Com H 8.1
RF_COM_H_8_SUDHA
COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

SURVEY

AUXILIARY NURSE MIDWIFE

TRAINING PROGRAM

TRAINING DIVISION
DEPARTMENT OF FAMILY PLANNING
MINISTRY OF HEALTH AND FAMILY PLANNING, WORKS
HOUSING AND URBAN DEVELOPMENT, GOVERNMENT OF INDIA.

April, 1970

INTRODUCTION

A basic assumption of the Family Planning programme is that the ANM is the primary contact for the delivery of Maternal Child Health and Family Planning services at the village level. This fact and the realization that much relevant information about the ANM programme and its progress is lacking, prompted the Training Division to undertake this survey of ANM Training.

Three hundred and thirty-seven (337) questionnaires were sent to addresses listed with the ~~Trained Nurses Association of India~~ ICN as conducting ANM training programmes. One hundred ninety-six (196) completed questionnaires were returned to the Training Division. Nine (9) of the returns showed that their programmes have been discontinued. Four (4) of the questionnaires were considered invalid due to illegibility and incompleteness. Omitting the discontinued schools and the invalid returns, this report covers data provided by one hundred eighty-three (183) schools or fifty six percent (56%). The geographic spread of the returned questionnaires is not significant.

Status of Current Enrollment

The one hundred and sixty-five (165) schools report a total enrollment of five thousand one hundred and forty-five (5145) students. Of these, two thousand six hundred and twenty-five (2625) students are in the first

year of training and the remaining two thousand five hundred and twenty (2520) are in their second year. The range of the class enrollment is from one (1) to sixty five (65). (Three of the schools neglected to report their current census.)

Over half of the respondent schools have a student enrollment of less than thirty (30) students per class. Wastage figure were reported somewhere between one percent (1%) and three percent (3%). Using a wastage figure of about two percent (2%) of the student class admission, the average school can be expected to graduate only eight (8) to ten (10) students per year.

The size of student enrollment is closely related to the size of the medical installation that provides the clinical experience for the ANM students. The overwhelming majority of the ANM schools reporting are attached to hospitals with two hundred (200) beds or less. A total of fifty four percent (54%) of the student enrollment is concentrated in hospitals with a bed census of less than one hundred (100). Another thirty percent (30%) of the students are enrolled in programmes connected with hospitals with a bed census of less than two hundred (200), while the remaining seventeen percent (17%) of the students are receiving their institutional clinical experiences in hospitals ranging from two hundred and one (201) to eight hundred (800) beds.

Supervision

A high proportion of the ANM programmes are conducted within institutions with a minimum amount of experience facilities and without nursing

guidance and supervision for that experience. Thirty-four (34) of the institutions providing clinical experience do not have a matron in staff position. Sixteen percent (16%) of the reporting schools do not have a sister tutor assigned to the teaching staff. A high number, some eighty-three percent (83%) do not have a public health nurse on the staff.

A further critical weakness is that eighty one (81) (sixty two percent 62%) of the schools reporting on this area state that no member of their teaching and nursing staff have had any Family Planning training at all.

Stipend, Diet and Nutrition Education

The amount of the stipends paid to ANM students varies widely from five (5) to one hundred and sixty (160) rupees per month. Obviously some of the very low stipends reflect only the pocket money given to the students for personal use. This practice is more common in training programmes run by the voluntary organizations. Food costs to the students are often assumed by these training institutions and are not considered as stipend.

The very highest of the stipends include allowances being paid to employees already on the state government payrolls and currently enrolled as students. The most common stipend seems to be between rupees fifty (50) and rupees sixty (60) per month. Central Government recommendations are for rupees sixty (60) per month. Seventy four percent (74%) of the schools provide rupees fifty (50).

Our overall survey and follow-up visits to many training institutions suggest that this amount appears to be inadequate to maintain a minimal diet* let alone provide for the personal necessities of the students such as uniforms, toilet articles and so on. Inadequate allowances impose much hardship on the students and is the most common item of complaint of all schools.

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* The following minimally adequate diet is suggested as a guide for use in ANM schools. These calculations provide a daily regimen for ten (10) students and the expenditure per day is calculated at rupees twenty five (25) per day per ten (10) students. This diet provides for one egg daily per student, vegetable once a day, rice or wheat twice a day, a pulse or gram twice a day, chapaties twice a day, four oz. of milk once a day, tea (including sugar and milk) four times a day and the ghee required for cooking. It may be noted that the graduate ANM is expected to include in her MCH services the very important component of nutrition education and it would be reasonable to expect that the diet provided the ANM would meet minimum nutritional standards. The calculations provided by the minimal diet herein outlined requires rupees ninety (90) per month per student outlay. This provides rupees fifteen (15) for personal necessities and rupees seventy five (75) food alone.

Community Nursing

The ANM programme includes two (2) major areas for clinical experience, institutional experience and community experience. The institutional experience is provided as previously reported. The second area that of community experience, many people believe should have a higher priority than the first, since the largest portion of the population is rural and training programmes should be designed to meet the general needs of the majority of the population.

The Indian Nursing Council recommendations include three months of experience in a PHC or similar institution toward meeting these priority objectives. Analyses of the questionnaires discloses the fact that there are only fifty five (55) ongoing ANM programmes meeting this significant and very crucial requirement. Twenty seven (27) of the programmes partially meet this requirement by providing a one to two months experience, while ninety six (96) programmes provide a few days experience for observations or none at all.

The factors contributing to the failure of the schools meeting this requirement emerge as the following: 1) The majority of the Sister Tutors working in the ANM schools have not themselves had experience or training in public health nursing. Sister Tutors are recruited mainly from general nursing staffs and public health nursing is not a part of this curriculum. 2) The absence of housing in the field and the transportation necessary for this experience to become a reality. 3) The overwhelming majority of the controlling authorities who administer the schools do not place a high priority on rural field community service as an element in ANM training.

Equipment

Some thirty (30) schools (eighteen percent (18%)) tell us that they consider their nursing care equipment inventory insufficient to adequately carry out the teaching of nursing routines and procedures in their classrooms. One can assume that nursing care equipment is in even shorter supply in the practice field or the hospital.

Teaching of Family Planning

Sixty-four percent (ninety eight (98)) of the respondents mention the teaching of family planning either as a part of midwifery or as a special block of instruction. The most common number of hours for the block teaching was four hours. Reporting of the integrated teaching of Family Planning was rare. Of the remaining thirty-six percent (36%) of the schools it was difficult to determine where Family Planning came into the curriculum if at all.

Current Needs

Each questionnaire requested information on how each training institution saw their priority needs for immediate assistance. There were over two hundred and fifty (250) items requested. Fifty four (54) schools requested more educational written material on Family Planning. These included books, graphs, journals, pamphlets and teaching guides. The second most common request was for anatomical and contraceptive models. Audio visual aids such as movie and slide projectors, films, film strips were frequently listed. Requests for more personnel, new or improved physical facilities also received high priority. A surprising

number asked for samples of contraceptives for classroom use. Other requests included such thing as change in stipend, uniform allowance, special training programme in various clinical areas and transportation. One interesting request that came up over and over was the request to be placed on routine mailing lists for Family Planning literature.

Summary

This report drawn from a questionnaire survey of one hundred-eighty three (183) ANM training schools reveals a very wide range of enrollment per class, from one to sixty five. The majority of the schools have an enrollment of less than thirty (30) students.

Class enrollment figures, hospital training sites, available nursing and teaching staff show a size correlation.

Family Planning training for nursing staff in ANM schools is at a low level.

Stipends currently provided appear to be inadequate to provide minimal nutritional diet needs.

The weakest area of clinical experience provided by these training schools is in community nursing. Family Planning is not integrated into the ANM curriculum.

RECOMMENDATIONS

The following recommendations are made based on the findings of this report:

1. All Sister Tutors should have training in teaching and in community

nursing. Community nursing includes experience in a PHC with a Family Planning component.

2. Community nursing experience for all ANM students is an absolute necessity.

3. Physical facilities and equipment inventories should be maintained at an adequate level. This level should be standardized and checked frequently.

4. All ANM schools should come under the technical direction of the Deputy State Nursing Supervisor, who should be a qualified Public Health Nurse.

5. A nation wide study of the functions and the role of the ANM should be undertaken as soon as possible.

6. The Indian Council of Nursing condition for training schools should be revised in relation to size of class enrollment, size of training institution, staffing patterns and admission policies.

7. The Indian Council of Nursing recommendations regarding matrons located at the site of training institutions should be enforced.

8. Stipends need to be revised.

9. All ANM schools should be on the mailing list of the State Family Planning Officer.

10. The status and pay scale of sister tutors working in ANM schools should be on a par with sister tutors working in other nursing schools.

Chart No. 1

No.	RANGE ORDER OF STATE	No. of Quest. Ret'd.	No. of Quest. Sent	% of Return
1.	Goa	3	3	100
2.	Madhya Pradesh	25	28	89.3
3.	Punjab	7	8	87.5
4.	Mysore	27	31	87.1
5.	Gujarat	25	33	75.7
6. a.	Assam	16	22	72.7
b.	Bihar	8	11	72.7
c.	Union Territories	8	11	72.7
7.	Orissa	8	12	66.7
8.	Tamil Nadu	9	15	60
9.	Uttar Pradesh	11	19	57.9
10.	Maharashtra	19	35	54.3
11. a.	Haryana	5	10	50
b.	Nagaland	1	2	50
12.	Kerala	8	17	47
13.	Andhra Pradesh	11	38	28.9
14.	Jammu - Kashmir	1	4	25
15.	Rajasthan	2	18	11.1
16.	West Bengal	2	20	10
		196	337	58.2

Chart No. 2

RANGE ENROLLMENT	1st Year No. of School	2nd Year No. of School		No.
0	17	17	34	1
1-5	8	19	27	2
6-10	32	30	62	3
11-15	33	28	61	4
16-20	26	20	46	5
21-25	14	18	32	6
26-30	18	19	37	7
31-35	5	3	8	8
36-40	3	4	7	9
41-45	3	0	3	10
46-50	0	0	0	11
51-55	0	1	1	12
56-60	2	0	2	13
61-65	1	3	4	14

Chart No. 3

Clinical Experience Facilities for ANM Students

No.	Hospital Size Interval	No. of Hospital	
1	0	12	
2	1-50	29	(1) 53% of student enrollment is here.
3	51-100	57	
4	101-150	34	(2) 30% of student enrollment is here.
5	151-200	16	
6	201-250	6	(3) 17% of student enrollmept is here.
7	251-300	7	
8	301-350	6	
9	351-400	0	
10	400+	10	
	Total:	177	

Chart No. 4

	STATES	No. of Students	No. of Students with Stipends 50 (Rs.) Schools	Students		STATES	No. of Students
1	Mysore	1020	23.5	945	1	Mysore	1020
2	Maharashtra	589	6	249	2	Maharashtra	589
3	Gujarat	499	12	259	3	Gujarat	499
4	Madhya Pradesh	450	15	445	4	Madhya Pradesh	450
5	Uttar Pradesh	446	1.5	33	5	Uttar Pradesh	446
6	Tamil Nadu	428	5	376	6	Tamil Nadu	428
7	Andhra Pradesh	259	6	109	7	Andhra Pradesh	259
8	Orissa	250	7	250	8	Orissa	250
9	Assam	213	15	213	9	Assam	213
10	Punjab	193	6	184	10	Punjab	193
11	Bihar	164	3.5	131	11	Bihar	164
12.5	Kerala	151	5	151	12.5	Kerala	151
12.5	Haryana	151	4	151	12.5	Haryana	151
14	Rajasthan	103	2	103	14	Rajasthan	103
15	West Bengal	96	1	20	15	West Bengal	96
16	Goa	47	2	47	16	Goa	47
17	Delhi	43	2	43	17	Delhi	43
18.5	Nagaland	17	1	17	18.5	Nagaland	17
18.5	Kashmir	17	0	0	18.5	Kashmir	17
20	Himachal Pradesh	9	1	9	20	Himachal Pradesh	9
		5145	118.5*	3735**			5145

Chart No. 4 (Contd.)

* 74% of total No. of schools.

Schools with less than 50 Rs. stipend not included.

** 73% of total No. of students.

\# 1 School not reporting.

\+ 11% of total No. of schools.

++ 9% of total No. of students.

COMH 8.2

DIPLOMA IN COMMUNITY HEALTH MANAGEMENT

RUHSA DEPARTMENT
CHRISTIAN MEDICAL COLLEGE HOSPITAL

RUHSA CAMPUS
RUHSA CAMPUS P.O. 632 209
N.A.A.DISTRICT
TAMIL NADU
SOUTH INDIA

RUHSA DEPARTMENT OF CMC HOSPITAL, VELLORE

COURSE DETAILS OF DIPLOMA IN COMMUNITY HEALTH MANAGEMENT

INTRODUCTION

The Diploma in Community Health Management is a course started at the RUHSA* Department, CMC&H, at it RUHSA Campus, in 1983 with the assistance of Voluntary Health Association of India, New Delhi. Planners of this course saw the need and demand for competent and committed personnel in community health management. The frustration faced due to lack of personnel and managers with the attitude, knowledge, skills and experience to provide dynamic leadership in this area was also identified.

The 15 month DCHM course is planned to prepare:

* Managers and Team Leaders for Integrated Community Health and Development projects of Voluntary Agencies.
* Effective Trainers and Personnel for potential community health and development training, Research centres of non-government and government organisations.

OVERALL GOAL

The overall goal of this course is to make available people who have the skills and knowledge to be effective at the management and supervisory level of Community Health and Development programmes, projects and activities; people who are concerned about social justice, health and economic status of the people, willing to work for the oppressed and marginalised and weaker sections of the community and prepared to learn and grow personally with a desire to make health and healthy community life a reality for all people.

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* Rural Unit for Health and Social Affairs

GENERAL OBJECTIVES: Upon completion of this course the candidate will be able to:

* Determine the effect on people's health of socio-political and economic systems at the macro and micro level.
* Create a desire to work collectively for a just and equitable society.
* Take responsibility for own learning.
* Apply problem solving methods.
* Plan, organise, implement and evaluate Community Health and Development programmes.
* Accept role of change agent/facilitator in order to make health a means and measures of development.
* Understand the team concept and show the ability to take leadership role in the team.
* Promote and facilitate training, research and consultancy programmes.

SELECTION CRITERIA

* Bachelor's Degree in any discipline: Arts, Science, Social Sciences, Law, Management, Engineering, Medicine, Nursing etc.
* Non-graduates with work experience and proven ability to handle the course are also eligible to apply.
* Ability to handle English as a medium of learning.
* Experience in the field of Health and Development programmes.
* Strong motivation and committment towards working for and with the poorest section of the society.
* Those sponsored by a voluntary agency with assurance of a job, after the course, will be given priority in selection.
* Passing entrance examination and interview conducted at CMCH.

COURSE CONTENT

* Studies of Society
* Health and Development
* Techniques of Studying Community Health
* Management and Administrative Principles
* Effective Change Agent
* Electives and Practicum

TEACHING METHODOLOGY

Methodology of instruction includes participatory techniques, simulation and self directed learning techniques.

Student centered participatory training technique is adopted. The following are the most commonly used methodologies:

a) Problem based learning
b) Workshops
c) Practical Field experience alternating with work at the RUHSA centre on analysis and study of problems and issues interlinking theory and practice.
d) Group Methods:- Discussion, seminars, panel, role play, simulation exercises, etc.
e) Individual Work:- Book review and project reports on problems in student's own field/interest and study areas in which the participant is deficient.

FACULTY

a) Full time core faculty in RUHSA with appropriate academic qualification, good field experience and close understanding of third world countries, its resources and problems.

b) Guest Faculty: drawn from specialists in India for short periods.

c) Visiting Faculty of experts from other countries who have had experience in other developing countries having appropriate knowledge or skills to share and can come for periods of time.

EVALUATION

This is done both concurrently and periodically. It is participatory and each student is actively involved in the process of his/her own evaluation. Comparison between student is not adopted but individual growth and performance of the students throughout the course is stressed. Students who satisfactorily and successfully complete the course are recommended to VHAI Educational Council for awarding the DIPLOMA IN COMMUNITY HEALTH MANAGEMENT.

COURSE DETAILS

* Venue : RUHSA Campus
RUHSA Post
North Arcot District 632 209
Tamil Nadu, S.India

* No.of Candidates : Upto 20 per course

* Length of the Course : 15 months (12 months residential and 3 months practicum postings with the sponsoring institutions)

* Costs

	Rs.
Tuition	1,500
Registration	100
Library	200
Assignment/Projects	250
Medical	75
Hostel (Rs.75x12)	900
Security Deposit (Refundable)	200
Certification Fee to VHAI	100
Project related Travel	625
	4,000

Additional Expenses

	Rs.
Food (Rs.500 x 12)	6,000
Books (suggested) (approximately)	600
	6,600

Note: Since the course is subsidised for students from India and its immediate neighbouring countries, an international fee of US $2000 is charged for students from other countries. Included in this is the cost of tuition, accommodation and the average cost of rural South Indian Food. International students need to make arrangements for additional funds to have food according to their own tastes and standards.

SCHOLARSHIP

Few scholarships are available for covering tuition and accommodation costs. Sponsoring organisations or individuals are responsible for boarding. The scholarships are provided by VHAI. Intending participants should write to the following* for scholarship and confirm availability of scholarship if this is necessary. VHAI scholarships are primarily meant for students from India and its immediate Neighbouring countries.

* The Executive Director
Voluntary Health Association of India
40, Institutional Area
South of IIT, New Delhi 110 016
Tel: 668071 Fax: 011-676377

STUDENT PROFILE

The characteristics of the 74 students (attended from 1983 to 1990) with respect to sex, age and educational background are presented below:

Total Students: 74

a) Sex:	Males	48
	Females	26
b) Age (Years):	15-19	2
	20-24	15
	25-29	23
	30-34	18
	35-39	8
	40-44	5
	45-49	3
c) Education:	Predegree/Intermediate	11
	Diploma/Non-Graduates	23
	Graduates	19
	Post Graduates	4
	Nurses	12
	Doctors	5

AGENCY PROFILE

The following are some of the important voluntary agencies which sponsored candidates for the DCHM course:

India

- Nazereth Hospital, Sisters of Charity, Bihar
- Child in Need Institute, West Bengal
- Hyden Hall Institute, Darjeeling
- Bangalore Baptist Hospital, Karnataka
- St.Luke Hospital, Vengurla, Maharashtra
- Holly Cross Institute, Bihar
- Department of Health, Central Tibetian Secretariat, Dharmasala
- Good Shephered Provincialate, Karnataka
- Bengal Rural Welfare Service, West Bengal
- Church of North India, West Bengal
- Taraknath Maternity & Child Welfare Centre, West Bengal
- Sihora Mission Marthoma Syrian Church, Madhya Pradesh
- Salvation Army, S.W.India Territory, Kerala
- Salvation Army, Cathrine Booth Hospital, Kanyakumari
- West Bengal Rural and Urban Development Centre, West Bengal
- Schefflin Leprosy Rehabilitation & Training Centre, Tamil Nadu
- Bethel General Hospital, Vuyuru, Andhra Pradesh
- Rural Development Trust, Andhra Pradesh
- Memorial Hospital, Uttarpradesh
- Christian Hospital, Sampalpur, Orissa
- Indian Evangelical Lutheran Church, Tamil Nadu
- Nava Jeevan Seva Mandal, Gujarat
- Dharmapuri Clinical Diagnostic Centre, Tamil Nadu
- CSI Rainy Hospital, Tamil Nadu
- SUCHI, Andhra Pradesh
- Congregation of Carmelite, Sisters of Charity Gujarat
- Lutheran Christian Health & Medical Centre, Tamil Nadu
- Bosco Reach out Provincialate, Assam
- CSI, Vellore Diocese, Tamil Nadu
- Trivendrum Social Service Society, Kerala

- Manipur State VHAI
- Rangammal Health Centre, Tiruvannamalai, Tamil Nadu
- CODEP, St.Thomas Hospital and Leprosy Centre, Tamil Nadu
- Rural Integrated Development Organisation, Tamil Nadu
- Sisters of St.Joseph of Chambery, Madhya Pradesh

Abroad

- Save the Children Fund, Nepal
- Godavari Alumni Association, Nepal
- Community Health and Development Project, Nepal
- Mityana Diocese, Uganda
- PERDHAKI, Indonesia
- CNARS, Djibour, East Africa
- HPSRN, Nepal
- Save the Children Fund, USA
- MERU, Kenya
- Holy Family Provincialate, Srilanka
- Lutheran World Service Community Development Project, Nepal
- Red Cross, Sudan

For further details please write to:

Dr.Rajaratnam Abel
Head of RUHSA Department
RUHSA P.O. 632 209
(Via) K.V.Kuppam
North Arcot Ambedkar Dt.
Tamil Nadu

Phone: K.V.Kuppam - 52, 53, 54

Grams: RUHSA, Kilvayattanankuppam

COM H 8.3

Title: COMMUNITY HEALTH AND ST. JOHN'S.

The Department of Community Medicine at St. John's has always played the pivotal role in fulfilling the most important objectives of the college. Serving the under privileged and more importantly training others to serve the underprivileged has been the main focus of the Department. The enabling process of identifying and attempting to meet the felt needs of the community, is done by the Department. The training and service components are provided to all members of the health team (from the grass-root level workers to tertiary care specialists).

TRAINING FOR COMMUNITY HEALTH CARE:

Being a Medical College, St. John's is in a unique position to provide all the training components in the formation of a Health team. This creates a better understanding of each member's role in Community Health Care rather than a isolated form of training to separate Health Team Members in separate institutions. The various Training programmes in Community Health are as follows:-

1. For Medical Students:-

a) Rural Orientation Programme:- Conducted every year, during the months of January - February, the main objective of the camp is to expose the medical students to the various facets of rural life through a residential programme at Dommasandra Primary Health Centre. The students visit all the rural subcentres and are guided in determining the various factors which govern rural life such as - Agriculture, Animal Husbandary, Small Scale Industries, Fairs, Festivals, Customs and traditions, Commerce and trade, Transport, Traditional systems of Health, Housing and environment, Role of women in society, Maternal care practices, Child Care practices and Food practices. These are presented in the form of field projects by groups of students. In addition, the students also organise many

b) Clinico Social Case work for MBBS Students:- This is conducted every month, by posting them in batches to the health centres. Their training involves case work in the field, working up the social aspects of a number of communicable diseases as well as antenatal cases. The objective is to train the students to consider a case as a holistic health care problem rather than a mere clinical entity. The socio economic causes, contributing factors and consequences of major diseases are highlighted in this training programme in addition to the usual clinical features of the disease.

c) National Social Services in rural villages:- Under this scheme, the medical students carry out community health and developmental projects at various villages in batches once a week. In contrast to the generally known NSS activities, the NSS programme of this institution aims at highlighting community health and community development, as the main features of this service . Education for school children, adult education, school health education, improving environmental health etc., are some of the main components of this programme.

d) Child to Child health education programme:- Evolved as a novel approach to health education, this programme has proved to be an immense success at Dommasandra, Anekal and Bidadi health centres. The basic objectives is to teach groups of children, various aspects of health, using innovative teaching materials, live demonstrations and "health songs". Later the children are allowed to share their knowledge with each other and each child is encouraged to tell the other what he or she saw in her/his group teaching. This way the factor of curiosity and natural thirst for knowledge and sharing the same, are invoked in each of the children. This greatly contributes to strengthening the health education in a natural cumulative manner from child to child. At each rural centre, the major middle and high school are covered under this programme. The positive aspect of this programme is the school teacher's involvement and their willingness to

e) Mothers' Motivation Programme: Groups of rural mothers are invited to the rural subcentres and they are made aware of various facets of nutrition, maternal care, child care, immunization etc. The Programme is conducted in the form of practical nutrition demonstration, immunization procedures, infant feeding techniques, preparation of weaning diets etc. Emphasis is laid on the fact that all the components of this programme must be done through practical demonstrations, using locally available resources only, with the mothers themselves actually executing the work. Emphasis is also stressed on the cost factor during these demonstrations.

f) Field work in urban slums:- Senior clinical students visit families and maintain family health records, enumerate eligibles for immunisation, do immunization coverage, refer to the St. John's Hospital those in need of medical services and also carry out field surveys in Nutrition, child health etc.

g) Seminars, discussions and Lectures:- Over 400 hours are spent in teaching community Health to medical students during their entire MBBS training period. All the subjects from concepts in Health care, to Nutrition, Maternal and Child Health, Occupational diseases, statistics, sociology, Behavioural sciences, Health Management and Planning, control of communicable and non-communicable diseases etc. are taught to the medical students.

h) Study tours to other Health related Institutions:- In an effort to expose our students to real life situations, they are taken to various health institutes, field projects and institutions of public health importance. Here they get a chance to interact with other Health agencies and their staff and actual field problems in health care."

2. For Nursing Students:

a) Rural Orientation Programme for Nursing Students:- Conducted every year during the month of May, the main objective of this camp remains the same as that for medical students. The camp is conducted at Bidadi Primary Health Centre and the rural Mobile Clinic stationed therein is used extensively during the programme. In addition to theactivities refered to in the medical students camp, the Nursing students are given extra assignments in the field of Maternal and child care, Domiciliary deliveries etc.

3. For Community Health Workers:-

Rural Training programme for Community Health Workers:- This course is a three months programme, conducted twice a year, during which one month is spent as a rural residential camp. The emphasis during this course is on various field, clinical, Lab and institutional training in the various aspects of community health. Additional training in first aid, home nursing, natural family planning, Herbal medicine, counselling, community development and human biology are also conducted. The rural posting comprises mainly of various field projects on the dynamics of rural life, rural Mobile clinic work, domiciliary deliveries, maternal and child health, school health etc. Rural projects planning and management of health centres is also taught to the community health workers. As of the current 20th basic course for Community Health Workers, a total of 355 community health workers from every state in India and also from Nepal have been successfully trained.

4. Interns:

Rural Internship training programme:- All Interns in batches, are posted to the six rural subcentres for a period of three months duration each. Apart from managing the rural clinic, these interns are also involved in epidemiological surveys, domiciliary visits, domiciliary deliveries, immunization and school health. Besides, they parti-

They have successfully participated in field evaluation surveys for immunization coverage, in remote villages in a number of districts in Karnataka.

5. Training programmes for Deacons, Seminarians and others:- Being basically a training institute, a large number of small organidations are constantly availing the facilities for training their own health workers. This programme is arranged on individual request basis with the theme of the training being highly specific to the need of that organisation. Many of these programmes are in the form of work experience in our ongoing rural programmes. Some of the programmes, however, are formal month long structured training programmes. The Deacons and Seminarians from St. Peter's Seminary, Suvidya College, Deena Seva Ashram, Workers from Association of Physically handicapped and several other Government and Non-governmental agencies, undergo these courses in Community Health conducted by the Department.

6. Food Hygiene Training Programme:- Keeping in view the importance of Food Hygiene in Public Eating Places, this training programme aims at providing appropriate knowledge and methodology of safe food keeping to Hotel Managers, cooks and Servers. This is a monthly programme conducted at the Hotel premises itself in the local language so that the programme is highly effective. The topics of food hygiene are especially selected to reflect Indian foods and indigenous techniques of food preparations.

7. Plantation Health Services:- Under the aegis of the United Planters Association of South India and the Department of Community Medicine, a series of training programmes, collaboration research and service Programmes are undertaken throughout the year for the plantation workers, Doctors, Managers and Lab Technicians of the Tea, Rubber, Coffee plantation of South India. Elective clinical training for

training of plantation creche attandants are some of the major areas of involvement of our institution. The main objective is to provide adequate community Health care to the workers of the plantation community in South India.

8. Rural School Health Programme:- Under this programme all the rural middle and high school teachers of Anekal Taluk are trained in the various facets of school health. The main objectives of this training is to train rural school teachers in basic health care, early detection of illness in children, immunization and health education. Follow up of this programme has revealed that the school teachers have successfully organised regular teaching programmes in health for their school children. In addition, some of the senior school children have been trained to supervise healthy practices, environmental cleanliness etc. Thus the responsibility for health is transferred to the school child. Periodical school health surveys and health camps in the specialised areas of ENT, Ophthalmology, Dentistry and Surgery are carried out by the clinical faculty of the concerned departments of the Hospital. These clinical faculty participate in these rural programme regularly.

9. For the students of Diploma in Hospital Administration:- Apart from severals hours of didactic teaching in Community Health, these students are posted to our rural health training centres and other field health programmes of the department. They also carry out Health Management projects with the guidance of the departmental faculty.

10. Colloquim for doctors and Community Health Workers working in rural areas:- In addition to basic training in health care to various categories of health workers, it is important that a follow up is done on the utilisation of the knowledge gained. For this purpose, several methods are followed. At the professional level, doctors can seek elective posting in selected specialities for skill development. Regional colloquim are organised for sharing professional experiences among

Alumni doctors, permanently working in rural areas, attended this two-day colloquim wherein they shared their experiences in management of clinical emergencies with limited resources, motivation of villagers on health awareness, communicable disease control, use of herbal medicine, management of social problem, cultural taboos, etc. The following recommendations were forthcoming as a result of this charing experiences:-

- To arrange a one year training programme in family medicine covering all major clinical subjects including behavioural sciences, counselling, community development etc. This could enhance the knowledge and skill level of the rural-based doctors. Several of the participating rural doctors have offered to participate in this course by offering their own centres for specific training sessions under rural conditions.

- A short in-service, skill oriented training for all interns, before they take up their rural postings. This training should essentially cover maternal and child health.

- To coordinate a national network of our rural graduate doctors' with our college newsletter acting as the mode of communication between the members of the rural doctors network.

- Conducting regional colloquia of a similar nature in various parts of our country on a regular basis. The present teachers of our college should participate in these regional colloquia in order to discover the actual needs of our rural graduate doctors, so that their teaching methodologies and syllabi can be restructured to suit rural realities.

11. Integrated child Development Scheme Anganwadi Training Programme:- Under this programme, the Anganwadi workers in the Anekal and Attibele circles are trained in various health programmes with greater emphasis

12. Extension training in agriculture, water resources and Veterniary care for village youth:- This programme has been organised in the Dommasandra, Anekal areas. The programme consists of imparting field training and guidance on improvisation of existing methods and provision of expert assistance to extension workers. The stress is laid on youth motivation and training in these areas since it has been found this scheme provides useful outlet for youthful energies and enthusiasm especially among those who are unemployed and sufficiently educated. This scheme is seen as a method of providing entry into the field of agriculture and veterinary care for fresh workers rather than merely intensify and promote already established rich farmers etc.

13. Integrated Health Care Training:- Villagers in India often resor to indigenous systems of medicine. The training at St. John's for the various categories of health workers including its own medical students comp-rise training in Herbal Medicine, Herbo-mineral Medicine, Accupressure, Homeopathy and Yoga. Many of its graduate doctors working in remote rural areas have substantiated the fact that there is this need to integrate allopathic Medicine with the other systems of Medicine.

14. Training of Govt. Medical Officers:- At the request of the State Government, our departmental staff conduct training programmes in Universal Immunization Programme methodologies for Govt. Medical Officers in various parts of the State.

15. Training of foreign Elective Posting Medical Students: Under this scheme, on an average, 10 - 15 Medical students per year from U.K., U.S.A.,France, Italy are given experiential learning in Community Medicine for 4 - 6 weeks each at our rural health centres.

SERVICE PROGRAMMES IN COMMUNITY HEALTH CARE:

1. Meternal and Child Health Clinics:- Conducted fortnightly at all the six subcentres by the faculty of the Department these clinics provide an apportunity for the women and children to avail themselves

5. Universal Immunization Programme: Organised in collaboration with the UNICEF, this programme is a major service programme whose main objective is to achieve nearly 100 percent of coverage with immunization against Diphtheria, Pertusis, Tetanus, Polio, TB & Measles for children below 1 year of age in Anekal, Dommasandra and Bidadi Primary Health Centres plus a five lakh population in the urban areas as well.

6. Rural Mobile Clinics:- As part of the Re-Orientation of Medical Education Programme, three rural Mobile Clinics operate in 18 remote villages of the Anekal, Dommasandra and Bidadi Primary Health Centres. On an average, 80 to 100 patients attend these clinics per day. The Mobile Clinics provide an ideal opportunity to conduct not only routine clinical care at the remote villages, but they also provide an opportunity to carry out specialists care such as ENT, Ophthalmology, Dentistry, surgery and Dermatology. Basic clinical features of common diseases can be taught especially to para-medical workers at these Mobile Clinics since the rural patients are not constrained by the awe inspiring presincts of a large hospital. This aids in better ineraction between the patients and health worker which is not possible in the sophisticated hospitals.

7. Serving the Urban under-privileged:- Urban slums in and around Bangalore, are also served by St. John's. Health programmes such as immunisation coverage against the major killer diseases for children, maternal and child health clinics for expectant mothers, school health programmes are some of the urban-based health activities of St. John's. In addition, the medico-social unit provides councelling in alcoholism drug addiction, juvenile delinquency etc. The trainees learn to serve the under privileged in all aspects of health care.

8. Referal Services:- Village patients are refered to the Hospital for tertiary care. The referal is done by the resident intern at the rural health centres and followed up by the social workers of the department.

This particular service is all the more important since large number of females patients often hesitate to be attended by our male residential interns. During these clinics, the opportunity to educate the mothers on ante-natal, natal, post-natal and child care services are also availed of.

2. Rural Specialists camps:- As mentioned earlier, the rural Mobile clinics are amply provided with facilities which are made use of to organise rural surgical camps in the field of Ophthalmology, ENT, and Dental surgery. This has been a novel programme. Through these rural specialists camps, it has been proved that it is possible to conduct surgical procedures such as Tonsillectomies, Antral wash, Cataract extraction, Dental extraction, Dental fillings, and other surgical procedures, even under General Anaesthesia. It has been heartening to note that there has been no post operative complications or infections reported so far although each camp has on an average of 30 to 40 operative cases. The local Youth Clubs are involved in the management of the organisation and publicity etc., of these camps. Follow up care is provided by the residential interns.

3. Natural Family Planning Services:- The family Welfare Services section of the Department of Ob & Gynae of the Hospital accampany the Maternal and child health service teams and conduct awareness programme in Natural Family Planning among the villagers of the Six rural subcentres, An average of 4 to 6 couples accept the Natural Family Planning each week.

4. Factory Workers Health Services:- Under the occupational Health Services provided for small factory workers, the department is involved actively ir the provision of pre-placement, periodic examination, factory safety education, Occupational hazards survey and executive health.

The ENT, Skin, Dental and Ophthalmology departments participate in these specialist camps.

9. Food Hygiene Inspection:- The Hospital Canteen and other Messes in the institution, are subject to regular food hygiene inspections carried out by the Department faculty. This is done in collaboration with the concerned administrative chiefs for effective and prompt implementation of the recommended control measures.

10. Immunization Coverage Evaluation Surveys:- In collaboration with the State Government Directorate of Health Services, teams of staff from the department conduct specialized immunization coverage evaluation surveys in various districts of the state such as Kolar District, Mysore District, Coorg District etc.

11. Preperation of Health Education Materials:- With a regular artist as part of the Department staff, several posters, charts, etc., on Health Education has been prepared and used in health exhibitions. These materials are also borrowed for use by various other institutions The same is true of audio cassettes prepared in local languages to depict songs and drama about important issues in Health of the Community.

12) Participatory process:- The main objective of the various health programmes of St. John's aims at a participatory process, wherein the the villagers themselves participate in financing health care, supply of materials and manpower, etc. This is particularly exemplified by the Mallur Health Cooperative Centre, which now has its own hospital building and other facilities provided through a cooperative movement which the college initiated in 1973. Village Health Committees have been formed at each of the Rural Health Centres, and all decisions are participatory in nature. A largepart of the organization of surgical and other speciality Rural Camps is also under taken by village youth groups and Mahila Mandals. Even the training of the various categories

RESEARCH PROGRAMME IN COMMUNITY HEALTH

The fact that a large number interns are posted to our rural health centres each year, has enabled the formulation and execution of several research studies, by the staff of the Department. Some of the important research projects covered over the years are detection of goitre in the Munnar region, health hazards of sreiculture workers, house dust mites and allergy in rural areas, Prevalence surveys of Leprosy, TB and other Major diseases, Polio lameness surveys Leprosy health education methodologies, helminthic surveys, Knowledge attitude practice surveys, school health surveys, environmental health factors surveys, anaemia and productivity among tea pluckers in the plantation etc. Papers have been published by the staff in various national and international health journals.

Publications in food hygiene and immunization methodologies have been written by the staff in English and the local language of Kannada as well.

Using appropriate technology, practical methods of solar cooking vegetable storage devices, smokeless chullas, kitchen nutrition gardens etc., have also been evolved by the staff of the Department.

LOOKING BEYOND:

All the programmes outlined, so far, are dynamic in nature since they are updated constantly depending on the feedback received of their effectiveness and efficiency. The emphasis is thus on training and health education rather than merely the provision of multiple services. This ensures that whatever may have been the programme inputs, the results will be long lasting, self perpetuating and effective.

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TRAINING A HEALTH WORKER AT VACHAN

Introduction:

In the context of Primary Health Care approach, a VHW is seen as

- MOTIVATOR
- EDUCATOR
- SERVICE PROVIDER

for all the activities under its perview viz,

antenatal care (registration, provision of iron supplement)
Post-natal care (same as ANC plus advice on breast feeding):
immunisation (motivate follow up)
growth monitoring (weighing and educating mothers)
diarrheal diseases control (ORT) and so on.

At VACHAN a different view is taken; particularly in the light of the lack of availability of curative services. A HW is

- a provider of primary level CURATIVE HEALTH care service.
- a provider of REFERRAL advice for serious ailments.
- an EDUCATOR as a part of his role as a healer.
- a MOTIVATOR for health measures hitherto not taken by the community : ORT/ disinfection of wells.

SELECTION OF HEALTH WORKER

Objective

To locate a person who is

- ACCEPTABLE to all sections of the community.
- having an EDUCATIONAL BACKGROUND to enable him/her TO LEARN the necessary diagnostic skills(Normal in VACHAN is fifth to ninth standard educated boy/girl).
- placed at a DISTANCE which can be comfortably traversed by a moderately ill person or a pregnant woman say about one kilometer.

Process:

- Nomination by the community usually in a community meeting.
- final selection (if more than one person nominated), by VACHAN after 2-3 contacts with the nominees in a training session.

TRAINING OF HEALTH WORKER

Level A:

Having knowledge and skills to tackle health problems that

- are not life threatening
- do not require complex decisions to diagnose
- are amenable to simple treatment
- do not involve use of antibiotics or medicines that may have serious side/toxic effects.

Problems include

- viral infection like cold influenza, mumps, chicken pox, uncomplicated measles, viral diarrheas with mild or moderate dehydration.
- other infections like uncomplicated amebic, bacterial dysentry with mild dehydration amenable to 48 hours of treatment, giardiasis fungal ingection of skins like ring worm.
- infestations like scabies, lice and worms.
- wounds with no sign of spread of infection and of injury to important structures like bones, arteries, nerves.
- allergic conditions like rashes, colds, uncomplicated asthama.
- symptomatic treatment for short period for headaches and joint pains, hyperacidity, dry coughs.

Training includes:

- Anatomy and Physiology particularly their applied aspects.

- Concepts in Pathology e.g.
  . immunity, antibodies and vaccines, inflammation and healing.

- Concepts in Microbiology
  . Different types of micro-organisms viz, viruses bacteria, fungi and unicellular organism like ameba

- Types of bacteria
  . Based on staining methods

- Concepts in Pharmacology
  . Drugs Action
  . Side and Toxic effects
  . Essential Drugs
  . Rational Drug use
  . Misuse of drugs incl. injections, tonics.

- Concepts in Nutrition:
  . Components of our food & their functions: Carbohydrates, fats, proteins, vitamins, minerals
  . Their sources
  . Nutritional deficiencies, symptoms and signs, treatment, prevention

- Concepts in Diagnostics
  . Problem solving Approach to medical/health problems
  . History, Examination and Investigation
  . Clinical Examination: What to look for: Anemia, nutritional deficiency etc.
  . Use of Diagnostic chart & Table : Fever & Diarrhea in adults. (See Table I and Chart attached)*

- Child Health:
  . Weight Monitroing
  . Nurtitional advice - weaning foods
  . Immunisation
  . Common diseases/ problems

* Source: 'Bharatvaidyak - A training manual in Marathi prepared by Drs Ratna and Sham Ashtekar, Bharatvaidyak Samstha, Dindori. D. Nasik, Maharashtra.

Level B:

Having knowledge and skills to tackle health problems that

- are not immediately life threatening
- do not require complex decisions for diagnosis
- are amenable to simple treatment/ first aid measures.
- may involve use of antibiotics or medicines that have no toxic effects if used with caution.

Problems Include

- Bacterial infections like tonsilitis, middle ear infection, pneumonias, bacillary dysentery, urinary tract infections, infections following delivery, vaginal infections,
- wounds with signs of spread of infection
- bronchitis following filarial infection,
- bleeding after delivery
- referral advice for ailments like sudden severe pain in abdomen, problems involving the central nervous system or the circulatory system, problems of children that cannot be tackled by them,
- Symptomatic relief for vomiting, motion sickness, pain in abdomen

Training includes :

- Pharmocology of anti-biotics
- Diagnostics involving clinical training in a hospital set up.

TABLE—1

CLASSIFICATION OF AILMENTS FOR PARAMEDICAL TRAINING PROGRAMME

Group of ailments	Diagnostic Feasibility	Treatment Feasibility	Safety Factor	Prevalence Factor	Ailments
1. Minor ailments	††††	††††	††††	††††	Common cold, minor cuts, headaches, constipation, fungal infection, scabies etc.
2. Major ailments	†††	†††	†††	†††	Diarrhoea, dysentery, URTI, malaria, otitis media, vaginitis, hyperacidity hepatitis, etc.
3. Serious ailments	††	††	†	†	Pneumonia, typhoid, fever Acute abdomen. meningitis, Diptheria, tetanus etc.
4 Important chronic conditions that need early detection and health education.	††	††	††	††	Tuberculosis, leprosy, filariasis cancer, etc.
5. Acute emergencies that need first-aid and referral	†	†	†	†	Snake bites, Burns, Severe dehydration; major accidents specially involving brain, chest abdomen and haemorrhages etc.

Note : 1) The examples under 'ailments' heading a.e not a compete list but only a few cases for illustration.

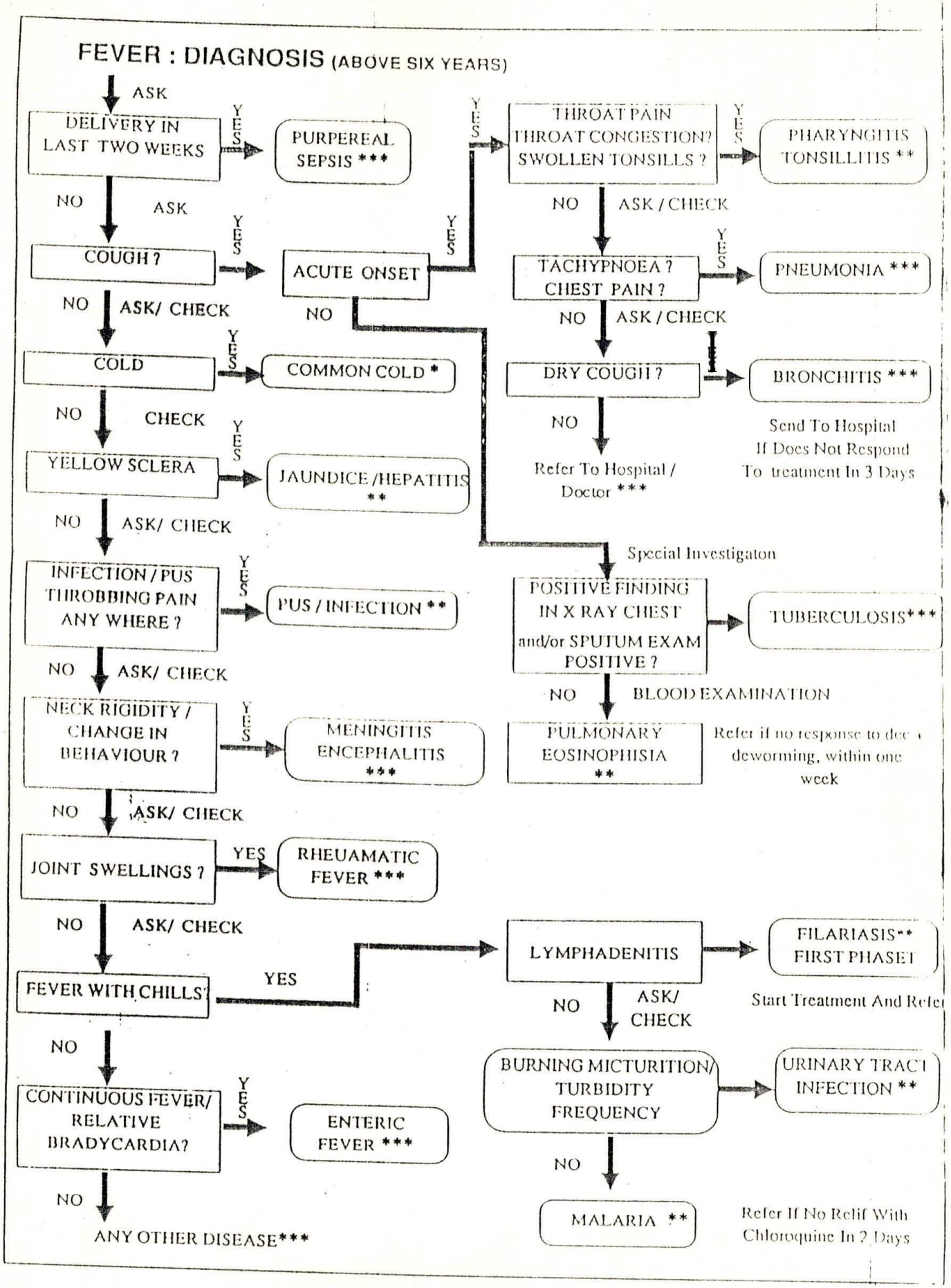
2) The difference betwen category 3 and category 5 is that in category 3 (serious ailments) there is little scope for first aid while in the later first aid can often save the patients.

3) The diagnosis of, say snakebite, is easy but that of its effects is difficult and hence the overall diagnostic feasibility is poor.

4) Category 1 can be safety attended by the paramdicals, while category 2 should be attended with caution watching for indications for referral. Category 3 should be immediately referred to medical experts. Category 4 needs high suspicion index for early detection. supervision over the treatment and health education and category 5 assisted with first aid before sending for expert care.

FEVER DIAGNOSTIC CHART (FOR PERSONS ABOVE SIX YEARS

OTHER COMPLAINTS								INFORMATION ABOUT FEVER					A : ALWAYS, C: COMMONLY, R : RARELY, L : LATE
								How Much			Character		
Cough	Throat Pain	Chest Pain	Abdominal Pain	Nausea Vomiting	Bodyache	Headache	Jointpain	Low	Medium	High	Continu-ous	Irregular	OTHER SPECIAL FEATURES
L	L				C	C	R	C	R		C	R	Eyes congested, Stuffy nose, Contagious
C	C				C	C	C	R	C		C	R	Malaise, Prostration
A	A			R	R	R	R	R	C	R	C	R	Redness on throat / tonsills, Dysphasia
A		C		R				C	R		R	C	Dry cough initially, Followed by productive cou
A		A	R		C	C	R		R	C	C	R	Acute onset, Dyspnoea, Prostration
C		C			C	R	R	C	R		R	C	Chronic condition, Anorexia, Productive cough
				R	R		R	C	R	R	R	C	Check site of infection, Lymphadenitis
			C		A	A	R		C	R	C	R	Prostrations, Relative Bradycardia
			A	A	C	C	R	C	R	R	C	R	Hypochondiriac tenderness, Yellow sclera
			R	C	A	C	R	R	C		R	C	Faer with chills, daily or alternate day
				A	C	A	R		R	C	C	R	Neck rigidity, Change in behaviour
		L					A	R	C		C	R	Joint swellnes, Valvular heartdiseas
								R	C			C	Lymdhadenitis, Send night blood smear
			C	C	C	R	R		C	R	R	C	Burning / ferqueney / turbidity of urine
										C	A		Hot environment, Acute onset
			C	R	C	C			R	C	C	R	Delivery in last two weeks


FEVER : DIAGNOSIS (ABOVE SIX YEARS)
ASK
DELIVERY IN LAST TWO WEEKS
YES
PURPEREAL SEPSIS ***
NO
ASK
COUGH ?
YES
ACUTE ONSET
YES
NO
ASK/ CHECK
COLD
YES
COMMON COLD *
NO
CHECK
YELLOW SCLERA
YES
JAUNDICE /HEPATITIS **
NO
ASK/ CHECK
INFECTION / PUS THROBBING PAIN ANY WHERE ?
YES
PUS / INFECTION **
NO
ASK/ CHECK
NECK RIGIDITY / CHANGE IN BEHAVIOUR ?
YES
MENINGITIS ENCEPHALITIS ***
NO
ASK/ CHECK
JOINT SWELLINGS ?
YES
RHEUAMATIC FEVER ***
NO
ASK/ CHECK
FEVER WITH CHILLS?
YES
NO
CONTINUOUS FEVER/ RELATIVE BRADYCARDIA?
YES
ENTERIC FEVER ***
NO
ANY OTHER DISEASE***
YES
THROAT PAIN THROAT CONGESTION? SWOLLEN TONSILLS ?
YES
PHARYNGITIS TONSILLITIS **
NO
ASK / CHECK
TACHYPNOEA ? CHEST PAIN ?
YES
PNEUMONIA ***
NO
ASK / CHECK
DRY COUGH ?
YES
BRONCHITIS ***
Send To Hospital If Does Not Respond To treatment In 3 Days
NO
Refer To Hospital / Doctor ***
Special Investigaton
POSITIVE FINDING IN X RAY CHEST and/or SPUTUM EXAM POSITIVE ?
TUBERCULOSIS***
NO
BLOOD EXAMINATION
PULMONARY EOSINOPHISIA **
Refer if no response to dec deworming, within one week
LYMPHADENITIS
FILARIASIS** FIRST PHASE
NO
ASK/ CHECK
Start Treatment And Refe
BURNING MICTURITION/ TURBIDITY FREQUENCY
URINARY TRACT INFECTION **
NO
MALARIA **
Refer If No Relif With Chloroquine In 2 Days

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Society for Community Health
Awareness, Research & Action.
No.326, V Main,
I Block, Koramangala,
Bangalore - 560 034.

Community Health Trainers Dialogue
3-5th October 1991

THE BAJAJ REPORT

Some View Points

BACKGROUND PAPER VI
(Compilation)

RESPONSE VII

On the whole I feel the thrust of the report is in the right direction. The report and the discussions on it should be publicised widely among government and non-governmental agencies and the general public. A few comments are, however, in order.

The situation analysis has been done well. The sections which need stressing are sections 2.5, 2.7 and 2.9. The generation of relevant data as part of health services research is in line with objective 4 of NEPHS. The mechanism envisaged is multi-disciplinary team work through Universities of Health Sciences (Section 8). The details of such research and the link between this and on-going generation of data for planning and evaluation is not clear and needs to be worked out.

Regarding Objective 1, development of 'man power for all health provider categories, a crucial element is the starting point of all education - viz. recruitment. The tone of the report relies on the progressive model of education as propounded by Dewey - stressing the problem solving approach, self-oriented learning, reconstruction of experience etc. What should be more relevant to our situation, however, are the more radical models which explore the relation between knowledge, culture and power on one hand and issues of schooling and socialisation on the other. According to these, education reflects and reproduces the structure and culture of dominant groups and the educational system distributes knowledge and skills so as to perpetuate the unequal power relations in society. The pedagogical process internalises and legitimises the values which sustain the status quo. In this context when we talk of a transformative pedagogy, a policy of health sciences should be in step with legislative and other policy measures of the government, for social change. Specifically, the NEPHS should examine how support can be provided to subjects drawn from the really oppressed sections of society - the dalits, tribals and other economically poor classes, in terms of additional / supplementary education before and during medical / other health courses. There are of course many grey areas, but in my opinion a national policy has to address the question of the sections of society from which the 'to be educated' are drawn. Obviously Prof. Bajaj has not cared to reflect on the anti-reservation agitations launched by medical college students in Gujarat and elsewhere.

In Gujarat I have seen that the nursing profession attracts a disproportionately high number of women from the Vankar community, a scheduled caste (I don't have reliable data). Can an educational strategy help such experienced people move into positions of 'power' as medical doctors? Wouldn't such people make better community-oriented basic doctors? In other words, one aspect of continuing

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education is the mobility of health personnel, competent and sound, towards different qualifications which involve more power. Another aspect of this link between, for instance, the nursing profession and Vankar women, is also that it emphasises the deprivation of this group in both the caste and gender structures. The tasks associated with nursing have been traditionally considered impure and polluting in some senses and certainly secondary: and therefore 'fit' for women and scheduled castes. (Since this point is not directly connected with the NEPHS I'm not elaborating this point further).

Another general comment relates to the medium of instruction. English is a language of the dominant / privileged classes and it effectively prevents large sections of people from gaining access to powerful sectors of health care educational systems. The difficulties faced by the few who do gain entry are well known. Why doesn't a national policy touch on this question? Translation of major texts, bi-lingual instruction and examinations etc. are areas for debate.

All the above comments are general in nature and related to entry into the health education system. Related minor points include the desirability of village experience for students prior to their joining the course (rural students may not need this experience; urban community experience may be needed for these students); age and experience criteria of candidates etc.

A very disappointing feature and major weakness of the report is the superficial treatment of linkages between health-care delivery and education in health sciences (Section 6). The "formidable" health infrastructure "suffers from sub-optimal performance". This is where continuing education (or should it be re-orientation?) has a role to play. Continuing education as defined in the report emphasises the skill component of a person's make-up. Perhaps a focus on the goals of health, more democratic planning and implementation, practical difficulties etc., could be included in a 're-orientation'. Can alternative trainers, whose experience is by and large with small-scale parallel systems, help here? What structures, maybe at the district or state level, can be used or introduced for this purpose? Can the processes of such training be used to build up what is called team-work among the different categories of health-care providers? What has to be done to make the idea acceptable?

One important point (Section 4.1.9) is the upgradation of the skills of para-medical personnel and of people working at the cutting edge of health care - community health workers. The NEPHS should consider the issue of how adequately equipped the CHWs are with quality medical skills. This it cannot do without recognising a decentralised model of health care and without tackling the question of support and official recognition of the work of the CHW sector. The areas of support could include financial, continued education, transport, participation in project design and implementation at community-level and training of medical students. Official recognition might imply some form of licensing. Thus policies for education of CHWs will imply recognition in their own right and not as add-ons of the existing health care systems.

A specific comment with regard to Sections 4.1.1 to 4.1.8. The speciality of Community / public health should be dispensed with or altered. These inputs should be stressed heavily at the degree-level. The bio-medical as well as super specializations have to be developed from a foundation of community medicine. The policy should allow flexibility to different institutions to include other subjects like teaching and management skills, social awareness, management of emergencies in poorly controlled environments etc.

One last point which needs to be stressed, though I cannot comment with confidence on it, is Section 3.4 - faculty development. The technology 'of' education needs to be worked out in greater detail. Perhaps compulsory placement of teaching staff in government or non-governmental health institutions as 'health care deliverers' for specific periods of time along with inputs on teaching methodologies may help. Our fresh medical graduates may then be able to handle emergencies in poorly controlled environments more adequately.

(P.G.Vijaya Sherry Chand, BSC,
Ahmedabad).

RESPONSE VIII

1. The formulation of such a National Policy is an important and necessary step. Several issues and concepts have been touched upon, however they need to be grounded to the situation and system in the country if the Policy is to be used to bring about change in a meaningful direction.

2. The report ignores important national documents which have dealt with the issue of education of health personnel - right from the Sokhey and Bhore Committee till the Shrivastava Committee. This is a major omission for a national policy document and tends to give the impression that there was total adhocism till the 1983 Medical Education Review Committee and National Health Policy.

3. More than 40 years post-Independance it may be worth reviewing certain important policies of the GOI e.g., concerning medical education

   i) Who benefits from the State subsidy provided to education of health personnel,

   ii) Implementation and impact of reservation policy,

   iii) Impact of the Department of Preventive and Social Medicine,

   iv) What is the present situation of the R.O.M.E. Scheme (Reorientation of Medical Education) etc.

4. While the report speaks of the Indian Systems of Medicine(ISM) and Homeopathy as our national heritage in the first and last paragraphs, there is no mention of the quantum of contribution in terms of number of health personnel, training institutions, training strategies and areas of strengths and weaknesses. If we really believe in our "national heritage", then members from these systems should also be represented in Committees drawing up National Policies.

5. There are certain inaccuracies in the report e.g.,

   i) The system of medicine which was developing in Europe was

first introduced into India by the Portugese in the16th century. The Royal Hospital in Goa was built in 1510 i.e., this system was not introduced in the last century.

ii) The statement that there was primarily a quantum growth in medical education till 1965, after which there was greater consolidation is not supported by data. In fact the quantum growth continues. That official statements have not been including private and unrecognised colleges, cannot negate the actual presence of these colleges training hundreds of students and quite often using hospitals and health services of the Government itself as their clinical training facility The figure of 106 medical colleges has been used for several years and only more recently is it accepted that we do not know exactly, but there are more than 140 medical colleges. The rate of growth in terms of number of doctors graduating per year has also been maintained, even post 1965.

6. The analysis is also rather weak about many factors, some of which are:-

i) The root causes of ill health in the country and the need to create an awareness of these factors during the 'formation' or training phase of health professionals.

ii) Recognising the role of folk health practitioners and local health practices, the need to understand them and preserve them if they are useful, and to educate health professionals in this regard.

iii) The questionable role played by the 'recognised'medical / health professionals e.g. that inspite massive State subsidy for the training of these groups and the build up of "formidable health infrastructure and manpower" we are still very far from the goal of providing effective health /medical services in the rural areas and to underprivileged groups.

iv) The regional / state level disparities between health professional - population ratios.

7. There is need for a much deeper analysis of the content and quality of education. This appears to be the weakest point in the report and the system itself.

8. Other areas like impact of selection methods on future career choices, types of text books available etc., could also be touched upon.

9. Important broader issues that need to be addressed are: corruption at entry, exit and all levels of education, rapidly declining values and medical ethics, the growing commercialisation of medicine as a whole and of the educational process, and the privatisation of medical education.

(Thelma Narayan, CHC, Bangalore).

COMMUNITY HEALTH TRAINERS DIALOGUE

3rd to 5th October, 1991

Vidya Bhavan, Bangalore.

TENTATIVE ; to be modified with participant involvement on 3rd October, Session I.

2ND OCTOBER :- PARTICIPANTS ARRIVE AND CHECK INTO VIDYA BHAVAN
(Wednesday) CONTACT CHC OFFICE IN VIDYA BHAVAN FOR REGISTRATION/FILES

Please Send Pre Registration Form in Advance

Please handover materials for display or distribution to CHC Office on arrival

- 08.00 p.m. - Dinner

3RD OCTOBER :- 08.30 a.m. - 09.00 a.m. - Breakfast
(Thursday) - 09.00 a.m. - 09.30 a.m. - Welcome and Introduction to Meeting

09.30 a.m. - 11.00 a.m. - Session I
- Getting to know each other
- Programme Outline
- Participatory Planning

11.00 a.m. - 11.30 a.m. - Mid Morning Tea

11.30 a.m. - 12.30 p.m. - Session I (contd.)

12.30 p.m. - 01.30 p.m. - Session II
Educational Policy for Health Sciences
i) An Outline
ii) Discussants : Key Strengths and Weaknesses

Two participants will be requested to set the tone for the discussion

01.30 p.m. - 02.00 p.m. - Lunch

02.00 p.m. - 04.15 p.m. - Session III
Group Discussion on Bajaj Report (I to IV)

04.15 p.m. - 04.30 p.m. - Tea

04.30 p.m. - 06.00 p.m. - Session IV - Plenary
Education Policy for Health Sciences - A SWOT Analysis
(Pulling infrom the Group Discussions)

06.30 p.m. - 08.00 p.m. - Fellowship

08.00 p.m. - - Dinner

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4TH OCTOBER :- 08.30 a.m. - 09.00 a.m. - Breakfast

(Friday) 09.00 a.m. - 11.00 a.m. - Session V -

GROUP REFLECTIONS

Group I : Laying the Foundation - Exercise

Group II : Critique of the 'Anthology of Ideas'

Group III: Building together - the Community Health Trainer Network.

Group IV } (to be decided during introductory

Group V } session on 3rd October)

11.00 a.m. - 11.30 a.m. - Mid Morning Tea

11.30 a.m. - 01.30 p.m. - Session VI - Plenary

A : Group Reports & Discussion

01.30 p.m. - 02.00 p.m. - Lunch

02.00 p.m. - 03.00 p.m. - Rest / Fellowship

03.00 p.m. - 04.15 p.m. - Session VI (Contd.) Plenary

B : Group Reports & Discussion

04.15 p.m. - 04.30 p.m. - Tea

04.30 p.m. - 06.00 p.m. - Session VI (Contd.) Plenary

C : Group Reports & Discussion

06.30 p.m. - 08.00 p.m. - Fellowship / Cultural Programme

08.00 p.m. - - Dinner

5TH OCTOBER :- 08.30 a.m. - 09.00 a.m. - Breakfast

(Saturday) 09.00 a.m. - 11.00 a.m. - Session VII

Pulling in Learning Experiences and follow up suggestions.

11.00 a.m. - 11.30 a.m. - Mid Morning Tea

11.30 a.m. - 01.30 p.m. - Session VIII

Finalisation of Collective Response (concluding) to Educational Policy.

01.30 p.m. - - Lunch

** Participants may leave after Lunch.

Convenors, Rapporteurs, Dialogue Report Editors, Group Leaders and Groups will be decided on 3rd October in Session I

Please note that the CH Forum meeting mentioned in the last letter has been postponed due to unavoidable reasons.

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Community Health Trainers Dialogue

Background Paper II

Collective Concerns

KEY COMPONENTS WHICH SHOULD FORM PART OF AN EDUCATIONAL POLICY FOR HEALTH SCIENCES IN INDIA

An opinion poll on the Key Components that the 'dialogue' participants feel should form part of an Educational Policy for Health Sciences in India was carried out as a sub section of the participant form.

These are collated under six sub sections :

1. Focus
2. Broad components
3. Content / skills
4. Methodology
5. Process
6. Issues

The collation will give participants a feel for the collective concerns of the group participating in the dialogue.

The list is exhaustive, covering a wide range of ideas and issues arising out of the diverse experience and perspectives of the group but the overall thrust towards a more community oriented, socially relevant, responsive, pro-people oriented educational policy is evident.

The listing is in a contextual order using original wordings as far as possible. Since who said it is not as important as what is said names have not been indicated though participants will be able to identify their contributions.

Note : These responses were received before the new Educational Policy was circulated to all participants. They not only emphasise many points covered in the Bajaj report but raise many other crucial issues which need to be discussed further at the workshop.

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Community Health Trainers Dialogue

Background Paper III

Collective Concerns

KEY CONCERNS / ISSUES WHICH ARE IMPORTANT TO REVIEW IN ORDER TO ENHANCE THE CONTRIBUTION OF COMMUNITY HEALTH TRAINERS IN INDIA.

An opinion poll, on the key concerns that the dialogue participants feel would help to enhance the contribution of Community Health Trainers in India, was carried out as a subsection of the participant form.

These are collated under eight subsections

- The Background
- Contextualising Community Health
- Exploring related issues
- Medical Education Policy
- Collating / Analysing Community Health Training experience
- Building Collectivity among trainers
- Issues arising out of community Health Training experience
- Additional issues.

This collation will give participants a feel for the collective concerns of the group participating in the dialogue.

The list is exhaustive, covering a wide range of ideas and issues arising out of the diverse experience and perspectives of the group but the overall thrust towards a more community oriented, socially relevant, responsive, pro-people oriented educational policy is evident.

The list is in a contextual order using original wordings as far as possible. Since who said it is not as important as what is said, names have not been indicated though participants will be able to identify their contributions.

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KEY CONCERNS / ISSUES WHICH ARE IMPORTANT TO REVIEW IN ORDER TO ENHANCE THE CONTRIBUTION OF COMMUNITY HEALTH TRAINERS IN INDIA.

THE BACKGROUND

01. Increasing poverty of the masses
02. Declining health situation of women and children
03. Growing communalism and religious fundamentalism
04. Ever-growing commercialization of health care system
05. The overall need for social justice
06. Disappearing ancient health patterns (practices) in rural areas (e.g. ragi to polished rice)
07. Dependency on Allopathic medicines especially injections/ tablets.
08. Neglect of rural areas by Government Health Departments / Doctors / Hospitals
09. Drugs coming within the scope of 'Industries'

The overall thrust in health care

10. To critically analyse the present development and health care system to see if it is helpful to the poorest or not; if not look for the alternative
11. To explore ways of discovering culturally relevant health information from the people
12. To make them (people) look at health problems in a more wholistic way
13. To discover ways of using alternatives to empower people especially the women and put health back into their hands

CONTEXTUALISING / CLARIFYING COMMUNITY HEALTH

14. Understanding of social realities in India and a deeper analysis of the situation
15. Exploring Community health components - curative, preventive and promotive in the local context
16. Community level workers / volunteers / their potential as primary health care provider
17. Community health in the context of people's organisations and changing health practices
18. Locating community health in the context of wider societal factors that operate in India.

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EXPLORING RELATED ISSUES

19. Changing life styles for positive health
20. What is scientific and relevant health care?
21. Integration of community health aspects of clinical medicine
22. Economics of Health
23. Integration of Indian Systems of Medicine with Modern medicine
24. Understanding of the economics of health / mechanics for appropriation of public finance and communication / organisation of the society
25. Lack of team work among different categories of health workers and ways of overcoming it
26. Avoidance of identity crisis between SPM / PSM / public health / community medicine / community health etc.
27. Using greater levels of behavioural sciences / psychology / communication to bring about long lasting changes in health practice among people
28. Identifying levels of demystification of medicine
29. Issue of non medical versus medical administration
30. Role of pharmaceutical MNCs in drawing up syllabus for medicine

MEDICAL EDUCATION POLICY

31. Understanding the existing situation
    - the class from where students come
    - the location of educational facilities
    - the appropriateness of curriculum and textbooks
    - the elitist and commercial nature of the products of medical schools
32. Reviewing the existing Medical / Health Education Policy from a social / economic / political context
33. Health Manpower Development - Policy exploring existing policy and the lacunae
34. Understanding Medical brain drain
35. Evaluation System should be reviewed
36. Internship should be made more effective
37. Health Management should be stressed to a large extent
38. Training in Social Sciences to be strengthened

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COLLATING / ANALYSING COMMUNITY HEALTH TRAINING EXPERIENCE

39. Review of training and finding out the impact of the training
40. Quality of training
41. Methodology of training in community health
42. Use of innovative methods
43. Identification of appropriate skills
44. Follow up of health workers 10/15/20 years after their training - what role are they playing / have they played in health work / what areas need strengthening / what methodologies are suitable for continuing education
45. New approaches to learning
46. Problem solving methods and approaches
47. Work experience in projects
48. Collection of experiences to modify text books / teaching materials in mainstream medical education

BUILDING COLLECTIVITY AMONG COMMUNITY HEALTH TRAINERS

49. Networking to share experiences and enhancing collectivity
50. Peer group evaluation to increase accountability and improve standards
51. Sharing experiences, avoiding duplication and wastage of resources
52. Sharing resources
53. Dialogue and sharing of experience between community health trainers
54. Develop a directory of what is available, where and for whom
55. Need to consider training at different levels
56. Regular exchange of ideas among community health trainers of different parts of the country

ISSUES ARISING OF COMMUNITY HEALTH TRAINERS EXPERIENCE

57. Community Health trainers to be clear on what being a catalyst means
58. Reinforcement of identity - community health trainees as 'social educators' first of all (attitudes, motivation, involvement)
59. To know and accept that health care is only one factor responsible for Health?
60. To have real experience at field levels by living with a low income family in the village and based on this experience to adapt their learning to give effective health education

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61. Population based education should be given higher priority
62. Need to consider training of trainers
63. Is there a need / role for registration / standardization?
64. Standardization of training needs with scope for flexibility
65. Communication / interactive abilities of trainers to be enhanced
66. Trainers should have field contact on an ongoing basis
67. Trainers should have awareness about politics in health
68. The Art of communication should be stressed for both trainers / trainees

ADDITIONAL ISSUES

69. The possibility of incorporating certain aspects of an alternative into the mainstream paramedical training
70. Accreditation to enhance security / recognition of trainees from a long term point of view
71. Provision of legal status to the trained
72. Provision for continuing education and capability to work upward from any level of trainee knowledge
73. Transferring NGO experience to Government
74. Sharing of experiences / methodology with government / professional groups in a spirit of dialogue
75. Interaction of community health trainers and 'the system' be it professional or government
76. Mechanics of intervention at policy level (political action)
77. Community health trainer's deep commitment to participatory approach should influence policy of health care and medical education.

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This collation is derived from the response of the following 24 participants (received as of 31st July 1991).

Dara Amar, Rajaratnam Abel, Desmond D'Abreo, Margaret D'Abreo, Pramesh Bhatnagar, Vijay Sherry Chand, C.M. Francis, Ulhas Jajoo, Hari John, Prem Chandran John, Abraham Joseph, Daleep Mukarji, Jose Melettukochyil, Sujatha de Magry, Dhruv Mankad, Ravi Narayan, Thelma Narayan, Shirdi Prasad Tekur, Sebastian Poomattom, Amla Rama Rao, F. Stephen, Satish Samuel, Valli Seshan and John Vattamattom.

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THE BAJAJ REPORT — BACKGROUND PAPER V

Some View Points — (Compilation)

The responses to the Bajaj Report have been very varied and interesting among the six participants who have responded by 31st August. These comments are listed out for other participants to consider and reflect on. As in the earlier compilations greater 'integration / dialogue' will be an outcome of the meeting.

RESPONSE I

By going through the National educational policy in Health Sciences I feel that it is again the policy statement without giving details of its implementation. From the beginning comprehensive approach towards medical education research and Health have been recommended. The National Education Policy further emphasize that - For effective delivery of health care services, appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as a team must be a part of their education. The main emphasis should be on the outcome of the educational programmes and a person needs to be prepared for the tasks he / she has to perform at the end of the educational process.

On page 3 in second para:- "Teaching, learning activities must receive equal recognition and importance ------" has been talked about, but nowhere does it suggests what kind of learning activities will improve the performance of a doctor. Para 2.9 where it says that "primary health centre require teaching outside the four walls of hospital ------". It was a big mandate and the Department of Preventive & Social Medicine came in existence because of that, but even after 30 years of their existence in various Medical Colleges they have not created any impressions on the minds of the students nor have they strengthened themselves with the physical facilities and appropriate learning materials. Why? needs to be looked into.

Unless different methods of learning are adapted, the improvement in the system cannot be expected. There is no learning that is complete at the end of a period. Therefore various methods and

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modalities for continuing education needs to be worked out. To be able to keep abreast of the advance in medical technologies the large number of continuing education programmes for different health professionals need to be developed. Only regional training centres can not do that as continuing education should be according to the needs.

Suggestions

If in the policy statement we keep repeating objectives and goals but unless our strategies are very well defined the goals can not be achieved. All 8 or 9 educational strategies recommended by the policy can be achieved if the trainers themselves are given similar type of orientation. Little is done to develop the faculty, and there is no training for teachers before they are selected alone.

As Health care programmes of this country are at three levels we need 3 different kinds of medical educational policy to be able to man these services.

For primary health care approach - Public Health Nurses and a Doctor with more humanities background and leadership qualities can be utilised whereas for secondary and tertiary care more emphasis on problem solving, learning, teaching methods may be required.

For super specialists we need people with more post-graduation education. The more practical training is given to the doctors, nurses and para medical the better it is going to be for their performance. The number of students admitted in Medical Colleges each year being so large it is not possible for them to have any practical experience under supervision. Therefore when they go out they are not confident enough to use their skills and depend mainly on theoretical knowledge with the result the services suffer.

Changes in the curriculum content have not been recommended anywhere.

The poor methods of assessment and evaluation policy is well recognised but the alternatives have not been suggested.

To my mind the policy requires little more thinking and the strategies for its implementation must be planned in a phased manner and each step must be clearly defined for the benefit of trainers.

(Amla Rama Rao, VHAI, New Delhi).

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RESPONSE II

This is a very useful process of attempting to solve the problems at present. If well done this could prove extremely useful in developing health sciences. Specific comments are as in the following area.

2.7. I agree with the observation that there is a general lack of education technology in health sciences. A basic ability to handle current educational technology is essential for effective development of health sciences.

33.3. For over a decade there has been a desire to reorient medical education. However, in actual implementation the process is very slow. Without getting bogged down to any one method, skills in as many methods as possible should be provided so that there are competent faculty for providing medical education.

3.4. Technology of education and technology in education, has been adequately mentioned above. Again I am more interested in the technology of education and I believe that Doctors are basically ignorant of this. Suitable remedial and corrective measures had to be applied in this area especially in developing suitable curriculum.

4.1.1 This issue of basic doctors has been discussed for a long time. I am afraid that this process has not being adequately carriedout and this need to be hastened.

4.1.5 & 4.1.6 Basic nurse itself is an area where we have constant conflict with the nursing profession. The nursing professional feel more skill and higher qualification are necessary in carryingout the work. Those of us in the field believe that this may be true, however, in practical term it does not take place, as the higher qualified personnel leave the institution quickly to far away places for higher emoluments, whereas the auxiliary level personnel stay on for a long period of time providing and catering to greater services. This issue of ideal nurse at each level needs to be solved at an early date.

4.2. In continuing education provision must be created and facilitated for medical personnel working in rural areas to register for Ph.D under acceptable guides so that they could receive Doctorate while working in rural areas. This will greatly facilitate in decreasing the urge to move to big centres.

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5.1. & 5.3. Education Commission in Health Sciences is a good idea. I trust that this body would be able to promote inter council interaction which is very vital.

5.5. Having a National Apex Body would also be a very useful suggestion.

7. Practitioners of Indian systems of medicine and Homeopathy need to be standardised especially with their qualification and registration. The registration at present is very loose and therefore the allopathic doctors do not give necessary respect for these practitioners.

8. Medical research is an area of crying need and I trust with this suitable mechanisms would be developed for promoting research in various aspects of applied primary, secondary and tertiary levels of health care.

(Rajaratnam Abel, RUHSA, Tamilnadu).

RESPONSE III

Background : It would have been good to give the projected manpower requirements for health functionaries at various levels (including different systems and alternatives). No educational policy can avoid the type, responsibilities numbers, and time frame.

Preamble : Modern medicine was introduced much earlier than "last century". It was first introduced in Goa and then, Pondicherry.

Rapid expansion : How many institutions (colleges and schools) for the training of students in various systems were there at:

1. beginning of the century
2. time of independence
   What was the output?
3. What was the stock, additions, attritions (various causes including migration, looking after family, etc.,)?

"Delivered" & "Providers" : This words seem to be inappropriate when we talk about health and especially community health.

Attitude : Mention is often made of the development of "skill and competence". Does that include "attitude"?

Situational analysis : 17 medical institutions?

Postgraduate medical education : Self-reliant or surplus?

Primary health care and training : "A major lacuna has been the inadequate physical facilities". Do we want another medical college there? "Experimental learning" or experential learning?

Faculty development : Can promotions be linked to further training and assessment?

Health manpower development : "Over the successive years, particularly for the past 1.5 decade there has been a phenomenal increase in the number of the health institutions that have been established in the country". Any statistical support?

Experiments : Unless the institutions are allowed to experiment with new ideas (same will succeed, some will fail), there is no possibility of improvement. Selected institutions may be given autonomy and freedom to experiment. Review may be done at the end of every 10 years. More frequent review will not be able to show results.

Specialities and Superspecialities : "With the dominant influence of western medicine, there has been a fragmentation of basic art of healing into specialities and superspecialities". In an earlier section (4.1.3) it is stated that "The order of the day is production of a well groomed specialist. The order of tomorrow will soon lead to an era of super specialists". It is not clear as to what is wanted.

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Eligibility for admission : Nothing is mentioned about eligibility. Are the presently agreed criteria sufficient to ensure "care, compassion and concern"?

(C.M.Francis, SMH, Bangalore).

RESPONSE IV

I find Bajaj's report talking of high ideals without indicating how to go about. In any opinion, direction of right perspective and strategy to implement the ideals have to be spelt out simultaneously. The high set goals should not look like hanging in vaccum beyond the comprehension.

The Bajaj report is tight-lipped about the minimum structural changes which may be obligatory to achieve the goals. It discusses inculcating attitudinal change and social commitment without suggesting how can it be brought about.

The report does not talk about minimum resources required and their distribution as per priority need. It is silent about privatisation in health care and medical education and how to restrain this cult. It has imagined vertical planning and does not mention need of empowering people for a pro-people medical education and health delivery system. It does not spell out how can alternative medical education evolve during implementation of pro-people health care delivery system.

I suggest the following for consideration in the Community health trainer's dialogue - - -

* In the present structure, medical science teaching institutes and public health institutions (hospitals and health delivery structure) are run parallel and independent of each other.

  The two institutions need to merge together with authority and responsibility be shouldered by medical science teaching institutions i.e., medical colleges, nursing schools, para medical schools etc. Each teacher of medical science teaching institutes be made responsible to provide primary health care services to the defined population.

* . Every graduate and post-graduate from medical science teaching institutions should work for say 5 years in state health care services before awarding degree or licence to practice.

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* The over-all control of such institutions must be decentralised to the extent possible. I suggest it to be shouldered by a governing public body comprising a nominated member from each village council (Gram-Sabha) or Municipal Ward.

The financial resources of educational institutes and public hospitals serving a defined area be channelised through governing public body.

The planning be decentralised and be shouldered by intellectuals nominated by governing public body.

The evaluation of work performance of village based staff should rest with Gram-Sabha and that of central institutional staff (college, schools, hospitals) with the governing public body by co-opting experts.

(Ulhas Jaju, MGIMS, Sevagram)

RESPONSE V

The impression one gathers is that it is all due to lack of emphasis on newer educational technology - pedogogical jargon most of it - that has stood in the way of preparing our medical professionals adequately in this country. There is hardly any pointed reference to the lack of social awareness - orientation and commitment on the part of the teaching faculty and policy planners which I think is the most glaring lacuna in this document. There is of course no serious effort to look at the rural realities and the gross inadequacies and imbalances within the health system. There ought to be atleast some guidelines and directions as to how this could be corrected. Not certainly by making our health system and the structure more complicated through the dumping in of more specialists and super-specialists in the scenario and putting all of these under the protective, over-arching umbrella of a new commission.

(George Joseph, Council for Healing Ministry, Madras).

RESPONSE VI

Major drawback of the policy is that it sees medical profession as a static career eternally fixed at a particular level and type of performance suitable to the community needs. However in reality the

professional aspires for career mobility, as long as he has freedom of choice. Hence any system of education planned which does not consider career planning of the individual pupil will automatically fail because of the inherent conflict of interests as has been in medical education in India.

Some other areas policy statements are vague:

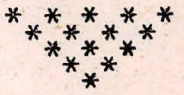
i) India may have a rich heritage of medical sciences but unfortunate none of these systems were researched or developed systematically till now.

ii) The lack of concern for other categories of health workers and over emphasis on medical manpower has been attributed to 'medical bias' in the planning process. Is it so? Or was it because medical colleges made good business sense?

iii) Inadequate efforts to facilitate acquisition of skills by teachers that would facilitate self directed learning is also because most of Indian education uses rote learning methods than skill learning and it is difficult to change over.

iv) The definition of the basic doctor in 4.1.1 is quite idealistic but unrealistic.

(M.J.Thomas, Bangalore).



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Background Paper - IV

Community Health Trainers Dialogue

October 1991

OVERCOMING NEBULOUS THINKING AND ACTION ON MEDICAL EDUCATION IN INDIA

Debabar Banerji*

June 24, 1991

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* Professor, Centre of Social Medicine & Community Health, School of Social Sciences, Jawaharlal Nehru University, New Delhi - 110 067.

Overcoming Nebulous Thinking And Action On Medical Education In India

Foundation of Practice of Medicine

Admittedly, human beings anywhere in the world have almost the same anatomical configurations, physiological activities and pharmacological responses. Disease causative agents cause similar pathological changes in them and they have responses to therapeutic interventions. However, it is important to note that these elements of medical sciences are used under different conditions in different communities. In any case, they form only a small component of the practice of Western medicine. They are merely the bricks of edifices that are built under different conditions. In terms of other components of practice of Western medicine, there are many fundamental differences between Western industrialized countries (i.e. the North) and the Third World (i.e. the South). The North and the South are indeed poles apart in the practice of Western medicine. Performance of a delicate heart operation by a pediatric surgeon in a sophisticated hospital in an affluent country and treatment of a severe case of diarrhoea in a child by oral rehydration by the mother in a remote hamlet in the Himalaya's underline extreme variations in the practice of Western medicine.

The difference in these two models of practice of Western medicine is in the terms of: (a) relevance of different elements of medical sciences; (b) formation of technologies that embody those elements of medical sciences; and, (c) organisation and management of the health services for the "delivery" of the chosen technology. Interplay of the complex factors associated with the prevailing ecological setting, epidemiological situations and cultural, social, political and economic conditions have brought about these major differences in the two models.

Health service development in a country like India should, therefore, be studied in terms of the cultural response to the complex process, referred to above. This response generates: (a) cultural perception of health hazards and their cultural

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meaning; (b) health behaviour; and (c) various forms of health technologies, practitioners and institutions, through cultural innovation, cultural diffusion and/or through purposive intervention from outside agencies. Thus, this complex process forms the foundation or the base on which the health service system of a country is built. The complex conditions forming the base determine the shape of the health service system or the superstructure and its subsequent growth and development. The base thus places a constraint on the architecture of the edifice that can be built on it.

The task before socially sensitive community health physicians in India is to become architects who have the competence to understand the basal (i.e., concerning the base or the 'infrastructure') conditions, both at a given time and in a time dimension, and use such understanding to build a superstructure which can maximise the alleviation of suffering due to health hazards, again both at a given time and in a time dimension. It may be noted that production of architects is itself a function of the dynamic interactions within the base. When there is a strong democratic movement within a socio-political system, it is conducive to the formation of more competent socially sensitive community health physicians and in larger numbers.

Sometimes, as a result of the struggle of the masses, the basal conditions may be favourable to building a stronger edifice for a people-oriented health service system; the reverse may be the case on other occasions. It may be emphasised that favourable basal conditions do not automatically lead to the formation of a stronger superstructure. A society would need a balanced team of architects, engineers, masons and other workers to take full advantage of the favourable basal conditions. The onus for attaining this balance is on the political leaders.

Efforts Towards Social Orientation

One of the significant aspects of development of medical education in India is that even before attainment of independence, both the colonial rulers as well as the leaders of the National Movement were conscious of the need for adopting a different approach in the context of the entirely different conditions prevailing in

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India. The concern of the leaders of the National Movement were expressed in the report of the National Health Sub-committee of the National Planning Committee (1948) of the India National Congress (Sokhey Committee). The Bhore Committee (GOI 1946), which was constituted subsequently, was much more forthright on this subject. It had very carefully discussed the central question of abolition of the licenciate programme. One of the major arguements of the majority of the members for abolition of that programme was that they visualised fundamental changes in medical education to create what they had termed as a "Social Physician". The Bhore Committee had observed (GOI 1946 : 18) that the physician of to-morrow must be:

> a scientist and social worker, ready to cooperate in teamwork, in close touch with the people he disinterestedly serves, a friend and leader he directs all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down, the social physician protecting the people and the guiding them to a healthier and happier life.....
>
> A health organisation enriched by the spirit of such a medical profession will naturally work towards the promotion of the closest cooperation of the people. It will recognise that an informed public opinion is the only foundation on which the superstructure of national health can safely be built.

The inter-linkage of the National Movement and thinking on re-orientation of medical education is a very significant phenomenon. Indeed, this has given quite a distinctive perspective to the approach to medical education in India.

As early as in the mid-fifties, India had taken the bold step to bring about fundamental changes in the approach to medical education, with the upgraded departments of preventive and social medicine, expected to play the pivotal role. Subsequently, a number of commissions have sat and a number of national conferences have been held to stimulate this process.

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Taking note of past experience, the Group of Medical Education and Support Manpower (Shrivastav Committee) (GOI 1975), which examined medical education in the context of the reorganised health services, submitted in April 1975 a programme for immediate action. Against a background of the need (a) to relate the problem of health to poverty; (b) to provide training in health services to community representatives; (c) to strengthen primary health centres; and (d) to develop a referral service complex, the Group made many far-reaching recommendations concerning the basic content, structure and process of medical education. Essentially, the group was for the creation, by an Act of Parliament, of a Medical and Health Education Commission (patterned on the University Grants Commission) charged with the responsibility of determining and implementing a radical programme of reform in medical and health education, and with functioning as an apex coordinating agency in close and effective collaboration with the statutory national councils of health professions.

The Shrivastav Committee emphasised the need for in-depth discussions and taking of concrete steps for "immediate", vigorous and sustained implementation" in tackling important issues. These included: determining of objective of undergraduate medical education; giving it a positive orientation; reorganising pre-medical education, revising the undergraduate curriculum, including training of teachers; production of teaching and learning materials; adopting suitable teaching and evaluation methods and creating necessary physical facilities; reducing the duration of the course while ensuring improved standards; reorganising the internship programme, postgraduate teaching and research and continuing education; and, research and evaluation of health manpower needs.

The report of the Group was favourably received by the Government of India which called yet another nationwide conference of heads of medical colleges to work out details for implementing atleast some of the recommendations. The ICSSR-ICMR report, Health for All: An Alternative Strategy, further reinforced the Group's recommendations (ICSSR-ICMR, 1981). The working Group of the Planning Commission set up to work out a detailed strategy for attaining Health For All by A.D. 2000, reiterated the need for

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radical transformation (GOI 1981a).

These efforts are reflected in the Sixth Five Year Plan (GOI 1981b) which states that the "emphasis would be on bringing about qualitative improvement in medical education and training" which should include, at the undergraduate level, six months of compulsory internship and modifications in curriculum, training of medical undergraduates in certain fields relevant to the problems of rural health care, community orientation, etc., and encouraging private doctors to settle in rural areas through various incentives". Flowing from the ideas in the Sixth Plan, the Government of India (1983) had asserted that post-graduate education would be rationalised to effect a balance between the national requirements of specialisations and opportunities for medical graduates for advanced study. Continuing education and inservice training would be promoted. Medical research would be directed towards several problem areas like bio-medical and public health problems, particularly communicable diseases, the economic aspects of health administration and management, etc. Among the task-oriented research programmes for achieving the above objectives, would be "close and continuous studies in the area of information support, manpower development, appropriate technology, management and community involvement to ensure the reach of benefits of primary health care programmes to the rural population" (GOI 1983 : 53).

The report of the consultative group of the National Education Policy in Health Sciences (1989) is the latest document in the series. Even though it had the benefit of the hindsight of the earlier reports, it contrasts very sharply even in the process of analysis of issues, in drawing inferences and in making recommendations. It marks a new low in the quality of study of medical education in India.

Health Services, Health Manpower Development and Medical Education

One of the most significant requirements for strengthening medical education in any country is to consider it as a part of the overall approach to policies and programmes for Health Manpower Development (HMD) (WHO 1985). It is not possible to consider undergraduate medical education in isolation. It has to be seen in the background of post-graduate medical education, including education

and training of physicians and other personnel for community health work, in terms of nursing education, education for public health engineers, social scientists, health educators, communication specialists, and so forth. In turn, HMD can not be visualised without having a clear understanding of the overall health service system. Again, a health service system has to be developed on the basis of data derived from carefully conducted health systems research. Therefore, research for HMD can only be conducted in the context of Health Service Research for Manpower Development (HSMD) (Fulop and Roemer 1982).

It is not always possible to work under ideal conditions. If one has to consider medical education without having enough information concerning health manpower development and/or the health service system, it is essential to have atleast a broad understanding of the structure of the health service system and the approaches to develop other components of the required health manpower.

Even with a very broad understanding of the conditions, it becomes quite clear that defining the content of medical education is a crucial issue in medical education in India. If the contents are not defined adequately, all the other activities in the field of medical education lose a great deal of their relevance. This is because in a country like India it is totally unacceptable to interpolate the contents that have been developed in the context of the affluent Western countries. The onus for bringing about social orientation of the practice of clinical medicine and public health in India rests squarely on scholars of this country. It is in this area that medical education in India had suffered most. Even when very well researched ideas have been developed to give a different content to medical education in India, that has not been followed by the authorities concerned. This active resistance of the authorities to bring about a social orientation of the content of medical education in India is rooted in the power relations emanating from the social structure and is by far the most critical problem facing this field. The Shrivastava Committee had raised the question of content or curriculum. However, it has not realised adequately how critical this issues is in itself and in giving shape to the other elements of medical education, which are discussed below.

The consequence of the active reluctance to change the content is

that the teachers by an large have alienated themselves from the actual requirements for the making of Social Physicians visualised by the Bhore Committee. Over and above, there are very serious problems of having infrastructural facilities for providing medical education. An extreme example of almost a mockery of medical education is to be found in the establishment of the so called capitation fee medical colleges in the country. That despite their very poor infrastructure, politicians have not taken steps to curb the mushrooming of this type of medical colleges is a reflection of the socio-cultural and political conditions prevailing in the country. Weaknesses in the infrastructure is reflected in providing the so called rural exposure to the students. Unfortunately, by rural exposure it is usually meant to take students to rural areas where teachers of the medical colleges teach them about rural health. What has been the basis of the teacher's teaching about rural health? What has been the competence of the teachers to do that? What efforts have been made to develop the content of rural health teaching? Such crucial questions are seldom asked. Because of these limitations it is not surprising that the much acclaimed Rural Orientation of Medical Education (ROME) has failed so consipicuously. The same applies to the experience of involvement of social scientists in medical education.

The problems in medical education that are being seen today ought not to have been so serious had the institutions which had been specifically developed for strengthening medical education had satisfactorily performed the functions assigned to them. One example is that of the All India Institute of Medical Sciences (AIIMS) in New Delhi. One of the key mandates of the AIIMS has been to provide leadership in medical education to the country as a whole. Development of the discipline of preventive and social medicine was an integral part of that mandate. AIIMS has fallen far short of that mandate. Similarly, there has been the Indian Association for Advancement of Medical Education. They have made some brave efforts. However, these efforts were seldom followed up in the form of specific action programmes. The idea of having separate medical universities is being tried out in states like Andhra Pradesh and Tamilnadu. These Universities have not yet come out with any new directions for action. As pointed out earlier, the Consultative Group of National Education Policy in

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Health Sciences is the latest in this series. An analysis of the process of thinking which formed the bases of the recommendations and actions of these institutions will reveal the reasons why they could make so little contributions.

Crisis in the Medical Profession

One very unfortunate outcome of the present state of medical education in India has been the nature of socialisation of the students who go through the process of education. It is indeed difficult to imagine that the graduates who come out of medical colleges, and who join various services or undertake private practice, indeed belonged to the cream of the society at the time when they had entered medical colleges. It is a severe indictment of the system of medical education in India that it "converts" some of the brightest students of the country into such dull and unimaginative groups of the physicians, after they complete their education. As if that is not enough, they receive a very raw deal if they happen to join the health services in the union and state governments, when compared to, say, those belonging to the IAS. The product that are seen, say, 10 years after their graduation most often bears almost no resemblance to the bright young boys and girls who had been chosen for entrance into medical colleges. This sums up the real crisis in medical education and the medical profession (Banerji 1989). This needs to be attended to urgently.

The Shrivastva Committee has described the situation in the following words (GOI 1975: 38-39):

> It is widely recognised that the present system of undergraduate medical education is far from satisfactory. Despite the recommendations made by numerous Committees and Conferences, improvements in the quality and relevance of medical education have been tardy. Although the setting up of Department of Preventive and Social Medicine in the medical colleges over 15 years ago was a step in the right direction, this by itself has not met with significant success as it lacked scholarly foundations and the field practice areas have not

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been adequately prepared. The stranglehold of the inherited system of medical education, the exclusive orientation towards the teaching hospital (five years and three months out the five years and six months of the total period of medical education being spent within the setting of the teaching hospital), the irrelevance of the training to the health needs of the community, the increasing trend towards specialisation and acquisition of post-graduate degrees, the lack of incentives and adequate recognition for work within rural communities and the attractions of the export market for medical manpower are some of the factors which can be identified as being responsible for the present day aloofness of medicine from the basic health needs of our people".

Reporting four years later, the ICSSR-ICMR Study Group (ICSSR-ICMR, 1981: 156-59) did not find the situation any better:

"In spite of all expansion, doctors are still largely urban-based; and their distribution between different States is uneven. Standards have improved in some institutions and some sectors, but the average has declined considerably because of the proliferation of sub-standard institutions. The medical education system and the health care delivery system have each gone their separate ways. There is little congruence between the role of the physician and the needs of society, little equilibrium between medical education and health care. Medicine is still regarded essentially as an enterprise of science and technology; the physician is the repository of all knowledge and dispensations; specialisation is the hallmark of progress; and the training ground is the teaching hospital. Recent efforts to change this unhappy situation, to produce the 'right' kind of doctor and to give a community orientation to medical education, have yet to make any meaningful impact".

Conclusion

The field of medical education reflects the paradox that exists in

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many other fields of socio-economic development in the country. Gunnar Myrdal had long back labelled this paradox as a "soft state" -high on rhetoric and low in implementation. It may, however, be noted that the very fact that the leadership had to take to rhetoric shows that there are pressures from the people which impel them at least to talk about social issues; there are so many countries which do not even have the rhetoric.

The critical need to bring about social orientation was being talked about by the political leadership well before India attained independence. Active steps were taken to bring about the needed changes about four decades back. However, these efforts did not bear fruits. On the contrary, the political leadership and the leaders of the medical profession have not been successful in preventing the steep decline in almost every aspect of medical education. The profession has failed even to diagnose the malady. The result is a plethora of prescriptions mainly focussing on isolated symptoms. There is little scientific efforts at a holistic conceptualisation of medical education as a complex interdisciplinary system, which, in turn, is a subsystem of the wider health manpower development. Again, health manpower development must be based on a scientific approach to health service development to meet the health needs of the people of the country. Seen against this background, the approach adopted by some key studies of medical education is nothing short of quackery. For instance, the Shrivastava Committee and the ICSSR-ICMR Working Group had advocated the setting up of a Medical Education Commission on the lines of the University Grants Commission (UGC) as a keystone of their recommendations. If they have studied the role of the UGC in relation to strengthening higher education in India, they would have been at least a little less euphoric about their recommendations. The analysis and the recommendations of the J.S. Bajaj Consultative Group provide an even more disturbing example of poor quality of thinking among top level medical educators of the country. This shows how deep is the malady that is afflicting medical education in India to-day and how urgent it is to have a critical mass of scholars who are capable of developing a more holistic and a more scientific approach to this very important problem.

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Summary report of the workshop on 'Trainers Dialogue' held at NIMHANS, Bangalore on 13th & 14th October, 1988

The 'Trainers Dialogue' at Bangalore started with a welcome address from the Dean & Professor of Psychiatry of National Institute of Mental Health & Neuro Sciences, Neuro Surgery, Dr. S.M. Channabasavanna. He shared the training programme of the Institute and told the participants how the staff is involved in the training of Community Health workers in relation to Mental Health, that was till today a neglected and weak-link in the training of all health functionaries. They also organised training of multipurpose workers and medical officers of Primary Health centres.

After the introduction of twenty two participants gathered there from different organisations (list is attached in Appendix), Dr. Amla Rama Rao explained the objectives and purpose of this dialogue. She said that this is the first time Community Health trainers are meeting and entering into a dialogue at one place where not only voluntary organisations, but also the govt. health functionaries are involved. The main purpose of the workshop was to find out about the training programmes and to share the facilities and type of courses that are being run by each organisation. If time permits, the group might look into the type of training material available but would also like to discuss important issues pertaining to health training in general.

Dr. Ravi Narain, as a result of 'Brain Storming' brought out the following important issues concerning health training programmes.

a. Type of courses
b. Course contents
c. Curriculum planning
d. Selection of students

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e. Motivation of students

f. Relevance of course and needs

g. Govt. & NGO participation in training programme

h. Planning process in training - tasks analysis, writing of learning objectives

i. Evaluation of training programme.

j. Trainers' training programme

k. Net-working mechanism with clear objectives.

Each participants started sharing their experiences keeping these issues in mind and most of the time one issue was related to the other and as such, a lot more was discussed during the day.

As a result of day's deliberations, the whole group had decided that there is a need for networking. On 14th morning the group divided itself into two and started working on objectives and mechanism of the Network. As an outcome of their recommendations the following was suggested:

Objectives:

1. to collect information on various types of training programmes in health in the country, both govt. and non-govt.

2. to store the information and disseminate to other network members.

3. to conduct seminars and workshops relevant to the needs of trainers.

4. to help identify, strengths and weaknesses of existing training programmes of the members for the purpose of self-appraisal.

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5. to develop a long term strategy for networking.

6. to influence the govt. on policies of training in health field.

Mechanism of Networking:

The group considered VHAI to take responsibility for dissemination of information through five regional centres, North, South, East, West and Centre.

RUSHA from South, & CHETNA from West, volunteered to do that. CINI was suggested to work as a regional resource centre for East but Regional centre for North & Centre was yet to be identified.

VHAI was made responsible to develop minimum requirement for various types of training programmes that are conducted, with their strengths and weaknesses and how each programme must be assessed on these basis. May be this can be used as a guideline for self assessments or for peer evaluation, for further improvement of the programme.

Regional resource centre will take the responsibility of collection of information from individual network members, and listing their resources including human and material and the type of training programmes run by them.

VHAI should also take a lead in identifying training institution and help others to become a part of the network.

After some discussion on recognition of courses by the govt. or universities, it was considered not important, but the group felt that their should a national level umbrella to offer recognition to all courses. With the result, the standardisation of training course at different level must be considered seriously.

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It was suggested that:

a. A column in 'HFM' magazine of VHAI can be spared in each issue for Community Health trainers' Network news, it would be a good start.

b. Members of the network could advertise their training courses through 'HFM'.

c. Certain issues that need to be discussed pertaining the training should become a regular feature of HFM.

d. VHAI should also be able to review various training material available and assign what is needed to various regional centres.

e. VHAI should organise a meeting every year for Network members.

The action, responsibility and programme plan was prepared with the help of the group(copy attached).

The meeting ended with reading out the summary of the recommendations of the two groups. The Dean joined the participants for an informal get-together at lunch and was also present in the veledictory function.

The meeting ended with thanks giving to all the participants, organisers, director and staff of NIMHANS by Dr. Dara, Hony. Secretary, Voluntary Health Association of Karnataka.

DR. AMLA RAMA RAO.

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24.10.1988

THE PROGRAMME PLANNING

ACTION	RESPONSIBILITY	DATE
Preparation of report for collection of information.	VHAI	End of October, 88.
Getting feed back from members organisations.	Members network	by November 15, 88.
Draft of Directory of the Regional resource persons	VHAI	by January 1, 89.
Evaluation of training programme - an article for HFM for April issue.	Nandita - Pachod.	first week of March, 1989.
Collection of Bibliography and other training material from Network members.	Regional resource centre.	by February 15, 89.
Compilation and circulation of the material.	VHAI	by March, 1989.

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THE DEVELOPMENT WORKER AND THE PEOPLE

1. THE MEANING OF HELP:

One can safely assume that a voluntary organisation is primarily in the field to help the beneficiary. The word beneficiary itself speaks of a person who is helped. Therefore, the relationship between the voluntary organisation and the beneficiary will be one of helper and helped. In this relationship two different parties which often have very little in common are brought together by a magic word: "help". When this word is understood in exactly the same way at both the conscious and the unconscious level, by both the giver and the receiver the likelihood of misunderstanding between the voluntary organisations and the beneficiaries are minimal. But, unfortunately, this is not always the case.

For the beneficiary help was a very narrow meaning. In the lives of poor people, there is always one thing which needs urgent solution; to pay back a debt, to find employment, a well in the fields. This is his need. Help means to take care of that need. Any talk on something else is just words, words, words!

For the voluntary organisation on the other hand, help is very likely to be understood in a very different manner, and in different ways depending on the main aim of the organisation. Thus, if the main aim of the VO is education, then the help which the beneficiary needs will be understood to be education; but his main need will change to curative medicine, housing, agriculture, lift irrigation, control of rodents or road building depending on what is the voluntary organisation's main area of activity.

In short, help may mean one thing to the voluntary organisation and a very different one to the beneficiary, giving rise to a misunderstanding. Indeed, the very first question, that a voluntary organisation should ask itself is this: "If help has to be given in answer to a need, whose need does it answer the help which I give?" Sometimes our needs meet: the patient needs the doctor as much as the doctor needs the patient ! But sometimes the doctor may need the patient more than the patient needs him; in which case, the doctor may feel tempted to protract the illness of the patient. In other and clearer words, the need of the voluntary organisation or its personnel is made to be the need of the people. Or, in other words, the former project their needs on the latter. This projection can be of either institutional or personal needs. Let us explain each separately.

2. PROJECTION OF PERSONAL NEEDS :

The distinction between personal and institutional needs takes cognizance of the fact that the personnel manning the voluntary organisation may have needs different from those of the institution he serves. Now these personal needs may work against the beneficiary. To clarify this point, let us take a hypothetical example where the voluntary organisation aims to help the beneficiary precisely where he wants to be helped. The example: A voluntary organisation well aware that there is lot of unemployment and eager to solve the problem sets out to help the beneficiary by setting up a milk-producers' Cooperative on the understanding that the scheme will provide additional employment and income. The organisation provides the initial loan, the managerial and animal husbandry know-how and even helps in buying the buffaloes: The result is a magnificient cooperative. The cooperative is so successful that people from all over the country come to see it; even international organisations take interest in it. The voluntary workers feel nice. The cooperative helps so many people that the local politicians begin to court its managers. The voluntary worker feels powerful. The cooperative now becomes an end in itself. It did satisfy the first need of the beneficiary. But the cooperative is subsequently made to serve the personal needs of the so-called people's helpers. The cooperative which could have helped the beneficiary first to achieve economic independence, then competence in animal husbandry and finally managerial skills to run the cooperative himself, stops short of these lofty goals. All this, of course, in the name of the people and their true welfare. Because, it is agreed, if the management is given over to beneficiary, the cooperative will soon end up in corruption and mismanagement. Those who so speak might not have been able to answer an entirely different question; "If I give power to the people where am I?"

Here the personal needs of the voluntary worker stand in the way to the true development of the beneficiary. The need for power, the need "to feel needed", the need to father-or mother people are all examples of such personal needs.

From the above some may draw the conclusion that development work demands so much detachment, as to be beyond the possibility of ordinary human beings. This is not true. Development work does not ask for mahatmas or saints; All that it asks for is enlightened self-interest. Let us see how: To begin with, it is important to stress that no personal need is bad in itself; therefore, nobody should be ashamed of having such needs are motives. Secondly, it is very important that these needs be accepted by the person in question and by his organisation. Needs which are denied by

and his organisation must find out creative ways of dealing with those needs. A creative way is that which satisfies the personal needs without harming the client. Thus, in the above mentioned example withdrawing in time will not decrease but increase the prestige of the voluntary organisation and its personnel. And, by replicating the model somewhere else, personal power, far from being lessened, is greatly enhanced.

The only difficulty in the whole exercise is that the person in question requires personal courage to accept one's own needs to oneself and to others. One requires self-confidence to believe that what has been done here can be replicated somewhere else. Personal courage, self-confidence: are not these great "developmental" needs of every individual? Here is the great paradox of life: "The more we give, the more we receive". "Acceptance of the developmental needs of our clianted leads to our own personal growth". A person need not be a great man to do development work; but he may very well end up by being one if he does it in a professional manner. For, if development work demands from us self discipline and detachment so does personal growth and emotional maturity. This may not be perceived by voluntary workers because they, like the beneficiaries at another level, are so blinded by their immediate needs that they forget their long-term interests. Development work may bring about this awareness.

3. INSTITUTIONAL NEEDS PROJECTED ON THE BENEFICIARY :

The above example has taken for granted that sometimes, the professed need of the organisation and the felt need of the beneficiary can meet. But unfortunately that is not always that case. Sometimes they differ, in which case the likelihood is that the voluntary organisation may project its needs on the beneficiary.

Here again is a hypothetical example of an organisation which specialises in slum clearance. Food, clothing and housing are understood to be three of the basic needs of man. In a city lack of decent house is seen by the affluent society as a crying need which demands urgent solution. And so an organisation has been set up to take care of this need. A number of rich and well-meaning citizens offer their money. Government and international agencies see it as their duty to help in the venture. And so the new organisation goes to a slum. What is the help the slum dwellers need? For one set of persons atleast there is no doubt - what these people needs is a good housing scheme.

Now the chances are that housing is a need which is very low in the slum dwellers' list of priorities. In which case help (the satisfaction of their needs) will be understood differently by the beneficiary and the

Let us now examine the possible situations which this misunderstanding may give rise to. A voluntary worker goes to a slum to meet the people. There they are: he and they, rich and poor. After the first initial misunderstandings they begin to receive a clear message: "He wants to help them". But they need money or employment and he offers them housing. Some of them say: "We don't want anything to do with him". Others cleverer say: "He is rich, he has influence. We do not want a house. But it may very well be that if we accept it we shall secure what we want". The others see reason in this and now all agree to go along with him.

This situation has all the elements of a bargain. Briefly: there is a party(a voluntary organisation) which has a need to set up a housing scheme. There is another party(the beneficiary) which needs, let us say money. In this situation how does the latter see the former and its project?

1. The beneficiary may look at the organisation as something he needs. In which case the project will be seen as something to be done in order to preserve the organisation's services.

The project then becomes the tribute the beneficiary has to pay to the voluntary organisation. A tribute is always paid reluctantly. No wonder if the project is sabotaged in more or less subtle ways. For example, the houses may be sublet or sold and the people may revert to the slums.

2. The beneficiaries may not see the voluntary organisation as indispensable; but they may see the project as means to achieve their aims In this case, the project becomes the handle which can be used to manipulate "them". "They have plenty of resources. We need money. The need a housing project. We give it to them. Let them now give us money". OR "This project must be giving plenty of money to "them". Now we also cooperate in it. Therefore, we should also share in the spoils".

In this situation, the beneficiary feels that a tough bargaining is ahead; and, therefore, he is likely to adopt the usual bargaining tactics. Secrecy will be one of them "One does not show one's cards". Indeed he may even try to mislead the voluntary organisation. And, of course, in every bargain the stakes must always be kept high.

In the process the slum dwellers keep on looking at the voluntary organisation as the other bargaining party. All its moves will be interpreted in this light: "How do the voluntary workers play their cards?"

1. They may be very soft towards the beneficiary, in which case the letter is likely to interpret this attitude in three possible ways: (i) That the former are stupid, and there-fore, have no credibility,

2. If the voluntary organisation is seen as a very hard bargainer he is likely to see it as an improved replica of the local money-lender Zamindar. This means that the relations between him and the voluntary organisation will be patterned very much along the well known relationship of money-lender and the poor.

3. There is, of course, a third possibility i.e. when the voluntary workers turn the whole situation into a learning one. More will be said about this later.

This attitude of the people may trigger off similar reactions among the voluntary workers. Thus, they may brand the beneficiary as a cheater, as a lazy person or ignorant, or any other adjective to describe a situation which they see as unreasonable. If that be the case, the relationship between them and the beneficiary becomes vitiated.

4. THE NEED OF DIALOGUE:

The important thing in all the possible situation described so far is that the relationship established between the people and the voluntary organisation is not a sound one, simply because it is based on either a misunderstanding (in the case of help being understood differently) or in attitudes which are not authentic when the voluntary worker's avowed aim is one and his real motivation is another.

When such a relationship exists, it is evident that no dialogue is possible because no real communication has been established. Therefore, growth does not take place. And who can deny that growth may be required sometimes by the beneficiaries, sometimes by the voluntary organisations and sometimes by both? In development work it is first the duty of the voluntary workers to grow by making sure that they are not acting out their personal or institutional needs on the people. One way to do it may be self examination and another way is to start a dialogue with the people in order to understand them better and also to make themselves better understood by the people. Whatever may be our shortcomings the people have a way of teaching us and correcting us which is wonderful, if we only listen to them

The beneficiary in this case must be made aware that his need is only part of a bigger reality, and that no affective means can be taken to solve their felt needs unless the totality of the situation is taken into consideration. An example will help to illustrate this point.

A Voluntary organisation working in a village, studies the situation and comes to this conclusion: the expenditure of the beneficiaries is higher than their income and consequently the people are indebted. A study of their expenditure reveals that not enough is spent on the necessaries of life, food, clothing, housing and agriculture, while too much is spent on social customs, medical bills and uneconomic borrowing. Since they are so hard for money they are forced to accept loans on adverse terms. Again, since they don't have money to buy they must take on credit paying double. The amount of money paid on interest is higher than the original amont of money borrowed.

A study of their income reveals that their income from agriculture is too low because their methods of cultivation are too primitive and because not enough is invested in their fields.

The beneficiaries are haunted by the money lenders and have an unavoidable need of cash. If the organisation gives them money, it knows too well that it is helping to perpetuate a system. If the voluntary worker, ignoring the beneficiary's needs, tries to push, say an agricultural improvement programme, than he is facing a sure failure, since the beneficiaries are not likely to give their full-hearted cooperation to something which they consider irrelevant to their present needs.

There is only one way out and that is a true dialogue where the voluntary organisation keeps on relating the beneficiaries' need to the totality of the situation. Education is anotherword for this dialogue.

On the other hand, this dialogue is not as easy as it may appear, It requires from the organisation's personnel professional skills; (i) The ability to listen to the people and understand not only their words but the real meaning

(iii) Knowledge of the wider reality viz., that of the whole country (and of the world at large) of which situation is only a part.

It requires also certain inner attitude without which those skills will not be put to good use:

1. Self-confidence: to face the seduction, opposition and indifference of the beneficiaries without either being trapped or feeling personally threatened.

2. Authenticity and courage to ownup one's needs and motivation.

3. Faith in the people: If voluntary workers lack this faith no meaningful dialogue is possible with the beneficiaries and no real education will take place. Indeed the chances are that the voluntary organisation will eventually work against the long term interest of the beneficiary. If the social workers believe that the beneficiary cannot take care of himself, evidently they will never work towards an eventual stage where he becomes self-reliant. If they do not believe that he can learn they will not even try educating him, or, if they do they will unconsciously undo what they are professedly doing Let, on the other hand, the voluntary organisation have on the people and that faith will be communicated to them. If the voluntary workers fail they will attribute the failure not to the beneficiary but to their approach or methodology their imperfect understanding of the situation and the people. In other words, when there is faith, failure makes the voluntary organisation search. When there is no faith failure makes the voluntary organisation blame the beneficiary.

Faith in the people can be said, without fear or exaggerting, to be most important virtue of all those required by development workers.

Much is being said in development literature about dependence and ofter it is assumed that social or developmental work leads unavoidably to a state of dependence. That this happen often is evidently true. Taht this is in the nature of things is not so clear. Faith in the people and courage to

foster in the people, the attitudes and skills required to become self-reliant at an early stage.

5. THE NEED OF PROFESSIONALS:

This paper assumes that development work may be of many types and it claims that all of them establish a specific relationship with the beneficiaries which requires very definite skills and attitudes. In other words, development work requires professionals: people who have mastered their own discipline be it agriculture, medicine, economics or engineering and at the same time have acquired the skills required to effectively dialogue with the people. And development workers like all professionals must have their own code of conduct based on the inner attitudes which have been mentioned earlier. Development work, like education, like medicine or education demands a certain dedication and a code of conduct. When a person possesses them, he is a good professional. Unfortunately, little is done to create a cadre of professionals in the field of development work -- even though its need is so keenly felt by everybody. This cadre has, of course, been developed by government and all government related agencies. There are other examples like the National Dairy Development Board which in its effort to create Milk Producers' Cooperative of the Anand type, has set up its own group of professional cooperative men. But this is not the rule with voluntary agencies.

To create a body of professionals in this field two things are required. 1) Professional salaries should be offered to prospective candidates, and 2) Institutional support must be provided which will guarantee permanence in service. There are many organisations (National and international) which make material resources available for development. They are ready to pour their money in buildings, equipment, digging wells, offering food for work, procuring loans, etc. etc. But how many agencies are ready to create the only thing which will make all these projects successful-honest and competent development workers? If my experience is an indication, then there are practically none. For some time I found it almost impossible to secure money to pay salaries.

It is difficult to have competent people working for a task which is hard in itself. But, if on top of this, they are not sure of a professional salary, or if that salary can be offered only for the duration of short project; is there any likelihood of creating the desired cadre? Without it, the development work carried out by voluntary organisations is left either to amateurs or to that select band of exceptional people who are ready to work at a great personal sacrifice. The task ahead of us is so great that it is shortsighted to depend only on exceptional people. A wider not must be cast to draw into this work all the honest and competent people available.

India has at present a great number of unemployed graduates who could be utilised for development work. There are better trained people whose training and creativity are wasted away in routine jobs which can provide no challenge to them and consequently give them no satisfaction. But the security offered by Banks or Government (in a country where employment is such a big problem) will not allow them to accept a better paid and more challenging job at the risk of that security.

Even apart from the employment problem there is special difficulty in India to find people who are ready to do development work. This work usually entails working with the lower castes and the poor people. Given the caste system prevailing in the country, many people have still ingrained prejudices against the lower castes. It is not easy to overcome this prejudice. Even religions, like Islam and Christianity which in principle uphold the equality of all men, have, in practice fallen prey to caste prejudice. An individual may overcome them and still he may succumb to the pressure of his relatives and friends demanding him to either uphold the values of the caste system or at least, to conform externally to them. Hence the difficulty of finding people who are really committed to social change. Now when financial insecurity is added to the difficulty, specially when it is question of giving up a secure job, the chances of creating a cadre of professional men are very small indeed.

One of the objectives of this National Work-shop on Rural Development is "to evolve a more effective strategy for the mobilization of people and the resources in the struggle against poverty and injustice". The above consideration have been submitted having this objective in mind.

6. THE NEED OF PROFESSIONAL TRAINING:

One often hears complaints about the shortcomings of the people working for development. To point out defects is the first step to remedy a situation; but it is not enough. One must study the causes leading to such a situation. This paper has already suggested the first step towards better development work -- the professionalisation of its services by creating those conditions which will make it possible to recruit people who are both competent and comitted.

There remains one question to be answered: are there such people available in the country. The answer, unfortunately, is negative. Dr. Kurien of the National Dairy Development Board has been forced to plan his own training services to provide his cooperatives with competent personnel.

While much of the theory needed in development work is given at the various schools of social work, theory alone is not enough. And indeed the same theory may mean one thing when given within one value system and it may mean something quite different when the values held are different. In any case, theory alone does not bring about committment. The latter is the product of the values one upholds. And, unfortunately, the values prevalent in our universities are not likely to promote the right attitudes towards development work. To be more specific: mention can be made of those values which lead people to believe that teaching is more important than learning; that city people are better than their rural counterparts; that money and power are the standards of success of life; that a successful student is one who has made it into

understand others and to communicate with them which is the basis of a meaningful dialogue and true education? Therefore, development work cannot rely entirely on the training given by our universities.

May be that this work shop could explore the possibility of using the existing voluntary organisation to develop our own training facilities.

If the voluntary organisations could set a model of unity and cooperation; if the aid-giving agencies could also do the same; and if, as a result, permanance of service and professional salaries could be offered to proppective candidates, then the system could be rounded off by a number of volunatary organisations joining together to offer training services as well.

Let this paper end by stating in clear words the assumption on which the whole paper has been based: True development means, in the last analysis, personal growth the ability to cope every time more effectively with difficult situations; the ability to make history meaningfully. May be if voluntary organisations spent a little more time in "developing" their staff they would be in a better position to help in the development of others.

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WORKING WITH THE COMMUNITY

3.1 DEFINITION

A community is a social group determined by geographical boundaries and/or common values and interests.

The members of a community, particularly in a rural area, know and interact with each other and create certain norms, values, and social institutions.

> COMMUNITY HEALTH REFERS TO THE HEALTH STATUS OF THE MEMBERS OF THE COMMUNITY, TO THE PROBLEMS AFFECTING THEIR HEALTH, AND TO THE TOTALITY OF HEALTH CARE PROVIDED FOR THE COMMUNITY.

The assessment of the health status of the community requires an understanding of the general populations to be served. Refer to sections 4.3.1 and 4.3.2 for the methodology for collecting general information and conducting a base-line survey.

> HEALTH CARE PROVIDES A WIDE SPECTRUM OF SERVICES INCLUDING PRIMARY HEALTH CARE. THE INTEGRATION OF PREVENTIVE AND CURATIVE SERVICES? HEALTH EDUCATION, THE PROTECTION OF MOTHERS AND CHILDREN; FAMILY PLANNING AND THE CONTROL OF ENVIRONMENTAL HAZARDS AND COMMUNICABLE DISEASES.

The system of health care delivery, if it is to be effective and serve the needs of the community, must have the following characteristics:

i. It must be accessible to all the population.
ii. It must be available when needed.
iii. It must be free of economic barriers, i.e. it should be available to all economic groups.
iv. It must not be limited by social or cultural distinctions.
v. It must reflect certain inherent characteristics of the community.
vi. It must be flexible in its approaches.
vii. It must recognize that the primary avenues to health may be through education, economic progress, legislation or other aspects of society rather than through organised health structures.

3.2. YOUR ROLE IN COMMUNITY HEALTH ACTIVITIES

As a health worker in a rural community you are also a community worker and you must, therefore, work very closely with the community and other workers, e.g., agricultural, educational, public works, housing and communications, working within the same community.

3.3 WORKING WITH THE COMMUNITY LEADERS

If your services to the community are to achieve their objectives you must create a demand for these services within the community, This demand can be created in the following ways:

i. Involving the community in all aspects of health services delivery, i.e. in the planning, delivery, utilization and evaluation of health care.
ii. Inter-relating the services with other operating social systems within the community.
iii. Sharing the services around the life

Your success will depend on how fare you will be able to get the support of the community to help you with your work. A very crucial part in this respect is played by the community leaders.

3.4 TYPES OF LEADERS

In every rural community there are formal and informal leaders who can either promote or obstruct any health programme.

i. Formal leaders (Official/Functional): These individuals are often employed by the Government and include the sarpanch, school teachers, tax collectors, etc. Some may be elected or appointed to be the leaders of non-governmental organizations.

ii. Informal Leaders (Natural/Status): These individuals may be any influential men or women in the community such as midwives, shopkeepers, farmers, housewives or other persons who have the respect and confidence of the people. They may hold a position of leadership on account of their age, caste, religion, wealth or education.

SUPPORT FROM BOTH TYPES OF LEADERS IS NECESSARY SO THAT THEY CAN POSITIVELY INFLUENCE PERSONS WHO BELONG TO THEIR RESPECTIVE GROUPS.

3.5 IDENTIFICATION OF LEADERS

Much care needs to be given to the identification of community leaders so that they are well-accepted by the people. Trusted local leaders can be expected to exert considerable influence on their community.

There are various methods you can use for identifying leaders in any community. These methods are:

1. Interview Method: You may interview formal leaders to obtain the names of men and women whom they consider to be influential in the community and who represent various community groups.

ii. Observation Method: You may observe which persons in the community are consulted frequently by the people who are in need of advice and assistance.

iii. Sociometric Method: You may ask several recognised leaders to name three or four persons whom they consider as leaders. Those whose names are mentioned frequently are identified as community leaders.

iv. Sampling Method: In this Method you may interview the head of every third, fifth, tenth, etc., family to get his opinion as to whom his family would like as a leader. The persons whose names are mentioned most frequently are approached to act as leaders.

3.6. ORIENTATION OF LEADERS

Orientation sessions for community leaders and their expected roles with regard to health programmes should be planned by you along with with your supervisor. The participation of the Medical Officer and the Block Health Assistant from the Primary Health Centre often adds importance and prestige to such meetings and arrangements should be made for this, if the situation requires it.

2. The various health problems existing in the community and the role of the leaders in helping to solve these problems.
3. Specific information related to various health problems and programmes, e.g.,
   i. Cause and control of communicable diseases
   ii. Maternal and child health
   iii. Family planning
   iv. Nutrition
   v. Environmental sanitation.
4. Identifying and utilizing the resources in the community to improve the health status of the community.
5. Methods of educating and motivating the community to improve their health status and change their health behaviour.
6. The need for coordinating the various developmental activities of the community so achieve improvement in the total well being of the community.

3.7 UTILIZING THE COMMUNITY LEADERS

When you work with the community leaders, you should remember that you are working, through them, with community you are serving. They can promote or destroy your programme, so you should ensure that your relationship with them remains cordial, friendly, cooperative and promotes team work. Utilize the community leaders as follows:

i. Enquire what the current needs of the community are.
ii. Relate these needs to the objectives of the health services and ensure that your activities will satisfy their needs. If you are unable to satisfy these needs explain to the leaders why you cannot do so, and what they could do to meet their requirements.
iii. Plan with the leaders the delivery of health services, their timing and what motivational steps are necessary to promote health programmes.
iv. Request the help of the leaders in the delivery of the health programmes.
v. Enquire from the leaders whether the community is satisfied with the services being delivered. If not, ask why and try to find ways, in consultation with the leaders, fr improving the programme.

REMEMBER THAT BECAUSE OF FINANCIAL CONSTRAINTS ONLY THE ESSENTIAL NEEDS OF THE COMMUNITY CAN BE SATISFIED. HOWEVER, YOU CAN HELP THE COMMUNITY TO SELECT HEALTH PRIORITIES AND MOBILIZE THE COMMUNITY RESOURCES IN ORDER TO OVERCOME THESE CONSTRAINTS.

vi. Stimulate the leaders to relate health programmess with other developmental programmes in the community Remember that major improvements in the health of the community can result from minor changes in the cultural behaviour and economic standards of the people or in the existing community organizations.
vii. Use the leaders to motivate members of the community who are resistant to health programmes. This can be

viii. Influence the leaders to assist you in your work through community participation in health activities.

REMEMBER THAT IF A PROGRAMME IS PLANNED AND OPERATED WITH COMMUNITY PARTICIPATION, THEIR INTEREST WILL BE MAINTAINED AND THE PROGRAMME WILL BE MORE EFFECTIVE.

ix. You should plan for meetings with the leaders from time to time either individually or in groups. At these sessions, the following topics could be discussed:

a. Information about the achievement of the health programme in the area.
b. Specific problems or doubts raised by the community members.
c. New developments in the health programme.
d. Planning for involvement of the community in the education and service programme.
e. Orientation of new leaders in the community.

3.8. WORKING WITH OTHER COMMUNITY WORKERS

Besides workers from the health department, there are workers from other departments such as teachers, agricultural workers, community development workers, balsevikas, etc., all of whom have specific responsibilities but with the same overall goal of improving the welfare of the community. It is necessary for you to work closely with all these workers in order to benefit the community to the maximum extent possible The following are some of the ways in which you can get assistance from your colleagues, or help in their work:

i. Participate in the activities of the team.
ii. Exchange information with the other community workers to identify areas of work where you can cooperate with each other.
iii. Look for opportunities where you can contribute to improving the welfare of the community, e.g., by giving health talks to school children, cooperating with the panchayat leaders etc.
iv. Request the assistance of other workers in your programme, e.g., the community development officer can help with water supply schemes, the agricultural officer with advising the community on kitchen gardens, etc.
v. Request the panchayat leaders for assistance with manpower to support health progr ammes, e.g., in spraying **oporalien.**

3.9. THE COMMUNITY LEVEL WORKER

The idea of utilizing community level workers to deliver health services of an elementary nature has now been accepted as part of the health delivery system in India. These workers will not be government employees but will be selected by the community and, after training, will work within the community. These community level workers will be drawn from among teachers and educated and willing housewives.

Your help may be requested by the village leaders or community in selecting a proper person who can be trained in elementary health work. In giving this advice you will need to use your judgement and to keep in mind that you will be working closely with this worker.

REMEMBER THAT THE COMMUNITY LEVEL WORKER IS NOT IN COMPETITION WITH YOU, BUT THAT HE IS YOUR HELPER AND IS THERE TO EXTEND HEALTH CARE IN YOUR ABSENCE.

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ST. JOHN'S MEDICAL COLLEGE & HOSPITAL, BANGALORE

TRAINING PROGRAMME FOR COMMUNITY HEALTH WORKERS

COMMUNITY DEVELOPMENT

J.M. Heredero*

Definition of Community:

A sense developed by people of their local common good.

a) Sense : To the extent to which a group of people develop a sense of their common good, to that extent, we say, there is a community.

b) Common good : It embraces various aspects:

1. Political: (Political is taken here in the sense of sharing power).

Aims:

a) to avoid a position of dependence which may lead to exploitation. The community (through united organisation) acquires sufficient power to defend the rights of its members. In other words, the community asserts its rights.

b) The individual whether in a traditional or in a modern society has very little control over his life. Most of the decisions which affect his life are taken by others. In the western consumer society this has led to non-conformist movement like the hippies. In India, the caste controls the majority of individuals through the manipulations of a few traditional leaders. In either traditional or modern society the net result is the loss of individual autonomy.

The community where each member is aware of these facts and willing to do something about them is the only means to restore the autonomy of the individual.

2. Social : Man is a social animal. There are certain things which can only be satisfied in a society. Thus, for example, the need of mutual support, of friendship, the need of celebrations, are needs which are best taken care of by the community. More in particular, man is communicative. The community provides a forum where its members can exchange their ideas. Again, man needs recreation. The Community helps each member, according to his age etc., to fulfill this need.

3. Religion: a) Religion has always been a social phenomenon. The community helps its members to worship in common.

b) Society imposes on man values which run counter to his religious convictions. One man can individually reject these values, but it is in and through the community that man can have his religious values accepted in a manner which is relevant to him and his neighbours at a particular time in a particular place. To extent to which the true fundamental values of religion are accepted in the community to that extent religion has meaningful relevance in society. This is a living process where men discern in their own religion, the difference between fundamentals and accidentals, between inner attitudes and external rituals and, in their daily lives, men are able to see the difference between real needs and addictions or compulsions.

c) Community work should be an antidote against institutionalised religion where the institution becomes more important than the message and, especially the people.

d) The community is important to religion (and vice versa) because it is in the former that the ideas of the latter are implemented. Specifically, it is through the community that the fight against social evils and injustice can best be waged.

4. Education: The community helps its members to teach and to learn.

a) The community helps its members to learn:

i) to be more ethically sensitive in solving problems by taking cognisance not only of one's own interests but also of his neighbours;

ii) re-assess one's own attitudes and habits vis-a-vis their impact on one's own neighbours;

iii) some very specific skills which an individual learns in the community are communicationsand leadership s skills;

iv) in short, the individuals learn how best to help the community to achieve the common good.

s:

of the socio-economic structures which influence or manipulate it;

ii) the community may organise other minor schemes where individual members will impart specific skills to others.

5. Economic: Among the weaker sections of society, the community may be the only means to solve his economic difficulties. Cooperatives of all types may be the only answer to solve problems like indebtedness, marketing difficulties and even unemployment.

II. Types of Community: Their characteristics and advantages

The Caste as Community

Caste are autonomous groups within the country, with their own legislative, executive and judiciary systems operating independently within their own sphere. Consequently, each group has a well-defined code of legislation which regulates their social life, and which confers on every caste member his own set of rights and duties.

This social structure provides for a clear sense of identity and belongingness, which is found missing in the so called "atomised society" of the West.

Another characteristic of the caste is that it is not merely an effective group, or a group organised for action but also an affective group or a group bound together by links of common fellowship.

Religion as a Community:

In India religion creates a community clearly among the Parsees. Although religion has united the Muslims as a minority in some well known political fights, still, in the day-to-day working of community the Muslims are too divided by castes and sects as to create a community. Something similar may be said about the Christians. Hinduism as a religion seldom gives rise to a community.

Territorial Group as a Community:

Government have consistently taken the view that caste and religion lead to casteism and communalism and consequently, they cannot form the basis of a community. Therefore, government and many liberal organisations claim that the territorial groups should form the basis of the community. In rural areas, it is the village, and in an urban set up it should be the neighbourhood.

While there is no doubt that certain caste evils must be rooted out it is an open question whether the whole system must be eradicated. In which case the caste would serve as an obvious basis for community development. This will become clearer if we study the characteristics of traditional and modern societies.

Characteristics of a Traditional Society:

Without attempting to define it, certain characteristics are given

not questioned. This sense of belonging binds the members of the community together.

ii) This common membership defines their identity. Traditionally groups are characterised by a strong sense of identity.

iii) A traditional group tends to possess distinctive qualities of social life which are peculiar to itself.

iv) Like all groups it has its own culture but unlike other groups this culture is more rigid. There are three components of this culture. First, the normative system that tells people how they should behave. Secondly, the action system which includes the actual ways in which things are done -- the custom, folk ways, etc. Thirdly, the things which are produced, the symbols and material products, must also be included.

v) As for the acceptance of fundamentally perceptual and normative values, it is above all the community which largely determines the individuals' perception of possible questions and their answers.

Characteristics of Modern Societies*

"Over the last centuries, it is clear that the Western societies have moved from an emphasis upon social organisation based upon kinship, fealty and status to one based upon contract and rational co-ordination. This movement is characterized by increasing specialization of function and increasing rationality in the lives of the members of the society.

Specialization has led to the growing division of labour. There has been a powerful process of social differentiation which has operated in the separation of function of the major institutions in society and in the growth of associations aimed at furthering specific interests.

Rationality has helped the Western Society to move away from uncritical acceptance of the established order. There has been a trend towards secularism and pragmatism. Ways of doing things are measured in terms of effectiveness in achieving some material end. This has been summarised by Talcott Parsons in the notion that the dominant value theme in advanced society is mastery of the world around. This emphasis upon secularism and rationality is believed to go hand in hand with impersonality in human relations - an emphasis on heads not hearts. This society, according to Tonnes, produces the 'mass society' of rootless individuals bound together, not by unquestioned perceptions of reality and an undisputed normative order, but by personal choice. Thus, the bond is still there, but it is a much less secure one. It is dependent upon fads and fashions of individual choice and is more prone therefore to violent change and to 'sickness' or 'normlessness'.

Advantages of Traditional over Modern Societies:

1. Greater sense of belongingness
2. Greater sense of identity
3. More emphasis placed on affective links

Therefore, a traditional society lends itself better to community development.

Disadvantages:

1. It may give undue prominence to its leaders. (This may be counteracted by greater awareness of all its members).

III. COMMUNITY DEVELOPMENT *

1. Definition:

Community Development is a social process by which human beings can become more competent to live with, and gain some control over, local aspects of a frustrating and changing world.

2. Explanation:

i) It is a group method for expediting personality growth, which can occur when geographic neighbours work together to serve their growing concept of the good of all.

ii) It involves cooperative study, group discussions, collective action, and joint evaluation that leads to continuing action.

iii) It calls for the utilization of all helping professions and agencies (from local to international), that can assist in problem solving.

iv) But personality growth through group responsibility for the local common good is the focus.**

From the above it is clear that in recent times there has been a change of emphasis from improvement of facilities, and even of public opinion to improvement in people. But this personal betterment is brought about in the midst of social action that serves a growing awareness of community need.

3. Community Development is a Process:

As we shall use the word, process refers to a progression of events that is planned by the participants to serve goals they progressively choose. The events point to changes in a group and in individuals that can be termed growth in social sensitivity and competence. The essence of process does not consist in any fixed succession of events (these may vary widely from group to group and from one time to another) but in the growth that occurs within individuals, within groups, and within the communities they serve.

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*Extracts from: Biddle & Biddle: The Community Development Process.

** The Community development process is, in essence, a planned and organized effort to assist individuals to acquire the attitudes, skills and concepts required for their democratic participation in the effective solution of as wide a range of community improvement problems as possible in an order of priority determined by their increasing levels of competence". J.D. Mezirow, "Community Development as an Educational Process", Community Development, National Training Laboratories Selected Reading Series No.4, (1961), p.16.

IV. THE COMMUNITY DEVELOPER

1. His Aim:

Community development is, essentially, human development. In the field of community development, the goal is to create an atmosphere in which men and women can express their inherent right to "Life, liberty and the pursuit of happiness", unfettered by the chains of hunger, poverty and ignorance. The attainment of that goal must start with the basic need of the human soul to express, to grow, to build a life that will fulfill its dreams. He needs only the stimulus of understanding; the knowledge that others recognize his individuality and respect it; and the guidance that evokes his latent ability to achieve his goals.*

2. His Role:

a) A nucleus level worker is the central figure in the drama of community development . He is the instigator of process. His responsibility is significant, but difficult, for he has a role of paradoxes. He is called upon to take actions that seem to be contradictory in themselves or to run counter to much conventional wisdom. He is a central figure who seeks prominence for others.

b) Is a nucleus-level encourager an innovator? Most people use the word "innovator" to describe the inventor, the introducer, or the promoter of a new idea. A community developer is none of these; he is rather an instigator of processes that call upon others to become innovators. He takes the initiative so that others will take the initiative.

c) Neither is the community developer a change agent in the sense of an advocate of (to him) favourable changes. He is rather the expediter of the favourable changes that people have chosen.

Though the process may begin and continue without him, he is central to any planned and organized utilization of it. Professionaly nucleus-level workers of some sort become indispens-able, and some institutional responsibility for employing and training them is called for, if community development is to have any impact upon the history that is lived. But if the professional workers do their job adequately, they can expect people to learn how to develop with less and less encouragements from themselves. An encourager instigates a growth of initiative that should run away from him.

3. Dilemmas of the Community Developer:

a) The Institutional Dilemma:

All helping professions face a dilemma posed by their institutionalization: Which shall come first -- service to human beings or loyalty to employing organization?

The flexibility that is required to serve the people's needs is restricted by the pressure upon the community developer to support the sponsoring institution and to follow its programme prescriptions.

The institution makes its own demands, many of which are incompatible with the processes of community development. For example, an institution may demand to be aggrandized, "played up", given credit; and, usually there is pressure to follow traditional rituals. But the community may go off in pursuit of activities of its own choosing -- Indeed, the

In working with people through the community development process, it is easier for a community developer to be self-effacing than it is for him to reduce the prominence of his institution. But then, institutions, too, can change - in aspiration and in the nature of their programmes. Sometimes they do this as a result of pressure (gently applied) from employees. There are some that are beginning to set up programmes which call for the flexibility to meet people where they are and which will free employees to follow the stumblin g yet hopeful development of ordinary people

b) The problem of financial support:

The employed community development worker wants to keep his institution solvent, if only to preserve his salary. But if the work with community nuclei is so little heralded that the donors to the institution do not hear of it, this particular work may fall on evil days, or the institution itself be in jeopardy.

c) Identification with bourgeoise values:

Most institutions, once they have received public recognition for their work, tend to identify with the "establishment". In practice this may mean lining up with middle-class morality and values, with the ethic of "success", and so on. Indeed, most community developers must wrench themselv away from their accepted beliefs to accept the patterns of value that may gro in the nuclei. Uncomfortable as the community developer may be, an institution is even more uncomfortable when it discovers that its employees have identified with people other than those who accept middle-class values. The community developer who does come close to people's needs and thinking may be condemned for lowering his standards of excellence or for being disloyal to middle-class ethics.

d) Personal Dilemmas:

1. Personal Relationships:

There are uniquenesses of personal relationship that seem to effect outcomes favourably or unfavourably. The success of process seems to depend upon a mutual trust between the community developer and the community developed. Unless the community developer trusts and is trusted, unless he is acceptant* of people, the process cannot be expected to work.

The relationship (rapport) is one of warmth toward people, one in which they come to trust him because he obviously believes in them. He is acceptant of them, as they are, but with the expectation that they will become better in a process that develops from friendship. He likes them as individuals and believes in their favourable potentials. His belief, expressed in manner, tone of voice, and activity, more than in words, tends to create an atmosphere of confidence -- confidence in themselves and in the growing competence of other members of the group and in the group as a whole.

The community developer contributes to this social atmosphere by being the kind of person he is. He is imperturb-ble, non-shockable, quietly confident, patient, nonpartisan but devoted to people.

The people thus encouraged tend to discover that they are creative in ways that they had not earlier expected. This leads them to act increasingly better. In other words, to the extent to w ich the community developer is successful to that extend his services will gradually become less and less necessary. This is the shoke of diminishing dependence - when he realises that he is no longer necessary to the on-going process. Will he be satisfied

2. Self-concepts:

i) Expectation of Prominence:

Most trained workers-with-people feel obligated to exhibit the skills in which they are expert. The teacher must instruct; the social worker must take care of people; the religious worker must conduct worship services; the sociologist must make community surveys; and so on down a long list. The trained person's concept of his own dignity rests upon his doing the job that is associated with his own sense of importance. Merely to understand people, to share their worries, to believe in them, and to create circumstances that will chlp them to solve their problems, may not give a community developer enough of a conviction of his contribution, a sense of his importance.

The desire for personal prominence tends to interfere with sensitivity to the people who are to develop. Hopes for recognition (conscious or unconscious) reduce the probability of learning along with the participants It is better to seek the triumphs of success in the lives of those who develop. There is satisfaction in discovering such triumphs, But this is not likely to be apparent until the expectation of prominence has been cheerfully abandoned.

ii) Do-Gooder Impulses:

All community developers suffer from another dilemma, which is as old as the impulse to helf people. This might be termed "the frustration of the do-gooder". Since community developers have humanitarian motives, they have, or rapidly acquire, ideas about the "correct" improvements people "must" accept. They set out to bring the benefits they have chosen, and then they find the potential beneficiaries unwilling to acquiesce. In an extreme form, the do-gooder becomes desperate because he concludes that the people are so apathetic, stupid, or badly motivated that they will not or cannot do his bidding.

The emphasis upon predetermined imporvements and the reliance upon process represent extreme poles of a scale of operational influence. Few community developers fully escape do-gooder impulses. The seeking of acquiescence to "my" good ideas is ever a temptation. But some developers, have been attempting to make clearer a method that seeks the strengthening of problem-solving initiative among the beneficiaries of development.

iii) How much influence?

A final paradox needs to be mentioned. It has to do with a community developer's concept of his influence. He may be instrumental in bringing about the fundamental changes in people's lives that make them more ethically competent citizens. At the same time he must recognize that his voice is a feeble one among the cacophony of influences that exist in modern life.

A community developer wields one very small influence in the midst of a confusing complex of forces. The process he hopes for may never start, may be stopped after starting, or may be diverted to undesirable purposes by extraneous events and circumstances. While almost miraculous changes may occur in people (we have seen them occur time and time again), he must also be prepared for the disappointment of poor response.

SUMMARY

1. The community developer attaches more importance to man than to institutions/ideologies.
2. His main aim is to make the individual-in-the-community grow.
3. His method is to develop in the people critical awareness.
4. His most effective weapon is faith in the people.
5. His greatest joy is to see that he is no longer needed because the community has taken over.

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COMMUNITY HEALTH TRAINING IN INDIA--PROFILES

COMMUNITY HEALTH AND DEVELOPMENT

1. 4 Weeks training programme on Community Organization and Development in English, Telugu and Tamil for Rural Health and Community Development Workers: conducted by Rural Unit for Health and Social Affairs (RUHSA).,

   They also conduct Workshops on HOW TO START A COMMUNITY HEALTH PROJECT.

   For details write tp:

   Head of RUHSA Department
   RUHSA Campus Post
   North Arcot Dist 632209

2. 6 weeks Leadership Course in Community Health and Development: conducted by Deenabandu Training Centre. It is designed to upgrade the skills of middle level community health workers without specific academic qualifications. The participants should however be able to read and write English. The training programme covers topics such as concepts and approaches to community health; human relations; communications; programme management; maternal and child health; communicable diseases; development actvities including income generation; survey methods etc.

   For details write to:

   The Course Coordinator
   Deenabandu Training Centre '
   R.K? Pet 631303, Tamilnadu

3. 10 weeks training programme on Community Health and Development: conducted by International Nursing Services Association (India). The course is for health professionals and others involved in community health programmes. It is divided into 6 weeks class room teaching and 4 weeks field exposure. The topics covered include health and development, drug issues, nutrition, teaching methodologies, communicable diseases, cost analysis etc. The course is followed by a Workshop after one year. The medium of instructior is English.
   For details contact: The Programme Director,
   INSA/India
   2 Benson Road, Benson Town
   Bangalore 560046

COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT
BANGALORE.

4. 12 weeks training programme for Community Health Workers: conducted by St John's Medical College and Hospital. The training is both institutional and field based. The course is directed at attaining self-sufficiency in knowledge and skill for independent management of a health centre. The trainees are also given basic skills in herbal medicine, homoeopathy, accupressure and herbo-mineral medicine. The course is open to candidates with a basic educational qualification of SSLC or equivalent engaged in health and development work. For details write to:

The Principal
St John's Medical College ,
Bangalore 560034

5. 2 years Diploma Course in Community Health (CH Guide): conducted by Christian Fellowship Community Health Centre and Christian Education, Health and Development Society. They also conduct various training courses such as:

--PG Diploma in Applied Nutrition and Dietics and Catering

--PG Diploma course in Health and Development

--Multipurpose Health Workers (ANM) Course

--Village Health Workers (VLW) Course

These courses are either under Madurai Kamaraj University or are recognised by the government. They also conduct special courses on Rural Health Orientation and short term courses for voluntary institutions. For further informations, write to:

Christian Fellowship Community Health Centre
and Christian Education, Health and Development
Society
Santhipuram, Ambilikkai 624612
Anna Dist., Tamilnadu

6. a. Two years M.Phil programme in Social Sciences in Health for postgraduates in Sociology, Psychology, Public Administration, Political Science, Economics, Anthropology.

b. Three years PhD programme in Social Science in Health for M.phil in Social Sciences in Health or a for a distinguished research worker.

c. 2 years MCH (Masters in Community Health) programme for MBBS graduates and MSc Nurses.

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d. PhD programme in Community Health for physicians and MSc Nurses.

For details, write to:

The Centre of Social Medicine and Community Health
Jawaharlal Nehru University,
New Delhi 110067

COMMUNITY HEALTH MANAGEMENT

1. 6 weeks residential training programme on Management of Primary Health Care: conducted by Institute of Health Management, Pachod. The course is designed to provide a working knowledge of the process of management in the field of health including management concepts; community organization and development; principles of public health and health and management information system. The course is open to people who are involved in primary health care services. The medium of instruction is English.

   For further information contact:

   Institute of Health Management
   Pachod
   Dist Aurangabad
   Maharashtra 431121 ,

2. 11 months Post-graduate Diploma course in Health Care Administration: conducted by St John's Medical College Hospital. The course is not a traditional class room lecture oriented one. Emphais is on job training, case studies, exercises, seminar etc. It is open to medical doctors, qualified pharmacists, graduates in commerce, science and arts with hospital experience. Some of the topics covered in the course are Principles of Management; Organizational Behaviour; Materials Management; Personnel Management; Finance Management and legal aspects of health care. Successful candidates will be awarded a "Post-graduate Diploma in Health Care Administration". The medium of instruction is English and organizational sponsorship is essential. For further details contact:

   The Coordinator
   Health Care Administration Office
   St John's Medical College Hospital ,
   Bangalore 560034

3. 15 months Diploma course in Community Health Management: Conducted by RUHSA in conjunction with Voluntary Health Association of India. The course is residential and is conducted in RUHSA campus. The course is open to people engaged in health and development field preferably with a Bachelor's degree/Nursing Certificate. On completion of the course a Diploma will be awarded by the Voluntary Health Association of India (VHAI). For details write to:
   The Director
   DCHM Course
   RUHSA post, North Arcot Dist ,
   Tamilnadu 632209

COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT
BANGALORE

4. 2 years Certificate Course in Community Health Planning, Organization and Management. This is a correspondence course designed for managers, supervisors, and others involved in health and development work. The course covers principles of management; personnel management; materials management; elementary accounting; basic labour legislation etc. For details write to:

The Coordinator
Community Health Education Training & Personal Development
Voluntary Health Association of India
40 Institutional Area, South of IIT
New Delhi 110016

5. Diploma in Hospiral Administration (DHA)

On year Diploma:	conducted by Armed Forces Medical College, Pune (eligibility MBBS with 3 years Army service) under Pune University
	Post Graduate Institute, Chandigargh (eligibility Postgraduate or graduate in any discipline plus 2 years experience in hospital/health service)under Punjab Univ.
Masters in Hospital Administration (MHA)	conducted by All India Institute of Medical Sciences, New Delhi Post-graduate/graduate in any discipline with experience in health/hospital services are eligible.

PREVENTIVE AND SOCIAL MEDICINE/COMMUNITY MEDICINE PROGRAMME IN INDIA

M.D.

Name of institution	University	Basic qualification	Duration
Andhra Medical College Vishakapatnam	Andhra	MBBS	3 years
Darbhanga Medical College, Laheri Sarai Bihar	Mithila	MBBS + 1 year rotating internship + 1 yr house job or 6 months in allied subjects	2 years
Patna Medical College, Patna Bihar	Patna	MBBS + 1 year compulsory rotating internship	2 years
BJ Medical College Ahmedabad	Gujarat	MBBS	3 years
Smt NHL Municipal Medical College Ahmedabad	Gujarat	MBBS	3 years
Govt Medical College Baroda, Gujarat	Sayajirao	MBBS	3 years
Govt Medical College Surat, Gujarat	South Gujarat	MBBS	3 years
Bangalore Medical College, Bangalore	Bangalore	MBBS	3 years
Medical College Trivandrum	Kerala	MBBS	3 years
Medical College Calicut	Calicut	MBBS	3 years
Govt Medical College Jabalpur	Jabalpur	MBBS + 1 year housejob	3 years
MGM Medical College Indore	Indore	MBBS	3 years
Govt Medical College Nagpur	Nagpur	MBBS	3 years

Name of institution	University	Basic qualification	Duration
Grant Medical College Bombay	Bombay	MBBS	3 years
Armed Forees Medical College, Pune	Pune	MBBS with 3 years service in Army Medical Corps	2 years
Seth GS Medical College Bombay	Bombay	MBBS	3 years
Topiwala National Medical College, Bombay	Bombay	MBBS	3 years
Govt Medical College Aurangabad	Marathwada	MBBS	3 years
Dr VM Medical College Solapur	Shivaji	MBBS	3 years
VVS Medical College, Barla	Sambalpur	MBBS	3 years for direct students
MKCG Medical College Berhampur	Berhampur	MBBS	2-3 years
Medical College, Amritsar	Gurunanak Dev	MBBS + housejob 1 year	2 years
Govt Medical College Patiala	Punjabi	-do-	-do-
SMS Medical College Jaipur	Rajasthan	-do-	-do-
SP Medical College, Bikaner	Rajasthan	-do-	-do-
RNT Medical College Udaipur	Rajasthan	MBBS	2 years
Christian Medical College Vellore	Madras	MBBS + 1 year housejob	2 years
SN Medical College, Agra	Agra	MBBS + 1 year housejob	2 years
Motilal Nehru Medical College, Allahabad	Allahabad MBBS	MBBS	2 years
JLN Medical College, Aligarh	Aligarh	MBBS + 1 year housejob	2 years

GSVM Medical College Kanpur	Kanpur	MBBS + 1 yr housejob	2 years
LLRM Medical College Meerut	Meerut	MBBS + 1 year housejob	2 years
Karnatak Medical College Hubli	Karnatak	MBBS	3 years
All India Institute of Hygiene and Public Health Calcutta	Calcutta	MBBS + 1 year housepost	2 years
All India Institute of Medical Sciences, New Delhi	AIIMS	MBBS with 55% Marks	2-3 years
Maulana Azad Medical College, New Delhi	Delhi	MBBS + 1 year housejob	2 years
Lady Harding Medical College, New Delhi	-do-	-do-	-do-
Goa Medical College, Goa Panaji	Bombay	MBBS	3 years
JIPMER, Pondicherry	Madras	MBBS	3 years

D.P.H.

Name of Institute	University	Basic qualification	Duration
Institute of Medical Sciences, Hyderabad	Osmania	MBBS	2 years
Armed Forces Medical College, Pune	Pune	MBBS with 3 years army service	1 year
Govt Medical College Aurangabad	Marathwada	MBBS	2 years
Seth GS Medical College, Parel Bombay	Bombay	MBBS	1 year
Topiwala National Med College, Bombay	Bombay	do	-do-
SMS Medical College, Jaipur	Rajasthan	MBBS + 1 year housejob	1 year
All India Institute of Public Health & Hygiene, Calcutta	Calcutta	MBBS	1 year
Bangalore Medical College, Bangalore	Bangalore	MBBS	2 years

DMCW (Diploma In Maternal and Child Welfare)

All India Institute of Hygiene & Public Health	Calcutta	MBBS	1 year

DTM&H (Diploma in Tropical Medicine)

Darbhanga Medical College, Leheri Sarai	Mithila	MBBS + 1 year housejob	1 year

DMLT (Medical Laboratory Technology)

Govt Medical College, Aurangabad	Marathwada	BSc	1 year
St John's Medical College, Bangalore	SJMC	PUC	1 year

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VARIOUS HEALTH TRAINING PROGRAMMES CONDUC

BY NGO'S OF INDIA

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Organisation (1)	Type of course (2)	Duration of Course (3)	Method of Selection (4)
Child in Need Institute Post Box 16742 Calcutta	Job training course for supervisors	3 months	Through Govt.
	6 day refresher course for supervisors	6 days	DO
	Training of Instructors of Anganwadi training centre	18 days	Interview
	Orientation course for Statistical Assistants	6 days	Through Govt.
	Anganwadi Training	3 months	Through Panchayat
	Anganwadi Helpers	6 days	DO
	Training programme on Community Health for B.Sc. nursing students	15 days	College of Nursing, Govt. of W. Bengal
	Orientation course on M.C.H.	4 week	BY NGOs
	Orientation course for Doctors forC.H.	6 months	Through interview

(8)	(9)	(10)	(11)	(12)
Satisfactory	Around 30	It depends on Gov't.	ICDS community Health & Nutrition, Early childhood stimulation, Approaches of work with the communities.	Residential
DO	DO	DO	Focusing on learning needs	DO
DO	Around 20 to 25	Availability of trainers. At least two courses in every year.	ICDS training methodology, subjectwise input.	DO
DO	Around 30	This course has started very recently	Bio-statistics, management information system.	DO
DO	Around 50	Depends on selection	ICDS, NUTRITION, Health, Child Development and Community contact	DO
DO	Around 50	DO	Child care, supplementary nutrition, certain skills to support child care activities.	DO
DO	Around 30	From 1988	Community Health nursing	DO
DO	DO	Summer & Winter	Comprehensive Mother and Child Care.	DO
DO	DO	Usually end of this year	Health care management, community health & Nutrition, Exposure to different community health work, writing project proposal on community health.	DO

(1)	(2)	(3)	(4)
	Participatory Training methodology	It takes in 3 phases, duratin of each is 7 working days	Straight offered to Instructors of different trg. centr
	Short orientation on C.H. for village practitioners	6 working days	Through village selection committee
	Orientation on child survival and development course	6 days	Through Mahila Mandal
	National project on Demonstration on Improved chullah	10 days	Through village working committee
	Training for primary health care in collaboration with the Jadavpur University	6 weeks	Through interview
2			
RUHSA Dept. Christian Medical College & Hospital, RUHSA Campus, P.O.632209 North Arcot Dist. T.N.	**Issues & Strategies in** Adult Education	5 days	Personnel involved i policy level promoti of adult education/ heads of adult educa programmes
	Curriculum Development	5 days	First come first ser -sponsored candidate

( )	( )	(10)	(11)	(12)
D	25 to 25	End of Winter	Participatory training approach and its Philosophy	DO
DO	30	Beginning of Winter	Community Health, Use of drugs, management of referral services	DO
DO	25	End of Winter	Child survival & development	DO
DO	20	April to March	Environmental sanitation, demonstration on improved chullah.	DO
DO	30	The beginning of winter and end of summer	Community health & Nutrition, Child Survival	Non res -tial
8 years	20-30	1983	Design & develop a curriculum, identify atleast 5 strategies, plan & implement, evaluate the learners, identify areas of evaluative research in the field of Adult Education.	
4 years	20-30	1985	Analyse availablemethods t select community volunteer identify criteria for sele tion of VLWs, demonstrate teaching methodologies, develop model for supervision monitoring system, develop instruments to evaluate training, analyse administrative issues	

(1)	(2)	(3)	(4)
4			
Centre for Health Education, Training & Nutrition Awareness, 2nd floor, Drive-in-Cinema Building, Thaltej Rd., Ahmedabad.	Training for ranging from Balwadi Teachers(pre-School)	3-7 days depending on orientation/refresher course	
Ms. Pallavi			
	Health workers Training	5-7 day orientation/ refresher course	
	Health workers Training	Ongoing with local voluntary agency once a month 3 days training	
	Dai Training	3 days Refresher/ Orientation course	
	Participatory training & communication techniques	6 days	
	Nutrition Health training for middle level functionaries	3-5 days	
	C-to-C workshop (child-to-child) training implementors/teachers	3-5 days	

(1)	(2)	(3)	(4)
	C-to-C workshops with children, youth.	3-5 days	6-14-18 years old children.
	Nutrition and Health Training for gross-root level workshops.	3 days	Balwadi teachers
	Training Creche Workers.	3 days	Creche teachers Day Care Centres.
	Training for organisers awareness generation programme.	7 days	Organisers from village level awareness camps.
	Awareness generation camps. (Womens awareness nutrition health care etc)	2-3 days	Women of the village

(5)				
Christian Medical-Association of India, P.B.No.24, Nagpur-MS. Dr.Bimal Charles.	Project Managers Training (CBPHC)	15 days	Advertisement	Project Ma
	F.S.Training (CBPHC)	15 days	Calling applications.	Middle lev Health wor
	Project Managers Training.	5 days	screening invitations	Project ma

(1)	(2)	(3)	(4)
	F.S. Training (CBFP)	5 days	--
	CSCD Staff training	5 days	-
	Women Health & Dept. project staff training	3 days	-

CBPHC - COMMUNITY BASED PRIMARY HEALTH C.
CBFP - COMMUNITY BASED FAMILY PLANNING
CSCD - CHILD SURVIVAL & CHILD DEVELOPME

(6)			
Christian Fellowship Community Health Centre, Santhipuram, Ambilikkai-624 612 Dr. Jacob Cherian	Post graduate diploma course in applied nutrition, dietics & catering.	1 year	Written exam & ora
	P.G. diploma course in health & development	2 years	"
	P.G. diploma in Business management (Part time)	1 year	DO
	Certificate course in Rural Development science	1 year	DO
	B.Sc. Nursing under M.G.R. Medical University	4 years	DO

(1)	(2)	(3)	(4)	(5
	Multipurpose Health Workers Course(ANM)	2 years	Written Exam & Oral	Womens Mens
	Dip. in Community-Health.	1 year	"	"
	Dip.in Civil, Mechanical, Electric & Electronic.	3 years	"	"

N.B: Mess fees extra.

(7)

National Institute of Mental Health & Neuro Sciences, Bengalore	Training in Mental Health Care.	2 weeks	Deputation by Dept.of Health Family & Welfare.	PHC Doc
	-- DO--	1 week	--DO--	Health
	-- DO--	4 weeks	--DO-- or through ICMR or individual application.	Mental Teacher
	-- DO--	3 days	Deputation by	Anganwa
	Training in Mental	3-7 days	on request	Any gro who are
	Training in Counselling.	Once a week for one year.	on request	Any int

(8)	(9)	(10)	(11)	(1
-	-	-	-	
-	-	-	-	
-	-	-	-	
	10 - 16	1982	Management of common mental disorders.	Resid
	20 - 25	1982	DO	DO
	10 - 16	1983	Principles & practice of Community Mental Health	DO
	20 - 30	1985	Identification & management of child hood psychiatric problems	DO
	20 - 30		Identification and care of mentally ill.	Non-r tial
	20 - 30	1982	Principles and methods of counselling.	DO

(1)	(2)	(3)	(4)
(8) St.John's Medical College, Bangalore, 560 034. Dr.Dara S.Amar.	Community Health-Basic Course.	3 months	Direct application Experience in rural health work.
	Food Hygiene Course	10 days	Direct application
	Health Care Course for Seminarians/Deacons	2 weeks	Application through their superiors.
	Training programme for Medical workers in universal Immunization Programme.	4 days	Deputation from their Organisation.
	Training programme for Para-medical workers in universal immunization programme.	2 days	--DO--
(9). International Nursing Services Association.(INSA) 2 Benson Road, Benson Town, Bangalore. Ms.Sujata de Magry Ms.Edwina Pereira.	Rural Health Development Trainers Training Programme	10 weeks 6 weeks theory 4 weeks practicals 1 year supervised correspondence which includes one faculty visit and ends with one follow up workshop.	Screening of application forms. (only 15 at a time

	(8)	(9)	(10)	(11)	
(8)	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
	-	-	-	-	
(9)	10 weeks supervised, 1 yr followup	Max. 20	May 1982	Health in development subjects. Administration of C.H. Dept. program Project planning in implementation Evaluation of projects.	Re 10 No f y

(1)	(2)	(3)	(4)
(10)			
Vivekananda Girijana Kalyana Kendra, B.R.Hills P.O.& Via.Chamarajanagar Mysore.Dt.571313. Dr.Abbey John.	Village Health-Workers training programme.	3 days every 6 month.	Existing VHW's
	Dais training Programme.	--DO--	Any practising D
(11)			
Community Health Cell 47/1 St.Mark's Road (Ist Floor) Bangalore-560 011 Dr.Ravi Naryan.	The Community Health Cell (CHC) is a resource supporting on-going initiative in Community H Awareness building efforts. It is not primari Trainer and does not run specific courses of on-going basis. It participates as resource i to explore more participatory approaches and groups to plan and evaluate their training ex together manuals based on this experience.		

(9)	(10)	(10)	(11)
(10) 3 years	15 - 20	1986	i. Treatment of common ailments ii. Giving competence to be health educators
3 year	10 - 15	1986	i. Review of existing obstetric practises ii. Antisepsis
(11) -	-	-	-

(1) (12)	(2)	(3)	(4)	(5)
Voluntary-Health Association of India.	Health Management (CHPOM)	1 Year.	By applications	People in the who are area ma middle of Com. i.e., a in the with de powers.
	School Health	3-5 days	By applications	Health working
	Teachers Training in School Health.	7 days	By applications	School
	Health Awareness	3-5 days	By request	Develop
	Training on Information & Documentation	5 days	By request	Who are & invol & Docum
	Training for Dais	3-5 days	on the request of State VHAs.	Local p
	Traditional Medicine	5 days	Health workers	Local H

(12)	Working in Health Projects.	20	every year in Sept.	Study of Society Health & Development Techniques of Studying in Community Health. Management & Administrativ Principles. Effective Change Agent Elective, practicum.
	Working in Health Projects.	20-25	Any time	What is School Health Prog How to start School Health Basic Principles of Planni Involving teachers & Stude in School Health Communication strategies.
	Working Schools	20	----	Health related subjects Common Problems with child How to deal with them How to involve children in activities.
	-----	30 or 40	As and when required.	Health Issues.
	-----	20	As and when required.	Concepts on Documentation Theory part of Information Source/selection/collectio classification.Cataloging/ Indexing/Bibliography etc. Practicals on the tech.asp of classification, catalog indexing, cross reference bibliography. Visit to other documentati centres for further study. Village survey/data collec audio-visual documenation, common techniques & networ Cases & group discussions

9	10	11
(12) -----	20	As and when required	Pre-natal, Anti-Natal & Post-natal care. Delivery Care Better Child Care
Anybody	20	As and when required	Health awareness on Home Remedies.

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ST. JOHN'S MEDICAL COLLEGE, BANGALORE 560 034

Orientation of the College to Community Health
AIMS AND OBJECTIVES

Goal: The education process in Community Health is so designed as to pay attention to problem based education. Which is learner centered and Community oriented. This is done by acquiring the knowledge, skills and attitude necessary to grasp the social and political dimension of health action, such that it will enthuse the people in the community to be enablers of their own health in all its dimensions.

Objectives:

1. To bring about, in the student, an awareness of the social, political and economic status of the Community, the environmental problems, the existing health practices and beliefs.

2. To study the role of the Government and Voluntary Organisations in the integrated welfare of the rural community.

3. To acquire the skills of carrying out a field survey and other studies, using appropriate sampling techniques and learning the analysis and interpretation of data.

4. To get acquainted with the principles of health education to individuals and groups in the rural setting and to understand the role of various members of health team.

5. To acquire knowledge and skills in epidemiology, health planning and administration, national health priorities and programs, population and family welfare programs, maternal and promotive services to vulnerable groups in the population.

6. To catalyse the process by which the families in the village/urban slums will own up the responsibility for their health and take appropriate promotive, preventive, curative and rehabilitative measures, harnessing the available resources in the community.

12. Movement for Alternative and Youth Awareness. Which silk route this? A situational analysis of child labor in the sericulture industry. Bangalore. MAYA 2000