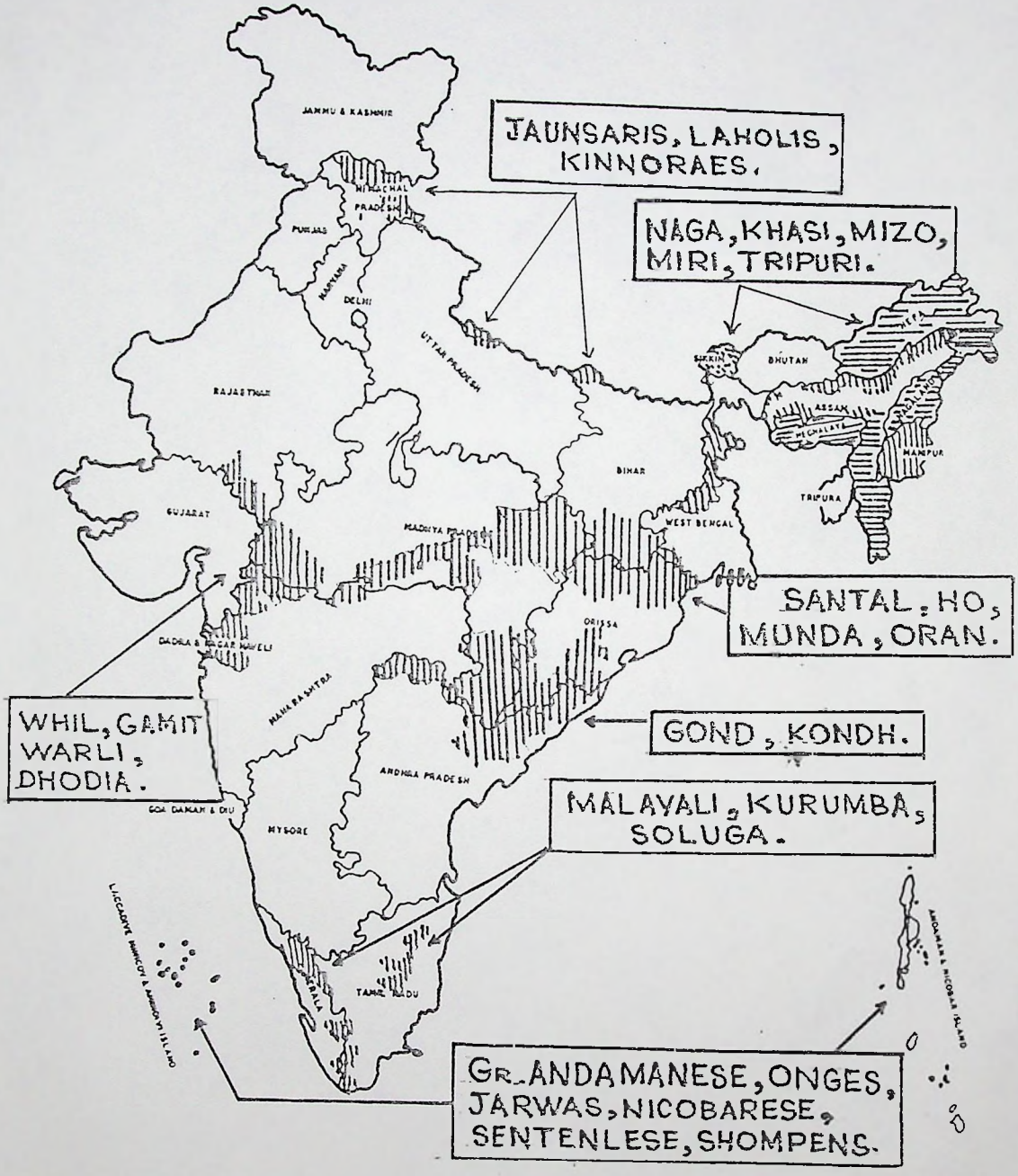

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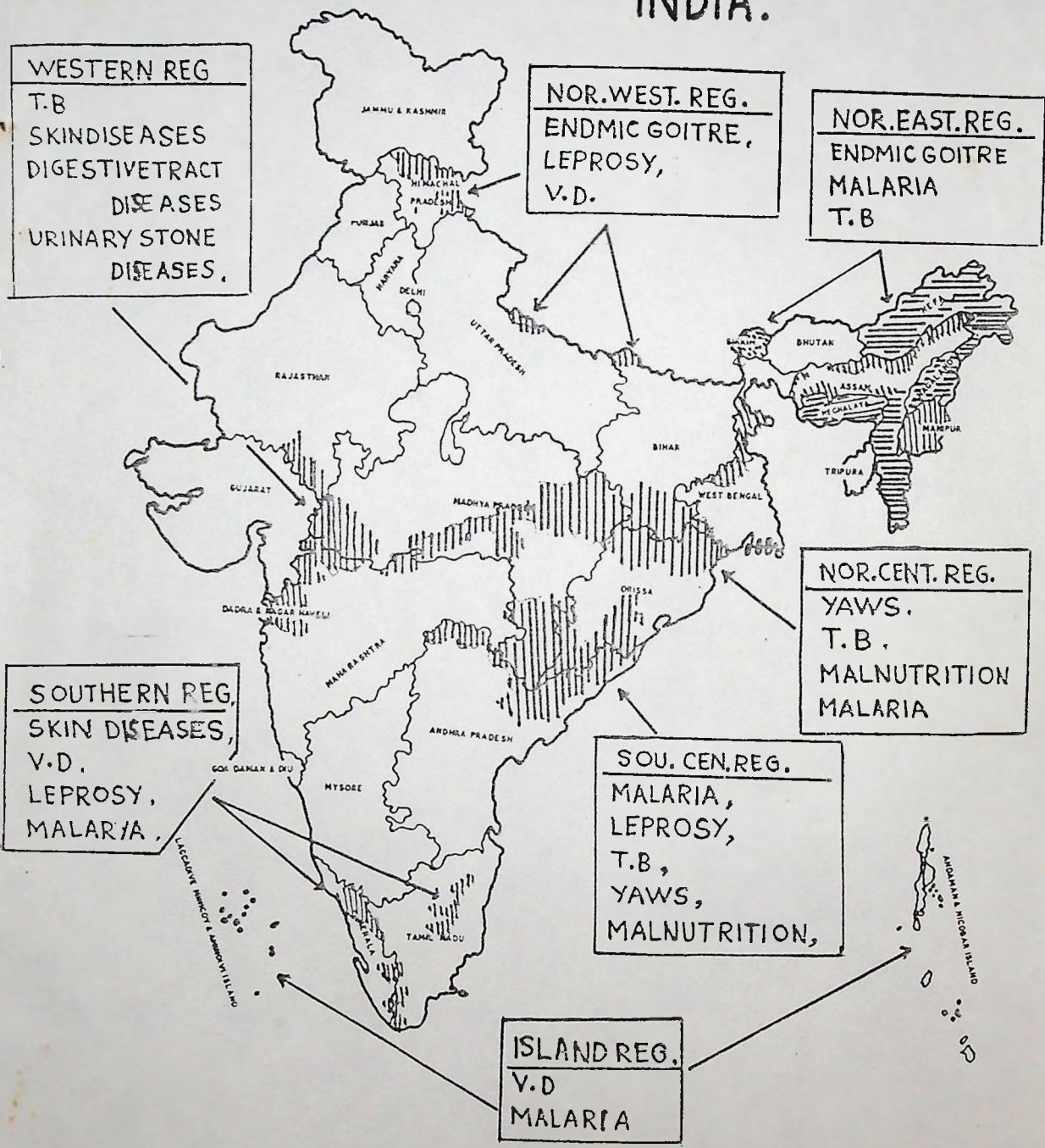
REGION WISE PREVALENCE OF MAJOR DISEASES.

INDIA.



WESTERN REG
- T.B
- SKINDISEASES
- DIGESTIVETRACT DISEASES
- URINARY STONE DISEASES.

NOR.WEST. REG.
- ENDMIC GOITRE,
- LEPROSY,
- V.D.

NOR.EAST.REG.
- ENDMIC GOITRE
- MALARIA
- T.B

NOR.CENT. REG.
- YAWS.
- T.B.
- MALNUTRITION
- MALARIA

SOUTHERN REG.
- SKIN DISEASES,
- V.D.
- LEPROSY,
- MALARIA.

SOU. CEN.REG.
- MALARIA,
- LEPROSY,
- T.B,
- YAWS,
- MALNUTRITION,

ISLAND REG.
- V.D
- MALARIA

COMHSA.

Draft 05.06.99
sanjiv kumar

Border Cluster Districts Project
Strategy Paper

I. Background and justification:

The primary health care infrastructure has rapidly expanded since independence. The population norms for the peripheral health institutions were revised to achieve these goals. The number of subcentres and primary health centres has grown to 136,339 and 22,010 respectively (as on 1.4.97). The National Health Policy lays down the goals to be achieved for achieving the *'Health For All by 2000 A.D.* India's commitment to the goals related to maternal and child health have been further reconfirmed when India signed the 'Convention on Child Rights' and developed the 'National Plan of Action' to achieve these goals.

The RCH programme aims at making the health care system more responsive to the community needs. The Govt. has done away with the targets imposed from the top and has asked the health workers to base the Family Planning work on the community needs. To make this approach successful the community needs to participate in health care more effectively. To facilitate this the health workers need to be trained to identify the community needs and build effective partnership with the other functionaries and the formal and informal influencers in the community. The availability of supplies needs to be reviewed and made more responsive to the local situation. The supervision needs to support the responsiveness of the system to the community.

UNICEF has been supporting Government Of India in many programmes related to women and children in the past. At present there is a need to accelerate the implementation of RCH programme and bring a rapid decline in IMR and MMR so that we can achieve the goals related to Maternal and child Health. GOI has requested UNICEF to work closely with the state governments and intensify the implementation of the RCH programme in selected border districts to bring down the IMR and MMR by half in the next four years. The districts proposed to be covered in this project are from the clusters of the districts at the border and are contiguous with the districts in the neighbouring states. These districts are far away from the state capital and have poor health performance indicators hence need special attention. Being contiguous with adjoining states it also provides opportunity of collaboration with the adjoining districts. This model may then be replicated in the other districts. The clusters of border districts with the grouping of states and the process to be followed in operationalizing the project has been given in GOI guidelines.

II. OBJECTIVES:

Systems Objectives: the overall objective is to reduce the infant, child and maternal mortality to half.

1. To develop the curative care capacity of the public health care system at the community level including referral of mothers and children.

(1)

2. To improve present logistics system to assure availability of drugs and other supplies at the community level.

Health Care Objectives :

1. To ensure 100% registration of pregnancies
2. To increase immunization to 100% by reaching the unreached.
3. To reduce the number of childhood deaths due to diarrhoea, ARI, Malaria, malnutrition and vaccine preventable diseases.
4. To reduce neonatal care in the institutions and the community to reduce neonatal deaths.
5. To identify the major causes of maternal mortality and work out strategies to reduce these.
6. To promote proper age at marriage, spacing between births and timely adoption of terminal contraception
7. To improve institutional deliveries keeping in mind both the Govt. and private sector facilities
8. To improve functioning of FRUs including providing RTI/STI/AIDS related services.

III. Areas needing special attention:

As the cluster border districts have special focus on reduction of IMR, MMR by half the following components of RCH need special focus in these districts:

Newborn Care: Neonatal mortality accounts for about two third of infant deaths and this proportion has been increasing as post neonatal mortality has shown faster decline. Hence this period needs special attention to bring down IMR further. The strategies for reducing NNMR have been developed with National Neonatology Forum. These need to be adapted to suit the state needs.

Emergency Obstretric Care: Maternal mortality has not shown any appreciable decline in India. Hence this is another area of special attention in the project.

IEC and Social Mobilization: The health of the people depends on their health care taking behaviour at home and health care seeking behaviour. The decision to seek care at an institution is taken by the individual and the family members. The timely utilization of services depends on when they decide to go to these institutions. This behaviour can only be influenced through effective IEC activities. Social mobilization plays avery important role in complementing IEC activities especially in areas where literacy is low and reach of mass media poor. There is a need to identify and work with communication and health care providing partners in the community.

Other areas needing special focus in the districts need to be identified by the local authorities.

(2)

IV. Components of the Strategy

The public health care system still remains the most important provider of preventive and promotive health care and curative care to those who cannot afford to pay to the private set up. The utilization of services from the public health care system can be improved upon if the services are made more reliable by making the health worker available at the pre-decided and convenient timings with regular supplies of drugs and other supplies, involvement of the community in the functioning of the subcentre etc. The coverage by immunization services improved substantially in 'Universal Immunization Programme' after the fixed day strategy was put into operation and the days were decided by keeping the local needs in mind. The supplies and logistics system at present does not respond to the variation in demand for services at the subcentre level. The drugs, calculated based on population norms, are supplied in kits which do not arrive at regular intervals. Some of the drugs in the kits get utilized fast whereas the others get piled up and expire. This system needs to be made more responsive to the local demand. The subcentres are the frontline of the primary health care systems. The health worker (female) is the most important frontline functionary in the delivery of health care services. She has the capacity to mobilize the influencers and the community to develop desirable health behaviour. At present, however, the private sector provides curative health care for most diseases in the community, both in rural and urban areas

The acceptance and prestige of Health Workers in the community will be enhanced if they are able to help the community by treating them for common illnesses. This will also improve acceptance of preventive and promotive care and the surveillance of diseases. The referral linkages between the community and health worker and the PHC/FRUs and other referral institutions is another week area which needs to be improved.

The following components may be included in the strategy :

1. Community needs driven Subcentre service delivery.
2. Community based monitoring and management of Subcentre including financing.
3. Supportive monitoring and supervision including better mobility Strengthen
4. Drug supply and Logistics Strengthen Drug supply and Logistics
5. Improving referral services.
6. Capacity Development of health functionaries through training.

1. Community needs driven Subcentre service delivery : The following major areas need consideration in making health care system more responsive to the community needs

1.1. Providing Services at the sub-centre on fixed hours: The curative services should be made available at the subcentre at predictable hours on certain days. The days and the clinic hours should be decided based on the following:

1.1.1. Number of villages covered by the subcentre: The subcentres which have only one village to cover can practically run the clinic almost every day (except the days of Block and sector level meetings). The subcentres with two villages may have the clinic on alternate days. Similarly the subcentres with three or more villages may fix the days of clinic. The days of the clinic should be fixed in a way that the outreach fixed

day immunization services and other important outreach services do not affect.

1.1.2. Posting of Health Worker.[Male] or a second ANM: The subcentres where HW(M) is also posted, OT as in some districts under RCH where two ANMs are posted, the clinic days can be alternated between the two workers. Where there is one worker, the aim is to be available for two hours at least every other day.

The services in the identified area may be initially started in the sub-centers with smaller number of villages, sub-centers with two workers etc. and then expanded to the other areas in a phased manner.

The health worker and AWW play a complimentary role and it is necessary that they work as a team.

Building Health and Nutrition Team:

The health worker has many allies like Anganwadi workers (AWW), Members of Mahila Swasthya Sangh, Panchas, schoo teachers, TBAs in the community especially in mobilizing the community for desirable behavioral change. AWWs are present in almost every village of the subcentre and have many complementary responsibilities. Anganwadi centres can be used effectively as the extensions of subcentre into every village. The close coordination of health and ICDS workers can lead to a true impact on reduction of health and nutrition problems.

This has been discussed in another approach paper.

1.1.3. Mapping Health Care services and Utilization: The following components of health care services and their utilization in the area covered by an institution will help in better understanding and planning of health care services:-

1.3.1. Mapping distribution of population in the area: The distribution of population in villages , helmets, caste and group specific pockets should be plotted. The other important land marks, roads, government institutions should also be plotted on the map.

1.3.2. Mapping Health institutions: This should include all the health are providers and institutions in both Government and non-government sector in the area. This may be done at the sector/PHC meeting.

1.3.3. Human Resource Mapping: The formal and informal health care providers and communicators need to be plotted to identify all the possible channels of health care and communication related to health. It will include Private Practitioners, TBAs, AWWs, Health workers male and female etc.

1.3.4. Treatment and cost profile: The treatment seeking behaviour of the local community is very important to know. This can be done by interviews of individuals in the community, clients coming to the system, observation, prescribing practices and locally available drugs. Similarly it is important to get the cost profile of the health care in the area which should include the cost of services, supplies, transportation to get services/supplies and opportunity cost.

1.3.1, 1.3.2 and 1.3.3 above may be done by doing Focus Group Discussions in the community, interview with formal and informal leaders or using the participatory learning for action

techniques etc. The information we get from all the above areas will help us in finding some possible activities to move further in response to in the following questions:

- How do we extend services to the sections of the community where system does not reach at present?
- How do we change the health seeking behaviour of the community?
- How to enhance the competitive edge of the Health worker?
- How do we enhance the Health Workers ability to provide curative services?

1.4. Community Convenience: The days of clinic should be decided in consultation with the formal and informal leaders of the local village.

2. Community based monitoring and management of Subcentre including financing.

The community should be able to recognize the strengths and weaknesses of the service delivery at the subcentre. It will be important to define how the community can help and respond to these in overcoming some of the difficulties the Health Workers face in providing these services. The details of this can be worked out at the district level planning workshop in which health and all related sectors should participate and finalized after the community needs assessment exercises..

This can be operationalized through a community subcentre advisory board. This board may be created by expanding the existing mechanisms like Mahila Swasthya Sangh, Mahila Mandals, Panchayat etc. The board should include the members of Panchayat, NGOs, if any, formal and informal influencers etc. from each of the village served by the sub-center.

This board should be empowered to review:

2.1. Services utilization at the sub-center and what can be done to improve the situation.

2.2. Referral of cases, especially for emergency care. The utilization of funds, which have been placed at Panchayat level under RCH programme for use in transportation of cases for emergency referral, should be reviewed by them.

2.3. Availability of commonly required medicines and mechanism of procurement/purchase of medicines from the funds generated at the local level should also be worked out by this board.

2.4. Maintenance of sub-center building including stay arrangements for the Health workers should be looked after by the board. The board should also decide on if they need any repair/additional construction in the subcentre building and the accommodation of the ANM.

2.5. Identification and decide the services, if any, for which the community should pay for and which families in the village from the deprived or the underprivileged groups in the village should be exempt from payment of such charges. The mechanism of handling the fund by the advisory board should also be agreed upon and reviewed regularly.

2.6. Review Meetings: The community board should meet every month or more frequently if required and review the functioning of the subcentre. They should specifically look at the following questions during review meetings:

- How do we extend services to the sections of the community where system does not reach at present?

- How do we change the health seeking behaviour of the community?
- How to enhance the competitive edge of the Health worker?
- How do we help the Health Worker to provide services?
- How do we improve the physical condition of the health centre?
- How do we facilitate the working together of health care providers? etc.

3. Supportive Monitoring and supervision including better mobility:

It is very important that the supervisors provide proper support and guidance to the field level functionaries. At present this is one of the weakest links in the health care delivery system in the government system. One of the reasons is that the role of supervisors is not clearly spelled out.. Hence there is a need to clearly spell out the role of supervisors both as supporters for the Health Worker in providing services to the community and on the job trainers for the workers. A check list should be prepared for use by the supervisors which should be reviewed by the next level of supervisors. The supervisor will need better mobility to carry out this role.

The role of ANM in supervising and supporting TBAs, AWWs and other influencers in the community has not been adequately recognized. She needs to realize the importance of working with these service providers as a team and take a leadership role. Her skills in this area need to be enhanced. The functioning of ICDS/Health can be coordinated better through joint trainings of ANM and AWW, LHV and LS and similarly for higher level officials and strengthening the existing mechanisms of joint field visits and meetings.

4. Strengthen Drug supply and Logistics:

Supply of drugs and other supplies at present is irregular and erratic. One of the major reasons for the community turning to private practitioners is that hardly any drugs are available for the treatment of common sicknesses with the health worker. There is a need to review the list of drugs available at the subcentre and to include some more essential drugs to treat common sicknesses at this level. A series of focus group discussions may be organized with the community to identify the common sicknesses they expect to be treated at subcentre level..

The essential drugs need to be identified and included in the regular supply to the subcentres and all referral institutions. The supplies provided by Central and state level need to be coordinated . A mechanism for community financing of additional supplies needs to be put in place.

5. Improve Referral Services :

At present, referral of cases needing emergency care, gets delayed due to various reasons. This leads to the cases reaching referral institutions too late to be saved. This further erodes the credibility of referral institutions. Community needs to be aware of :

5.1. When and where to refer : There is a need for the community to identify the conditions needing institutional care and which institution is appropriate for which conditions. All the TBAs, AWWs, RMPs, formal, informal leaders and members of MSS/Community advisory board should be aware of when and where to refer.

5.2. Transportation: Availability of transport for taking the emergency cases needs to be worked

out in advance. The available modes of transport for reaching referral institutions need to be discussed at the community level. However studies have shown that the major delays take place in arriving at a decision to transport rather than during transportation. If transport is readily available and community is aware of the details in advance, this delay also can be reduced.

6. Capacity Building through Training: The functionaries in the project will need to be trained in improving quality of services, assessing community needs , improving communication skills and building partnership with others in their area of work. The supervisors will need training in improving supervisory and managerial capacity. Team trainings with related functionaries like AWW and TBAs will also need to provided.

V. Geographical Areas to be covered in the Project :

The proposed districts have been identified in consultation with GOI, State Govt and UNICEF..

VI. Monitoring and Evaluation :

The OR project on sub-center strategy should be properly monitored and evaluated. The project should include:

1 Evaluation: This will include:

1.1 Baseline information: This should include curative care provided at the subcentres, community-based information collected on morbidity and mortality of common and notifiable diseases, immunization coverage, antenatal coverage, prevalence of malnutrition in children, cases referred, availability of common drugs and other supplies etc. at the subcentres. An effort needs to be made to get as much of the above information routinely for concurrent monitoring and evaluation. This will enable the project managers to take appropriate and timely action in addition to using it as baseline for periodic evaluations.

1.2. Mid-term evaluation: Midterm evaluation is important for evaluating the progress of the project at a mid point and deciding on changes if any required to be carried out in the project and see the trend of progress.

1.3. Terminal evaluation: Every project should be evaluated to get an objective assessment of the project which will facilitate the decision on the expansion/replication of the project.

Both mid-term and terminal evaluation will use the baseline information and compare the change in the indicators due the interventions in the project area. This should preferably be carried out by an external agency.

2. Monitoring: The indicators for monitoring must be identified in the beginning of the project. The monitoring should include:

2.1. Monitoring of identified indicators through routine reporting, at block/district level routine meetings and look at performance indicators, training progress and community processes.

2.2. Progress on Finance Related areas: This should cover activities related to Government and community financing included in the plan.

2.3. Utilization of Services: The utilization of services by numbers, illnesses, drug status and village/hamlet/pocket/caste/group-wise etc should be done.

2.4. Field Visits : The checklist /notes prepared during field visits should also be used for

monitoring purpose and made more meaningful for on the spot correction and subsequent discussion.

2.5. Monitoring by the Community: The role of the community in monitoring of the services is very important as the whole project depends on the community ownership. The indicators to be monitored by the community may cover running of sub-center clinics, availability of supplies and services and the action taken to improve the situation.

VII. Activities and timeline:

The timeline for activities will vary from state to state. However, the broad activities are listed below

1. Finalize districts with state/district level officials
2. Identify consultant
3. Orientation of the consultant
4. Development of draft district Plans
5. Orientation meetings
6. Collection of baseline information
7. Project operationalization
8. Monitoring
9. Mid-term evaluation
10. Incorporate changes into project
11. Terminal evaluation
12. Expansion of project area
13. Taking it to scale in the state

These are only the suggested areas in the district plan. Newer areas based on the local need and the areas missed out in this paper need to be added.

UNICEF SUPPORTED BORDER DISTRICT PROJECT

CLUSTER OF

ANDHRA PRADESH	KARNATAKA	MAHARASHTRA
1. Adilabad	BIJAPUR	Nanded
2. Nizammabad	GULBARGA	latur
3. Medak	RAICHUR	Osmanabad
	BIDAR	

3 States — 10 districts

(RN)
COMH-SA.

Draft Note for Karnataka Task Force on Health final report
By
Dr. Thelma Narayan
8th January, 2001

Public Health and Primary Health Care : Understanding the Synergy

As the mandate of the Karnataka Task Force on Health and Family Welfare is to improve Public Health and Primary Health Care, these concepts, as they have evolved, have been outlined briefly.

1. Defining Public Health

Public health is an evolving discipline through which major health gains for populations have been made in several countries of the world, since the early 19th century i.e., before development of antibiotics and vaccines. It has been defined by the International Association of Epidemiologists as follows :

"Public health is one of the efforts organized by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same : to reduce the amount of disease, premature death and disease produced discomfort and disability in the population" (JM Last 1983).

2. State responsibility for health and health care

One of the key principles of public health, that the State is responsible for the health of its people, was conceived by health philosopher Johanna Peter Frank (1745-1821) leading to the Public Health Act of 1848. The importance of this social principle remains and has been reiterated by several bodies such as the World Health Assembly (WHA), WHO (1977), WHO and UNICEF (1978) and more recently by the Peoples Health Assembly (PHA) in 2000. The role of the state remains critical, in present

To SRK/RRP
KTFH Paper on CDC for reading/comments/additions
RN
5/3/01

times and for the future, particularly to protect and promote the health of the poor and vulnerable sections of society in the currrent context of neoliberal privatization. Public health has an abiding concern for the health and social conditions of the poor and with the structural roots underlying poverty. The political dimensions of health were recognised by Rudolf Virchow over 150 years ago. The global primary health care movement is attempting to overcome inequalities in health. The role of the State is critical in bringing about this shift.

3. *Addressing determinants of health*

Diseases like cholera and typhoid earlier widely prevalent in Europe and the USA, were controlled by public health systems that ensured a mandated supply of clean, safe or potable water, functioning sewage systems, garbage and refuse disposal. Karnataka has initiated measures for water supply and sanitation through different projects namely the Dutch assisted project, DANIDA, UNICEF and the World Bank assisted Karnataka Integrated Rural Water Supply and Environmental Sanitation Projects. However the need and demands of the public in this regard are yet to be fully met. Water and sanitation related diseases still take a heavy toll in terms of sickness (morbidity) (see section on communicable diseases) and person days of work lost. The role of the DHFW will be in setting standards for water quality, use of chlorination / other methods of water purification, monitoring through regular water quality testing at local, taluk and district levels, and initiating quick containment measures following any disease outbreak. Related measures include intersectional collaboration at different levels; health promotion with children, of women; and special training of panchayatraj members as water and sanitation, fall specifically under their purview, under the 73rd and 74th Constitutional Amendments. The specific responsibility and accountability of the male junior health assistant needs to be clarified. They also need supervision in this regard. ***Provision of safe Water supply and sanitation form the very basic, first generation, public health interventions.***

An early development in preventive medicine, closely linked to public health, started in the 18th century relates to nutrition, another basic determinant of health. Use of fresh fruits and vegetables was recommended in 1753 for the prevention of scurvy among sailors even before the causative agent was known. There has been tremendous growth and development in the science of the nutrition since then. Our own ancient

Indian systems evolved food, diets and methods of cooking that provided a balanced diet in different seasons and suited to various physiological conditions. Despite rich traditional and modern knowledge bases, recent date from the NFHS2 and NNMB regarding nutritional status reveals widespread under nutrition particularly in young children and among women in Karnataka. Nutrition has also been found to have been very neglected by the DHFW. Malnutrition in Karnataka is a major public health issue and is being accorded the highest priority as an area for intervention by the task force on Health & FW. It is therefore being covered in a separate chapter (Chapter No. -) Deeper underlying issues of food and nutrition security are linked to irrigation, agriculture and seed policies; in income and purchasing capacity; and in access to public distribution systems.

4 4. ***The second generation of public health evolved with the discovery of bacteria and the growth of microbiology*** Development of diagnostics, therapeutics, vaccines, and an understanding of disease transmission patterns made it feasible to initiate control programmes for communicable diseases. The current disease burden due to communicable or infectious diseases in Karnataka has been outlined in a later section ( ) as it still comprises a major portion of morbidity and mortality. Cost effective public health interventions exist for most infectious diseases. For newer emergency diseases such as HIV/AIDS, research is taking place at a fairly rapid pace.

The method of transmission of communicable diseases determines the choice of the method of disease control to be used. Diseases with similar modes of transmission are grouped or classified together e.g., Water borne diseases, faeco-oral diseases, soil mediated infections, food borne diseases, respiratory infections that are air borne, insect or vector borne diseases, diseases transmitted via body fluids, ectoparasite zoonoses, domestic zoonoses etc. Only important diseases that require priority attention and intervention are covered in this report.

The faeco-oral group of diseases includes amoebiasis, giardia, gastro-entertis, bacillary dysentery, cholera, typhoid, hepatitis A & E, and poliomyelitis. Breaking the faecal-oral chain is the basis of control, namely by personal hygiene, increase in water quantity, improvement in water quality, food hygiene and provision of sanitation.

Priority is given for control of infectious disease based on criteria such as magnitude of problem severity and availability of effective, safe interventions. The task force expresses deep concern that tuberculosis which was identified in 1947-48 as India's foremost public health problem, continues to be so in Karnataka, despite having a well researched and designed control programme and despite the availability of cost effective drugs for treatment. The NTP has not received adequate attention or resources from politicians, decision makers, administrators and the DHFW. Thus it has been neglected and poorly implemented. In the RNTCP, Karnataka is the second poorest performing State in the country.

The early successes of the National Malaria Control programme have not been sustained. The increased number of cases and outbreaks in different parts of the state are of concern. Malaria was controlled in Mysore State in the pre-DDT era, through public health interventions including public health engineering. Other vector borne diseases also have a family high incidence and prevalence in certain regions e.g. Filaria, dengue fever, Japanese encephalitis, etc. Specific technical dimensions for each disease are given later.

5. However there are certain health system prerequisites and primary health care principles that need to be met, in order to achieve good communicable disease control. The strategy of improving the functioning of general health services especially at PHC and CHC level is important in providing diagnostic and treatment facilities as close to the houses of people as possible. Diseases control interventions need to be integrated into the functioning of the general health services as part of a comprehensive primary health care service. This horizontal integration at primary care level is to be supported by more specialized referral and support services at taluk/district and state level, through a referral system. The primary health care service needs to be credible so as to win the confidence of people. Only then will people utilize it to meet their basic health care needs and for what government may consider priority health programmes, be they communicable disease control or family welfare.

These basic tenets of a good community health care service have been found lacking in our sub-centres, PHC's and CHC's. The Interim Report of the Task Force

recommended 24 hour services at PHC's with filling up of gaps in infrastructure including residential quarters, water supply, electricity, vacancy positions for different grades of personnel, supply lines for drugs and laboratory equipment/stains, communication systems etc. These are prerequisites for a good service and for infectious disease control.

6. *The Primary Health Care (PHC) approach,* as a strategy to attain the international social goal of Health for All by 2000, was articulated and accepted at a WHO-UNICEF conference in Alma-Ata in 1978. Recognising the limitations of medical science alone in improving the health of people, it emphasized the need to address determinants of health through inter-sectoral collaboration, especially with departments of agriculture, water supply, sanitation, housing and education. It emphasis the need for equity and social justice in health, and health care. It recommended shifting control over health care systems, with greater decentralization and involvement of local people and communities in decision making and planning health care systems, to suit their own social, economic & cultural conditions. It utilized scientific methods of proven effective, safe, acceptable and affordable treatments and interventions in the preventive, promotive, curative and rehabilitative areas, but also encouraged indigenous and traditional systems of medicine. It had a social goal of improved health and quality of life; access to health care by all; maximum health benefits to the greatest number; increased self-reliance of individual persons and communities, and the promotion of social means of reaching these goals. Thus public health went through another paradigm shift. Experience and thinking from India along with those from other countries, helped in making this shift.

7. The following excerpts from the original documents are given for a clear understanding of concepts. These are being given in some detail as they form a core element of the task force recommendations.

"Primary Health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the countries health system of which it is the nucleus and of the overall social and economic development of the community" (WHO-UNICEF, 1978).

"It means much more than the mere extension of basic health services. It has social and developmental dimensions, and if properly applied will influence the way in which the rest of the health system functions" *(ibid)*.

"It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitute the first element of a continuing health care process (*ibid*)

8. The four key underlying principles of primary health care are
   a. Equity through equitable distribution of health resources.
   b. Community participation and involvement.
   c. Intersectoral Co-ordination between health and development.
   d. Use of appropriate technology for health.

   The eight components of primary health care comprising the core technical package are

   a. Education concerning prevailing health problems and about methods of identifying preventing and controlling them.
   b. Promotion of food supply and proper nutrition.
   c. Adequate safe water supply and basic sanitation.
   d. Mother and child health services including family planning.
   e. Immunization against major infection diseases
   f. Prevention and control of locally endemic diseases
   g. Appropriate treatment of common diseases and injuries
   h. Provision of essential drugs.

9. India was a significant contributor and signatory to the WHA, 1977 and the Alma Ata Declaration of 1978. The concept of comprehensive health care had already been articulated in India through the Bhore Committee Report, in 1946, a document which formed the early basis for India's health planning. Primary health centres had been initiated since 1952. The National TB programme, 1962, had the seeds of the primary health care approach. The Shrivastava Committee report 1974, made links between education and training of socially oriented doctors, all grades of health personnel and community health needs. A national scheme for Village Health workers was launched

in 1977. Post Alma Ata, in 1981. The Indian Council for Social Science Research and the Indian Council for Medical Research brought out a publication Health for All in 1981. The National Health Policy based on principles of primary health care was tabled in 1982 and passed by Parliament in 1983. It is still the operating policy statement as of now. State governments including Karnataka accepted the HFA goals and PHC strategies. The Ninth Plan document of the Government of India committed itself to the goal of "Health for all, particularly for the underprivileged".

10. However some of the statements and commitments appear to be rhetorical. Analysis reveals declining state expenditures on nutrition and lack of responsibility and accountability for nutrition by the DHFW. Intersectoral work to ensure potability of water and provision of sanitation facilities is ongoing since the early 1990s, but coverage is incomplete. Data reveals the continuing preventable burden of water related diseases. State health expenditure is stagnant and below norms. A large proportion of primary health centres continue to function sub-optimally. Coverage and quality of basic antenatal care and immunisation continues to be low in Category C districts. Diseases like TB continue to take a heavy toll with government health services providing complete treatment or cure to only 8-16% of expected sputum positive pulmonary TB patients. School health services are of poor quality and have limited coverage. Community mental health care programmes at district level have not been taken up seriously, though the epidemiological burden has been well documented. The essential drugs concept is not practised in spirit. Health education and promotion receive little interest and is too focussed on Family Welfare. For these and other reasons the Task Force has concluded that public health and primary health care have been neglected and distorted.

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① Content list
② cover page
③ Then format — Each chapter to start on a new page

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5. IMPROVING SERVICE QUALITY, ACCESS AND EFFECTIVENESS IN PRIMARY HEALTH CARE SYSTEM

5.1 *Renovating primary health centres*

There are 1685 Primary health centres (PHCs), including 9 urban PHCs. Of these, 1,000 which have buildings, are relatively better located and have greater access, have been identified by the State government for renovation and equipping according to norms. While identifying them, priority has been given to the seven backward category C districts. It is estimated that these 1000 are in a position to cater to the needs of over 70% of the people residing in rural areas. It is also proposed to map all PHCs, by the population they serve and by road connectivity etc. through a Geographic Information System (GIS). This will give more precise estimations of the population and geographic coverage of different PHCs. A detailed Facility Survey has been carried out to identify infrastructural gaps in each of the identified PHCs. The survey shows that most require physical renovations and improvements. Lack of continuous water supply is a major problem in many. Similarly, most PHCs are linked to the rural feeder grid for their power supply. As a result power supply is uncertain, irregular, and has high voltage fluctuations. In the older PHCs internal water supply and electricity lines also require major repairs. The buildings require refurbishing – cracks have appeared on walls, roofs leak, OTs and labour rooms have in many places become non-functional. Many PHCs have no compound walls, as a result the boundary has not been demarcated, and the physical surroundings do not appear inviting. A complete renovation of 1,000 PHCs will be taken up under the project.

Annual maintenance of buildings will need to be taken up throughout the project period. Due to the large number of buildings involved, minor repairs and maintenance work will be taken up once during the project period.

5.1.1 Construction of PHC buildings

The department has carried out a study to find out the PHCs which require their own buildings. Of the 1685 PHCs, 509 have no buildings. Of these *100 PHC buildings will be taken up for consideration with this project.* Only such PHCs which serve large population, and possess sites which are easily accessible and are on the roadside will be selected. The existing PHC design will be reviewed to make the building design easily accessible by the handicapped and the elderly. The area will also be reduced to keep the costs down. *50 of these buildings taken up will be in the backward districts of the state.*

5.1.2 Equipping primary health centres

Besides repairs, the 1000 PHCs, require gaps in furniture, equipment, linen required and consumables to be filled. A committee has identified essential equipment and furniture for a PHC. Based on this, for each PHC the gap will be identified and procurement taken up. Additionally, consumables required will be supplied on an annual basis.

5.2 *Family welfare services*

Population stabilization through fertility decline has long been a goal of the national family welfare programme. This fully centrally sponsored programme has been accorded a predominant place in the services provided by the Department of Health & Family Welfare. The IPP I, III, VIII and IX projects have provided support to infrastructural growth, service delivery, training of health personnel, to IEC and to development of the HMIS systems in the State.

Data from Karnataka indicates steady declines in birth and death rates. Declines in growth rates occurred, particularly after 1981, when the demographic inertia was said to have been broken. The momentum of the decline is likely to continue even without any specific additional inputs. In several parts of the State there is a demand for services which need to be met. The context and scope of IEC thus needs to be flexible and responsive to changed situations.

The Total Fertility Rate (TFR) is 2.13 and the effective Couple Protection Rate (CPR) 60%. Thus the state is very near to reaching replacement levels of fertility. *District wise data (Rayappa 1998) indicates substantial declines in growth rates in 1981-91 in all districts except the Gulbarga division. Even here declines occurred in Bellary district. It is likely that this region is following a slightly later cycle and the peak in growth rates may have just been passed.* Given the relationship between fertility decline and demographic transition with the Gender Related Health Index (GHI), Human Development Index (HDI), and Reproductive Health Index (RHI) (*ibid.*), and the low level of these indicators in the districts of Gulbarga Division (GOK-HDR 1999), it has been suggested by analysts that *improvement in human social development, quality of life and gender development will hasten the process of demographic transition. This will be an important component of the state strategy.* Bangalore district had a peak in growth rate 1971-81, attributed to a large extent to immigration and inter-state migration.

Keeping in mind the specificities of Karnataka and the National Population Policy 2000 guidelines, areas that will be addressed during this project phase in regard to Family Welfare and Reproductive and Child Health Services are,

- Improving the determinants of good health, viz., sanitation, water supply, nutrition and literacy. Specific attention will be paid to girls and women.
- Improving access to primary health care, by strengthening services through PHCs and subcentres. Develop an integrated approach to health, nutrition, family welfare and social development through convergence of services at village level.
- Placing two doctors in a PHC in Gulbarga division, with preferably one lady medical officer.
- Focussing attention on quality of contraceptive services with ,
  a. Careful *choice of reproductive technology*, that is safe and effective.
  b. Maintaining *good quality care* including screening and follow up service.
  c. *Monitoring of side effects of contraceptives* used through good recording systems and undertaking studies. A concern for instance is the very young age at which tubectomies are done, and the resultant early menopause symptoms and sterilization regret.
  d. Increasing *use of male methods*.
  e. Increasing use of *spacing methods*, including condom promotion.

f. Emphasis on *informed choice*.

- Making efforts through education and awareness campaign to *delay age of marriage*, no earlier than 18 years and preferably after 20 years. Delay in age of first pregnancy.
- *Registration of marriages, births and deaths* at village/ community level. Pilot testing of 100% births, deaths and marriage registration in one district will be carried out.
- Adequate *training of field staff in Community Needs Assessments* (CNA) so as to make the Target Free Approach (TFA) a reality. Using adult learner centered, problem solving approach to training.
- *Training of at least two dais* (birth attendants) per village, with provision of dai kits.
- Over the last five years, the health department has established cold chain infrastructure all over rural Karnataka. To ensure optimal vaccine quality and to ensure *universal immunization* there is a need to cover some gaps in maintenance.
- Providing for adequate diagnosis and *treatment of Reproductive Tract infections and Sexually Transmitted Diseases at PHC level*. This will require provision of microscopes, stains, training of lab. technicians, drug supply and health education.
- Encouraging *value based life skill and family life education of adolescent girls and boys* through the Department of Education and involvement of NGOs.
- *Woman's empowerment training* programmes focused on health and nutrition.
- Support to *promotion of Child Health and Nutrition* and reduction of infant and under five child mortality rates.
- *Lowered maternal mortality* by anemia prevention, complete coverage with good antenatal and postnatal care, maternity service including increased access to referral emergency obstetrics care at CHC and sub-district level.
- *Decreasing the need for illegal abortions* by provision of good contraceptive services, counseling services and access to safe abortions when necessary. Provide training and equipment for MTP.
- Increasing the role of panchayati raj institutions in planning and implementation through *devolution of finances and administrative power* and increasing their knowledge base through training programmes.
- The setting up of a *State Commission for Population and Social Development*.
- There is an unmet need in acceptance of family planning methods (12% for spacing and 6% for sterilization). Hence *skill based training for* health staff particularly in *IUD insertion* needs to be carried out.
- Urban immunization programmes will be planned in cities and towns to immunize all children less than 5 years. Involvement of private practitioners by contracting out immunization services will also be explored.
- *Training in MTP technique* for MO's of PHCs and provision of necessary equipment will also be carried out.
- *Perinatal care centres* at identified health institutions will be set up to strengthen perinatal care of the newborn.

5.3 *Improving health of SC/ST*

The Yellow Card initiative for health check up of SC/ST has received a very good response, and many SC/ST families have benefited under the scheme. However, there is need to appraise the programme and both deepen and strengthen the interventions. There is particularly need to improve the follow up and referral system under the programme, by provisioning of transport for seriously ill patients, enhanced drug supply, and conduct of repeat follow ups to ensure early detection of diseases and improved cure rates. An improved monitoring system also requires to be put into place. The emphasis should also shift more directly to SC/ST women. The goal is to provide the SC/ST population, along with others, to good quality care at all levels of the health system.

6. IMPROVING HEALTH AND NUTRITION STATUS OF CHILDREN

6.1 *Nutrition goals*

The nutrition goals under the Project will be to improve the quality of existing nutrition related services, enhance their coverage and effectiveness especially for under-two's, ensure better access to the underprivileged, emphasise care related aspects of nutrition and accord greater priority for nutrition so as to prevent and reduce malnutrition and iron deficiency anemia; and achieve virtual elimination of Vitamin-A and iodine deficiency over the project period. A related goal will be to ameliorate the gender differentials in growth and in 1-4 year old child mortality. Improvements in nutritional status will inevitably result in better infant and child survival.

6.2 *Focus on prevention*

The focus will be on under-two children in the backward seven category C districts. Presently only about 50% of the targeted under-two beneficiaries get supplementary food. Apart from this, these vulnerable children get little attention from the ICDS. These are the most responsive group to health education interventions. The project approach is to reduce the numbers that become malnourished by lessening the extent and likelihood of growth deprivations. Thus the lessening of growth faltering in the rapidly growing two years by growth promotion will ensure that we are able to avert to some extent moderate and virtually eliminate severe malnutrition. Community based rehabilitation of severe malnutrition is not only expensive in time but requires a tremendous degree of patience and faith on the part of mothers and families. Even when seriously malnourished children are successfully rehabilitated, the functional consequences of malnutrition in terms of impaired cognition and reduction of adult work capacity have major human and economic implications for society.

6.3 *Specific objectives and strategies*

a. *Strengthening ICDS*

- *Giving nutrition greater priority*
- *Improving quality of weighing data and Monitoring Information System*

- *Periodic deworming*
- *Mobility support for ICDS Staff*
- *Health check ups in the Anganwadis*
- *Gender sensitization*
- *Raising measles immunization coverage*
- *Intersectoral coordination*

b. Weaning food interventions

These are described under sections on reduction in regional disparities and in the section on nutrition education and promotion.

c. Improving the status of urban slum children

Presently there are only 10 ICDS Projects in urban areas. A special initiative will be launched in slums not covered by the ICDS Projects. Emphasis will be made to cover newly sprung up urban slum colonies. Wherever credible NGOs are present, working with the urban poor, their cooperation will be sought.

d. Enhancing nutrition education

At present about only 50% of the beneficiary children between the ages of 6 months and 2 years come to the Anganwadi centre. Thus the families of the children of this most vulnerable group susceptible to growth faltering and increased risk of malnutrition needs to be reached through other alternative methods rather than trying to reach through creation of more Anganwadi workers and centres. The following are proposed:

- *Nutrition education & promotion*

  Massive communication endeavor with messages focusing on care related nutritional aspects and on the girl child will be launched. Breast feeding and weaning will be given priority. The cooperation of the Govt. Of India's Food & Nutrition Board Regional Office will be elicited for organisation of nutrition camps. Demonstration of weaning food preparation, counseling of mothers and families of severely malnourished children and Nutrition education of the community will be organised. In the non-backward districts efforts will be made to get women's group involve in preparation of weaning foods and in their promotion.

- *Nutrition training of functional Stree Shakti groups*

  Karnataka has recently launched the Stree Shakti Scheme for formation of credit groups. The groups are given initial seed money. The project will seek to take advantage of functional groups so as to motivate them to take interest in nutrition & health. This will facilitate long term efforts of raising nutrition & health consciousness of the local community.

e. Building nutrition capacity of existing women's groups

This endeavor will build nutrition capacity of the existing women's groups in the State. For instance, Mahila Samhakya has formed vibrant women's groups. Similar women's groups including that of NGOs will be involved. One objective is to assist the Anganwadi workers in improving the well being of children. Getting communities

involved in the functioning of the Anganwadi will go a long way in contributing towards the rapid decline of malnutrition. This failure to mobilise the community has been a major reason for the continued persistence of malnutrition in Karnataka.

7. REDUCTION IN REGIONAL DISPARITIES

7.1 Special package for category C districts

A special health and nutrition package is proposed for the category C districts. This will include:

a. Construction and renovation

- Renovation and equipping of existing PHCs
- Upgradation of selected PHCs to FRUs
- Construction of new PHC buildings
- Staff quarters

As mentioned in previous Chapters, construction & renovation in the above four categories will be a priority in the seven Districts.

b. Special immunisation campaigns will be launched to enhance coverage.

c. Round the Clock services at PHCs . The Government of India norms provide for two doctors per PHC. Most Karnataka PHCs have only one doctor. One reason for poor utilisation is that there is no 24 hour Nursing service available in the PHC. To make PHCs functional for 24 hours, a second Medical Officer (preferably lady) and two staff Nurses will be appointed.

7.1.1 Special nutrition initiative - weaning food intervention

A major weaning food intervention trial will be initiated from the next year in four districts with the involvement of women's groups, by the Women & Child Department. Based on the success and the lessons learnt this will be scaled up to the category C districts of the state. The major objective here is to organise communities to prepare locally acceptable, less bulky and calorie dense foods for weaning and facilitating change in feeding practices. Food material costs for six months to under two children would be borne by the Project.

7.1.2 Special project management team

These special initiatives, as well as all the project components in these seven districts will be implemented through a special project management team to be based at Gulbarga.

7.1.3 Innovative programmes

- Linkages with NGOs and formation of networks for instant District Health Action Networks, facilitating the creation of NGOs where there are none.
- Flexible support to community based initiatives
- Focus on health promotion and empowerment

7.1.4 Fertility decline

Provision of good quality contraceptive services and all the components discussed under Family Welfare.

8. COMMUNICABLE DISEASES, NON-COMMUNICABLE DISEASES, EMERGING AND NEGLECTED PROBLEMS

8.1 Communicable Diseases

The development of a disease surveillance system will be taken up with a greater sense of urgency.

8.2 Responding to epidemics and outbreaks

Rapid action teams with microbiologists / epidemiologists / public health personnel are already formed at state level to take action following early warning signals. Presently the media is still often faster than the surveillance system. Linkages could be established in which they can continue to maintain their objectivity and freedom of expression. Divisional rapid action teams will also be developed. The routine responsibilities of Taluk and District Health Officers in this regard will be strengthened. A Reserve Fund will be created under the project for catering to epidemics.

8.3 Filling up gaps in existing national health programmes

Shortage of drugs, insecticides other supplies and problems of mobility / transport have been experienced, often at times when they are needed. Spraying of insecticides is done at the wrong period because supplies were delayed.

The project will have provisions for concerned authorities in the state to release funds for such requirements.

8.4 Proposed strategies for Mental Health

Mental health care requires special attention because of the stigma, prejudice, ignorance and neglect that it has received so far and the fairly high burden of disease and suffering caused by it.

- *Develop district mental health programme* in all 27 districts over the project period. Currently these have been initiated in three districts viz., Bellary, Bijapur and Kolar.

A district mental health team comprising of a psychiatrist, a clinical psychologist, a psychiatric nurse and a psychiatric social worker will be based at each district hospital. (To enter how many districts are already covered). They will provide daily outpatient services; ten bedded in-patient facility; referral services to Primary Health Centres, CHCs, and Taluk General Hospitals; follow up services; training and creation of community awareness through health promotion activities.

a. *The Karnataka Institute of Mental Health, Dharwad*, which was the only state govt. run mental hospital, has more recently become only a Department of the Karnataka Institute of Medical Sciences. The conditions there have been found to be poor and a review committee has been set up to recommend improvements. This institution will be developed as a major specialty institute with adequate facilities and staffing.

b. *Improve teaching in Psychiatry and Psychology in the 25 medical colleges and the nursing schools* affiliated to the Rajiv Gandhi University of Health Sciences. Workshops at the University and colleges to be organised.

c. *At Primary Health Centres,*

- Ensure uninterrupted supply of anti-epileptic drugs (phenobarbitone and phenytoin).
- Supply of basic psychiatric drugs in selected PHCs where PHC MOs have been trained. This will include Tab. Chlorpromazine, Tab. Imipramine, Tab. Trihexyphenidyl and Inj. Fluphenazine
- Phased training of PHC MO's using the modules and manuals developed by NIMHANS, as part of their clinical skill upgradation.

e. Provide an enabling environment and some seed money/ grant in aid for voluntary organisations and religious organisations to set up and manage day care centres, halfway homes and vocational centres for *chronically mentally ill persons*. The Richmond Fellowship, Medico-Pastoral Association, Atma Shakti and others are examples of such organisations in Karnataka.

f. A *Mental Health Unit in the Directorate of Health Services* will be created to give direction and leadership to the State Mental Health Programme. It could also develop links with NGOs and other private agencies providing counselling and other services e.g. Helping Hand, Vishwas, CREST, Banjara Academy and several others.

8.5 Care of the Elderly

With increasing longevity, all three levels of the health care system (primary, secondary and tertiary) need to increase their knowledge and skills regarding the special needs concerning medical care, prevention, promotion and rehabilitation for the elderly, particularly women.

8.6 Disability

This is a neglected area and requires greater attention.

- *The interventions in disability need to be medical, social and environmental.* The interventions at all levels of the health system will be :-

  - Reducing the occurrence of impairment i.e. *disability prevention.* This will include eradication of poliomyelitis, early diagnosis and treatment of diseases, adequate nutrition especially Vitamin A preventing blindness due to deficiency. Folic acid supplementation to pregnant mothers to prevent neural tube defects in infants, and propriylactic penicillin every month for children with rheumatic heart disease, etc. This will be addressed through improved coverage and quality of primary health care.

  - *Disability limitation* by prompt and adequate/appropriate treatment at all levels. Emphasis again is on primary health care, with referral to secondary and tertiary levels, whenever the necessity arises.

  - *Reducing transition from disability to handicap by rehabilitation.* This envisages the combined and co-ordinated use of medical, social, educational and vocational measures for training & retraining the individual to the highest possible level of functional ability. It includes medical rehabilitation (restoration of function), vocational rehabilitation (restoration of capacity to earn), social rehabilitation (restoration of relationships) and psychological rehabilitation (restoration of dignity). This is still a neglected area and will be provided support.

  - *Support to Community Based Rehabilitation* (CBR) through established NGO's working in the field will be actively encouraged (e.g. Action-aid, Association of the Physically Disabled, etc).

  - *Apex institutes* in the state will be assisted and consulted for various activities. There are many institutions in Karnataka for different types of Handicapped e.g. Mentally handicapped (NIMHANS, etc); physically handicapped, deaf & dumb (Institute of Speech & Hearing), blind (schools for the blind), and orthopaedically handicapped (Sanjay Gandhi Institute of Accident and Trauma Care, HOSMAT, etc). Support will be given for provision of *referral services* and conducting statewide training.

  - *Assistance for aids and appliances to disabled persons* who cannot afford them. This will be effectively monitored.

  - The *Health Worker* who is envisaged to play a key role will require *training* in topics such as community development, psychological counseling, child development, teaching, CBR principles as well as how to work with specific impairments.

  - They would require active support from the PHC staff as well as trained staff at District / Taluk hospitals.

  - An important aspect of the CBR is Health Promotion especially to sensitize the general population on the *need to concentrate on the abilities of the disabled and not on their disability.* They should realize that every individual could be a productive member of their society.

  - *Community participation* is the organisation of activities by groups of persons who have disabilities (or their family members / friends), in conjunction with others who do not, to increase their ability to influence social conditions, and in doing so to improve their disability situations.

8.7 Strategies for Non-Communicable Diseases

- PHCs to have facilities to detect, manage / refer patients with diabetes, hypertension, ischaemic heart disease i.e. provision of basic diagnostic equipment.
- Secondary hospitals to have needed anti-diabetic drugs, including insulin.
- Prevention and early detection cum treatment of rheumatic heart disease.
- Support to pilot projects for cancer control in Mandya district.
- To identify a few other districts for the same.
- Support to early detection and management of cancer cervix along the lines developed by Kidwai Institute of Oncology.
- Support to cancer prevention programmes.
- Oral health with dental surgeons in all district and Taluk hospitals.
- Support to development of occupational health programmes especially of unorganized sector in collaboration with the Regional Occupational Health Centre (ROHC).

9. HUMAN RESOURCE DEVELOPMENT

9.1 Quality of health services

Quality of care depends largely on the clinical, technical, managerial and other skills of various personnel at all levels. To improve the quality and effectiveness of staff, in-service training of all categories needs to be regularly carried out. There is also need for supportive supervision systems to become functional, as a part of follow up training.

The training components of National Health Programmes like RCH, RNTCP, NAMP, Polio surveillance etc., are presently carried out separately, thus resulting in duplication and wastage of valuable time. Therefore training in this project will be coordinated and telescoped in such a way that the training of the various staff will be done in a combined manner and with optimal utilisation of training funds. Team training will be conducted as appropriate.

9.2 Training needs assessment

The **State Institute of Health & Family Welfare** (SIHFW) was entrusted with the task to prepare Training Needs Assessment of various personnel and also to plan out detailed training programmes for various categories of health personnel in the state. The SIHFW recommended induction training for all categories of staff and subsequent refresher course at least once every five years. The training deals primarily with enhancing the participants knowledge, attitudes and skills in relation to specific procedures, activities or tasks and to health programmes in the context of a focus on public health, integration and implementation.. The training will be based on competency – based training or learning by doing. It will be learner-centred, using methods suited for adult learners. It will also be problem-solving in approach, besides relating to the work and social context of the people of the State.

9.3 Faculty development and strengthening

- The faculty positions of State Institute of Health and Family Welfare will need to be increased in view of the enhanced role. Criteria for selection will be developed in order to maintain high standards. Faculty attachments for persons with requisite skills from academic institutions, private bodies and NGO's will be made.
- Library and Computer facilities will be upgraded.
- Linkages between the State Institute of Health and Family Welfare and other training facilities in the state eg., ANMTCs, DTC's etc., will be established.
- Organisation of 'retreats' for senior officers in multi-programme groups to be able to discuss issues together, away from the administrative burden of day to day work.
- Introduction of workshops on group dynamics, organisation behavior, neuro-linguistic programming, personal growth and interpersonal skills, etc.

10. WOMEN'S HEALTH

Given the current poor health and nutrition status of women and girls, efforts by the State to improve women's health and increase their access to care would be a priority under this project.

10.1 Strategies

Strategies to improve women's health are multi pronged and being part of an integrated approach, crosscut all levels & components. A gender perspective would form the basis of the strategy. The gender approach to health recognizes that the biological differences between men and women are unchangeable, but believes that socially constructed differences that are inequitable can be changed. It recognised that social divisions and disparities in interrelationships between men and women determine differentials in exposure to risk; health status differentials; disparities in access to health care and technology; different rights and responsibilities and low control by women over their own lives (WHO-SEARO, 1998).

a. *Women's health empowerment training* will be an important mechanism used. This has been pilot tested in five districts of Bidar, Koppal, Bellary, Chamarajnagar and Bangalore Rural, during the period 1999-2000, with support from the Government of India. English training kits/ manuals were developed, modified and translated into Kannada for district level trainees and for women leaders. Mahila Samakhya in all their districts and NGOs are involved. There is scope for greater involvement of field level government health functionaries and elected women's representatives. A cascade approach is used with training of district trainers, who train women leaders (two per sangha to ensure sustainability), who in turn train their sangha members and then women in the community.

b. Special attention to the *nutrition of the girl child*.

c. Immunization coverage to be optimal. Specific attention to be paid to Gulbarga division. Additional ANM posts will be created, that will support all aspects of MCH work.

d. *Coverage and quality of maternal health services to be improved* statewide and, more specifically in Gulbarga division. The components of Antenatal care have been found wanting even in Bangalore city, with recording of blood pressure, urine testing and hemoglobin estimation not always done. This project will aim at improving the quality of maternal health services. Greater efforts will be made to increase access to emergency obstetric care, with provisions for transport to be subsidized, and payment of private practitioners and specialists. Linkages with professional bodies and the private sector has been established with FOGSI. These are being translated into field linkages in Bellary district and special provision will be made for Gulbarga division.

e. The provision of *counseling services at District and later Taluk hospitals* will help respond to emotional distress and mental health problems.

f. *Counsellors* could also help build positive self image and positive mental health of women and support / train local groups to act as lay counseliors. It will help to cope with alcoholic husbands / fathers, violence etc.

g. *Gynecological services to be available* at all CHCs and Taluk hospitals to handle referred gynecological complaints. Conditions such as low backache, osteoporosis, uterine prolapse etc to be given priority.

h. Provision of technical / health, management and financial *support to women's groups and NGO's* who run shelters for battered women, self help groups and community health programmes focussing on women's health.

i. Support for *research into women's health needs*.

10.2 Violence against women

Violence against women is an issue of public health magnitude, with health related causes and consequences. There is a need for intervention by a variety of agencies including the department of health.

Violence takes several forms including female foeticide, infanticide, higher female child mortality rates, higher levels of under nutrition in girls under 5 years, lower access to health care, poor coverage of maternal care, child abuse, domestic violence, sexual harassment and abuse at home and in the work place and unnatural deaths of young women.

Strategies include sensitization workshops for medical professionals, along with training for diagnosis, treatments recording and reporting of violence, implementation of Pre-Natal Diagnostic Techniques (Regulation) Act of 1994, provision of counseling services, support to women's groups and promotions of only safe contraceptives.

11. HEALTH PROMOTION, HEALTH EDUCATION AND EMPOWERMENT

Integrated and comprehensive health promotion strategy

- The newer approach to health promotion as a process of enabling people to increase control over, and to participate actively in improving their health, will be internalized by the Department of Health and used for all health promotion activities.

- Workshops will be conducted with personnel from State and District Health Education Bureaus, along with NGOs and experts specialising in health promotion and communication. These would evolve a framework for a comprehensive health promotion strategy covering major health problems and issues, also allowing flexibility to respond to local issues and even individual problems.

- Ongoing orientation programmes will be held at state, district and taluk levels so that an integrated approach to health promotion is maintained. Health education packages will not be resource, donor or programme driven. Health promoters will interact with people about health related problems faced by them.

- Priority areas to be covered include:

a. Nutrition education

b. Health promotive education and activities for school age children. This will include teacher training developing manuals and educational material, child to child methods and life skill education for adolescents.

c. Health empowerment training for panchayat members.

d. Women's empowerment for health.

e. Community mobilization for health using local folk media and cultural form, building on existing groups working in the state

12. PROJECT COSTS BY COMPONENTS

Detailed costing of project components and year-wise phasing has not been attempted. Table 12.1 shows an indicative costing which will undergo considerable changes, as detailed project design and development is taken up.

Table 12.1

Project cost by strategies

(In Rs. Crore)

Sl No.	Project strategies	Investment Costs	Recurrent Costs	Total Costs
1	Strengthening institutions and capacity building	70	60	130
2	Improving access quality and effectiveness of Primary Health Care services	190	70	260
3	Improving nutrition	10	40	50
4.	Reduction in regional disparities	20	30	50
5	Communicable diseases, emerging and neglected problems.	10	50	60
6	Human Resource Development	10	50	60
7	Health promotion and empowerment	0	50	50
8	Women's health	0	10	10
9	Partnerships	0	30	30
9	Health information system	20	20	40
10	Project management, monitoring and research	0	10	10
11	Total Base Cost	330	420	750
Price and physical contingencies				
12	Physical contingencies	20	0	20
13	Price contingencies	20	10	30
15	**Project Total**	**370**	**430**	**800**

TABLE - 1

GROWTH OF HEALTH SERVICES AND MANPOWER RESOURCES
1950 - 1971

CATEGORY/UNIT	1950/51	1955/56	1960/61	1965/66	1970/71
HOSPITAL DISPENSARIES					
INSTITUTIONS	8,600	10,000	12,600	14,600	
BEDS	113,000	125,000	185,600	240,100	
PRIMARY HEALTH CENTRES	NIL	725	2,800	5,000	5,183
MANPOWER					
DOCTORS*	56,000	65,000	70,000	86,000	115,725
NURSES	15,000	18,500	27,000	45,000	66,000
MIDWIVES & AUX'S	8,000	12,780	19,900	48,500	
HEALTH VISITORS	521	800	1,500	4,200	
NURSE-DAIS	1,800	6,400	11,500	40,000	
SANITARY INSPECTOR	3,500	4,000	6,000	31,700	
PHARMACISTS	NA	NA	42,000	42,000	
NATIONAL PROGRAMMES					
a) MALARIA					
UNITS	NIL	133	390	390	393
POPULATION COVERED (millions)	-	107	438	497	535
b) FILARIA					
UNITS	NIL	11	48	48	110
POPULATION COVERED (millions)	-	15.1	24.6	NA	NA
c) TUBERCULOSIS					
B.C.G. TEAMS	15	119	167	167	272
CLINICS	110	160	220	420	532
TRAINING CENTRES	NIL	3	10	15	17
BEDS	10,371	22,000	26,500	34,500	37,000
d) LEPROSY CENTRES	NIL	33	135	235	NA
e) V.D. CLINICS	NIL	-	83	189	288
f) M.C.H. CENTRES (Maternal & Child) (Health)	1,651	1,856	4,500	10,000	NA

NA - NOT AVAILABLE

* M.B.B.S. and LICENTIATES

SOURCE 1) RAO (1966)

2) INDIA (1972)

Source: Trends in Under-Graduate Medical Education in India.
Author: Dr. Ravi Narayan — 1973.

TABLE - 2

GROWTH OF MEDICAL EDUCATION (1950 - 1972)

CATEGORY/UNIT	1950/51	1955/56	1960/61	1965/66	1971/72
MEDICAL COLLEGES	30	42	57	85	103
ANNUAL ADMISSIONS	2,500	3,500	5,800	11,100	13,000
DENTAL COLLEGES	4	7	10	14	15
ANNUAL ADMISSIONS	150	231	281	400	680
*POSTGRADUATE INSTITUTIONS	NA	33 ('58)	57 ('64)	82 ('68)	
*DEGREES/DIPLOMAS	NA	NA	3,424 ('62)	7,025 ('68)	

SOURCE - RAO (1966)
INDIA (1972)
* CBHI (1968)

TABLE - 3

EXPENDITURE ON HEALTH SERVICES AND MEDICAL EDUCATION. I - IV FIVE YEAR PLAN (IN MILLIONS OF RUPEES)

1 U.S. $ = 7.5 RUPEES

CATEGORY	I PLAN	II PLAN	III PLAN	IV PLAN
TOTAL OUTLAY	23,600	46,000	82,000	159,040
HEALTH OUTLAY	1,400	2,250	3,418	11,555
% OF TOTAL OUTLAY	5.9	4.9	4.2	7.2
HEALTH CENTRES/ HOSPITALS	250	370	617	1,662
EDUCATION/TRAINING	216	350	563	982
COMMUNICABLE DISEASES CONTROL	231	690	705	1,270
OTHER HEALTH PROGRAMMES	204	90	210	421
FAMILY PLANNING	7	30	270	3,150
WATER SUPPLY/ SANITATION	490	720	1,053	4,070

SOURCE - PARK (1970)

TABLE IV.

MANPOWER - POPULATION RATIOS

CATEGORY	1946 (a)	1972 - End of IV PLAN (b)
POPULATION	300 million	540 million
DOCTORS	1 : 6,000	1 : 4,300
NURSES	1 : 43,000	1 : 6,400
DENTISTS	1 : 300,000	1 : 68,000
MIDWIVES	1 : 60,000	1 : 11,700
SANITARY INSPECTORS	NA	1 : 18,300

SOURCE (a) BHORE REPORT (1946)

(b) INDIA (1972)

NA - NOT AVAILABLE

medical colleges and other academic bodies. It has also established two Regional Medical Centres, one at Bhubaneshwar and the other at Port Blair, to promote research in some areas which are of local interest.

Earlier, research in Indian systems of medicine and homoeopathy was coordinated by a similar government-financed autonomous institution called the Central Council for Research in Indian Medicine and Homeopathy. However, recognising the need for much greater efforts in this area, the following separate research councils have been set up :

(1) Central Council for Research in Ayurveda and Siddha
(2) Central Council for Research in Homeopathy
(3) Central Council for Research in Yoga and Naturopathy
(4) Central Council for Research in Unani Medicine

INSTITUTIONS FOR TRAINING PHYSICIANS

As in the case of public health, four post-graduate medical institutions play pivotal roles in medical education. As recommended by the Bhore Committee (Government of India 1946a), the All India Institute of Medical Sciences (AIIMS) was established in New Delhi in 1956 with the following objectives (All India Institute of Medical Sciences 1979) :

(1) developing approaches to undergraduate and post-graduate medical education suited to conditions prevailing in India;
(2) training teachers for other institutions for education of physicians to enable them to attain self-sufficiency in post-graduate medical education;
(3) bringing together at one place, clinical facilities of the highest order for training of personnel in all important branches of health activity; and
(4) conducting high quality research.

Institutes similar to the AIIMS were also established at Calcutta, Chandigarh and Pondicherry.

Considering the complex problems involved in setting up a medical college, the progress in this field has been phenomenal (Government of India 1983c : 85-86). In 1948 there were only 25 medical colleges (Table 5.1). The number rose to 41 by 1957; to 60 by 1961; to 87 by 1966 and 106 by 1976. The increase in admissions capacity of these colleges was equally phenomenal (Table 5.1). There were 106 medical colleges in the country in 1982. The 100 Medical Colleges (from where information is available) have 11,054 seats for undergraduate medical education. The

TABLE 5.1 : **Number of Students Admitted in 1st Year MBBS Course and Qualified Final MBBS in India in Selected Academic Years 1947-48 to 1982-83**

Year	Total no. of medical colleges	No. of students	
		Admitted	Qualified
1947-48	25	1,983	959
1950-51	28	2,675	1,557
1955-56	41	3,660	2,743
1960-61	60	5,874	3,387
1965-66	87	10,520	5,387
1970-71	95	12,029	10,407
1974-75	105	11,615	11,911
1975-76	106	11,281	11,982
1976-77	106	11,176	11,981
1977-78	106	11,162*	14,156
1978-79	106	11,053*	12,370**
1979-80	106	10,988*	13,083**
1980-81	106	10,934*	12,170**
1981-82	106	10,749*	12,278**
1982-83	106	11,054	N.R.

N.R. Not received.

Note :

*Data not received from 1 Medical College in 1977-78; 3 in 1978-79; 2 in 1979-80; 1 in 1980-81; 6 in 1981-82 and 1982-83.

**Data awaited from 5 Colleges in 1978-79, 2 in 1979-80, 4 in 1980-81 and 6 in 1981-82 and 1982-83.

Source : Medical Council of India.

statewise admission capacity and turnout of these colleges are given in Table 5.2.

A significant aspect of growth of medical colleges in the country is the coverage of population in different states. As will be seen in Table 5.2, the number of admissions for each lakh (100,000) of population varies enormously. At one extreme, the figure is 2.73 for Karnataka, 2.36 for Jammu and Kashmir, 2.34 for Maharashtra and 2.31 for Kerala. At the other, it is 0.29 for Orissa, 0.76 for Bihar and 0.96 each for Uttar Pradesh and Haryana. This differential coverage has wide implications, quite apart from production of physicians. The attached hospital of a medical college makes available a high quality of medical care to the local population. Correspondingly, most facilities for post-graduate medical education are also concentrated in states which have a high ratio of admission in medical colleges. Distribution of medical colleges thus provides an important indicator of disparities in terms of health institutions and health manpower.

TABLE 5.2 : Population Coverage of Medical Colleges (MBBS) in India 1980-81

States/Union Territories	No. of medical colleges	No. of students admitted (1st year) 1980-81	No. of admission per one lakh* population	Entitlement of medical colleges**
1. Andhra Pradesh	8	911	1.71	11
2. Assam	3	N.A.	N.A.	4
3. Bihar	9	531	0.76	14
4. Gujarat	5	659	1.94	7
5. Haryana	1	124	0.96	3
6. Himachal Pradesh	1	66	1.56	1
7. Jammu and Kashmir	2	141	2.36	1
8. Karnataka	9	1,013	2.73	7
9. Kerala	4	586	2.31	5
10. Madhya Pradesh	6	509	0.98	10
11. Maharashtra	13	1,468	2.34	13
12. Orissa	3	75	0.29	5
13. Punjab	5	300	1.80	3
14. Rajasthan	5	460	1.35	7
15. Tamil Nadu	9	566	1.17	10
16. Uttar Pradesh	9	1,074	0.96	22
17. West Bengal	7	915	1.68	11
18. Delhi	4	763	12.31	1
19. Goa Daman and Diu	1	461	42.69	—
20. Pondicherry	1	70	11.68	—
21. Other and Union Territories	1	135	1.92	1
Total	106	10,927	1.58	136

*1,00,000. N.A. Not available.

**According to Health Survey and Planning Committee norm of one college per 50 lakhs of population.

Source : Government of India (GOI), Directorate General of Health Services (DGHS), *Health Statistics of India, 1981.*

About two-thirds of India's medical colleges have facilities for post-graduate education in one or more fields. These were, in 1978-79, able to offer admission to 3,851 for post-graduate degree courses and 2584 for post-graduate diploma courses. Table 5.3 lists the specialities covered, the number of institutions offering training in them and the level of admissions in 1978-79.

TABLE 5.3 : Specialitywise Seats Available and Number of Students Admitted in Post-graduate Medical Courses, 1978-79

Speciality	No. of insts. having (PG degree/ diploma course)	Seats available		Admissions (1978-79)	
		Degree	Diploma	Degree	Diploma
1	2	3	4	5	6
Anatomy	50	156	—	48	—
Physiology	54	169	—	70	—
Biochemistry	30	98	—	73	—
Microbiology	35	103	—	65	—
Pathology	52	177	177*	147	108
Pharmacology	53	154	—	62	—
Biophysics	4	2	22	2	16
Applied Biology	1	**	—	9	—
Medicine (General)	47	382*	—	373	—
Surgery (General)	48	373*	—	—	—
Obst. and Gynaec	64	391	421*	390	356
Forensic Medicine	23	33	19	22	7
Preventive and Social Medicine	36	105	53	77	30
Aneasthesiology	60	240*	324*	224	263
Ophthalmology	57	218	234*	205	195
Chest Diseases	29	43*	155	40	123
Child Health	42	—	247*	—	209
Orthopaedics	49	149	89*	146	76
Paediatrics	58	255	57	252	54
Radiology	53	140	205*	121	146
Public Health	3	40	72	36	63
Plastic Surgery	9	17	—	17	—
Thoracic Surgery	5	14	—	12	—
Psychiatry	16	66*	70	65	64
Occupational Health	3	14	5	2	1
Physical Medicine and Rehabilation	2	9	3	4	2
Cardiology	10	15	37*	13	33
Neurology	12	45	11*	38	9
Otorhinolarvex	51	124	167*	117	109
Vencroriology and Dermatology	29	56	91	54	70
Gastroentrology	3	10*	—	7	—
Genito Urinary Survey	10	8	—	3	—
Hospital Administration	3	2	6	9	5
Nutrition	1	10	—	**	—
Virology	1	—	6	—	4
Maternal and Child Health	2	—	30	—	13
Industrial Health	1	—	14	—	10
Health Statistics		—	5	—	2

1	2	3	4	5	6
Health Education	1	—	30	—	30
Basic Medical Sciences	—	—	15	—	8
Speech and Hearing	1	10	—	9	—
Medical Lab. Technician	1	—	12	—	12
Endocrinology	1	—	1	—	1
Immuno Haematology and Blood Transfusion	1	—	2	—	2
Nephrology	1	—	4	—	4
Urology	1	••	—	2	—
Mycology	1	••	—	••	—
Master of Dental Surgery	—	223	—	119	—
All Specialities	—	3,851	2,584	3,197	2,025

— Nil

*These are institutions which have not indicated seats available against admissions made. In such cases, the number of seats available has been taken as the number of admissions made.

**Information not available.

Source : GOI, DGHS, *Health Statistics of India, 1981.*

INSTITUTIONS FOR TRAINING IN TRADITIONAL SYSTEMS OF MEDICINE AND HOMOEOPATHY

In 1981, there were 95 institutes providing under-graduate training in ayurveda with a total annual capacity of 3,306. There were 16 institutions for undergraduate education in the unani system, with a capacity of admitting 535 students. One institution with a capacity of 75 provides training in siddha. There are 122 colleges of homoeopathy with a total annual capacity for 7,513 students. The details are given in Table 5.4.

The wide variations in the statewide distribution of number of colleges providing education in the three Indian systems of medicine and in homoeopathy is quite evident (Table 5.4).

INSTITUTIONS FOR EDUCATION OF DENTISTS, NURSES, PHARMACISTS AND OTHER HEALTH WORKERS

India has 22 dental colleges with a total capacity for training 722 dentists annually. Fifteen of them have facilities for post-graduate education, with a capacity for admitting 152 students (Government of India : 1983c : 92). There were only 4 undergraduate dental colleges in 1950-51.

There are 21 colleges of nursing offering graduate degrees is nursing with a total admission capacity of approximately 163 (Government of

TABLE 5.4 : Number of Colleges of Indian Systems of Medicine and Homoeopathy and their Admission Capacity—1981

Sl. No.	States/Uts.	Ayurveda		Unani		Siddha		Homoeopathy	
		No. of colleges	Admission capacity	No. of colleges	Admission capacity	No. of college	Admission capacity	No. of colleges	Admission capacity
1.	Andhra Pradesh	3	110 (3)	2	80 (2)	—	—	3	125 (3)
2.	Assam	1	25 (1)	—	—	—	—	5	200 (5)
3.	Bihar	11	180 (3)	1	40 (1)	—	—	26	2135 (16)
4.	Gujrat	9	258 (9)	—	—	—	—	3	190 (3)
5.	Haryana	4	200 (4)	—	—	—	—	—	—
6.	Himachal Pradesh	1	50 (1)	—	—	—	—	—	—
7.	Jammu & Kashmir•	1	— (1)	—	—	—	—	—	—
8.	Karnataka	8	195 (8)	1	15 (1)	—	—	6	435 (5)
9.	Kerala	5	170 (5)	—	—	—	—	4	250 (4)
10.	Madhya Pradesh	7	187 (7)	1	25 (1)	—	—	13	490 (13)
11.	Maharashtra	17	795 (17)	1	50 (1)	—	—	24	1221 (24)
12.	Orissa	2	60 (2)	—	—	—	—	3	140 (3)
13.	Punjab	3	130 (3)	—	—	—	—	3	140 (3)
14.	Rajasthan	3	180 (3)	3	80 (2)	—	—	3	140 (3)
15.	Tamil Nadu	2	40 (2)	1	15 (1)	1	75	1	21 (1)
16.	Uttar Pradesh	9	410 (9)	4	180 (4)	—	—	16	670 (13)
17.	West Bengal•	4	120 (2)	—	—	—	—	10	1236 (10)
18.	Delhi	4	150 (4)	2	50 (2)	—	—	1	60 (1)
	INDIA	95	3306 (85)	16	535 (15)	1	75	122	7513 (108)

— Nil information.

• Admission closed in three colleges viz., 1. in Jammu & Kashmir and 2. in West Bengal.

( ) Figures in bracket indicate reporting units.

Source : GOI, DGHS, *Health Statistics of India, 1982.*

Source: Health and Family Planning Services in India -1985
Author - DEBABAR Banerji. Lok Paksh

BULLETIN ON

COMH-STA.

RURAL HEALTH STATISTICS IN INDIA

FOR THE QUARTER ENDING

SEP. 1987

ISSUED BY

RURAL HEALTH DIVISION

DIRECTORATE GENERAL OF HEALTH SERVICES

MINISTRY OF HEALTH & FAMILY WELFARE

GOVERNMENT OF INDIA

NIRMAN BHAVAN, NEW DELHI-110 011

STATEMENT XV

HEALTH MAN POWER WORKING IN RURAL AREAS
MEDICAL SPECIALISTS WORKING AT UPGRATED PHCs/CHCs

S. No.	Surgeons			Obst & Gynaes			Physcians			Paediatricians			Total Specialists			Period upto which infor-mations to
States/UTs	S	P	V	S	P	V	S	P	V	S	P	V	S	P	V	
1 2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Andhra Pr.	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.3.85
2. Arunachal Pr.	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.3.87
3. Assam	8	4	4	8	6	2	8**	2**	6	INR	INR	INR	24	12	12	30.6.87
4. Bihar	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	NR	INR	INR	1.4.84
5. Goa, Daman & Diu	4	4	NIL	3	2	1	NIL	NIL	NIL	NIL	NIL	NIL	7	6	1	30.6.87
6. Gujarat	58	39	19	44	1	43	INR	INR	INR	44	7	37	146	47	99	31.3.87
7. Haryana	21	8	13	21	5	16	21	3	18	25	52	27(+)	88	68	20	30.9.87
8. Himachal Hr.	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	30	3	27	30.9.87
9. J & K	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR
10. Karnataka	18	21	3(+)	10	7	3	6	9	3(+)	12	10	2	46	47	1(+)	30.6.87
11. Kerala	NIL	NIL	NIL	4	4	NIL	4	4	NIL	NIL	NIL	NIL	8	8	NIL	30.9.87
12. Madhya Pr*	96	90	6	96	90	6	96	90	6	96	90	6	384*	360	24	30.6.87
13. Maharashtra	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	412	409	3	30.6.87

14. Manipur	7	3	4	7	NIL	7	7	2	5	7	1	6	28	6	22	30.9.87
15. Meghalaya	5	5	NIL	5	2	3	7	5	2	1	1	NIL	18	13	5	31.3.87
16. Mizoram	1	NIL	1	1	NIL	1	NIL	NIL	NIL	1	NIL	1	3	NIL	3	30.9.87
17. Nagaland	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
18. Orissa	42	40	2	25	25	NIL	42	36	6	25	20	5	134	121	13	31.3.87
19. Punjab	22	19	3	22	16	6	NIL	NIL	NIL	22	16	6	66	51	15	31.3.87
20. Rajasthan	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	INR	425	375	50	30.6.87
21. Sikkim	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.3.87
22. Tamil Nadu	33	31	2	31	31	NIL	NIL	NIL	NIL	NIL	NIL	NIL	64	62	2	30.6.87
23. Tripura	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
24. Uttar Pr.	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
25. West Bengal	22	22	NIL	22	22	NIL	22	19	3	2	2	NIL	68	65	3	31.3.85
26. A & N Islands	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
27. Chandigarh	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.12.86
28. D & N Haveli	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
29. Delhi	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	1	NIL	1	1	NIL	1	31.3.86
30. Lakshadweep	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.3.87
31. Pondicherry	NIL	NIL	NIL	NIL	NIL	NIL	1	1	NIL	NIL	NIL	NIL	1	1	NIL	31.3.87
Total	337	286	51	299	211	88	214	171	43	236	199	37	1953	1654	299	

Note : S = Number sanctioned, P = Number in position N = Vacant posts INR = Information not received
* = Revised figure received from Madhya Pradesh.
** = Including Paediatricians, as separate figure are not available.
Dated 9.11.87

(Figures are provisional)

S. No. States/UTs	DOCTORS AT P.H.Cs			Post of 3rd M.O. to be filled	Post of 3rd M.O. sanctioned as on 30.9.87	THIRD M.O.S. IN POSITION AS ON 30.9.87					Period upto which information relates to
	S	P	V			Allopthic	Ayurvedic	Homeopathic	Unani	TOTAL	
1 2	19	20	21	22	23	24	25	26	27	28	29
1. Andhra Pr.	1248	914	334	420	420	232	15	7	10	264	31.3.85
2. Arunachal Pr.	NIL@	NIL@	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
3. Assam	584	584	NIL	146	146	NIL	NIL	NIL	NIL	146	30.6.87
4. Bihar	2121	2121	NIL	587	587	587	NIL	NIL	NIL	587	31.3.85
5. Goa Daman & Diu	52	52	NIL	15	15	10	NIL	NIL	NIL	10	31.3.87
6. Gujarat	782	622	160	251	251	217	NIL	NIL	NIL	217	31.3.87
7. Haryana	666	476	190	89	89	89	NIL	NIL	NIL	89	30.9.87
8. Himachal Pr.	307	249	58	77	34	34	NIL	NIL	NIL	89	30.9.87
9. J & K*	INR	INR	INR	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.3.85
10. Karnataka	3493	3071	422	269	191	191	NIL	NIL	NIL	191	31.3.87
11. Kerala	607	607	NIL	NIL	30	30**	NIL	NIL	NIL	30**	30.9.87
12. Madhya Pr.	2556	1986	570	465	465	317	NIL	NIL	NIL	317	30.6.87
13. Maharashtra	3924	3058	866	428	428	428	NIL	NIL	NIL	428	30.6.87
14. Manipur	109	82	27	25	25	25	NIL	NIL	NIL	25	30.9.87
15. Meghalaya	75	53	22	22	16	NIL	NIL	NIL	NIL	16	31.3.87
16. Mizoram	16	13	3	12	NIL	NIL	NIL	NIL	NIL	NIL	30.9.87

17. Nagaland	21	20	1	14	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
18. Orissa	1061	945	116	314	314	163	36	37	NIL	236	31.3.87
19. Punjab	317	303	14	129	112	92	NIL	NIL	NIL	92	31.12.86
20. Rajasthan	961	861	100	232	232	211	NIL	NIL	NIL	211	30.6.87
21. Sikkim	35	20	15	15	10	1	NIL	NIL	NIL	1	31.3.87
22. Tamil Nadu*	1369	1369	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	30.6.87
23. Tripura	75	96	21(+)	27	27	23	NIL	NIL	NIL	23	31.3.87
24. Uttar Pr.	1026	1026	NIL	907	907	573	NIL	NIL	NIL	573	30.6.87
25. West Bengal	600	554	46	335	197	115	NIL	NIL	NIL	115	31.3.85
26. A & N Islands	12	12	NIL	2	7	NIL	NIL	NIL	NIL	NIL	30.6.87
27. Chandigarh	7	7	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	31.12.86
28. D & N Haveli	8	8	NIL	2	NIL	NIL	1	NIL	NIL	1	30.6.87
29. Delhi	29	22	7	8	3	3	NIL	NIL	NIL	3	31.3.86
30. Lakshadweep	9	9	NIL	7	NIL	NIL	NIL	NIL	NIL	NIL	31.3.87
31. Pondicherru	29	29	NIL	12	5	2	1	NIL	NIL	3	31.3.87
Total	22099	19169	2930	4810	4517	3505	53	44	10	3612	

Note : INR = Information not received.
S = No. sanctioned, P = No. in posotion V = Vacant posts
@ = The pattern of PHCs does not exist in this state
** = Village Health Guide scheme was sanctioned in two districts of Kerala in May 1985.
* Alternative Health Guide Scheme is functioning in these States.

Dated 9.11.87

(Figures are provisional)

Contributing to healthcare

The JJM Medical College, run by the BEA in Davangere, has modern infrastructural facilities in a range of specialities.

RAVI SHARMA

THE *piece de resistance* of the Bapuji Educational Association's numerous institutions is undoubtedly the Jagadguru Jayadeva Murugarajendra (JJM) Medical College at Davengere. This is the only institute that allows the Association to cross-subsidise its other ventures in education. Started in 1965, the College was initially affiliated to Mysore University. Now it is affiliated to the Rajiv Gandhi Health University. It received recognition from the Medical Council of India in 1987. Admission for under-graduate courses with an intake of 245, post-graduate courses with an intake of 107, and diploma courses with an intake of 90 are mainly through a State government-conducted examination, leaving a handful of seats available for the management.

Eighteen specialities — microbiology, community medicine, forensic medicine, general medicine, general surgery, obstetrics and gynaecology, paediatrics, dermatology, psychiatry, ENT, orthopaedics, ophthalmology, anaesthesia, radio diagnosis, pathology and pharmacology — are offered. The college has superspeciality departments such as neurology, neurosurgery, cardiology, cardiothoracic surgery, gastroenetrology, urology and nephrology.

The infrastructure that is available at the college is surprisingly modern for a college of its period. Located on a 25-acre campus, it has an impressive 72,000 square feet library, which can accommodate up to 1,500 students. Chief librarian P.S. Mahesh, said: "We have 35,000 textbooks and we subscribe to 295 journals. The expenditure on textbooks alone is Rs.15 lakhs per annum, while on journals it is Rs.65 lakhs." Most of the students hail from outside Davangere; the hostels accommodate 1,100 boys and 750 girls. The JJM College has 342 well-qualified teachers; with telemedicine catching up in a big way, exposure to information technology has been stressed upon.

Maintaining the college has not been easy in financial terms. Said Dr. M.G. Rajasekharappa, Principal: "With most of the seats being taken away from the management and the prescribed government fees being insufficient, it is an uphill task to maintain the high standards that the MCI and the University want us to maintain."

Attached to the JJM College are the 948-bed Chigateri Government Hospital, the 950-bed Bapuji Hospital, the 150-bed Bapuji Child Health Institute and Research Centre and the government-run 100-bed Women and Children Hospital. Said Rajasekharappa: "Besides these hospitals, in a bid to acquire exposure to rural conditions JJM interns go to primary health centres near Davangere and also to the Taluk Hospital at Chennagiri." According to Rajasekharappa, with over 500 out-patients visiting the Bapuji Hospital every day, there is no shortage of clinical material for the students.

The Bapuji Hospital, which was started in 1970, has over the years become a referral centre for patients from far-flung places such as Shimoga, Hospet, Bellary and Raichur. The hospital is equipped with a full-fledged 24-hour biochemistry diagnostic laboratory with CT Scan, portable X-ray machines, facilities for colonoscopy and endoscopy, and so on, speciality clinics in areas such as neurology, neonatology, cardiology, plastic surgery, and so on, a three-unit dialysis department, a cardiac laboratory, three ventilators, exclusive neo-natal and cardiac intensive care units and 11 operation theatres (OTs). The college has 11 lecture galleries too.

Said Dr. D. Mallikarjuna, Superintendent, Bapuji Hospital: "The hospital has been regularly performing such procedures as angioplasty, angiography, eco-cardiography, coronary artery surgery, valve replacement, total knee replacement surgery, keyhole surgery, orthopaedic and laproscopic surgery and gall

RAVI SHARMA

The Bapuji Pharmacy College.

BAPUJI EDUCATIONAL ASSOCIATION

P.J. EXTENSION, DAVANGERE - 577 002 (KARNATAKA STATE)
Telephones :(0819) 251302, 253550, 250659, 230236 Fax: 91-819-231201

BAPUJI DENTAL COLLEGE & HOSPITAL, DAVANGERE

Bapuji Dental college & Hospital was established in the year 1979 and was only the second Private Dental College in the country. Within the next 4 years it proved its worth to the Dental Council of India. The Dental Council of India had no reservation in granting its recognition. In 1985-86 the college saw yet another break through, the opening of Post Graduate Training Programme in various specialities. In 1988 the college commenced the Dental Mechanics and Dental Hygienist courses, which were approved and recognised by the Dental Council of India.

Courses Offered:

Under graduate BDS (Bachelor of Dental Surgery) 100 seats per annum. Post Graduate MDS (Master of Dental Surgery)

		SEATS
1.	Oral Medicine & Radiology	4
2.	Oral & Maxillofacial Surgery	6
3.	Pedodontics	6
4.	Orthodontics	6
5.	Periodontics	6
6.	Conservative & Endodontics	6
7.	Prosthodontics	6
8.	Preventive & Community Dentistr	3
9.	Oral Pathology	3

Bapuji Dental College & Hospital

Duration of Post Graduate Courses in 3 years. The college affiliated to RajivGandhi University of Health Sciences, Bangalore.

Admission:

Application form and prospectus can be obtained from the Principal, Bapuji Dental College, Davangere - 577 004. Karnataka on payment of Rs.500/-

Advance Reservation:

Due to heavy rush for seats, during the admission time, a few seats have been set aside for advance reservation. Enquiries to this effect can be made to the Chairman, Bapuji Dental College, Davangere. This facility closes by the end of April, every year.

Contact Phone No.0819-220573, 220574, 220575, 220579

I.P.Vishwaradhya
Chairman

Dr.Sadashiva Shetty
Principal

COLLEGE OF DENTAL SCIENCES DAVANGERE

College of Dental Sciences

B.D.S. Course

M.D.S. Course:

1. Oral Medicine & Radiology
2. Oral & Maxillofacial Surgery
3. Pedodontics & Preventive Dentistry
4. Orthodontics
5. Periodontics
6. Conservative Dentistry & Endodontics
7. Prosthodontics
8. Community Dentistry
9. Oral Pathology & Microbiology

✪ Dental Hygienist & Dental Mechanic Courses.

I P Vishwaradhya
Chairman

Dr.Subba Reddy
Principal

J.J.M.MEDICAL COLLEGE, DAVANGERE

Post Graduate Degree / Diploma Courses

Degree Course:

1. M.S ANATOMY 2. M.D.PHYSIOLOGY3. M.D.BIOCHEMISTRY
4. M.D.PHARMACOLOGY 5. M.D.PATHOLOG 6. M.D.MICRIBIOLOGT
7. M.D.COMM.MEDICINE 8. M.S.OPHTHALMOLOG 10. M.S.E.N.T.
11. M.S.ORTHOPAEDIC 12. M.D.DERM.& VENER 13. M.D.ANEASTHESIA
14. M.D.PAEDIATRICS 15. M.D.GEN. MEDICINE 16. M.S.GEN. SURGERY
17. M.D.OBST.& GYNAE. 18. M.D.RADIODIAGNOSIS 19. M.D.PSYCHIATRY

DIPLOMA COURSE:

1. D.G.O. OBST. & GYNAECOLOGY 2. D.C.H. PEADIATRICS
3. D.V.D. DERMATOLOGY, VENEREOLOGY 4. D.A. ANAESTHESIA
5. D.M.R.D. RADIODIAGNOSIS 6. D.C.P. PATHOLOG
7. D.F.M. FORENSIC MEDICINE 8. D.O. OPHTHALMOLOGY
9. D'ORTHO ORTHOPAEDIACS 10. D.L.O. E.N.T 11. D.P.M.PSYCHIATRY

J.J.M.Medical College

S Shivashankarappa
Chairman

Dr. M G Rajashekarappa
Principal

Big strides in dental education

RAVI SHARMA

THE two dental colleges run by the Bapuji Educational Association, the Bapuji Dental College and Hospital, and the College of Dental Sciences, both at Davangere, have a combined annual intake of 200 students at the undergraduate level. None of the seats has remained unfilled unlike in several dental colleges in Karnataka, and this fact points to the high standards that the two colleges have maintained

Said I.P. Viswaradhya, Chairman of the two dental colleges: "Both the colleges are equipped with sufficient dental surgery chairs and each college has its own dedicated hospital. Both hospitals conduct maxillo-facial surgery, which is helpful in oral cancer treatment. Also, with a busy highway passing through Davengere, the presence of these hospitals is crucial for the treatment of hundreds of motor accident victims. Both the colleges are recognised by the Dental Council of India."

The equipment available at the colleges includes high-end, multi-purpose and stereo microscopes, which are connected to an LCD (liquid crystal display) projector to enable a large number of people to view the slide, high-end X-ray machines such as the orthpantomograph (which enables the X-raying of the whole jaw), a ceramic furnace, an induction-casting machine and a motor cast (for ceramic and metal casts), soft tissue analysers and microtones for both soft (up to five microns) and hard (upto 75 microns) tissue biopsies. According to Viswaradhya, the combined assets of the two colleges exceed Rs.50 crores.

One of specialities of the Bapuji Dental College and Hospital is orthognathic surgery, which helps correct deformities of the face. Explained Dr. K. Sadashiva Shetty: "Hardly four or five institutions are doing this kind of surgery in the country. It involves pre-surgical splinting, and then surgery. This is performed when the jaw is protruding.

RAVI SHARMA

The College of Dental Sciences.

bladder/cyst removal". The hospital conducts cleft-lip and palate surgery for children as part of the American-sponsored 'Smile Train' project. On call at the hospital are 140 doctors and 250 staff nurses. "Occupancy rates hover between 50 and 60 per cent," Mallikarjuna said. According to Rajasekharappa the hospital has been recording losses of up to Rs.75 lakhs a year because the charges have been kept as low as possible.

Adjacent to the Bapuji Hospital is the Bapuji Child Health Institute and Research Centre. Established on Children's Day in 1993, the institute aims to provide quality healthcare for children. It provides round-the-clock casualty services, has a 20-bed neo-natal intensive care unit, which is equipped with incubators, radiant warmers, phototherapy units, ventilators and exchange transfusers and a biomedical diagnostic laboratory. The institute also has a 14-bed paediatric ICU, which is equipped for echocardiograms, peritoneal dialysis, ultrasound tests and computerised tomography.

BY SPECIAL ARRANGEMENT

R. Ramanand, chairman, Bapuji College of Pharmacy and Bapuji School of Pharmacy.

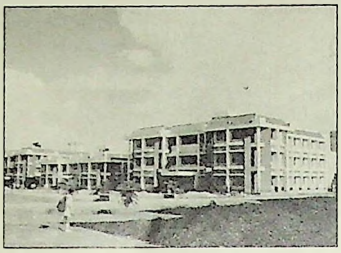
The institute has 12 doctors and 35 specially trained paediatric nurses; on an average the institute gets 150 out-patients every day. The operations performed at the institute include those related to intestinal obstruction, imperforate anus, oesophagealatresia, and so on. Only serious cardiac and multi-systematic anomalies are not performed at the institute.

According to Dr. G. Guruprasad, neonatologist, 35 per cent of all admissions were to the 14-bed fully equipped paediatric ICU. "We are a user-friendly hospital. For example, all the beds are normal sized. This is because in India young children generally sleep with their mothers. There is also a separate parental area where parents can cook and eat. We also have training programmes for mothers (in breast-feeding), doctors and nurses, and programmes to create awareness on the prevention of mother-to-child transmission of Acquired Immune Deficiency Syndrome (AIDS).

Part of the BEA's initiatives in the medical field are the Bapuji School of Pharmacy, which was started in 1977 and the Bapuji Pharmacy College, which was started in 1992. While the former offers a two-year diploma in pharmacy and has an intake of 60, the latter offers a four-year Bachelor of Pharmacy course with an intake 60 and a two-year Master of Pharmacy course with an intake of 8. Admissions are done through the Directorate of Medical Education, with a small percentage of seats reserved for the man-

BAPUJI EDUCATIONAL ASSOCIATION

P.J. EXTENSION, DAVANGERE - 577 002 (KARNATAKA STATE)
Telephones :(0819) 251302, 253550, 250659, 230236 Fax: 91-819-231201



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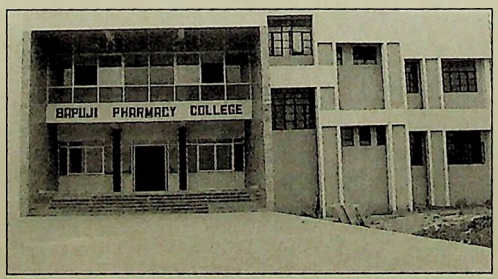
BAPUJI COLLEGE OF NURSING

OFFERS:

1. Diploma in Nursing (School of Nursing)
2. Degree in Nursing (College of Nursing)
3. Post Graduate in Nursing

A S Veeranna, FCA
Chairman

Bapuji College of Nursing



Bapuji Pharmacy College

BAPUJI PHARMACY COLLEGE DAVANGERE

OFFERS:

1. Diploma in Pharmacy
2. Degree in Pharmacy
3. Post Graduage in Pharmacy

A S Veeranna, FCA
Chairman

We diagnose whether the problem is purely one of the teeth or involves both the teeth and the jaw. If the problem involves both, we first take up the orthodontic part (teeth are made ideal), then perform oral surgery on the jaws."

The Bapuji Dental College and Hospital, which was started in 1979, has an intake of 100 at the under-graduate level and 48 at the post-graduate level. Said Shetty: "The college has 250 dental chairs and occupies 175,000 square feet of space. In all, we have around 800 students. Our library has 5,800 books and nearly 1,700 journals, and a video and audio room where students and the staff can avail themselves of free Internet facilities and present case studies." The college has a 25-bed hospital. The faculty comprises mostly of former students of the institute.

According to faculty members, an average around 200 out-patients visit the college every day. The Periodontics Department conducts regular clinics in schoolchildren and runs rural camps using the college's mobile clinic.

The Department of Oral Surgery has remained in the limelight for its impressive performance in the area of maxillo-facial surgery. Said Dr. David Tauro, a senior surgeon in the department: "We have been doing a lot of work with accident and head- and- neck tumour/cancer patients. In a recent accident case, we augmented the (deformed) cheek bone from the hip. The operation was performed not by making an incision but through the oral cavity (mouth)."

In 1991, the dental college was bifurcated and the College of Dental Sciences was formed. In 1996, it moved to a new 100,000 sq.ft building. The college has an intake of 100 students and 47 students at the under-graduate levels and post-graduate levels respectively. It is equipped with 320 dental surgery chairs and has a 30-bed hospital. Of the college's 594 students, 65 per cent and 50 per cent at the under-graduate and post-graduate levels respectively are girls. The college states-of-the-art equipment makes it available at the Bapuji Dental College and Hospital.

The college has the distinction of being the first in South-East Asia to be chosen as an examination centre by the Centre for Evidence Based Dentistry and Informatics, Oxford. The college has undertaken 36 dental educational programmes over the past four years.

Dr. V.V. Subba Reddy, Principal, College of Dental Sciences, said: "In October 2002, our college was chosen by the Diplomat Nationale Board for the conduct of practical examinations in four specialities — oral surgery, orthodontics, conservative and endodontics and prosthetics." The college's out-patient department receives at least 350 patients every day.

BY SPECIAL ARRANGEMENT

I.P. Vishwaradhya, Chairman, Bapuji Dental College and College of Dental Sciences.

Each of the college's departments has a seminar hall, which is equipped with a slide and overhead projector for presentations. Said Sadashiva Reddy: "We have a 225-seat auditorium and, besides all the state-of-the-art equipment that is required by a top-notch dental college, we have an intra-oral digital camera, which enables the making of slides. It can also be connected to a video cassette recorder. We also undertake oral health counselling in rural areas and have adopted five primary health centres, four in Davangere district and one in Haveri. Camps are conducted at these centres — three days for screening the patients and one day for treatment. During the past three months, we have been receiving nearly 150 patients every day. ■

agement.

According to Dr. C.V.S. Subrahmanyam, Principal, Bapuji Pharmacy College, the Rs.6-crore institute is equipped with a pilot plant for the manufacture of capsules, tablets, injections, gels and syrups, 13 laboratories and a computerised library. Added R. Ramanand, Chairman of the two pharmacy institutes: "Both the school and the college have been rated as the best in the State by the Pharmacy Council of India (PCI) and the All India Council for Technical Education. After considering the work done at our Research Centre, the PCI has given us a grant of Rs.8 lakhs. We have applied for a further Rs.70 lakhs as aid. Ours is the only college that has started a PG course in the region."

Ramanand felt that the State government was adopting a step-motherly attitude towards pharmacy education, compared to medicine and engineering. "The admission process is also affecting us badly," Ramanand said.

RAVI SHARMA

Dr. M.G. Rajasekharappa, Principal, JJM Medical College.

The BEA also runs a school of nursing, which was established in 1970, and a college of nursing. While the school, which has 220 seats, offers a three-year diploma course, the college, which has 190 seats, offers a four-year degree course. The college started a post-graduate course in Community Health Nursing and Medical Surgical Nursing in 2002. Student nurses are given free accommodation in the hostels. According to A.S. Veeranna, Chairman of the governing body that oversees the two institutions, the association has applied for an increase in the intake. ■

Technical excellence

Imparting quality technical education is the mission of the Bapuji Institute of Engineering and Technology, which is rated as one of the best in Karnataka.

RAVI SHARMA

WITH a number of innovations to its credit, the Bapuji Institute of Engineering and Technology (BIET) stands out both among the institutes run by the Bapuji Educational Association (BEA) and among the 110 engineering colleges in Karnataka. Recently, it was voted as one of the top 10 institutes in Karnataka. It is affiliated to the Visveswaraiah Technological University (VTU), Belgaum.

Established in 1979 on a 50-acre campus at Davengere, the BIET has the provision of quality technical education to students from the rural and socio-economically backward communities as its goal.

The institute started with five [illegible] es at the undergraduate level and an intake of 192 students. Today, it conducts undergraduate studies in 12 branches (14 branches are available under the VTU) and has a student intake of 660. In the academic year 2002-03, the institute started undergraduate courses in Biotechnology and Bio-Medicine.

Postgraduate programmes such as M.Tech are offered in disciplines such as Textile Engineering, Machine Design, Computer Science, Business Management and Computer Application (52 courses at the postgraduate level are available under the VTU). There are adequate facilities at the institute for research programmes that lead to the Ph.D degree in subjects such as Mechanical Engineering, Industrial Production, Computer Science, Environmental Science, Chemistry and Textile Technology.

The BIET is one of the 10 engineering colleges in Karnataka to be accorded accreditation by the National Board of Accreditation for its Mechanical Engineering, Industrial Production Engineering, Electrical Engineering, Textile Technology, Electronics and Communication Engineering and Civil Engineering branches for a period of three years from April 2001. In addition the Computer Science and Engineering and Instrumentation Technology courses have been accredited by the Institute of Engineers, Kolkata.

The institute has excellent infrastructure with well-equipped, independent, departmental and laboratory blocks, a large (seating capacity of 600) and fully stocked library (30,758 books and 166 journals), in-house medical facilities and a captive power plant, which cost more than Rs.20 crores. So far, the Institute has produced over 6,500 engineers in various disciplines and has bagged 264 ranks in Mysore and Kuvempu universities since 1984. The cumulative average result of the institute since its inception is 76 per cent.

Prof. Y. Vrushabhendrappa, Principal, BIET, said: "Since many of our students come from a rural background and are generally from a socio-economically poor milieu, we have to put in more as much effort as compared to the faculty in a big city college to get the [illegible] per cent result that we now consistently get." The BIET has 2,475 students, of whom 25 per cent are girls. Vrushabhendrappa has served as the Principal of the college for nearly 14 years, the longest period served by the principal of any engineering college in Karnataka. In 2001, he won the coveted Bharathiya Vidya Bhavan National Award for the best engineering college principal.

The BIET's initiatives include the establishment of 'continuing education' and product development cells, training of artisans and the signing of a memorandum of understanding with the information technology major IBM to train students for additional skills on hardware and software. The institute has been chosen by the VTU as one of the 12 centres in Karnataka to impart distance education.

The BIET has been adjudged the lead college by the Karnataka State Council for Science and Technology (KSCST) at their annual jamboree on at least four occasions. Vrushabhendrappa said: "Over the past 20 years, the KSCST has sanctioned 309 of our student projects, of which 100 secured prizes. We have been chosen as No. 1 for excellence both in terms of the number of projects selected for the exhibitions and in terms of participation in seminars."

According to Vrushabhendrappa, in the past two academic years, though there were no takers for as many as 6,000 engineering seats in Karnataka, the BIET managed to fill almost all the seats. "In this academic year we have filled up 75 of [illegible] 90 management seats," Vrushabhendrappa said.

RAVI SHARMA

One of the outstanding departments at the Bapuji Institute of Engineering and Technology is the Department of Textiles.

One of the outstanding departments at the BIET is the Department of Textiles. Established in 1982, it offers undergraduate and postgraduate courses in Textile Technology. It offers a Diploma in Textiles and a vocational Textile Technician course. The department is actively involved in research and consultancy projects with the financial/technical assistance from the All India Council for Technical Education, the Department of Science and Technology, the Tata Energy Research Institute, NSIL Designs, the Karnataka Power Loom Development Corporation, Sun Micro Computers and the Swiss Agency for Development and Cooperation (SDC). So far, the BIET has received around Rs.4 crores by way of grants.

The collaborative sericulture development programme between the Ministry of Textiles, Government of India, and SDC, called the Seri 2000 programme, which is being implemented in Karnataka, Tamil Nadu, Andhra Pradesh and West Bengal, aims at enhancing the sustainability of Indian sericulture by improving quality and productivity. The BIET, which took part in the programme, made a breakthrough in the commercial production of silk-knitted fabrics and garments using Indian mulberry silk.

This technology augurs well for the industry as it provides access to a niche segment in both domestic and export markets. More importantly, the fabric is developed using Indian mulberry silk, whereas the bulk of current Indian silk exports depends on imported yarn. The BIET has produced more than 40 varieties of silk-knitted fabric structures that can be used to produce inner as well as outer garments. In order to market and manufacture the silk-knitted fabric, the BIET has signed an agreement with Stallion Garments, Tirupur.

Another spin-off of the Seri 2000 programme has been the BIET's 'Bapuji Seri 2000 Hank Dyeing Machine'. Dr. H.L. Vijaya Kumar, Head of the Textiles Department, said: "At present, the technology of dyeing silk yarn is not colour guaranteed. To solve this we developed our hank dyeing machine. The semi-automatic machine, which works on the counter-current principle of dyeing, has a number of advantages — needs no skilled personnel to operate it, requires low maintenance as compared to imported machines, has a highly efficient spray system and a solenoid (temperature can therefore be controlled), and most importantly, ensures uniform and better colour fastness. The two-kilogram machine costs [illegible] while the five-kilogram one costs Rs.1.25 lakhs."

The Textile Department has also developed a technology wherein silk waste is used to manufacture thread, which can be used as yarn for furnishings, carpets or apparels. It has also developed technology for weaving silk waste into cotton cloth (again for furnishings), a computer-based machine that measures the 'hand' (sheer, thickness, compressibility, tensile strength and bending properties) of a fabric and costs a fraction of its Japanese equivalent; and proposed a project for the development of silk and modal (an alternative to viscose) for apparels.

The Bapuji Polytechnic, which was started in 1984.

Other departments have not remained idle. The Mechanical Department has used dry maize stems and areca fibres to make laminated blockboards, developed a technique that can be used to cut glass (up to 20 mm thick) using hot air, and designed a pedal-operated silk-reeling machine.

Over the past four years, the institute has spent over Rs.50 lakhs on its Environment Study Centre. Said Vrushabhendrappa: "One of the projects that this centre took up (it was sponsored by the Government of Karnataka) was to examine the potability of borewell water in the districts of Davangere, Dakshina Kannada, Haveri and Udipi. We tested the water in over 15,000 wells. The study showed that 70 per cent of the water was not potable — fluorides, nitrates even lead and chlorides were present beyond permissible limits."

Over the past five years, the centre has also been monitoring the Tungabhadra river for air, water and pollutants.

According to Kassal S. Vittal, Chairman, BIET, "most projects start off as student projects but get enlarged as staff/commercial projects once they are successful. Most projects are also the culmination of the efforts of more than one department." Vittal said further: "While many of our projects are import substitutes, our facilities are regularly used by industrialists from Karnataka and from the neighbouring States as well."

The Bapuji Polytechnic is another initiative of the BEA in technical education. Started in 1984, the institute has an intake of 260. According to Principal K.S. Veeresh, most of the 470 students (30 per cent are girls) hail from a rural, non-English-speaking background. The institute offers full-time three-year courses in Civil, Mechanical, Electronics and Communication, Computer Science, Electronics and Electrical Engineering and Textile Technology.

Given its record — results have hovered around the 70 per cent mark as compared to the state average of 40 — the polytechnic's facilities have been chosen by the Union Ministry of Human Resource Development to train people.

Besides MCA and BCA courses, the BEA is planning a BTech course in fashion technology from next year. ■

Making managers

The Bapuji Institute of Management Studies aims at emerging as an internationally reputed management training centre.

RAVI SHARMA

Prof. R.P. Narasing Rao, coordinator of the MBA programme at the BIMS, addresses students at a conference.

RAVI SHARMA

THE managements of most of Davangere's once-famous textile mills may have declared bankruptcy and closed shop. But the principles of management are being taught with gusto and panache in the city, at the Bapuji Institute of Management Studies (BIMS). Started in the academic year 1996-97, the college was initially run on the campus of the Bapuji Institute of Engineering and Technology (BIET). However, in 2000, it was shifted to a swanky 60,000-square-foot premises, which has classrooms, a computer laboratory, a library, an auditorium, faculty chambers, guest rooms, and so on, with state-of-the-art facilities.

The college offers a two-year Masters in Business Administration (MBA) Programme, which is approved by the All India Council for Technical Education. It is affiliated, along with the BIET, to the Visveswaraiah Technological University, Belgaum. Said A.S. Veeranna, Chairman of the MBA programme: "Although six of Davengere's nine textile mills have been closed, three sugar factories have come up. Besides, Grasim Industries is also active in the region. Management graduates are required. And we wanted to encourage rural students to learn management techniques."

Currently, the college has an intake of 60 students (the Association is trying to increase the figure to 100). According to Prof.R.P. Narasing Rao, coordinator, BIMS, a large percentage of the students come from places in and around Davangere, but there are students from Kerala, Andhra Pradesh, Gujarat and Maharashtra too. Around 35 per cent of the students are girls. He said the student community had shown a marked preference for management courses. "This is why we have sought an increase in the college's intake to 100."

The college offers specialisation in marketing, finance, human resources and information technology. It has 10 faculty members, who have distinguished academic and professional records.

The vision is to make the BIMS an "internationally reputed management training institute" that will equip the youth "to become effective managers and tomorrow's leaders". The institute's MBA programme offers training in quality management through lectures, case studies, seminars, group discussions, continuous counselling and guided study tours.

Another feature of the MBA programme is the 'Institute on Wheels', which came into being because of the lack of guest lecturers who were prepared to take time off from their busy schedules and travel to Davangere to interact with the students. Just as a 'floating university' takes students around various countries, the 'Institute on wheels' takes its students to the metros and urban centres. Interaction with business leaders, seminars and industrial visits are arranged at each stopover in order to expose the students to the rough and tumble of the business world.

According to Narasing Rao, it is more strenuous for an institute like the BIMS to raise the academic standards of the students to an acceptable level, especially in comparison to the Indian Institutes of Management (IIMs). "While the IIMs get the best students, we don't. This is why we have to work twice as hard," he said.

With regard to job opportunities, Narasing Rao said: "The BEA has opened a placement and consultancy centre in Bangalore to facilitate a better, faster and more effective coordination between industry and the institute, better interaction between personnel from industry and the students. The centre has a database of all the students who are passing out and their curriculum vitae will be made available to prospective employers. Campus interviews will also be arranged." During the first year of its operation, the centre was able to place 38 of its 60 MBA students, mostly in Bangalore, Hubli and Dharwad.

The BIMS campus also houses the BEA's Bapuji Institute of High-Tech Education, which offers a three-year Bachelor of Computer Applications (BCA) programme. The programme, which is affiliated to Kuvempu University, has an annual intake of 80 students. Founded in 2000, the institute has a faculty that includes four permanent teachers, besides those who have been engaged on a temporary basis.

BY SPECIAL ARRANGEMENT

A.S. Veeranna, chairman of the MBA programme.

According to Veeranna, buoyed by the success of the MBA programme at the BIMS, the Association wants to launch a similiar exercise in Bangalore. "An MBA college in Bangalore will allow us to interact more closely with industry. With this in mind we have identified some land at Yashwantpur. The institute, which will have an intake of 60, will come up in a couple of years," Veeranna said. ■

COMH-SA.

A P&M APPROACH TO PRIMARY HEALTH CARE

The Declaration of Alma Ata marked a historics step in the history of health. It was the first clear international declaration 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'[1].

The Alma-Ata declaration was a major step forward for it was beased on an understanding and implied that

(a) 'the main roots of poor health lie in the living conditions and the environment in general, and more specifically in poverty, inequity and the unfair redistribution of resources in relation to needs, both inside individual countries and internationally.

(b) That the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[3]

(c) Primary health care, defined as "essential health care, based on practical, scientifically sound and socially acceptable method and technology... at a cost that the community and country can affort to maintain atevery stage of their development in the spirit of, self-reliances & self determination.. is the key to attain the target of health for all by 2000 AD'[4].

Unfortunately despite the brilliant polemic and sweep of this declaration, its implementation lags far behind, and now 22 years since its adoption in practical terms, at least in India, this great slogan has had little impact. Unfortunately the World Health Organization who gave this call, has its contacts limited to the health ministries and to medical and allied professionals, and it is to these sections that the task of implementing this programme went. One critic ruefully comments 'Handing over the implementation of PHC to the medical establishment was similar to handing over the implementation of land reforms to landlords.'[5]. One outcome was to attach 'health for all by 2000 AD' as a slogan to already existing or on-going programmes or to set new series of targets and then to device a series of selective vertical interventions- on immunisation, on iodization of salt on family planning etc and to claim of all of this as part of a primary health care implementation programme. Not only is this a negation of the primary health care approach, even the targets set in selective areas were seldom realized.

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The other major thrust of the present primary health cave programme, as it is in India, is the establishment of primary health centres and the deployment of community health workers-both at subcentres and at village level. This too has run into serious problems. Not only is the number of health workers that have been trained and deployed far short of what is needed, but even those who are deployed yield only a limited quality of health service. The selection, training, monitoring and motivation of the community health workers is so poor that most tend tend to drop out & some even migrate and set up as quack medical practioneers themselves. 'Community participation', one important planned feature, is in most places completely absent. Almost no research, planning or training goes into identifying the problems and working out the tactics of health care delivery.

For the medical establishment, it is business as usual. The last 10 years have seen the mushrooming of corporate private hospitals and a number of private capitation-fee based medical colleges. A top few eminently 'successful' doctors preside over medical association, act on medical councils, advise governments on health policy, serve on its commitees and working groups, influence governmental decisions by virtue of their physician-level personal contacts with decision makers and in many a case even dominate research and private practice. The entire primary health care campaign and the Health for all by 2000 AD slogans are seen as empty politician's slogans or at best as the department of P & SM's responsibility. Clearly no major change is likely to be contributed by these sections.

It must be recognised that members of the medical profession can do little in their professional capacities to achieve this goal. Medical & paramedical professionals are well positioned to investigate the causes and consequences of ill health. However they can rarely tackle the root cause of ill-health-hunger, poverty, shelter, water, sanitation, employment, leisure etc., Without tackling these basic questions-primary healthcare as spelt out by the Alma-Ata declaration is not realizable.

This differentation between the wider concept of primary health care and the narrower concept of primary health services or basic medical services was not made in the original declaration. But subsequent discussions and debates have repeatedly pointed it out.[6]. The basis or primary medical services realte to curative services for simple ailments, & injuries, care for the pregnant woman, family planning, immunization, and some degree of health education--all traditional areas of activity of health professionals.

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It is possible with adequate political backing and administrative will to immediately achieve, such medical care at least in large areas of the country. It is possible for socially minded doctors, helpted by donations or grants to provide such basic medical services in remote rural areas or even in urban areas where the poor have limited access to such health services. There is a record of numerous doctrs from a wide variety of backgrounds the catholic hospitals associations, the people's polyclinics of Andhra Predesh, the work at Nagapur, at Chikmagalur etc., who have undertaken such work. Such work is a valuable contribution but in terms of the actual contribution to the health of the community as measurable by indices the impact has only been marginal. Impact on health itself can only take place by the implementation of primary health care in its broader concept. Though provision of health services and essential drugs are a part of the concept of primary health care, they are not the major part or the focus of primary health care.

This should not however be interpreted to mean that health professionals have no role in the implementation of primary health care. The word 'doctor' is itself the derrivative of the word 'to teach' The doctor and other health professionals are looked upon as a source of knowledge about health and disease. Today many of the ideas prevalent about disease, both right and wrong and most of the health policies have been contributed by the medical professional. To view disease as an affliction of an individual by a germ and lose its social dimensions is the result of a curative bias, that the PHC approach sets itself against. The result of such a bias in the sphere of health policy is to search fortechnological or managerial solutions to what are essentially social issues. The doctor has contributed to such a bias and the doctor can contribute to its unmaking also.

The people's Science Movement and indeed all other individual group's & organisations desirous of realizing the goals enchrived in the Alma Ata declaration need to plan for intervention to prevent the demise of a powerful concept "Health for All, by 2000 A.D." A great concept should not be allowed to dissolve into platitudes.

One of the primary areas that people's science movements can address themselves to is to create an awareness of what health is, to educate people of the causes of disease & ill health and the ways of preventing disease. To spread the understanding that most of the deaths, especially in infants, in India are preventable by very elementary measures and that it is possible to provide health for all-is itself a great step forward.

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Health education has many limitations and pitfalls. Much of the health education current today is technical, fragmented and culturally in-appropriate, other than being for that situation irrelvent. Thus a health worker may deliver a one hour lecture on diarrhoea, without ever mentioning that the water source in that village should be safe. Instead she would probably preach a sermon on cleanliness, suggest using boiled for water all drinking purposes and finish with suggesting oral vehydration therapy. By the time she reaches the most useful part, both sympathy and inevest would have been lost. Or a class on nutrition may tell all mothers assembled that they must give milk, eggs, fish, fresh fruits & vegetables to their children - when most of them are going hungry for want of ability to purchase rise. Even in many a people's science movement lecture we tend to leave out social causes and possibilities of remedial collective action and instead stress on technical causes and individual solutions.

It would of course be of little use if health education lectures were only polemical or philosophical in nature and discussed and curative knowledge will need to be imparted. But where collective action is the only real solution and the basic problem is a health determinant like water or nutrition or sanitation, health education should be aimed at exposing such causes and appropriate remedical collective action. The health professional should provide the technical information, if such is needed, to justify, a PSM effort to organising such action.

Could health by itself serve as an entry point for collective action? The health worker-can she become the agent of social change? Can oppressed people be organized around and for health issues. Though this debate is far from over some Indian experiences have replied in the negative. 'Health work they feel has only weak political implementation and without a proper political context not much of genuine people's participation can be achieved in community health work done.

However most are agreed that 'health should be one of the activities of a group trying to organise the rural poor for justice and for development' 78.

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The reception and popular response to proper health education is also limited by the dominent culture of seeking a pill or an injection as an instant remedy instead of trying for a more scientific understanding of the cause of disease. They come to the health professional for a 'cure' and not for knowledge. Many health education strategies therefore choose to combine therapeutic services with oral education-both within the governmental and in the non-governmental sections. Thus the women waiting to see a doctor in the queue before a primary health centre are given an half-hour lecture before he arrives, or while they are waiting for their turn. Or else after seeking the doctor they have to see a social worker who spends a few minutes talking to her about her disease. Both these of course are rare events, and only in an occassional centre, usually run by a socially concious doctor do they really occur.

Experiences in the people's science movement, though undoubtedly limited, have found greatest success where the health education has been done in the form of a mass campaign. The media used has been popular lectures, slide shows, street-theatre (the Kalajatha), posters and to a limited extent video. The popular response from the audience has been very positive but it is difficult to evaluate the gains of such general health campaigns.

Campaigns focussed on specific issues especially on provision of essential drugs and the drug policy have had a much greater impact. The KSSP in particular by its wide dissemination of books on essential drugs and on hazardous or irrational drugs, have been able to make a mark on drug consumption and prescription patterns. To this end they have held seminars and guest lectures for doctors, campaigned in the local press, used posters and [illegible] news papers and kalajathas to disseminate their views on [illegible] drug policy. Their successful efforts to expose multinationals selling anabolic steroids by intervening in the usual 5 star hotel drug promotional campaign also won them popular support and media coverage. Such a wide variety of activities and on such a scale needs a major organisational network and this the KSSP had. The KSSP organisational growth is a result of the wide varieties of activities the KSSP takes up-covering issues like environment, science, education, health, rural technologies Science popularization, book publication and sales etc., to name a few. Undoubtedly the presence of such a wide base contributed to the success of such a campaign-for the KSSP membership and the people involved in the campaigns were from all walks of life-not only health professionals. This same advantages of being a [illegible]

~~some of the are~~ other PSMs

a broad-based organisation has helped all PSMs in carrying out effective health campaigns. The K.R.V.P. the Lok Vigyan Sangatana are some of theother PSMs who have held such campaigns on health.

Another factor in the success of many KSSP programme is their educational campaigns not only on health but also on environment, do not stop at awareness generation but go on to mobilizing people for collective action. The scope for such health education campaigns which lead on to direct collective interventions by the people have not been adequately explored by other PSM groups & health activists mainly due to their organisational weaknessess.

But as the PSMs continue to expand the scope for such action increases exponentially. It is possible non to plan for campaigns for total immunization or control of diabotical diseases. It is also possible and meeded to campaign for implementing iodized salt distribution in the Terai & other iodine deficient areas of the north while at the same time opposing the ill advised move to ban common salt, commercialize salt production-handing it over to large monopoly houses all in the name of preventing a wide incidence of goitre that is far from established.

It is possible today to campaign extensively for ensuring provision of the 25 essential drugs within 1 km of any habitation and for banning hazardous drugs. In select areas it may be even possible to launch health education combined with collective action against diseases like guineaworm infestations which are potentially easy to eradicate and even against di eases like leprosy, measles which are potentially eradicable even within the present system with exi ting medic l knowledge.

Successful health education work however needs a lot of careful planning and knowledge of local conditions and culture. It also needs an analysis and understanding of the health problems involved. Given the bi s of the medical establishment and official structures today, one is seldom able to rely of official documents and pronouncements alone to evolve a people's understanding of the issue. As a r sult one major area of people's intervention has been to study health issues critically, subject them to meaningful debate and evolve an understanding on major issues.

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There are many groups notably the groups associated with Medicos friends circle, A.I.D.A.N. Helhi Science Forum, Karala Shastra Sahitya Parishat, F.M.R.A.I. who have made major contributions in this regard. Though due to their organisational structure most such groups have limited themselves to presenting critiques, such critiques are essential for future action. These critiques could have formed the basis for collective action by other groups like youth movements, women's organizations etc. but in practice such a cross-fertization has not occurred to any significant degree.

Most such analytical, theoretical contributions are desk work relying largely on secondary date or compilations from various published sources. There are however a number of significant health surveys and field studies by health activists which was formed the basis for critiques. Health problems comsequent to the Bhopal gas tragedy, occupational disease in selective areas & industries, the general health survey and the study of primery health centre facilities in Kerala are some examples of such intervention. It needs be pointed out that the major medical research institutes with elaborate research facilities seldom study such topics. The marked reluctance of such institutes to undertake study on areas of immediate relevance to people, especially if the topic is likely to be controversial and go against local vested interests in well known. Unless health activists intervere actively in such areas of research work, the PSM's and democratic groups will be unable to intervene in both the formulation of health policy or even identify the deleterious effects of ill concieved health or developmental strategies.

Even theoretical work, based on analysis of published data has a significant role to play. The drug policy is one area where health activists in India can take pride as being the sole force to have opposed the government's consistent pro-industry and anti-health policies. And most of this intervention is based on study done by various health activists themselves. Similarly on patent law and on iodisation of salt, official policies have been subjected to critical analysis and have become or are becoming the basis for collective action to press for a charge.

However despite the few areas in most fields, the PSM s and even all the health activists command inadequate knowledge, Training, experience and resources to present meaningful

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critiques or evolve alternative strategies. There is an urgent necessity for health activists to widen its contacts among trained and sincere health professionals who can help. A large number of doctors, especially junior doctors and medical students and many with good academic backgrounds are interested in a social activity of the medical system and willing to contribute to it. Their participation in the work of PSM should be ensured.

Can PSM s go beyond health education campaigns (both general health awareness and on specific issues) and beyond presenting critiques and critical reviwes of health policy? Can it attempt to tackle the concept of primary health care in its entirety? Can it by its work raise the level of health in a measurable fashion or contribute to such a rise in health status?

One approach to these questions is to work on a model- to take up an area varying in size from a village to a taluk or district and in this area attempt to render primary health care. Too often what is rendered is only basic medical services and then in the long run the results are not adequately rewarding. However there are attempts to integrate in such a model, basic medical services with major health educational campaigns, introduction of scientific imputs to upgrade existing rural technologies and launching rural development schemes that generate employment, provision of better nutrition not only through income generation but by a more optimal use of available resources especially for children, provision of safe drinking water and elementary sanitation and above all literacy education and scientific awareness. The people's science movement is better equipped than most groups to implement such an approach. It has within it folds considerable experience in rural technologies, in literacy and non formal education, in running campaigns on issues espeically using local art-forms as a vehicle for new ideas, in drinking-water and sanitation work - and in running basic health services. It should be thus possible for such a model to the built up with the available experience in the PSM s.

When building such models one needs remember the past PSM experience, that successful campaigns need a critical size for raising enthusiasm & for success. If work is too microscopic in diversions, success is less and the project merely peters off.

What would be the socio-political implication of such a model? At this time it is too premature to make any prediction. Definitely given existing social inequities such a model is not

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automatically replicable all over the country, by virtue of its being successful in one place. Even for the model area to succeed social inequalities will pose a problem but we need not assume they are insurmountable ones. (Such a model cannot therefore be posed as the road to success of primary health care).

Then what would such a model contribute? It could by its very presence and success help to pose the issue of an alternative strategy to health care and development. It could demonstrate that health for all is possible - now, given the administrative and political will. It would help bring, by virtue of its experience, the issue of health on to the agenda of national priorities - where it is there notionally but not in practical terms. In organizational terms it would mean mobilizing new sections into PSM activities and adding a newer dimension to activities aimed at social change.

What we should not do when the PSMs take up primary health care work is to confine it to health services, and to health professionals. Thereby we would be going back to locating health issues as separate from other social problems and nurture the belief that good health can be won by technological or managerial inputs alone. PSMs can organize people around health issues only - if they link it up. With other issues of development - especially literacy, education andemployment.

One area of expanding PSM activity that offers immediate scope for linking with the health issue is literacy. The concept of functional literacy as understood by us, includes an understanding of health. Literacy, and education by themselves, independent of all otherfactors have been shown to be major determinant of health status. Women's literacy in particular has been shown to affect, independent of other parameters, women's health, attitudes to family planning, number of children born and infant mortality. The process of imparting literacy is a useful vehicle for the generation of scientific awareness of which health awareness is an important aspect.

One major new area of contribution of PSMs is in adult literacy. With the landmark success of the Ernakulam campaign and the subsequent initial experience of the on-going total literacy campaign in Pondicherry, Goa and Kerala it is likely that PSMs can contribute significantly to health and literacy by their role in evolving and catalyzing mass campaign approaches to total literacy. The Ernakulam literacy project is now being followed

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by operation smiles - a project for 100% immunization in Ernakulam district. Diaorrheal deaths & mortality have come down significantly. In Pondisherry too a health phaseis likely to follow the total literacy campaign.

The coming Bharat Gyan Vidyan Jatha, being organized by the people's science movements of India isone major avenue for health activists to enlarge the scope of their work. The B.G.V.J. aims to organize one cultural groups of volunteers from all walks of life in each of the 500 odd districts of India. In each of these districts the jatha will give performances at 120 to 150 centres. Their performance is aimed at creating an awareness of literacy and science. The basic organizational task of the BGVJ is to organize 60,000 centres all over India to receive thesetroupes. Each centre will also identify a resource persons to give 10 lectures each onetopic. One of these topics is 'Being Healthy' - a basic talk expalining the causes of diseases and the need and nature of primary health care.

The generation of such wide and diverse voluntary network of activists by the people's science movement opens up vast potentials for future action by the people's science movement. Literacy is definitely the major follow-up action envisaged - and definitely the issue we need to address ourselves to most urgently. But it is not possible to open up actual teaching work in all these 60,000 centres as follow up, nor will we be able to sustain even the active centres with a single point programme of literacy alone. Health is definitely one major thrust area for follow up work in these centres. The follow-up work may take the form of health education campaigns or even of intervention in areas like immunization, guinea worm eradication etc.

Or there may be areas where we could attempt comprehensive primary health care. It is premature at this stage when the 60,000 centres exist only on paper to plan for a detailed follow-up but we need to start thinking about it. We can however state confidently that the very attempt to train 60,000 voluntures to give a talk on primary health care in every village of India, is an unique attempt that is bound to throw up a major manpower resource for futurehealth activities.

The People's Science Movement are only in an embryonic stage in most of the states in India and its health work as an even smaller pread. This paper has touched on some areas and types of activities for this movement to undertake but it is no means comprehensive or final. It is only presented as a starting point for growing strategies and activitiesthat will pool the available experience amongst health activists and PSM activitsts. We must use the opportunities presented by the expanding PSM movement, especially the BGVJ for developing a genuine people's health movement, and we must base such a people's health movement firmly on the concept of primary health care.

for schools and colleges operated by the voluntary sector.

The principle is that every citizen has a right to both health care and education. The duty of providing education and health care devolves primarily on government. There is an immense energy and resources of buildings and personnel in the voluntary sector in India, which at least at this stage should not be jettisoned by nationalization. The need is to come to the assistance of the voluntary system so that those who conduct it can realize their original goal of serving a large number of poor people in the area of their institutions.

There is also need both at the state and national levels for a government commission or other appropriate body which can dialogue with voluntary agencies and creatively assist them especially for determining goals, selecting priorities, for area planning, and eventually for financing, so that the maximum service may be provided for the largest number of people, till eventually we can say that health services, at least at the primary level, are available for all our people. We can be inspired to believe this is possible, because even now every citizen can receive a letter through the government postal service. Similarly, we cannot have peace with a sense of responsibility until every citizen can have the privilege of at least elementary education and primary health services.

An effective way of reaching this goal, is by a joint and planned effort of both government and voluntary agencies, on a basis of mutual trust and shared resources. This improvement cannot take place in the present laissez-faire attitude of government toward voluntary hospitals and health centres. There is need of recognition by government of the value of the national resource we have in our vast voluntary hospital system in India, and to assist this system to contribute in the most effective way possible to the realization of a more just society, and the recognition of the human dignity of all our people, but especially of those who are most neglected.

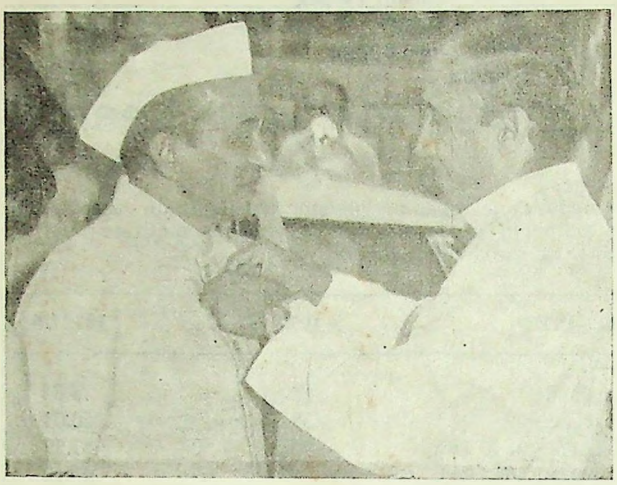
13 paise for your health

How much money does the government spend on your health? Given below in rupees are the per capita expenditure incurred by each state on health

State/U.T.s	1974-75	1975-76
Nagaland	80.84	75.84
Pondicherry	38.84	50.04
Goa, Daman & Diu	35.20	47.59
Arunachal Pradesh	—	43.12
Meghalaya	18.52	24.81
Sikikm	—	23.06
Himachal Pradesh	17.10	19.36
Punjab	12.34	17.88
Jammu & Kashmir	15.77	17.02
Manipur	16.20	16.98
Kerala	12.87	14.12
Maharashtra	13.52	13.41
Rajasthan	12.11	13.27
Tripura	11.09	13.22
West Bengal	9.78	12.31
Haryana	9.99	11.19
Karnataka	8.81	11.26
Tamil Nadu	9.81	10.94
Gujarat	8.57	10.68
ALL INDIA	9.44	10.63
Assam (including Mizoram)	9.56	10.27
Orissa	6.93	9.13
Andhra Pradesh	7.85	8.86
Madhya Pradesh	8.38	6.98
Uttar Pradesh	5.08	5.36
Bihar	4.09	4.46

But if you are in the villages your share dwindles further. As Dr M. P. Mangudkar, Chairman of the committee appointed by the Government of Maharashtra to study the state of health services in Maharashtra reported, out of the total health expenditure of Rs 156 million by the Government in the state, 80% was spent on 3 cities — Bombay, Pune and Nagpur; 6.2% was spent on the district towns; 4.5% on the villages and 0.9% on the tribal areas. Per capita per year health expenditure in the village was 13 paise!

cmai biennial, cha convention



ENDORSING PRIMARY HEALTH CARE IS Vice-PRESIDENT B. D. JATTI welcomed by Fr Bernard Moras, Executive Director, CHA.

Primary Health Care and Community Health are no more the controversial topics they once used to be. This issue of Health For the Millions reports on the endorsement the world community has given to these concepts.

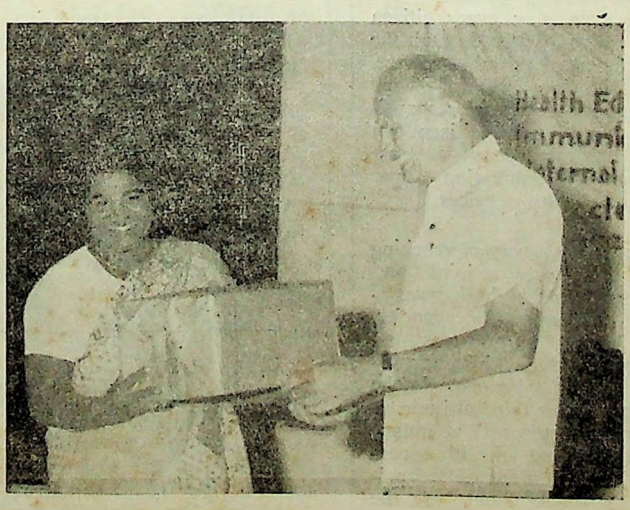
Nearer home both the Christian Medical Association (CMAI) and the Catholic Hospital Association of India, CHA, two very large associations of hospitals and health-care personnel have in their recent annual meetings committed to redefine and rearrange their services to the needs of the communities.

The three day biennial conference of CMAI, concluded on September 14 at Kottayam, was attended by 600 delegates. The General Secretary said "Health services as currently generated and offered to the community by our institutions, requires to be rearranged, wherein it would become a community based programme and into which the hospital is to find its relevance as an essential component in the spectrum of health care."

The Catholic Hospital Association held its national hospital convention and exhibition in New Delhi a month later. A galaxy of experts addressed the delegates on all aspects of primary health care. The scientific sessions made detailed action plans. One of the major recommendations of the convention was to initiate diocesan health plans in every diocese with a view to integrate the health services rendered by various institutions and tailor their functioning to the needs of the community.

Vice-President Mr B. D. Jatti who inaugurated the convention described primary health care as a "means of humanising health care, which has generally been performed in a detached and coldly scientific manner with the least personal equation between the doctor and the patient." According to him primary health care visualises the involvement of thousands of workers. People in large numbers will have to take part in it.

"Perhaps," he hoped, "as we gather experience, it may be possible to evolve a simple technology more suited to our conditions, thus reserving the more advanced hospitals and medical institutions for solving more complicated problems."



WHAT'S COOKING UNDER PRESSURE? CHA thanks Dr James S. Tong, a former executive director, and till recently a member of its advisory board. Presenting the token of gratitude is Sr Sara Kaithathara SCMM, Secretary, Executive Board, CHA.

at alma ata

world votes for primary health

The world's first International Conference on Primary Health Care concluded at Alma-Ata, Soviet Union with a call to all nations to make primary health care for all people a corner-stone of socio-economic development policy.

The six-day Conference, sponsored by the World Health Organization (WHO) and the United Nations Children's (UNICEF), focused world attention on the failure of existing health services to serve rural populations and the urban poor. It sought a firm commitment from governments to remedy this situation.

The 140 nations attending the Conference endorsed a strategy aiming at a comprehensive approach to the promotion of health, coordinating all related activities with the health services as such. Community participation and health education in the planning and delivery of services appropriate to each country's needs are key factors in the strategy.

Stressing the need to ensure coordination of health care efforts with other sectors of development, the Director-General of WHO, Dr Halfdan Mahler said nations must give "absolute priority" to allocating health resources for the benefit of the most needy communities. He called for reforms that would ensure availability of the needed trained manpower and technology to provide primary health care services everywhere within 20 years. Dr Mahler urged governments to formulate health care patterns that they could afford, and after reviews of health care systems within the next two years, to draw up national action plans.

Drawing special attention to the urgent health needs of the world's children, the Executive Director of UNICEF, Henry R. Labouisse, said 15.5 million infants and children die every year for lack of health care. Governments would have to "drastically re-order their priorities" if nationwide health care was to become a reality. This change of attitude would have to begin at the top level of government and national leadership.

The challenge facing developing countries was to devise programmes capable of reaching everyone and still keeping within the limits of available resources, Mr Labouisse said. The problem was not to extend existing health services outward, but to "begin building at the other end", in villages and city slums, and mobilize the people themselves to improve health standards. He stressed the need for an integrated development approach, in which primary health care was vigorously supported by concerted action on other fronts such as safe water supply, housing and better food production.

Princess Ashraf of Iran (Vice-President) pointed out that primary health care implied true decentralization and restructuring of community organization on a democratic basis. Effective power must be delegated to the people concerned, rather than to a combination of vested interests such as local chiefs and landowners, she emphasized. She also warned against the import of "ready-made" health care solutions that might not be suitable to local conditions.

The importance of national political commitment, the role of the medical profession and the recognition that health care entails inter-sectoral effort were some of the focal points of the Conference's deliberations.

Developing countries highlighted funding and manpower constraints to the development of badly needed basic health services.

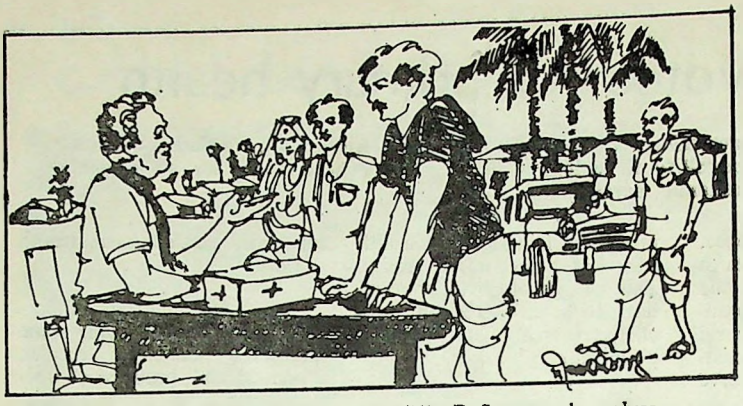
While stressing the importance of political will, some delegates pointed to chronic "brain drain" problem of doctors migrating to developed countries as a major impediment to national health programmes.

Delegates emphasized that health care went far beyond provision of medical services and called for a concerted developmental effort encompassing nutrition, education, environmental sanitation and housing. It was a part of over all national development planning.

Divergent views emerged on the question of whether adequate health care could be provided without country-wide deployment of qualified medical workers. Some countries urged large-scale expansion of medical services manned by doctors and nurses, and felt the use of grass-roots workers could not meet the people's health needs. Others held that primary health care was not a second rate substitute for conventional health services. It was an indispensable first level in a graded scale of health services.

Debating national and international commitment to primary health care, many countries stressed national policy as the first pivot and urged self-reliance and equitable sharing of available resources. This had to precede outside assistance, it was felt. Each country had to base its strategy on its own situation and means. The need for national plans that suited each nation's level of development was underlined.

Some countries felt the bulk of health funding should go to



THE NEED TO TRAIN AND MOTIVATE DOCTORS FOR RURAL SERVICES was stressed at the conference. Some countries drew attention to the high cost of medical training. Many felt the bulk of health funding should go to community based health services.

community based primary health services, and drew attention to the high cost of medical training. But others stressed the need to also train and motivate doctors for rural services and develop different levels of health services.

Hailing the Alma Ata Conference as a unique event because it had brought diverse nations together to discuss a basic human right — the right to health, Senator Edward Kennedy of the United States condemned the persistent toll taken by disease and lack of health care as "an outrage". More than fifteen and a half million children aged under five will die this year; more than 15 million of them would be from developing countries, he said.

Behind these statistics were the faces of millions of people "dying of diseases we can treat or prevent entirely". The world would not tolerate a fraction of this death toll if it occurred during a war. The size of the health problem generated a feeling of hopelessness, and nations needed the vision to use available simple approaches to solve the problem. The human tragedy called for action, not despair, he said.

He called upon nations to help realize the WHO goals of immunizing all children against disease in the next decade. This would give meaning to the coming International Year of the Child (IYC).

According to the declaration, primary health care

"(1) Reflects and evolves from the economic conditions, 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 supplies 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 disease, 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, 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 the 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; and

"(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."

The declaration says: "An acceptable level of health can be attained for all the people of the world by the year 2000 through a fuller and better use of the world's resources, a considerable part of which are now spent on armaments and military conflicts."

what can they do?

Excerpts from a paper presented by the World Federation of Public Health Associations, at the Alma-Ata Conference. This paper is the outcome of a series of consultations among non-governmental organizations in official relations with WHO and UNICEF, as well as with other interested non-governmental bodies, national and international. The paper stressed the vital contributions non-governmental organizations can make to development of health care programmes.

In the field of health, the voluntary organizations have long helped to set standards for practice, training, and continuing education and to define the role of health workers in national programmes. Others have concentrated on a particular disease or activity (e.g., cardiovascular diseases, leprosy, tuberculosis, programmes for the disabled).

The diverse programmes and competencies of numerous organizations, not directly involved in health care, also contribute in one way or another to total human development. They include projects to improve nutrition, food production, and housing, provide safe water, promote literacy, provide educational and other instructional materials, further community development, provide training in a broad range of skills, protect the environment, etc. In short, they are helping to create conditions conducive to the protection, promotion and maintenance of health and the prevention of illness.

Recent years have seen a growing capacity of non-governmental organizations to develop patterns of cooperation among themselves, locally, nationally, and internationally, for consultation and exchange of information, or for joint action.

Non-governmental organizations support the view that the promotion of primary health care must be closely tied to a concern for total human development. The totality of human development, and in fact, a holistic view of health encompasses the physical, mental, social, and spiritual well-being of the individual. Ill-health comes to rich and poor alike. However, much ill-health is a result of poverty and in itself is a serious barrier to breaking out of the bondage of poverty. Thus substantial improvements in the well-being of people cannot be expected merely as a result of better health care, but require a whole range of social, economic, political and cultural activities, i.e., primary health care must be an integral part of the overall development of society.

Human development cannot be fragmented. Social and economic factors are closely inter-related and inter-dependent. It is not enough, for example, to disseminate health and nutrition education if land tenure and utilization preclude the production of adequate food for local consumption. It is futile to promote a health insurance scheme if employment opportunities are so limited that participation is beyond the reach of many. Provision of a source of clean water to a community will have impact on water-borne diseases only in so far as the community is educated in its use and management.

The integrated approach to human development embodies a concern for "people" rather than merely "economic growth". It takes into account the needs and aspirations of the population and aims at providing the community with the means to promote its own well-being and to participate in its own health care. All factors that improve the quality of life must be integrated and made available. Meeting community needs is the basis for the design and implementation of such activities and, in satisfying those needs, promote a confidence within the community for further involvement in development activities. Initiation of health care services often provides the opening wedge for a broader approach to community development. Efforts to secure the fullest possible participation of the community in all aspects of this process are dictated not merely by considerations of economy and efficiency but by the conviction that this is an enhancement of the individual, a necessary part of achieving a basic human right which is presently unattainable in conditions of poverty. Where the patterns of poverty, dependence, and marginalization are engrained, a motivational process is needed to create an awareness in those who believe there can be no change, that possibilities in fact do exist for change.

There are several approaches to health care and none is universally applicable. The appropriate form of primary health care will vary with the differing needs of the community. There should be a rational balance among the curative, preventive, promotive, and rehabilitative components. Education of the community is essential for maximum use of the "primary" approach and for increasing the responsibility of individual families for their own health care, such as well-informed self-medication and modification of lifestyles.

Ample opportunities for a self-sustaining style of health

care can be realized by relating the health care system to other community development programmes, such as fishing and farming cooperatives, credit unions and insurance schemes. Overfinancing of primary health care is as serious a problem as underfinancing. It tends to create unsustainable structures and institutions, and to reinforce patterns of dependency. Levels of external assistance must be appropriately limited in order to promote the self-reliant use of local resources.

effective measures

1. At all stages in the development of primary health care programmes, voluntary organizations can be effective. Recognition by government of the contributions voluntary organizations can make in support of primary health care will ensure maximum benefits of these contributions to the national health programme.

2. Voluntary organizations can work for **greater understanding** and positive attitudes toward primary health care by:

(a) promoting dialogue within the vountary sector; tor;

(b) sustaining dialogue with governmental authorities;

(c) providing information and creating new ways of explaining primary health care to the general public; and

(d) strengthening means of communication to accomplish this.

3. Voluntary organizations can assist **national policy formation** in the areas of health care and integrated human development. They can present health care needs based on their contacts with communities, and they can also interpret primary health care plans to relevant donor agencies.

4. They can establish means for greater **collaboration and coordination** of primary health care activities. This can be done with voluntary sector, and between government and them, locally, nationally and internationally.

5. Voluntary organizations can contribute to primary health care in many ways through **programme implementation.** They can:

(a) provide assistance to develop and/or strengthen local voluntary organization capabilities and activities with particular attention to local community development groups;

(b) conduct reviews and assessment of existing health and development programmes and assist communities in the exercise of their own role in such reviews. A greater emphasis on evaluative techniques will render all new programmes more accountable to real community needs;

(c) develop innovative programmes placing primary health care in the context of comprehensive human development;

(d) ensure that their existing programmes and new initiatives promote full participation by individuals and communities in the planning, implementation, and control of these programmes;

(e) expand their training efforts to respond to the needs of primary health programmes, e.g., training of health workers, supervisors, administrators, planners and various agricultural and development workers. Included would be training schemes which build on the skills of traditional healers and midwives;

(f) extend their efforts to develop locally sustainable and appropriate health technologies and use of resources, with particular attention to energy, water, agriculture, sanitation and medical care;

(g) contribute to the creation of new and effective methods of health education which enable both individuals and communities to assume greater responsibility for their own health;

(h) recognize the essential role of women in health promotion and in the full range of community development concerns; and

(i) further extend their capacity of work with poor, disadvantaged, and remote populations, enabling them to break the cycle of deprivation, and in this way contribute to the search for greater social justice.

NEW INITIATIVES TO PROMOTE PARTICIPATION: Health Workers trained by voluntary organizations speak the local dialect and idioms and are better understood by the community.

a muslim response

Dr Victoria Mathews and her team have increased the awareness in the predominantly Muslim community of Malappuram, Kerala. Women who have earlier refused to go outdoors are now trained as community health workers and are becoming instruments of social change. When health comes development does not lag behind.

Malappuram, a predominantly Muslim area in Kerala has the lowest literacy rate, and the highest incidence of population growth, infant mortality, and T.B. in the entire state. Recognizing the need for a few outreach approach to the health problems of the community, and acceptance, approval and their active cooperation, the Christian Welfare Centre started a community health project under the direction of Dr Victoria Mathews and Mr Tharyan Mathews in February 1972.

HEALTH EDUCATION IS THE SECOND PRIORITY. Basic health workers, many of whom Muslim women, are also active health educators. They carry flash cards and other teaching materials while on regular house visits.

Project areas are selected from the municipality and panchayat, and at present cover a population of almost 20,000. Among the various projects undertaken in community health work, the first priority has been given to maternal and child health care. Weekly antenatal clinics are conducted at all centres as well as the main centre. This work includes medical check up; detection and correction of toxemia, anaemia, nutritional deficiencies; teaching personal hygiene and diet; immunization against tetanus. The underfives clinics maintain growth charts of the children, immunize them, treat them for minor ailments and worm infestation. The community is also advised on the advantages of the small family norm

Health education is the second priority. Basic health workers, health visitors, auxiliary nurse Midwives, local dais, and public health nurses are all taking an active interest in this through regular house visits in addition to conducting classes at the clinic centres and the main centres. People are taught that unhygienic living conditions and impure water supply will cause infectious diseases. In order to improve these conditions, the centre has with the cooperation and participation of the people, launched programmes for repairing and deepening existing wells, providing water sealed latrines slabs to those who dig enclosed latrine pits, and for digging compost pit. There is already a marked decline of worm infestation, diarrhoea, dysentery, and typhoid in areas where these programmes have been started. Exhibitions, teaching demonstrations of well balanced and low cost diets, supply of seeds for kitchen gardens, have all helped reinforce nutrition education.

The cilinics pay special importance to treatment of T.B. and leprosy, and provide leprosy patients with special shoes at subsidized costs. A significant effort is made by the centre to train local dais and basic health workers. The role of the local dais is very important for the promotion of health in the project area. The traditional job for dais is to conduct home deliveries and also take care of the mother and the baby for a few days. They are illiterate and untrained people. So these local dais are trained by the public health nurse for a period of nine months to conduct safe home deliveries and also take care of the newborn babies. They direct the abnormal and complicated cases to the main centre. Along with other basic health workers, these dais are also taught the basic aspects of health. So far seventy-two Muslim women between the ages of 20 and 45 years in the project area have been trained in four batches as both dais and basic health workers, and three other women have received training as basic health workers only. It is worth noting that the Muslim women who always remained in their homes.

without participating in the social activities are now prepared to go out of their homes with the approval of their men folk, to attend health training classes conducted by the centre. It is no exaggeration to state that there is a craving for knowledge and also an awakening among these women and men in the Muslim community.

Once they complete their training, the basic health workers conduct house visits, bring children for immunization and and pregnant mothers for check up, promote family planning, conduct health education, giving cooking demonstrations, help in the MCH and underfives' clinics, and work as intermediary personnel between the community and the centre.

Caring for the physical health needs is not enough; and mental health is closely related to economic stability, in areas where exploitation and illiteracy have been the password for ages. In order to help people help themselves economically, the Christian Welfare Centre gives professional training to girls who are unable to continue their academic studies. The centre also gives interest free loans of Rs 100 to Rs 200 for investment in a small business or industry like buying and selling poultry and fish, cultivating vegetables, making charcoal, etc. So far, almost everyone has repaid the loan by monthly instalments.

The centre, which works in close cooperation with local community health leaders, local doctors, primary health centres, paramedical workers, and other women's organizations, will take on school health programmes, using teachers as media for promotion of health; start adult education; and supply scholarships to needy and eligible students in project areas to continue their education.

Community health programmes under the Christian Welfare Centre have created a great awareness among the traditional and orthodox people in the project areas. They realize the possibility of controlling diseases and also improving their existing living conditions economically and healthwise by their own efforts. Diseases like worm infestation, diarrhoea, respiratory disorders and nutritional deficiencies among the people in the project areas have been reduced considerably. Change is no more looked upon with distrust, but has become a way to a better life.

TO PROVIDE HYGIENIC LIVING CONDITIONS the Centre with the cooperation and participation of the people has launched programmes for providing water sealed latrines. There is already a marked decline of worm infestation, diarrhoea, dysentery and typhoid.

important opportunity

health based community development course

The Voluntary Health Association of India plans to run a four to six weeks residential course on "Health Based Community Development". This course will be held in the Comprehensive Rural Health Project of Jamkhed, Maharashtra, from 4 January to February 14, 1979.

Candidates for this course should be already involved or about to be involved in a Community Health Programme. The number of candidates will be restricted. Those interested in this course should write to :

Miss Ruth Harnar, VHAI, C-14 Community Centre, SDA, New Delhi - 110 016.

fair to one fair to all

Just before the close of the monsoon season of Parliament, end of August 1978, the Hospitals and Educational Institutions (Conditions of Service of Employees and Settlement of Employment Disputes) Bill No 141, 1978, was presented in the Lok Sabha. We are happy to observe that the Bill is favourable for the benefit of hospitals, patients and employees.

We now point out in summary of the notable features of the Bill.

Purpose : To consolidate and amend the law relating to the conditions of service of employees in hospitals and educational institutions with a view to securing the welfare of such employees, and for the investigation and settlement of disputes between such employees and their employers, and for matters connected therewith or incidental thereto.

Possible Exemption : The appropriate government (state or central) is authorized to exempt an institution from the operation of the Bill, if the government is satisfied that the grievance procedures of the institution are equivalent to those required by the Bill, and are found to be working satisfactorily.

Coverage : The Bill applies equally to all hospitals, government, voluntary and commercial.

Special Character of Hospitals Recognized : The Bill recognizes that hospitals and educational institutions have special characteristics, and an atmosphere which eschews conflict has to be maintained in them. For this reason hospitals and educational institutions are excluded from the general Industrial Relations Bill. This hospital Bill, however, does intend to provide adequate protection for employees, and set up a rational procedure for settling of disputes.

Small Institutions Exempted: Institutions employing less than twenty persons are exempted from the provisions of this Bill.

Employee : The word is meant to include those who are not serving in an administrative capacity, and who draw less than Rs 1,000 per month.

Consultative Council: Every hospital or educational institution shall establish a Consultative Council for the institution. The Consultative Council shall consist of not less than six and not more than twelve members representing both employer and employees. The number representing the employees shall equal the number representing the employer. The employer may nominate the chairman of the Consultative Council.

Central Requirement of the Act : Every hospital or educational institution must set up a Grievance Settlement Committee. This committee must have not less than four and not more than eight members representing both employer and employees. The representatives of the employees must equal in number those of the employer. The employer may appoint the chairman of the committee.

Term of Office : For both Grievance Settlement Committee and Consultative Council the term of office of members shall not be less than two years and not more than five years.

Employees May Have an Association : If the majority of the employees desire to have an association for the benefit of the employees and the institution, they may have it. However, no office bearer of the association may be a person who is not employed in the institution. If the requisite conditions are fulfilled, the employer shall recognize the association.

Strike and Lockout Prohibited : No employee of a hospital or educational institution, in breach of contract, may go on strike, and no employer shall lockout his employees.

Arbiters : The appropriate government must maintain a roster of arbiters to assist when necessary in the settlement of disputes. However, the parties to the dispute are not obliged to choose an arbiter on the government list, but may agree on one of their own choice.

Certain Regulations to be Formed : Every employer institution shall make regulations pertaining to method of recruitment, qualifications for appointment and eligibility for promotions, and procedures for settling disputes before appeal is made to the Grievance Settlement Committee, as well as regulations concerning the procedures of operation for the Grievance Settlement Committee.

Arbitration : If the dispute cannot be settled agreeably by the Grievance Settlement Committee, or by private arbitration, the next step is to proceed to arbitration by an arbiter or a board of arbiters appointed by government. The decision of the arbiter will normally be final. Before arbitration, however, every effort should be made to settle the problem by the Consultative Council of the institution or

by the Grievance Settlement Committee.

Rules for Implementation of This Bill (Act, if Passed): The appropriate government is authorized to make suitable rules for the implementation of this Bill when and if passed into an Act. A copy of the Bill, which is eighteen pages, may be obtained free of cost from the office of the Voluntary Health Association of India. All readers and members are requested to read the Bill and to send their comments or suggestions for improving the wording of the Bill to :

Executive Director, Voluntary Health Association of India, C-14 Community Centre, S.D.A., New Delhi - 110016.

health in parliament

In Gujarat, eight districts have been brought under the Community Health Workers Scheme. In these districts, the reorientation training under Multipurpose Workers was completed by April 1977. It has also been introduced in one primary health centre from each of the remaining districts.

Earlier, Mr. Yadav had informed the Lok Sabha that about 42,000 CHWs have been trained in three batches all over India. Another 14,000 such workers are presently undergoing training in the fourth batch.

against blindness

The government has launched a programme of "Prophylaxis against blindness due to vitamin A deficiency among children between 1 to 5 years of age." Under this programme children between the specified ages are given a dose of vitamin A in oil every six months. The programme which started in the Southern and Eastern states during 1970-71 has now been extended to cover all of India.

* *

In order to take eye care closer to the people, the government has also launched a programme for Prevention of Visual Impairment and Control of Blindness. This programme, the Minister said, will educate the community in eye care measures so as to preserve sight and prevent visual impairment. It seeks to provide immediate eye relief through mobile units in the remote areas, and also undertakes surveys of the community including pre-school and school-going children for early detection of eye trouble. The programme aims at developing permanent infrastructures for comprehensive eye care services at the primary health centres, taluka and district hospitals, medical colleges, and Regional Institute of Ophthalmology.

handicapped

The government, gives assistance to voluntary organizations for the establishment and maintenance of SET Centres. The Department of Social Welfare, under its scheme of "Assistance to Voluntary Organizations for the Handicapped" gives financial assistance upto a maximum of 90 per cent or deficit to those voluntary agencies which propose to create or expand services for the education, training and rehabilitation of physically handicapped. These include cured leprosy patients.

small percentage

Mr Yadav acknowledged that only a very small percentage of patients suffering from Sexually Transmitted Diseases, go to the general hospitals for treatment. He informed the House that at present there are 237 STD clinics and 106 medical colleges where proper diagnosis and free treatment are available.

life expectancy

The expert committee on population projections has estimated that the expectation of life at birth for males and females will be 52.62 years and 51.55 years respectively as on 1st September, 1978.

This was stated in the Lok Sabha by the Minister of State for Health and Family welfare.

drugs

The Minister of Petroleum, Chemicals & Fertilizers, Mr H. N. Bahuguna, told Lok Sabha on August 28th that a close watch is maintained over the availability of essential drugs. The supply position of drugs and pharmaceuticals is by and large satisfactory. Occasionally reports of shortages of patent or proprietary products are received but in these cases equivalent substitutes of other produces are available. Recently reports about the non-availability of proprietary and non-proprietary substitutes in respect of the following formulations have been received :

1) Dapsone Tablets.
2) Adrenaline in Oil Injection.
3) Neoepinine Tablets.
4) Clinestrol Injection and Tablets.
5) Gas-Gangrene Anti-Toxin.
6) Insulin Lente.
7) Ethyl Chloride Spray.
8) Mycostatin Tablets.

Suitable action to relieve the shortages has been taken in consultation with the manufacturers concerned.

news from delhi...

☐ The Union Ministry of Health and Family Welfare is introducing a new scheme to more fully involve traditional midwives, "dais", in maternal and child health care in the rural areas.

The scheme will be introduced first in twelve districts of Bihar, Orissa, Madhya Pradesh, Rajasthan, and Uttar Pradesh. These districts have been chosen for their high concentration of tribal, scheduled caste and backward class population and their high incidence of infant mortality.

The emphasis of this scheme is on improving antenatal care, reducing mother and child mortality, and popularizing small families. Each subcentre in the district will have four dais. These dais will notify pregnancy cases in their areas to the officer in charge, ensuring supervision from the early stages. They will conduct normal deliveries, advise on the advantages of small families, distribute condoms, and assist the health worker in getting the children immunized. Cases that are complicated or those needing medical termination will be referred to the officer in charge. The dais will also be trained to recognize signs and symptoms of communicable diseases.

Under this scheme, the dais will be paid an honorarium of Rs 50 per month.

Announcing the scheme, Mr Jagdambi Prasad Yadav, Union Minister of State for Health and Family Welfare, said that this would, for the first time, take maternal and child health care to some of the most backward and inaccessible areas in these states. He stressed the relationship between high incidence of child mortality and large families. Improved maternal and child health care, he was confident, would lead people to accept the small family norm.

The scheme is estimated to cost a little over one and a half crores rupees during the entire Sixth Plan period.

☐ The Community Health Department of the Holy Family Hospital, Delhi organized a seminar on Community Health. It was attended by twenty participants from dispensaries around Delhi. Sr Anne Cummins, Ruth Harnar and Ashok Subramanian from VHAI led sessions on community health planning, project review and the village health worker.

and the states

kerala

The Annual General Body Meeting of the Kerala VHS was held on July 19, 1978. Dr S Joseph from MGDM Hospital and Sr Philomena Marie were re-elected as President and Secretary respectively.

☐ A two-day seminar on Personnel Management in Hospitals was held in Kottayam in July. Topics discussed included problems of personnel management, the merits of group insurance scheme as a staff welfare measure, disputes, grievance procedures and machinery for settlement of disputes, and the Supreme Court judgement.

☐ A three-day seminar was held at the Post-graduate Institute of Social Work, Kalamassery, on Social Awareness. The discussion covered the need for change, analysis of the socio-economic conditions, adult literacy programme and its role in overall development.

karnataka

☐ Our Lady of Lourde, Charitable Hospital, Kelgheri Road, Dharwar and Karnatak Ayurved Vidyapeeth Society's Hospital, Dharwar have been enrolled as new members of the Karnataka VHA.

☐ The Karnataka VHA organized a seminar in Hospital Finance at Fr Muller's Hospital, Mangalore from September 12 to 16. Two representatives from six hospitals and two medical colleges were invited. Fr Norhona, who has succeeded Fr Moras as the Administrator of FMCI, inaugurated the seminar.

The seminar was unique in that the participants discussed certain theoretical aspects of a good accounting and financial hospital system, broke up into groups and observed each area in actual operation at Fr Muller's Hospital. The main sections included in the observations were billing, payroll, accounting and financial reporting and purchasing and stores. One area was selected for an aftenoon session of discussion and comments for each day.

Besides the above, sessions were held on hospital legislation, financial management including proper use of hospital resources and financial analysis.

Much of the success of the seminar was due to the time and effort given by Mr George Sebastian, Finance Officer of FMCI. Most of the participants were appreciative of the fact that the accounting staff of the hospital did not hesitate to show all the records, answer questions and indicate areas where the system still could be improved. The participants agreed that discuss-

ing a specific system in relation to theory was much more meaningful than merely classroom exercises.

Besides Mr Nabert of VHAI, experts on Income Tax, financial analysis and auditing assisted Mr George Sebastian in conducting the seminar.

Gujarat

☐ The Western Region VHA secretaries met in Ahmedabad from July 12 to 15. Present were Fr Urrutia, Dipti Dikshit, Sr Terezina Dias, Dr Porwal, Denis Carlo, Marjorie Hill and Ruth Harnar of VHAI. Discussions included the job descriptions of the organizing secretaries, goals and priorities of VHAI and the VHAs, relationship of the organizing secretary to the executive boards of VHAI and the VHAs, and the future of state associations with particular reference to financing.

As a result of the discussions, the participants agreed on the need to share information about legal matters, resources and project through periodic newsletters, act as a liaison between the government and the association members, organize seminars, and discover through visits and correspondence the needs, problems and expectations of the members.

bihar

☐ A training programme for the "Trainers of Village Health Workers" was held in August at the Kurji Holy Family Hospital in Patna. Sr Anne Cummins and Ruth Harnar of VHAI participated. A similar programme was held earlier in March at the Kodarma Holy Family Hospital. The Patna team, which attended the March programme, started an initial training programme for village health workers of eight villages at Beriarpur alongwith the adult literacy camp. As a result, the VHWs initiated the cleaning of a few village wells with the total support and participation of the community. They have also succeeded in involving the government and the people together in their massive immunization programme. Over 1000 people below the age of twenty have been administered B.C.G. The opportunity provided by the campaign was fully and effectively utilized for health education.

☐ Five dispensaries in the Palamau district, Bihar, are planning an integrated health programme. With the assistance of Simone Liegeois and Manab Chakravarthy of VHAI, they are conducting a study of health needs and their economics in their area of work, and planning out programmes and priorities.

☐ A total education camp was organized at Khadigram near Jamui, Bihar, Fr P. J. Manthara for the Santhal population of Lakshmipur Block. The camp aimed at helping the people realize Gandhiji's dream of "Real Swarajya". The participants discussed all their problems in the socio-economic, political and health contexts.

Literacy classes for children, young men and women generated much interest. There was a weekly evaluation session.

In the health field, a medical team from the Holy Family Hospital, Patna, trained village health workers for five weeks on maintenance of health through nutrition education, family welfare, child care, immunization, recognition and treatment of common diseases and sanitation. In addition, a lady was elected to function as a midwife.

The camp which lasted almost seven weeks helped the participants gain awareness of their rights, and the need for unity in attaining them.

MOVES IN THE WESTERN FRONT. Marjorie Hill from Madhya Pradesh, Sr Terezina Dias and Dr Porwal from Rajasthan and Fr Urrutia of Gujarat at the Western Region meet.

Maharashtra

The Catholic Relief Services, Bombay, organized a workshop on Training Village Health Workers at Jamkhed from July 17 to 27, with the help of Sr Anne Cummins and Ruth Harnar of VHAI. Dr Arole and his staff members explained the philosophy and the beginning of their project, and the selection and training of village health workers. The role of the members of a health team was discussed along with community organization. The session on nutrition gave particular emphasis to the CRS nutrition education programme, including role clarification of the consignee.

ComH-5a.

b. more 'community' oriented

Understanding health in its community sense and not just as the problem of individuals.

c. more socio-epidemiologically oriented

Understanding health in its wholistic sense — which involves the biological, social, economic, cultural, political and ecological dimensions.

d. more democratic oriented

More participatory and democratic in its growth, planning and decision making process.

e. more accountable

Increasing subservience of medicine, technology, structures and professional actions to the needs and hopes of the people, the patients, the consumers, the 'beneficiaries' and the communities which they seek to serve.

This confrontation of value systems and re-orientation will help the superstructure and its different elements to emerge from their present ivory-towered isolation and irrelevance and gradually become supportive infrastructure of a more just and healthy society. However this change cannot be miraculous or based on just good intentions or any amount of wishful thinking. It must be a serious commitment to social analysis, participatory evaluation and critical self-searching for greater relevance by all those concerned with planning and decision making in the present superstructure.

Box No 14

THE ANTWERP MANIFESTO FOR PRIMARY HEALTH CARE

Academicians, community health specialists and practitioners from several industrialised and Third World countries gathered in Antwerp, in November 1985, for 2 day seminar where they took stock of the achievements of the Primary Health Care approach.

Since the 1978 Alma Ata Conference, the member states of the World Health Organization agreed that this Primary Health Care strategy, which sees people as active partners, is the most suited to answer their needs and can provide the basis for Health for All.

However, in Third World countries, in spite of the lessons of history and of past experiences, major national and international donor agencies are diverting scarce resources into a short term approach known as "selective primary health care". This approach concentrates exclusively on certain interventions claimed to be the most efficient and aimed only at sections of the population. This self-contradictory term should be banned, since at their best, such programmes can only be considered as "selective health status interventions". This approach is in total contradiction with the fundamental principle underlying Primary Health Care.

These principles are:

★ The main roots of poor health lie in living conditions and the environment in general, and more specifically in poverty, inequity and the unfair redistribution of resources in relation to needs, both inside individual countries and internationally.

★ Since health is only one of the concerns of people, it is self-defeating not to consider them as partners who are able to play a great part in the protection and the improvement of their own health. They thus have to be fully and really involved in the making of decisions which affect their health, including of course, the provision of health services.

★ Health services must provide both curative and preventive care, as well as promotive and rehabilitative measures. This has to be done in a coordinated and integrated way which responds to the people's needs.

The Primary Health Care approach is being used with success in many parts of the world. Being a continuous process, much remains to be done.

This manifesto is issued because the proliferation of selective health intervention programmes undermines the health services at the exact moment when they try to reorganise themselves towards Primary Health Care.

It is issued also because these interventions purport to offer "quick solutions" and "instant success" for which they divert scarce resources from the solution of the real underlying and continuing problems, thus helping to maintain ill health.

In addition, experience has taught us that selective interventions tend to become permanent even though they are presented as "interim" responses only. In fact, they need specific structures which a country could not easily get rid of at the moment it decided to reorient its health policy towards comprehensive Primary Health Care.

And, above all, the selective approach rules out the possibility of people's participation in decision making about their own health.

The undersigned thus wish to reaffirm the principles of Primary Health Care in its comprehensive form, and reject other approaches instituted and propagated as "selective primary health care".

Source: UNK (Ref No. 16)

COMMUNITY HEALTH: IS A MOVEMENT EMERGING ?

A study of the dynamics of community based health action and the evolving approaches from micro level experience show that 'community health' could become a movement linked to a wider development and social change process in the country. There are many positive trends which support this possibility. However, there are many negative trends as well which could become major obstacles for a genuine health movement in the country.

The positive trends are —

i. Policy reflections of the Government

Policy documents and expert committee reports have been echoing new approaches. Many decision makers, administrators and technocrats within the entrenched medical system are aware of these new approaches.

ii. "Village Health Worker Army"

A growing army of villagers and lay

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

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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 orientations 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 on methods to be used. Any comments made regarding structures at whatever level were only attempts to concretize the problems in order to be able to search for the most suitable solutions.

1. 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 miracles 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 personal, following this principle, serve at the same time, their own personnel 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 man in Christ. We proclaim this Good News through the witness of our lives, and by taking up the saving attitudes manifested by Christ towards each person, his environment and his traditions. Through us the Church evangelizes men 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 conjunction 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 health 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 learn 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 direction 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 to 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 the 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 comprehensive 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 educate 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 vocation and constitutions 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. *[illegible] 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 them 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 conscience 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).

ComH SA. 14

COMMUNITY PARTICIPATION - ROLE OF DIFFERENT AGENCIES IN MULTI-SECTORAL APPROACH

by
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Before any discussion of the topic assigned to me is commenced, I wish to comment on the term "Community Participation" itself. Is there in modern India the feeling, awareness of the community in the sense of "for a nighbourhood/body of people living in same locality"; not in the sense of "the antagonistic religious and racial communites in a district". Both these quotations are taken from the Concise Oxford dictionary. The politicians in India should be thanked - or, will "blamed" be the correct term - for this position in which "community" has becomme a dirty word and not understood in the same way as it should be in any modern society. It is therefore essential that we should as a first step restore a proper community feeling as an area, neighbourhood feeling that was part of our ancient culture.

Primary Health Care must necessarily have its origin in the most remote villages where the problems arise. It will be better therefore to talk about community action with participation by the Government or organised voluntary health agencies. The programme should be conceived and executed by the community with whatever technical and financial support may come from the Government or other agencies.

To reiterate that the organizations for Primary Health Care should start in the villages is in consonance with Sutton's Law. Sutton, an Australian Bank robber when asked why he was robbing banks in particular, gave the simple reply "because the money is there"; likewise the problems of health care are in the villages, and urban slums and not in New Delhi.

A distinction should be made between voluntary agencies which on par with the Government can be regarded as donors, and the individuals in the community, the consumers of health services who are the recipients. Our effort should be to alter the role of the community from that of a passive recipient to that of an active initiator. Therefore I shall start with the illiterate citizens who to a large extent are the beneficiaries. Here the mistake is often made in thinking that an illiterate person is un-intelligent. God, or if you like nature, has endowed all human beings with a basic intelligence and the villager who has not had the opportunity to go to a university is nevertheless very intelligent and capable of providing excellent support to the health team. In 1973, the WHO World Health Day's Theme on April 7th was "Health begins at home",

We conducted a number of meetings, to stress how the most important reliable and dedicated para-medical worker in a health team, is the mother in the house. Field experience since then has further given support to this concept that if only she can be properly involved many of the targets can be achieved.

In our programme we have local action committees, who have been told clearly that the health centre is their project to which the medical profession, with its auxilliaries, only provides the technical skills. It should not appear to be a paternalistic condescending gift of better off persons to their inferiors.

The Community Health Volunteer/Lay First Aider is the one individual who can make maximum contribution to health education. In her training, therefore, we emphasise environmental sanitation, personal prophylactic methods, improved nutrition with locally available products, mother and child care, and family planning.

Talking of environmental sanitation, one notable area in which community involvement has failed is in the individual families putting up their own cheap latrines even when they could afford it.

Taking another example, the resurgence of malaria is not due so much to the resistance developed by the mosquitoes to pesticides or by the malarial parasites to chloroquine, as it is due to the failure to build up the infrastructure. The infrastructure should require every householder to take care of the mosquito breading foci in his own surroundings and report every episode of fever to the MHC/CHV. This is a clear example of community involvement without which public health measures cannot succeed.

We often talk of health care delivery. It should be realised that health care cannot be delivered; it is essentially a "do it yourself" proposition. For example, drug addiction, alcoholism, smoking and sex permissiveness are four, recent important additional causes of disease. None of these can be controlled in the community unless the individuals involved are motivated to co-operate in their cure and prevention. Likewise patients in need of prolonged treatment (e g. pulmonary tuberculosis, leprosy) cannot obtain a cure even with modern, wonder drugs if they default in taking the drugs.

Health Education therefore is of the utmost importance. Health Education specialization is a profession practically non-existent in India. It is questionable whether we can afford a new category; every health worker should therefore be a health educator.

Briefly the objects of health education are (a) to educate people and alter the behaviour, where necessary, to promote and maintain their health; (b) to impart the minimum knowledge required for people to be aware of the factors that affect health and recognise the early symptoms of disease; (c) to assure the people of the availability of the needed services and the accessibility of those services to the poorest family.

It has been shown that it is comparatively easy to achieve success in situations depending on techniques eg. vaccinations, mosquito control. But where techniques play only a minor part and people must be persuaded to change their habits, the situation becomes much more difficult eg. choice of correct food, smoking, family planning.

It will thus be seen that health education must adopt different approaches and must be continuous and simple.

Most authorities believe that mass media do not produce as consistent and good results as personal man-to-man approach. Obviously the latter will require many more teachers of health education; that is why health education is stressed as the most important function of the CHV.

The ideal set-up for community health must provide for the following essential requirements:

A health post manned by a lay first-aider/community health volunteer for every 1000 population.

A male and a female multi-purpose worker for every 5000 population;

A doctor being available at the mini-centre for atleast three hours a day on three days a week;

The identification of, and liaison with, a referral hospital within a reasonable distance.

The LFA at the Health Post is in fact the most effective volunteer in health work and all organised voluntary health agencies are only subordinate to these Queen Volunteers. The mother in the house has been justly acclaimed as the most dependable medical auxiliary. In view of her importance we ensure that the LFA is selected, trained and supervised in the proper way.

"The effects of a world wide plan of action on behalf of Primary Health Care, extend well beyond the frontiers of health itself and into the economic and social fields" said Dr.Mahler (Director General, WHO) at Alma Ata.

Of the many facets which one may consider in "integrated/total rural development" abolition of illiteracy, maximised through Non-Formal Education, is very important and should be regarded as a project that can be taken up even by health agencies. Among the reasons for the failure of community participation in health programmes set up for their own benefit is the lack of knowledge of the average citizen on the possibilities of modern medicine and the availability of solutions to his problems. He now has considerable fear and diffidence in reaching those who can deliver the goods. The inaccessibillity to the health services really arises out of illiteracy and, true democracy and illiteracy are incompatible in as much as the former demands on the part of its citizens a knowledge of all its institutions.

Here the National Service Corps in the various colleges should be mobilised for non-formal and for health education in a big way. To my mind giving them such jobs as building roads is a rather futile exercise. It is understood that most Universities in India have taken a firm decision that community service should be compulsory for every student and that marks will actually be allotted for the same. More than the decision itself is the exact method of implementing the decision in such a way that the entire community gets maximum benefit, quite apart from the good it will do to the student's motivation.

Next in importance is the production and utilisation, at the local level, of nutritional needs -obtainable from agriculture (staple carbohydrate); horticulture (vegetables and fruits) animal husbandry (milk) and poultry (eggs).

Unorganised community/citizens/sharing an old traditional customs is not to be given up for the western models of centralise impersonal, official ridden institutions. CHARITY is to be pronounced as SHARITY, the CH as in Chicago. The poorest citizen in a welfare state need not ask for charity; he is entitled to share the available resources/facilities with the richest.

The challenge is tofind the solutions for poverty and apathy; local community action, under proper guidance and leadership, can cure the latter atleast and that will be an essential fore-runner for curing the former. Shultz (Royal College of Medicine, International Congress Symposium No. 24, P. 57) has underlined the importance of stressing on <u>self interest</u> which is a natural fact and an intrinsic aspect of human nature.

Ergonomics is the management of people. It is time one forgets New Delhi, metropolitan elite and concentrate on the poor people where they live and change their attitudes if possible.

We have no doubt that a very effective way of involving the community, is to get a monetary contribution from each family. The principle of obtaining such contributions from the community is no longer disputed.. No Government in the world can offer to provide all health services free, i.e. on its own general revenues. Besides such a personal conttribution will ensure the cooperation and wholesome participation of the community, Any service which is entirely free at the point of consumption is bound to be abused and is bound to enormously increase in cost year after year, as has been demonstrated in UK National Health Service.

In our scheme of Medical Aid Plan and Mini Health Centres it has been provided that each family should contribute, on behalf of all its members, 0.5% of its annual income subject to a minimum of Rs 12/- per annum and a maximum of Rs 200/- per annum. Here let me quote Dr.Mahler, Director General of WHO: "Are the costs exorbitant ? Recent small scale studies have shown that considerable improvements in people's health can take place for as little as 0.5 to 2% of the yearly gross national product per person- or what amounts to a few dollars a year.

This is by any standard a reasonable cost, around a hundredth of what is spent on health by people in many rich countries. So cost factors should not hinder Governments when they consider if, and to what extent, they should commit themselves to the target of health for all by the year 2000" (World Health, November '79)

In addition, at the Health Posts manned by the Lay First Aiders, which form an integral part of the Mini Health Centre scheme, there is a provision for collection of 25 paise from the patient for the symptomatic treatment given by the LFA. Patients normally seek curative treatment only from the Mini Health Centre and they go to the LFA only when a sudden symptom arises at odd hours and she gives the symptomatic treatment, based on the complaint, for once only after collecting the 25 paise. She also tears off a coupon, writes on the back, the name, the complaint and the treatment given. The LFA has been provided with a Hundi box in addition to the kit bag. The Hundi box has two slits, one for the coin and the other for the coupon. The supervisory staff open the box at fortnightly intervals; the coupon provides both a financial and technical check on the LFA's performance. This charge is to ensure that the LFA is not taxed without a real need. She has also been empowered to waive this payment in a really poor patient and enter the fact on the coupon.

The pre-payment plan is better than payment for each service. A combination of both systems is effected when 0.5% of the annual income is charged for the community health programme and further charge, if any, made when the need for referal arises. Of course it is understood that while the family will contribute according to its ability to pay, the services provided will depend on the medical needs and will have no relation to the quantum of the family's contribution.

It is therefore imperative that, on behalf of their employees, the Central and State Governments should offer 0.5% of the salary of each employee living in the MHC area. This will be towards the individual's/community's contribution and will have nothing to do with the expected Government grants (totalling 75% from the Central and State Governments) to meet the annual recurring expenditure.

Likewise the 0.5% contribution on behalf of industrial workers covered by the ESI Corporation must be transferred to the MHC entitled to it.

I began by saying the community initiates and the Governments should participate; likewise at the end I wish to focus evaluation not on the lowest level of the LFA/CHV but on the highest level. For example, will Governments and ESI Corporation contribute on behalf of their employees? As regards the financing of health care there are several methods which need to be urgently evaluated particularly on their content of preventive services. These schemes like, the Central Government Health Scheme, The Employees State Insurance scheme, the "awards" given by large employers like the Life Insurance Corporation and the Nationalised Banks really provide very little for prevention of disease and maintenance of good health. Cost-benefit studies are so difficult in the area of health delivery.

Finally, let us consider organised voluntary associations. It is good to remember that voluntary health agencies have played a significant role in the development of health care in India. Their main assets are (a) in their capacity to enlist the services of devoted workers, particularly doctors, (b) to tap private financial resources for the development of health and (c) to work out operational experiments due partly to the personnel they can command and partly to the grater academic and administrative freedom they ordinarily enjoy. Their main handicap is the inadequacy of financial resources available and this inadequacy is increasing continuously because private charity is being spread too thinly over an ever increasing number of voluntary organisations. It is obvious, therefore, that the voluntary organisations can play a very vital part in the reconstruction of health care if the three principal assets mentioned earlier are recognised and developed to the full and if their principal handicap is obviated through special financial assistance.

EXTRACTED FROM THE REPORT OF A SYMPOSIUM ORGANISED JOINTLY BY INDIAN COUNCIL OF MEDICAL RESEARCH AND INDIAN COUNCIL OF SOCIAL SCIENCE RESEARCH ON "ALTERNATIVE APPROACHES TO HEALTH CARE" AT THE NATIONAL INSTITUTE OF NUTRITION, HYDERABAD FROM 27TH TO 30TH OCTOBER 1976.

SERVICE RESPONSIBILITY OF A DEPARTMENT OF COMMUNITY MEDICINE THROUGH A HEALTH CO-OPERATIVE

B. MAHADEVAN*

Background

Health facilities in rural areas in the country were provided through Primary Health Centres 9(PHCs) started as part of an national rural development scheme called "Community Programmes" in 1952, with a very modest staff in each centre to form the nucleus of integrated health services and cater to the need of about 60,000 population in a Block. There are now over 5,200 PHCs, each Centre caters to a population ranging from 80,000 to 1,20,000. Each PHC therefore has to take care of a very large number of persons. The scheme was extended to involve Medical Colleges in rural health work and through deliberations of many committees, the status of PHCs was improved both qualitatively and quantitatively. An integrated approach of providing health services to the rural people, with the provision of two doctors to every PHC and a Basic Health Worker (BHW) with an Auxiliary Nurse Midwife (ANM) to every 10,000 population, was attempted.

A pilot Mobile-cum-Training-cum-Services Hospital Scheme was introduced in some Medical Colleges with a view to involve medical and nursing students in rural community medicine. The intention was to establish ultimately one mobile hospital per medical college. More medical Colleges were established with the sole purpose of providing rural health services. Specialist camps were organised for cataract operations, vasectomy and tubectomy. Although the government's idea is to train doctors for rural areas, these doctors are not attracted to such places. The migration of Indian doctors to the more developed countries continues. Even passing a Parliament Act which empowers government to oblige doctors and engineers below the age of 30 years to work for a period of four years in rural areas, the problem remains unsolved due to the inability of providing reasonable living conditions for them in villages.

Some medical colleges like vellore Christian Medical College incorporated in their teaching programme, the rural dimension in significant way. The organisers of the community Health Centre, have found that it costs about Rs. 8.50 per person per year, which includes preventive, promotive and curative services. The administration is not very happy about this project due to the high recurring costs.

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The Kerala Government with Government of India's initial one time grants, have established Health Co-operatives in 11 districts. Doctors are encouraged to seek self-employment in these co-operatives. Doctors and paramedical staff take shares in these co-operatives. A certain fee is levied on services, and medicines are also paid for. One is looking forward anxiously to the success of the scheme. The initial reaction of the people has been good.

Voluntary agencies have established a large number of hospitals in urban areas. However, funds are not available to these hospitals for any significant rural health work, although an increasing number of dispensaries are being opened in the rural sections of the country.

From the facts and figures just given, it is clear that the government in spite of its herculean efforts has not been able to seriously tackle the problem and with the scarce allotments made for the health services, no tangible improvements is possible in the near future. No voluntary agency can hope to embark on a scheme where even the government has failed but is in a better position to try out new methods through pilot projects.

When planning rural health services, one has to consider two components, namely the delivery of package of rural health services in villages and recruitment of personnel who will deliver the same. At the same time, there is an inescapable need for complementary services which will develop the villages economy and education of the rural people. Many rural health schemes taken up enthusiastically at the beginning flounder for lack of popular support that has to be expressed by financial contributions. This is the crux of the matter. Any health delivery scheme should be a self-sufficient fiscal entity. This may be a limiting factor but the only sound way of attempting to solve rural health problems, is to start it in places where conditions are favourable for the introduction of self-supporting scheme.

Funds for rural health schemes may be raised through many ways

1. Tagging health services to co-operatives.

To start health co-operatives by themselves is difficult as health holds a low priority in the felt needs of the people and may not get the required support in the initial stages. The procedure of tagging on health services to existing co-operatives has many advantages - good leadership, a readymade frame work of Community administration for introduction of effective health services and community envolvement, as channels of communication with the people have already been established. Co-operative Dairying and Marketing Co-operative of different commodities like grains, cereals, cottage industrial products etc., lend themselves admirably to this type of health services.

2. Running health services with assistance from factory administration where labourers are from villages nearby.

A minimal deduction at the source of salary and a contribution from the factory management will help to build-up the required funds and formation of a health co-operative. Geographical location of industries and rural labour in close proximity are limiting factors but the scheme is worthy of trial, in special areas.

3. Assistance from Panchayats.

Please where Panchayats and the people are interested in health services and are willing to contribute to the same, may venture on this method, but unless sufficient funds are forthcoming regularly and persistently the scheme will collapse.

A devoted team of health workers can establish themselves in a village and build-up the required clientele and popular opinion. The people can then be induced to form a co-operative and directly employ the doctor and essential paramedical staff. Until such time, a central agency or other funding agency may have to meet the expenses. This can be attempted even without forming a co-operative in areas of affluence, where people are willing to pay for the health services and employ the doctor and other staff through collection of revenue for the purpose.

The Mallur Milk Co-operative (MMC)

Mallur is a village in Kolar district of Karnataka, situated about 60 km. from the city of Bangalore. The Mallur Milk Cooperative (MMC) was an established concern with a sound and progressive leadership and has been functioning for many years. In addition to production and sale of milk, it provides other benefits like provision of fodder and cattle feeds, tractor facilities and loans at low rates of interest.

Besides the people of Mallur, two other villages, Muthur and Kachahalli are members of the Co-operative and the total population covered is about 3,000. These villages have a silk farm cooperative besides cooperative dairying. The economic position was satisfactory, and therefore all conditions were favourable for the introduction of other self-supporting schemes.

The inspiration for establishment of a Comprehensive Health Care Programme for the cooperative members and their families of these villages, came from Sr. Anne Cummins of Coordinating Agency for Health Planning and Fr. Jones of the Catholic Bishop Conference of India. With these pioneers, the Dean and the Department of Community Medicine of St. John's Medical College, representatives of the Karnataka Government and Bangalore Government Dairy with leaders of the MMC worked out a scheme for tagging on a health services to it.

The main objectives of the Mallur Health Project are:

1. To study and devise methods by which the financial base needed for effective health services could emerge from the people themselves in a self-sustaining manner;

2. To help in the establishment of rural health centres with the staff and rendering of effective health services to a wide circle of needy people without distinction of race, caste or creed;

3. To study the required strategy and methodology for the effective rendering of primary health care in rural areas by trying to determine the priority areas in health care and devising the structure found suitable to village conditions;

4. To help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas; and

5. To train intern doctors, nurses and other medical and paramedical staff for the purpose of rendering assistance in rural areas.

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The St. John's Medical College and its Department of Community Medicine were to be mainly concerned in acting as a catalytic agency, in the formation of self-sustaining rural community health scheme, fulfilling the above objectives.

Sponsorship was by the following agencies organisations

1. NDC.
2. Coordinating Agency for Health Planning
3. Catholic Bishops Conference of India
4. St. John's Medical College (Dept. of Community Medicine).

Source of funds

It was estimated that a monthly budget of Rs. 2,500-3,000 would be required for running the Health Co-operative and financial support was forthcoming by a joint contribution of three paise per litre of milk from the NDC and Bangalore Dairy, in a phased formula as shown in Table 1 below. Ultimately the NDC was to completely finance the scheme.

Table 1 - Contribution to the Health Co-operative.

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
First	1p*	2p
Second	2p	1p
Third	3p	nil

* Paise

This budget was adequate to support a health programme, organised by a Medical Officer, Nurse Compounder and an Ayah. The staff were appointed by the Health Co-operative Committee.

The Health Co-operative Committee included the following members:

Chairman, NDC
Secretary, NDC.
Dean, St. John's Medical College Bangalore.
Head of the Department. of Community.-
Medicine, St. John's Medical College.
Director/General Manager, Bangalore Dairy.
Representative of State Health Service.
Medical Officer Hallur Health Co-operative (Secretary)

The composition ensured integrated planning between the NDC and Health Co-operative.

The Health Co-operative got off to a good start by being inaugurated on 19 March 1973 by the Minister of Animal Husbandary. Dr. V.K. Rajkumar, a Senior House Officer in St. Martha's Hospital, joined as Resident Medical Officer in-charge of the Co-operative. This Medical Officer by dedicated work and self-sacrifice, made the Hallur Health Co-operative a successful enterprise.

Coverage, services and benefits provided

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The St. John's Medical College adopted this Health Co-operative as a rural training centre for interns. Visits by specialists of other departments including specialists camps were organised. At present, four interns are attached at any one time for whom residential accommodation has been provided by the MCC on a rental basis. The interns conduct baseline demographic surveys, immunization and school health programmes, special health projects and mass health education programmes.

The Health Co-operative Committee meets by turns, at Mallur and at St. John's Medical College, to discuss progress and plan for the future.

The Health team comprising Dr. Rajkumar, Miss Maria and interns under the technical supervision of department of Community Medicine has made good contact with the villagers and a comprehensive health care programme has been introduced. The community of Mallur and other member villages with a population of 3,000, actively participate in all programmes. They have no unreasonable expectations or demands, as the health project is their own contribution. This is a basic difference between Health Centres organised through cooperatives and governmental agencies. The leaders are actively involved in the planning and organisation as the Chairman, MCC is the Chairman of the Health Co-operative Committee and the Secretary MCC is its member. Paramedical workers are drawn from the village community and trained for community health work.

The young Farmers Association actively assists in many of the health programmes. They help interns in their surveys, programmes of immunization and environmental sanitation, including chlorination of wells and construction of sanitary latrines. They also organise the physical arrangements for the mass health education programmes. The Mahila Mandal under the dynamic guidance of Mrs. Rajkumar, runs a nursery school and acts as a forum where health education, applied nutrition programmes and mothercraft are taught to the womenfolk of the village.

The health team and interns organise the following services with community participation:

Personal services

1. Curative Clinic (daily outpatients):
2. Maternity and child health services:

   (i) antenatal care,
   (ii) midwifery (domiciliary),
   (iii) postnatal care, and
   (iv) under five clinics (domiciliary).

3. School health services for village schools.
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and cholera.
5. Tuberculosis (TB) and Leprosy-case detection, treatment and follow-up.
6. Motivation for family planning.
7. Specialist camps at Mallur (periodical visits by St. Martha's Hospital specialists).
8. Hospital referrals.
9. Family record maintenance.

Community Services

1. Protection of well water supplies by chlorination.
2. Popularisation and construction of sanitary latrines.

3. Collection of health data through periodical surveys.
4. Coordination and cooperation with government health personnel in national health programme activities.
5. Health education at personal, group and village levels.
6. Nutrition education and nutrition supplementation Programmes.

Members of the Milk Co-operative and their families are entitled to all the above mentioned services free of cost. Non-members coming from other surrounding villages pay for drugs/dressings and minor surgery. All preventive and promotive work are given free to all categories. Table II shows the number of member and non-member families in each village.

Table II - Number of member and non-member families in each village.

Village	Families		
	Member	Non-member	Total
Mallur	188	202	390
Muthur	63	124	187
Kachahalli	30	21	51
Bhaterenhalli	17	14	31
Harrulunagenahalli	6	18	24
	304	379	683
	45 percent	55.5 percent	

Personnel, facilities, resources and mode of payment for personnal

The Health Co-operative in November 1973 was joined by another dedicated worker, Maria, an Italian Public Health Nurse, She with her companion Cathy, a volunteer from Canada, looked after the maternal and child health work.

Within five months of starting the project (August 1973), the cost of fodder went up and milk production of the milk Co-operative fell as some members began to sell out on higher rates. The MDC took a decision, much to the discomfiture of the Government Dairy Authorities, to sell directly to private parties in Bangalore, who offered better prices. The Govt. Dairy, therefore, stopped its contribution of two paise per litre of milk as health subsidy, and the Health Co-operative was in a critical situation. It is at this stage a momentous decision was taken by the responsible village leaders who were more than convinced of the positive role of the Health Centre and its staff in improving the health status of the people in Mallur and other villages. The Milk Co-operative was doing well and decided to contribute five paise per litre of milk for health and took over financial responsibility for running the Health Centre. This financial strategy on the part of village leaders resulted in the project becoming a viable unit. The Milk Co-operative has borne the entire recurring costs of the health project ever since, and Table III gives the Income/Expenditure position for the period July 1974 to June 1975.

Table III - Recurring Costs - Year - July = 1974 to June 1975.

Total milk production	6,27,898 litres
Income estimated at five paise/litre	Rs.31,394.90
Actual income received from MDC	Rs.33,100.00
Total expenditure for the year	Rs.33,790.74

Present position: Salaries:

At present the Milk Co-operative is supplying about 2,000 litres of milk per day to Bangalore. Each member is now contributing six paise per litre of milk a day. The contribution towards the Health Centre is Rs.3,600.00 per month.

The actual expenditure per month is indicated below:

Salaries (Medical Officer, Clerk, Compounder, A.N.M. and Ayah)	Rs. 1,600.00
Drugs	Rs. 1,500.00
Rent and electricity	Rs. 200.00
Miscellaneous	Rs. 250.00
T O T A L :	Rs. 3,500.00

In case the actual expenditure exceeds this amount, the extra expenditure is met by the Milk Co-operative. The Staff of the Health Centre consist of a Medical Officer, an ANM, a compounder, an Ayah and a clerk.

In addition, members of the Youth Association, women's Association and Village Panchayat participate in the activities of the Health Centre.

Although the Kollur Health project is mainly financed by the Kollur Milk Co-operative, it also receives help and technical direction from St. John's Medical College and the Government Health Services. These inputs are shown in Table IV.

Table IV - Inputs from other agencies/organisations.

Source	Capital	Recurring
1. Kollur Milk Cooperative	Buildings, furniture, refrigerator health education material	Salaries, rent/ electricity, drugs, general stores and petrol.
2. St. John's Medical College	Physicians and mid-wifery kit, minor surgical equipment, motor cycle (on loan through UNICEF)	Interns services, specialist services and rent for interns quarters.
3. Government Health Services	Nil	Vaccines, vitamin A, Iron and folic acid supplement, family planning devices, surveillance of communicable diseases (through PHC, Sidlaghatta), health education films (through Health Education Department of Director of Health Services).

Factors affecting quality of services, difficulties faced, methods of enforcement of control and evaluation

The experience over the last two and a half years has shown that:

(i) A health function can be grafted on to an economic co-operative;

(ii) A sound cooperative such as MMC can support substantially the recurring costs of a health programme;

(iii) Tagging on of a health function to a cooperative benefits not only the members and their families but also the nonmembers who get indirect benefits of professional services, preventive and promotive programmes.

The Department of Community Medicine and its staff were mainly concerned in acting as a catalytic agent, in the formation of a self-sustaining rural community health scheme. An experiement was embarked upon and the Mallur Project is this experiment. A total health care programme can be effectively delivered through a cooperative in rural areas. The MMC is even contemplating construction of a 15 bedded hospital at Mallur, with the help of government and its own funds.

Further, the Health Centre with its working philosophy, has indirectly helped the Department of Community Medicine to conceptualise a primary health care system for training of future physicians, so that they play their rightful role in a contemporary society.

The health team and interns have played an important role in the development of the village in general and health aspects in particular. Attempts are being made to increase the membership of the milk cooperative by purchase of more cows and increasing enrolment. Other economic activities such as development of village/cottage industries and handicrafts and ensuring sale of products, are contemplated. It is fully realised that in the planning of such self-supporting programmes, the health team has to be actively supported by other members who will attend to the social and economic development problems of the community. Success or failure would depend on tackling the financial side efficiently.

The quality of promotive and curative services would have to be improved. Simpler skills, cheaper drugs and intermediate technology have to be introduced to suit rural conditions. A drive to improve the education of the people, including health education, is to be attempted through the use of Village Level Workers. Their training Programme is being organised. Whether there has been an improvement in the morbidity and mortality statistics at Mallur, subsequent to the introduction of these cooperatives in comparison with other areas in the vicinity, needs study and this has been taken up as a health project.

The question of introducting such self-sustaining Co-operative Schemes to other areas around Bangalore is under active consideration. These are challenges that have to be met in rural India and it is hoped that with the cooperation and participation that are readily forthcoming from the simple rural folk, the economic and health projects will meet with success.

Conclusion

A good and well informed faculty with modern concepts of medical education, has a capacity for extensive research in the organisation and delivery of health services through experiment, models and pilot projects. Medical educators in general, and faculty staff of departments of Community Medicine in particular, must assure their share of responsibility for meeting the quantitative as well as qualitative needs of the people and must be concerned not only with the basic mission of the university or government which is learning, but also actively help the people of a locality or region in organising and running their own primary health care services.

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For establishing an effective and viable primary health care system, the cooperation of the local community must be ensured. In fact, the people should be adequately motivated, involved in decision making and actively participate in health programmes, so that ultimately it becomes their own "peoples programme". Local resources such as cooperatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local programmes. It is desirable that the primary health care system should be a self-sufficient fiscal entity. Community priorities are more likely to be met if the people themselves raise and spend the resources required. A "total health" approach is essential, promotional, preventive and curative care need to be completely integrated.

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PRIMARY HEALTH CARE THROUGH IPP-III(K) IN KARNATAKA

The India Population Projects are a series of developmental projects financed by World Bank, Government of India and the respective State Governments to support the effective implementation of Family Welfare, MCH and other Health Programmes by providing infrastructural facilities, manpower, IEC, Training, Research and Evaluation. India Population Project-I was taken up in the five districts of Bangalore Division during 1973-80 with very beneficial results as reflected in the achievements in FW and MCH Programmes.

The current IPP-III has been taken up in the six Northern districts of Gulbarga, Raichur, Bidar, Belgaum, Bijapur and Dharwad from 1984 with a budget outlay of Rs.71.31 Crores.

The main objectives of India Population Project-III(K) are:-

(i) To support attainment of IndiasPopulation goals,
(ii) To create awareness in the Population regarding the Family Welfare and MCH Programmes,
(iii) To generate demand for their effective implementation at field level,
(iv) To improve accessibility and availability of Health Services at the rural levels and
(v) To improve the professional and managerial skills and training of the Staff.

Through effective implementation of the project, it is aimed at achieving the IMR by reducing from 125 to below 60, CDR from 14 to 9, MMR from 5 to below 2, CBR from 35 to 21 and CPR from 23.6 to 60.

India Population Project-III(K) consists of the following components.

i) Service Delivery, (ii) Project Management, (iii) Demand-Generation, under which the IEC activities and Population Education play major role and (iv) Research and Evaluation. These components are being carried out extensively for the effective implementation of the Project.

Under Service Delivery component 2451 building are to be taken up of which 2060 buildings have been completed by December 1989 and Rs.3836.55 lakhs have been spent.

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This activity includes 700 ANM Sub-centres, 255 SHC buildings, 17 Dormitories, and other buildings under facilities and residential quarters.

1292 incremental posts are created in these districts, to assist in the Project Management and implementation.

663 Vehicles of various types have been provided to the Service Institutions, for Service Delivery.

Equipment and Furniture worth Rs.320.99 lakhs are provided to the various service units, for surgical, laboratory and patient wards.

Under, India Population Project-III, I.E.C, is an important component which aims at educating and guiding the people especially the rural folk on the importance of Health of the Mother and the child.

The Key tasks outlined in both FW, Mother and child Health requires Demand Generation and acquiring of new skills through Information, Education and Communication activities. This Programme is being implemented through community Education, Extension Education and Mass communication.

Under Community Education, 6024 Orientation Training Camps have been organised at a cost of Rs.2.40 lakhs to train leaders in rural areas.

Under Extension Education 2700 Health Education Kits at a cost of Rs.9.34 lakhs have been produced and additional 16,500 Health Education kits at a cost of Rs.29.70 lakhs will be produced during 1989-90. 18 Strip Films with 3528 prints at a cost of Rs.2.57 lakhs have been produced. Eighteen 16 m.m. films at a cost of Rs.13.52 lakhs have been produced, with necessary prints.

Under Mass Communication, nine 35mm films with 45 prints, each have been produced at a cost of Rs.18.42 lakhs have been produced. Ten types of Cinema slides each with 115 copies have been produced at a cost of Rs.0.22 lakhs. 20 dramas and 20 songs on Health and Family Welfare have been recorded in 800 Cassettes at a cost of Rs.2.62 lakhs.

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10 Folders and 16 posters have been produced by spending Rs.2.69 lakhs, Twenty eight thousand copies of Male and Female Health Workers Manual, 2000 copies of O.T.C Manual, 1200 books on A.I.R lessons etc., have been published.

To motivate the Public to accept the small family norm, 3 intensive campaign on spacing methods, Area specific strategy for educating the rural masses in C.P.R poor villages, at the rate of two villages per P.H.C, per year, Radio listening programme in 300 sub-centre Villages, Honouring 1000 Kalyana Matha's during 1988-89 and training them during 1989-90, special campaign to involve minority groups, involvement of voluntary organisations in Bidar district in Family Welfare Programme etc., were undertaken

It is proposed to provide 150 colour T.V.sets to India Population Project-III(K) districts, during 1989-90.

Different types of training programmes are being conducted. Training in Inter-personal-Communication to Para Medical Staff, Management Training to Medical Officers, Communication Training to Health Educators, Training for teaching Faculty, Continued Education Programme and basic training for Multi-purpose workers etc are being conducted.

Population education programmes like Lectures to college students, production of training and educational materials etc., are being carried out through the Director of State Education, Research and Training, with a special cell for implementation of the Programme.

To assess the effectiveness of different IPP-III Programmes, Research and Evaluation work is being carried out by the Population Centre, Bangalore. The centre has taken up the study and Research Activities to evaluate the programmes, through baseline survey, MIES and other studies.

The facilities provided and the programmes undertaken under IPP-III(K) have given greater impact in improving the Health Status of women and children ~~in IPP-III~~ and also in improving the performance of National Health Programmes in these districts.

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Primary care tomorrow

Is primary care essential?

Barbara Starfield

Primary care is widely perceived to be the backbone of a rational health services system. But is this perception correct? Some see it as an anachronism in the present medical era, denying and delaying the specialist attention to which patients are entitled. When primary care physicians act as "gatekeepers" to specialist services, what is the effect on outcomes? How many general practitioners are needed in a primary-care-oriented system? In this paper I address these and other questions. Let me begin with definitions.

What is primary care?

The conference convened by the World Health Organization at Alma Ata in 1978[1] used 100 words to describe primary care; they included essential, practical, scientifically sound, socially acceptable, universally acceptable, affordable cost, central function and main focus of overall social and economic development, first-level contact, and first elements of a continuing health care process. Serious planning for primary care requires a conceptualisation that is easily and uniformly understood, implemented, and amenable to measurement

Primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system. The elements of first contact, continuity, comprehensiveness, and coordination are included in most definitions proposed by professional organisations, agencies, and commissions.[2-5] When viewed from the perspective of populations as well as individual patients, a health system that seeks to achieve these four elements will be achieving what was envisaged in the Alma Ata Declaration.

Primary care is only one level of a health system, albeit a central one. Other essential levels of care include secondary care, tertiary care, and emergency care (especially for serious trauma). Secondary and tertiary care are distinguished by their duration as well as by the relative uncommonness of problems that justify them. Secondary care is consultative, usually short-term in nature, for the purpose of helping primary-care physicians with their diagnostic or therapeutic dilemmas. Secondary care may be provided by informal consultations of secondary-care physicians with primary-care physicians, by regular visits of secondary-care physicians to primary-care facilities for the purpose of advising on management of patients with particular disorders (eg, diabetes), or by short-term referral of patients. Tertiary care, in contrast, is care for patients with disorders that are so unusual in the population that primary-care physicians could not be expected to see them frequently enough to maintain competence in dealing with them. When the disorder has a substantial impact on other aspects of a patient's health, the tertiary-care physician may have to assume long-term responsibility for most of the patient's care, consulting with the primary-care physician for problems and needs that primary-care physicians are better equipped to handle. All of these other levels of care require integration with primary care for the patient to receive clear and consistent advice.

Roles and functions of primary care and their measurement

All countries, faced with ever-increasing costs of health care, are experimenting with reorganisation.[6] To assess the extent to which a health system is adequately providing primary care, and the extent to which reorganisations are adversely or beneficially affecting the provision, we need some way of measuring the elements of primary care. An early attempt was made by a committee of the Institute of Medicine in the United States in 1978. This committee recognised that primary care is a practice environment rather than a set of services or a professional discipline, and it developed twenty-one questions to assess the achievement of accessibility (necessary for first-contact care), comprehensiveness (ability to handle problems in the population), coordination, continuity, and accountability.[7]

In a subsequent approach to measurement I postulated that two characteristics are needed to assess each of the unique attributes of primary care—one that addresses a structural feature that provides the ability to achieve the attribute, and one that addresses the actual performance ("process") that succeeds in achieving the attribute.[8] Thus, *first contact* involves assessment of both accessibility of a provider or facility and the extent to which the population actually uses the services when a need for them is first perceived. *Longitudinality* (person-focused care over time) is assessed by the degree to which both provider and people in the population agree on their mutal association and also the extent to which individuals in the population relate to that provider over time for all but referred care. *Comprehensiveness* requires that the primary care provider offer a range of services broad enough to meet all common needs in the population, and assessment includes the extent to which the provider actually recognises these needs as they occur. *Coordination* requires an information system that contains all health-related information; and assessment again includes the extent and speed with which the information is recognised and brought to bear on patient care. In this approach to measurement, *accountability* is considered a feature of all levels of a health system, and not unique to primary care.

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These normative approaches to measurement are distinct from the more common (and less useful) measures involving assessment of characteristics that are merely descriptive ("empirical"). Primary care is often defined by the type of practitioner who delivers it. Most commonly, at least in Europe, this is the general practitioner. In the Americas, however, primary care is considered to include both general internists (for the care of adults) and general paediatricians (for the care of children), as well as family and general practitioners; thus when attempting measurement we cannot assume that these types of practitioners are equally skilled in providing primary care. In fact, one study showed systematic differences in the training experiences of general internists and paediatricians, according to whether the training programme was specifically directed at training in primary care or not.[9] A second approach to assessing primary care assumes that it is equivalent to a set of specific services—such as prevention, diagnostic and therapeutic services, health education and counselling, and minor surgery. Data from practices indicate that many if not most acknowledged specialists provide the same spectrum of services. For example, the practice of most ophthalmologists (at least in the United States) has a large element of prevention as well as diagnosis, treatment, follow-up, and minor surgery. Similarly, most cardiologists are engaged in health education and counselling as well as the more standard aspects of their care. Primary care is more usefully seen as an approach to providing care rather than a set of specific services, with its practitioners or facilities judged on the degree to which they implement this approach. This focus on measurement allows for different types of practitioners (including nurses as well as physicians) as well as for teams to compete for designation as "primary care practitioner", and for training programmes in primary care to emphasise those aspects of practice in which their graduates should excel.

How many primary care personnel are needed?

Opinions differ on the proportion of practitioners that are needed for the adequate provision of primary care. In Canada the proportion of primary care physicians is 50%; in the United Kingdom it is 70%.[10] If primary care means care for all but the most uncommon disorders in the population, the number of different types of practitioners should be determined by the distribution of disorders in the population and the frequency with which disorders need to be encountered for practitioners to maintain their competence in dealing with them. The epidemiological data to perform these calculations are generally lacking, but they may well emerge from more organised forms of practice and new information technologies. On present assumptions, between 75% and 85% of people in a general population require only primary-care services within a period of a year. The remaining proportion require referral to secondary care for short-term consultation (perhaps 10–12%) or to a tertiary care specialist for unusual problems (5–10%). These projections are amenable to empirical testing; the proportions will probably vary from place to place and for populations with special health-care needs. When the data become available, it will be possible to calculate the appropriate proportions of primary-care practitioners and specialists, instead of relying on demand-oriented projections that reflect the current state of practice[11] rather than rational planning.

Is a primary care oriented health system better than one based on specialty care?

The phenomenon of medical practice variation, which exists across different health care systems[12] as well as within them,[13] has been difficult to explain. One recent study, unique in its examination of the effect of a specialty-oriented health system, indicated that medical practice variations are heavily related to differences in direct access to specialists, at least in the case of cataract surgery rates.[14] Roos et al[15] had previously shown that both the appropriateness and the outcomes of tonsillectomy and adenoidectomy were better when patients had been referred to specialists by primary-care physicians than when they had been self-referred.[15] As early as 1945 Bakwin demonstrated the "threshold" effect—whereby medical experts judge a similar proportion of successive waves of referred patients to need intervention. This means that self-referred patients will have higher rates of unnecessary interventions than referred patients, so it is a plausible hypothesis that much of the variability in both hospital admission rates and surgery rates results from differences in primary care resources.[16] What is more surprising is that this important feature of health systems is seldom considered in research on medical practice variations.

It is not intuitively obvious, however, that better health will result when services are organised so that primary care forms the first level of care. With increasingly sophisticated populations, it might be that self-selection of the most appropriate type of specialist is more efficient and effective.[17] Comparisons of specialist care with generalist care indicate that specialists are more efficient for some diseases but by no means for all.[18] Furthermore, it is important to remember that much of primary-care practice is focused on problems that are not and may never be resolved to definitive diagnoses.

Recognition of the importance of primary care within US health services has lately resulted in a few studies in which primary care had been explicitly addressed. In each case, a primary-care orientation has proven more salient than other variables in analytic models.

For example, Shi's[19] analysis of 50 US states and the District of Columbia showed a consistent relation between the availability of primary-care physicians and health levels—as assessed by age-adjusted and standardised overall mortality, mortality associated with cancer and heart disease, neonatal mortality, and life expectancy—even after controlling for the effect of urban-rural differences, poverty rates, education, and lifestyle factors (smoking, seatbelt use, and obesity rate). This study confirmed the findings of an earlier and similar study that showed the ratio of primary-care physicians to population ratios to be the only consistent predictor of age-specific mortality rates, even when considering such other characteristics as rurality, percent of female-headed households, education levels, minority status, and poverty rates.[20] The increase in effective care is coupled with a decrease in costs, as demonstrated by Welch et al, who found that expenditures for care among the elderly in the US (all of whom have health insurance under the federal Medicare programme) were lower in areas of the country with high ratios of primary-care physicians to population.[21] At clinical level, a case-control study showed that the most important determinant of uncontrolled hypertension, even above factors such as the presence of insurance, was the unavailability of a source of primary care.[22] And, as will be noted below,

noted below, countries whose health systems are more oriented towards primary care achieve better health levels, higher satisfaction with health services among their populations, and lower costs of services overall. The distinction, in recent studies, between primary care resources and specialty care resources has made it possible to discern an important effect of medical care on health outcomes—in contrast to earlier work that showed no relation between the availability of physicians and health status.

The gatekeeping function

The mechanisms by which primary care, in contrast to specialty care, operates in improving health status are related at least in part to its "gatekeeper" role.[23,24] The first-contact feature of primary care implies that patients do not visit specialists without a recommendation from their primary-care practitioner. Since specialists are much greater users of tests and procedures, and since all such interventions have a finite risk of iatrogenic complications (as well as a cost-inflating effect), the interposition of primary care is protective for patients in reducing both unnecessary procedures and adverse events.

What of the converse effects of gatekeeping—the risk of undertreatment through failure to refer for indicated specialty care. These have been more difficult to demonstrate; indeed, there is little evidence for a systematic association between the gatekeeping function and poor outcomes, once confounding factors are taken into account.[24]

In many areas (particularly in the United States), the first-contact aspect of primary care is regarded as a threat to free choice and therefore incompatible with a market (competitive) approach to the delivery of health services. A reasonable compromise might be to ensure free choice of primary-care source where there is a sufficient supply of primary-care personnel to permit choice; the development of trust in a freely chosen primary-care source might make it acceptable to have a more limited choice of specialists for referrals, particularly if there were an ongoing system of monitoring and surveillance of the quality of specialty (as well as primary) care across areas and across different medical care organisations and centres.

Primary care and health—an international view

At least among western industrialised nations, a primary-care orientation of a country's health service system is associated with lower costs of care, higher satisfaction of the population with its health services, better health levels, and lower medication use (table).

This conclusion emerged from a study in 11 countries during the mid-to-late 1980s,[8] in which the primary-care orientation was characterised by a score derived from an average of scores on eleven different features of primary care. Five of these features were characteristics of the health system in general—universality of financial access to services and the extent to which it is guaranteed by a publicly accountable body; extent to which the country explicitly regulates the distribution of health-service resources to achieve or encourage equitable distribution; the assignment of a primary-care function to one particular type of physician rather than to more than one type or to a multiplicity of types; earnings of primary-care physicians relative to those of specialists; and the percentage of active physicians who are primary-care physicians. The remaining six characteristics reflected the extent to which primary-care practice explicitly attempts to achieve a higher level of performance for the specific features that define primary care and for two additional related ones. These six features are: first-contact care as assessed by the extent to which access to specialists is principally by referral from primary care; longitudinality as represented by the explicit assumption of responsibility to provide care to a defined panel of patients, irrespective of whether they have specific diagnosis or ailments limited to specific organ systems; comprehensiveness as represented by the breadth and uniformity of benefits for preventive care; coordination as assessed by the use of formal mechanisms for the transfer of information between primary-care physicians and specialists; family centredness as reflected by the explicit assumption of responsibility for care of families; and community orientation as assessed by the use of community or other epidemiological data in planning for and evaluating services. Information on these characteristics was derived from published data, supplemented by interviews with knowledgeable individuals in each of the countries.

Information on levels of satisfaction with health services was obtained from the nationally representative surveys of Blendon and colleagues[25,26] in which individuals were asked whether they believed their country's health system to require only minor changes, fundamental changes to make it better, or a complete rebuilding.

Information on levels of health was obtained from reliable sources including the Organization for Economic Cooperation and Development,[27] the World Health Organization,[28] the US National Center for Health Statistics data bank (courtesy Robert Hartford and Sam Notzon), and the Centers for Disease Control.[29] Fourteen indicators were available in comparable form for each of the countries—namely, low birthweight ratio; neonatal mortality; postneonatal mortality; total infant mortality; life expectancy for males and females separately at ages 1,

	Primary care ranking	Outcome indicators				Average rank for "outcomes"
		Satisfaction	Expenditure per head	Health indicators	Medications per head	
United States	11 0	8 0	11 0	8 0	7 0	8 5
Australia	8 0	5 0	6 0	5 0		5 3
Belgium	9 0		4 0	11 0	6 0	7 0
Germany (West)	10 0	3 0	8 0	9 5	9 0	7 4
Canada	6 5	1 0	10 0	3 0	8 0	5 5
Denmark	3 0		3 0	6 5	1 0	3 5
Finland	3 0		5 0	6 5		5 8
Netherlands	3 0	2 0	7 0	2 0	3 0	3 5
Spain	5 0	7 0	2 0	4 0	5 0	4 3
Sweden	6 5	4 0	9 0	1 0	2 0	4 0
United Kingdom	1 0	6 0	2 0	9 5	4 0	5 4

Table: Ranks for primary care and "outcome" indicators

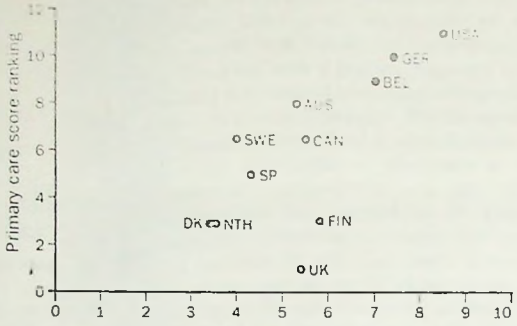

Figure 1: Primary-care score *vs* "outcome" indicators
NB, rank 1 is best, rank 12 worst.

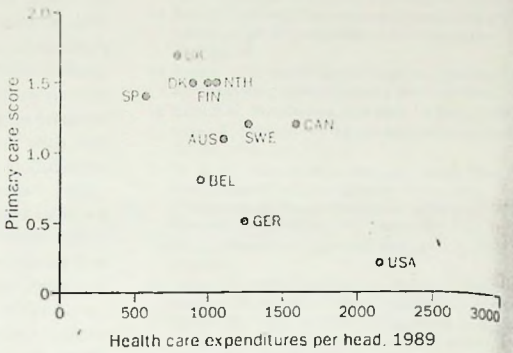

Figure 2: Primary-care score *vs* health-care expenditures

0, 65, and 80; age-adjusted life expectancy; and years of potential life lost. (Information was also available on an additional five indicators but not for all of the countries, depending on the indicator. Findings, including these additional indicators where available, were consistent with those in which indicators from all of the countries were used; thus only the latter are included, so as to achieve uniformity of comparisons across all of the countries. For comparisons including all indicators, see ref 30.) Information on expenditures for care derive from the World Health Organization data bank and the Organization for Economic Cooperation and Development,[31] and data concerning medication use from the calculations of Rublee and Schneider.[32]

Countries were ranked according to their primary-care score, and these ranks were compared with "outcome" indicators including total health-care expenditures per head; the level of satisfaction as determined by subtracting the percentage reporting major changes from the percentage reporting only minor changes needed; expenditure per head for medications; and health levels as characterised by the number of the fourteen indicators in which the countries were in the top third of the distribution for all countries minus the number of indicators in the bottom third of the distribution. Figure 1 plots the rank on the primary-care score against the average ranks for satisfaction, total costs, costs of medication, and health levels (when data were available). The average rank for the "outcome" indicators generally parallels the rank on the primary-care score, as does the rank for at least three of the four components of the combined outcome score (perhaps excluding satisfaction), suggesting that the primary-care orientation of a health system is associated with lower costs, less medication use, and better health levels. Of considerable interest are the differences among countries in the three groups shown in the table. The countries in the top group are market health systems, which are driven by demand.[33] The countries in the bottom group are those in which the supply is regulated according to perceived need for resources. Canada has characteristics of both, and is correspondingly intermediate.

The rankings on primary-care orientation are similar to the ranking of countries according to the disparity of wealth within the population.[34] That is, countries with more equitable distribution of wealth are, in general, countries that attempt to distribute health resources equitably and with a focus on primary-care services. They are also the countries best able to control total health-care costs (figure 2), to satisfy their populations, and to achieve high levels of health (figure 1).

Improving the state of science and the art of primary care

The international comparisons presented in the previous section suggests that certain features of health systems, especially those concerned with a primary-care orientation, are conducive to better outcomes. There are, however, great voids in knowledge about the effect of other health-system features of care that are related to primary-care practice. The differences among countries in these characteristics are greater than the similarities.[35] Some of these differences may account for the less than perfect correlation between the primary-care score and outcomes, as noted on figure 1. Some countries rely chiefly on family physicians to deliver primary-care services whereas others rely on a combination of family physicians, internists, and paediatricians. In some countries, specialists are restricted to practice in hospitals, whereas in others specialists do most of their work in outpatient settings away from the hospital. In some countries (for example, Denmark), only certain specialists are restricted to hospital practice. Some countries allow direct access to certain specialists while generally requiring referral from a primary-care physician for access to other specialists. In some countries primary-care physicians admit patients to the hospital whereas in others hospital-based specialists must do so. There are also differences in the extent to which primary-care physicians assume responsibility for care when their patients are admitted to hospital. Modes of payment of physicians vary, some countries favouring fee-for-service, others capitation or salary; the system for paying primary-care physicians is not always the same as that for specialists, even within an individual country.[36] There are also differences in the extent to which cost-sharing is required in primary care; in general, countries with better regulated systems have less cost-sharing for primary care, although some are instituting small co-payments to discourage apparently excessive utilisation.[37] Some health systems organise their primary care services in health centres rather than in individual offices. The effects of each of these characteristics and their effect in various combinations and permutations are unknown, although there is information on some of these characteristics individually from multi-site studies (eg, on the effect of co-payments, in the US-Rand Health Insurance Study).[38]

Can any conclusion be drawn about fee-for-service payments? A descriptive international comparison[39] suggested that in primary-care practice this method discourages longitudinal relationships with patients. Where fee-for-service predominates, referral rates are generally lower as are the number of encounters with patients per week. Fee-for-service reimbursement seems to be associated with a greater frequency of home visiting, possibly as a means of competing with specialists in systems where there is no gatekeeper. Fee-for-service also seems to be associated with longer consultations, but with less equitable distribution of physicians in the population. Gatekeeper arrangements did not generate public dissatisfaction and seemed to be associated with a community orientation of primary-care practice as well as total numbers of visits per head. However, gatekeeper systems are not necessarily cheap to run; the impact of gatekeepers cannot be divorced from the mode of financing.

Although the data in this paper provide strong evidence of the importance of a primary orientation in health services, there is room for speculation on the individual and combined effect of specific characteristics of primary care and on the impact of the reforms of the early 1990s. Subsequent papers in this series will expand on the challenges for the future in understanding, delivering, and improving primary care.

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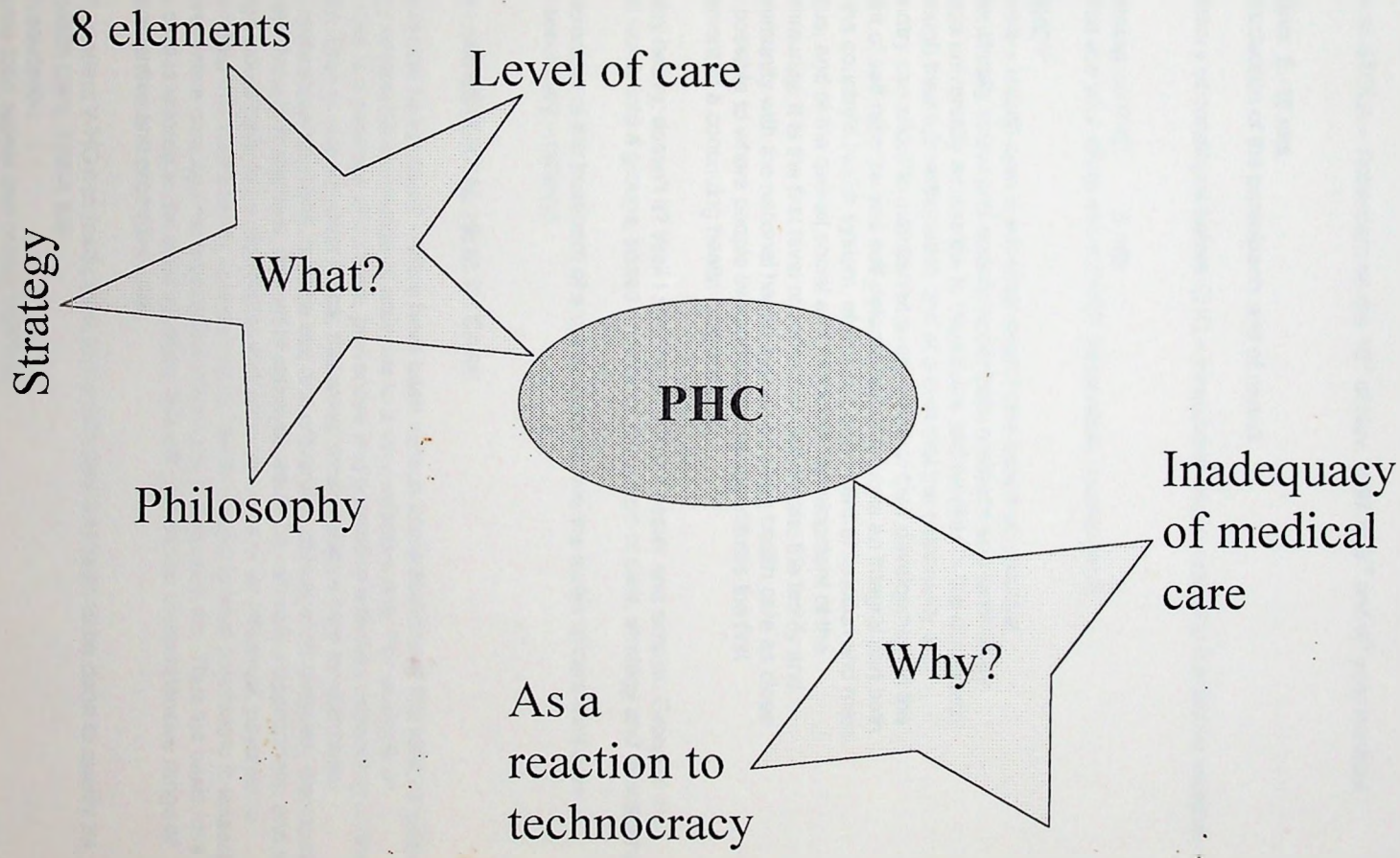
Primary Health Care



PRIMARY HEALTH CARE

Talk given at STOLA – Rotterdam on the 18th of Nov. 1997.to 3rd and 4th year medical students

Introduction: 5 -10 mts.
Introduction of the participants and of myself.

A brief history of conditions before PHC – inequitable health care and ineffective medical care.[1]

Brainstorming on PHC: 5 mts.
What are your ideas about PHC? (accessible, involvement)

What is PHC?[2]

> 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.

Sounds very heavy, doesn't it? Well I shall try to make it easier and simpler. Grouped the underlined words into 4 groups, based on level of care, type of care, strategy and philosophy.

Took the example of the treatment of a cut to demonstrate the levels of care (self care – primary – secondary – tertiary)

Let us start with **ESSENTIAL HEALTH CARE**.

What is essential health care? – there have been various interpretations of this idea ranging from a very comprehensive range of activities to a very selective one. For example an accepted idea is a package of curative, preventive and promotive activities depending on the local reality. Thus in sub-Saharan Africa, this would mean curative care for diarrhoeal diseases, respiratory infections, malaria etc; and preventive care against measles, diarrhoeal diseases etc. Now in Rotterdam, this set of diseases would be naturally inappropriate, and so the package would have to be modified to include curative care for influenza, psychiatric illness (I am told that Netherlands spends half its health budget to treat psychiatric illnesses) etc, and preventive care against myocardial infarctions and strokes etc. Thus the basic idea is that the care is tailored to the local situation, but will include the comprehensive range of curative, preventive and promotive care.

To simplify matters WHO has made a list of the activities that need to be done to qualify as Primary Health Care. These are

1. Health education
2. Adequate food supply and proper nutrition
3. Adequate water supply and basic sanitation

4. Maternal and child health
5. Immunisation
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs

The advantage of this list is that it is easily comprehensible and verifiable. The disadvantage is that it is very simplistic and gives rise to the theory that PHC is not needed for the Developed nations – only for the developing countries. Also there have been instances of countries doing only this set of activities and claiming that they are implementing PHC. While PHC is more than providing health care.

The Americans carried this list to a more extreme limit – they calculated the costs of implementing the above activities and said that it would not be cost-effective. So they targeted a list of diseases which they said was cost-effective to treat and told the whole world that they (the world) must focus on only these illnesses (GOBIF). This was called Selective PHC and was very popular with donors during the eighties. Thankfully it has died a natural death, but only after wasting tremendous resources in terms of time, money and effort.

So one can see that the concept of essential health care ranges from a comprehensive definition to a limited set of activities to a very selective and narrow range of tasks. I personally would favour the first definition.

Whatever the interpretation, what is important is that this care is scientifically sound and is acceptable to the community for which it is being offered. This implies that there is a process of dialogue with the community and a common agenda is drawn up.

So much for the contents of the care – the next question is **WHO WILL DELIVER THIS CARE?**

As per the definition, PHC should be delivered by the staff of the National health system who are at the FRONTLINE, i.e. those staff with whom the community consults first. This again is very context specific – e.g. in sub-Saharan Africa this will mean the Medical Assistant in the Health Centres, inmost of Asia, America and Europe it would mean doctors. For example in the Netherlands, the people consult their GPs and they are the best professionals to deliver PHC. Why do I say this?

Firstly, the FLHS is close to the people – so they are accessible, unlike hospitals which are far away and relatively inaccessible.

Moreover, the staff at the FLHS are close to the community (not merely distance wise, but also culturally, socially and economically) and so there is a better understanding of the individual's/family's/community's problems and needs. Thus the care has a chance of being holistic. Unlike care provided in the sterile and ivory tower environment of a hospital which is totally cut off from reality.

In that case what is the **ROLE OF THE HOSPITALS** in PHC?
This is yet another contentious issue. Many health professionals feel that PHC is only for the GPs and Public Health nurses, but this is not so. The hospitals have a very definite role in Supporting PHC. E.g. One of the main functions of the hospitals is managing those illnesses which cannot be managed within the community or by the GP. The hospital thus should negotiate with the FLHS on the criteria for referral, on the counter referral etc. This would ensure that there is continuity of care.

The hospitals can also support the FLHS by supervising them, by providing training, logistic support (e.g supply of drugs, staff etc)

Thus there should be a reorientation of the hospitals towards PHC and the whole system of GPs and hospitals should form an integrated whole which works towards a common objective – better health of the community.

Is PHC **ONLY ABOUT HEALTH CARE**? NO !

PHC is a philosophy, an ideal, a concept. It is about equity, about social justice, about community participation, about efficiency, about intersectoral collaboration, about development, about self reliance and self determination.

Equity in health care means that the health professionals should ensure that EVERYBODY (and not only the haves in society) has equal access to health services. This is one way of reducing the existing disparities.

Social justice implies more than health care. It implies that as a Primary health care provider, one may have to look beyond the bio medical cause of illness – e.g unemployment, domestic violence, marital discord, landlessness, etc. Depending on the circumstances, the health professional maybe able to do very little, but at least he/she is sensitive about it and this itself will make a difference in the care

Community participation implies that we as health professionals recognise that the individual and the community have a right to decide on the health care that they need. From this arises the corollary that one should negotiate with the community on all health matters and arrive at a mutually acceptable plan of action.

Efficiency implies that one provides health care which is in keeping with the available resources. This is as much true for Developed countries as for developing countries. Just as India is struggling to finance its health sector, so is Netherland. Resources are finite. Only the scale is different. So one has to remember that providing the BEST for a particular patient may be at the cost of another patient. As medical students this may seem sacrilegious but that is the reality of practise today.

Intersectoral collaboration implies that the health sector interacts with other sectors (social sector, housing, education etc) to improve the quality of life of the community that it is working with.

Self reliance and self determination are self explanatory.

Now does this definition make more sense. (read out the first definition)

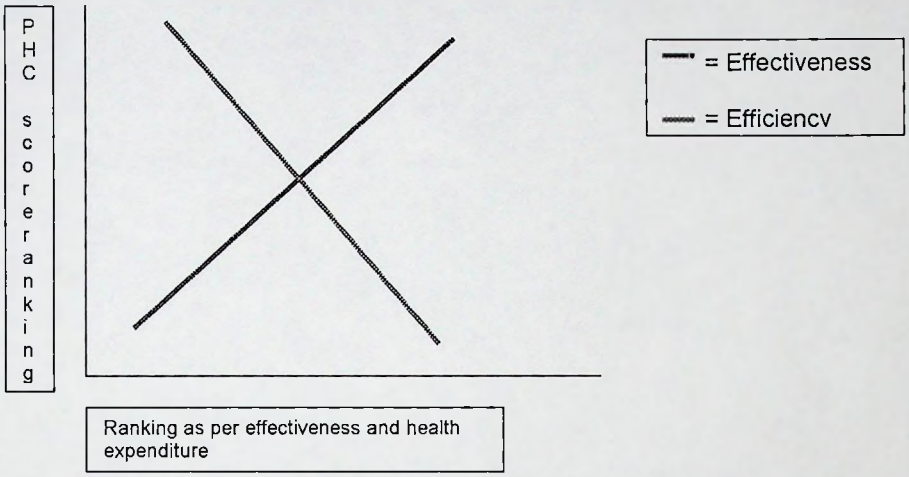
Any questions ?

If there isn't maybe we can go onto the next issue – why PHC? Yes, we know that there was inequity and the Health services were ineffective to meet the needs of all the population – but is PHC the answer?

Politically and idealogically it appeals because one is talking of transferring power from the hands of the technocrats to the community – thus empowering the latter. But this may not be

a sufficient answer for many of you. So I shall provide an answer in health services terms – e.g the effectiveness and efficiency of PHC.

A study done at John Hopkins and published in the Lancet compares the PHC orientation of countries with their health status, the satisfaction that the health system generates, the amount of drugs used and the health costs.[3]



As can be seen from the above graph – the more oriented a country is towards PHC, the more effective its health system is, the more satisfied its population is vis-à-vis the health system and the more efficient it is.

With this I rest my case for PHC and reiterate that it IS NOT A SOLUTION FOR THE POOR, FOR THE HAVE-NOTS, BUT A SUSTAINABLE AND BETTER SOLUTION FOR THE ENTIRE WORLD.

Some questions:
Your study on effectiveness of PHC is based in industrialised nations – is there a similar study in III world countries?
If this is a good system – why is it that all countries are not accepting it? What are the barriers?

Ref:
Barbara Starfield. *Is Primary care essential?* Lancet
WHO – UNICEF. *Alma-Ata Declaration* (RM 162)
Hannu Vouri. *Health for all, primary health care and general practitioners.* Journal of the Royal College of General Practitioners.(RM 242)
Julia Walsh, Kenneth Warren. *Selective Primary Health Care.* NEJM. (RM 309)
JP Unger, James Killingsworth. *Selective Primary Health Care: A critical review of methods and results.*SSM (RM 310)

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[1] OHT - 1 on inequity and OHT – 2 on technocrats/charity based medical care.
[2] OHT – 3 giving the definition
[3] OHT – 4 the effectiveness of PHC