COM H 11.1

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Dear..... Ravi Narain

I am herewith sending my paper on 'Nurses - The present status and the future potentials' to you for your comments and suggestions .

I presented this paper recently at a Workshop on ' Women , Health and Reproduction ' arranged by ' Feminist Resource Centre of India ' at Bombay. I had following views in my mind while preparing this paper.

— Nurses form a very important part of the health care system and represent ' Woman' im medical system.

— Nursing profession is overwhelmingly occupied by females and the problems of the nurses are essentially the problems of women . So the nurses can feel identity with the oppression of women in all feilds of the society and can be activised in the liberation movement of women . For this the feminists can and should take a lead .

Thanking you

Yours Sincerely,

Rani

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NURSES: THE CURSED NIGHTINGALES

The Present Status and Future Potentials

Dr. Rani Bang*

Present Status:- "How to motivate doctors to go to rural areas?" "Appoint beautiful nurses at the Primary Health Centres", was the reply.

Future Potentials:- "An auxiliary can treat 90% of children's sicknesses" -Rural Health Research Centre, Narangwal.

(A) Present Status of Nurses.

This can be studied under following heads:-

i) Manpower studies
ii) Training
iii) Role in health care.
iv) Social status.
v) Sexual exploitation.

1) (Wo)manpower (numerical) in Nursing Profession:

(a)

Category	Number (1971 Census)
General Nurses (G.N.)	68,252
Auxiliary Nurses midwives (ANM)	41,522
Lady Health Visitors (LHV)	5,914
	1,15,688

(b) The Bhore Committee in 1945 recommended a nurse population ratio of 1:500 to be achieved by 1971. But it was 1:4731 in 1971. To reach a nurse population ratio of 1:1000 by 1980 and 1:500 by 1990, nursing womanpower required will be 6,68,900 and 16,67,600 respectively. The shortfall with the present level of training will be of the order of 4,85,494 and 14,04,902.

The worst nurse-population ratio is in U.P., Bihar and Orissa:- 1 Nurse: 18 to 19 thousand population.

(d) Nurse - doctor ratio:

In 1971, this was 1:2.3

The ideal one is 3:1 (Sweden)

To achieve this ideal by 1990, there will be a deficit of 7,87,302 nurses with the present level of training.

Do these figures represent certain wrong values and priorities in our health care system?

2) Training:-

a) Nursing Schools:- The number of these in India in 1970 was 557. In spite of gross deficit in the number of nurses, the number of training schools declined over a period of 1966-70.

b) With the training facilities available in 1970, nurses trained were, G.N.6257 and ANMs 5416. The total is 11673. This number is almost the same as that of the number of doctors trained per year.(2) It is interesting to observe this equity in spite of the fact that there is a big deficit in the number of nurses while the recent WHO report says, that India has got surplus of doctors.

c) In a significant number of nursing training schools attached to hospitals, objective of the nursing students training is according to the needs of the hospital for their services, often to the extent that their training suffers.

d) According to TNAI survey, it is found that there is in-adequacy of facilities like clinical training, hostels, class -room space, laboratory facilities, recreational areas etc., in particular for ANMs. Even sanitory facilities and water supply are sometimes inadequate. Some students must spend their rare off hours procuring and preparing food. Unsafe hostels for ANM students expose them to the attention of unsocial elements of the community. Very few opportunities are there for these girls to come in social and intellectual contact with other student groups.

The cumulative effect of these poor working and living conditions on the whole leads to poor training and

f) Only a small fraction of the training centres have a separate budget from the hospital and even if it exists, its preparation and operation is usually in the hands of administrative heads of the hospital or the District Medical Officer.

g) Cost of training per nursing student - The calculated cost is based on expenses on salaries, stipends etc. directly related to training but excluding the capital cost.

The average cost is:- B.Sc. Rs.12,607/-
G.N. Rs. 5,650/-
ANM Rs. 3,185/-

The cost of training per doctor, as quoted by Health Minister in Tamilnadu assembly 4 years ago was Rs.1,20,000. As the method by which this cost is calculated is not exactly known, it is difficult to compare the training costs of nurses and doctors but still the gap is obviously very wide.

All these inadequacies in the training of nurses point towards the inferior status and priority accorded to the nursing training and profession.

3) Role in Health Care:

There are mainly 2 categories of nurses, GNsand ANMs.

a) General Nurses(GN):

i) In spite of 3½ years training which is more than most of the diploma holder doctors, only 4.3% of Gns. are given independent patient assignment while 82.7% are given merely functional assignment, i.e. to mechanically obey the orders of the doctors. The hierarchy is seen in all realms of health care and the doctor - nurse relationship.

If one agrees that the prestige and recognition to a particular professional group should be in proportion to its usefulness to the society, then doctors and nurses deserve equal prestige and respect. But unfortunately, what one observes is that the service of the nurses are very poorly recognised by the society and there is a vast difference in the status of doctors and nurses. Cahp-Tnai nursing survey

the doctors or from the patients. The creative satisfaction goes to the doctors and what remains in the nurses' lot is the laborious monotony.

Why?

The answer to this why is deep-rooted in the values of our social system. In our morbid society the intellectual work fetches more respect than manual labour. A white collar job of officer is always superior to the filthy sweating job of a labourer. And as lot of physical and non-intellectual work is involved in nursing the status of the nurses becomes inferior to those 'God figures of health care' - the doctors.

(ii) Working conditions:- It is observed that in most of the hospitals, staff nurses have to do many jobs other than patient care and find inadequate time for both patient care and supervision of students. The Indian Nursing Council (INC) has recommended a ratio of one nurse to every 3 patients in teaching hospitals and one nurse to every 5 patients in non-teaching hospitals. The reality is - only 15% of the teaching institutions have the recommended ratio and nearly 80% of the teaching hospitals and over 50% of non-teaching hospitals record over 80% of crowding.

(iii) Job satisfaction:- About 77% of nurses don't have job satisfaction. The main reasons for unsatisfaction are overwork, salary and working conditions.

b) ANMs:- The main role which ANMs are supposed to perform is maternal and child health, family planning and health education in the rural areas. So ANMs should form the backbone of the community health care in rural areas. But in reality, what happens?

WHO survey has shown that an ANM spends 45% of her time in giving medical care, 40% in travelling, 5% on paper work and only 10% in performing duties for which she has been trained.(3)

4. Social status of Nurses:

a) Majority of the nurses come from low socio-economic class with their guardian's income below Rs.300/- per month; and with an average family size of seven members.

WHO working group on selection of students for medical education (1971) came to the conclusion that the majority of medical students come from urban areas and that too from the elite class.

This difference in the family background does have a bearing

This sex characteristic of nursing profession plays an important role in the status accorded to it. Ours is a male dominated society and hence a profession like nursing overwhelmingly occupied by feamles can hardly get equal status, however unique its contribution might be.

The doctor nurse relationship also reflects the male - female relationship in our society. A doctor, even if she is a female, becomes the husband figure - ordering, scolding, dominating the nurse. The point becomes very clear when one observes that the male nurses, brothers, receive very different treatment. Brothers command more respect by the doctors, patients and even by the sisters. Doctors admit that they don't feel that free to order or shout at brothers while the sisters are, at times, even physically assaulted by the male doctors. Sometime back, there was a news in Dinman, that one doctor slapped a sister in Rewa Medical College. In protest the sisters went on strike asking for the appropriate action on the concerned doctor. But their strike failed miserably as they received constant threats from the college authorities who probably felt it insulting to see the nurses protesting and challenging the authority of the doctor, that too a male.

5. Sexual exploitation:

In no other profession, the Chastity of the woman is less secure than in nursing, except of course in prostitution. Many nurses are often at the mercy of everyone in the hospitals - the superintendents, doctors, patients, relatives of the patients and even the ward boys. The relatives of the patients in private wards very frequently harass the nurses, specially during the night duty. And since they are influential people, they threaten the nurses. The timid ones subject while those who don't have to face complaints, suppensions and remarks in their records as 'disobeying, negligent in the duty' as if to please every male is also a part of their duty.

Recently when one old political leader visited Wardha as state guest one staff nurse was posted to take care of him. Apart from other duties, the main duty given to her was to massage his naked body and give him bath. When the nurse refused she was threatened with transfer and suspension and also she was told that it was her duty and should do it considering him as father and respected person.

Look at few news clippings:-

- In Rajasthan 3 Keralite sisters became prey to death due to sexual exploitation by doctors.
- In Bombay one nurse Aruna committed suicide because of rape.
- At Basti (UP) 5 gundas entered the hostel of nursing college and raped 5 sisters in day time.
- In Nalanda Medical College, one 23 year old student sister Mary was found dead in most suspicious circumstances on 1st Dec.1979 and the truth came out later, she was sexually assaulted by one notorious medical student. (The whole case was suppressed by political pressure)(4)

Specially in the remote villages, where ANMs are posted, they are very insecure. The nurse is looked at as a catchy prey by all the village 'Dadas'. There was a tragic case of Miss Vaidya who was murdered in Vada Village in Maharashtra because she refused to give in to the sexual overtures of the local leader. One ANM who left the job, told "In the nights, many village gundas come to me and show their sex organs and ask for the Nirodh of the particular size".

In such circumstances, without any protection, how can nurses work safely in the villages?

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From all this analysis of the present status of the nurses, it seems that:-

i) There is incomplete utilisation of the full potentials of nurses in the present health care system.

ii) Their status and problems are reflections of certain wider values in our health care system and the society in general. Hence we cannot look at the prbblems of nurses in isolation but must see them in the context of the wider reality of the whole social system and its values.

B. Future Potentials of the Nursing Profession:

In view of the preceding analysis, the future potentials of the nurses can be seen in two main fields;

(1) Role in the health care (2) Role in the social change.

1) Role in the Health Care:-

It has been realised now that the doctor is a 'White elephant' which our poor society and people cannot afford to train and sustain in large number. Hence WHO ideal of one doctor for 750 population

a) Maternal and child health (MCH):

Women of child bearing age and the children below 15 years of age together constitute 2/3rd of the total population in our country. They together also form the 'biologically vulnerable' section of the population succumbing to the various diseases. Most of their diseases are easily preventable and treatable. They are also the 'weaker section' in the family structure, and hence neglected.

Due to these reasons, MCH has been accepted as the main thrust of community health care.

ANM has the key role in MCH services for the needy masses. Because of her sex, less elitist social status and education, and low cost of her training and functioning she is more suited for this role than the doctors and the other male functionaries.

b) Family Planning:- Again ANM is more relevant in this role than male functionaries for helping women to take benefits of F.P.methods.

c) Attitude towards Women's Health:

The present outlook of the medical system with regard to the women's health in general and the Family Planning in particular is oppressive. Being a part of this set up ANMs are also infected with this attitude. The ANMs should be helped to discard this attitude of seeing the problems of women through the male's eyes - with indifference, contempt and coercion, and should be helped to learn to see the women's health problems through the women's eyes and understanding. ANMs can also help women in general to get rid of the guilty feelings and ignorance about their own health and learn to have a positive attitude towards their own body and health.

iv) Nutrition and health education:

Being a woman, ANM can best convey the message to the women including mothers who form the most important target group for the purpose of nutrition and other health education.

v) Curative Services: ANMs have limited curative powers today. A diploma holder doctor is allowed to use all the medicines. Why can't an ANM use more medicines to be able to treat most of the common illnesses with some more training of this role?

"An auxiliary can treat 90% of children's sicknesses"

-Rural health Research Centre, Narangwal.

"I am convinced that in any field of health technology, it

will also improve the status and acceptability of the ANM by the community as important health functionary.

vi) Other Health Functionaries:

The 'village health worker' (VHW) who should essentially be a female and the 'rural obstetrician' - Dai - are the further steps of the same logic. They should be welcome in the health care system.

ANM, VHW and Dai together can form a strong female infrastructure for the community health care. They together can manage more than 90% of the health problems of the community and specially of women. Such female network will greatly help the women of the rural areas who don't have an access to proper health care today.

vii) Role in Hospitals: The nurses in the developed countries perform much more complex duties independently. There is no reason why our general nurses should merely be robots. They can be and should be given more responsibility, respect and freedom.

viii) Corrective Measures:

To enable nurses to grow to these fuller potentials, certain steps are essential.

(A) Increasing the woman-power:- In 1971 ANM: population ratio was 1:13170. The Govt. has recognised the importance of ANM and has set the target of one female multipurpose worker(formerly called ANM) per 5000 population to be achieved by 1985.(6) But even this ratio is also inadequate. Ramalingaswami Committee (1980) has recommended one for 3000 population.(7)

To meet this target number of the nurses training schools and the training capacity will have to be increased manyfolds. Though both - general nurses and ANMs, are needed in much larger number to reach the optimum reqirements, the priority should be given to the ANMs as they will form the backbone of the rural community health care.

(B) The training facilities will have to be improved not quantitively alone but qualititively as well. The living and working conditions should improve. The training should not be geared to use the student nuses as a pair of hands for the hospital routines. The training should be more community oriented and community based than hospital based.

(C) The new upgraded and expanded role, functions and status of the nurses in health care should be clearly defined and their training and working conditions suitably modified.

eyes on admission in medical college, a shift in the focus will be vehemently opposed by this class and the doctors.

2) Role in the social change:

(A) The present problems of nurses are essentially the problems of the woman, of the manual worker, of the low socio-economic group. Nurses cannot get their new role and the just status unless the social system and its values change. So the nurses will have to identify themselves with the problems of women and poor in general.

(B) The nurse is probably the only professional group which is so exclusively made up of the women. The problem of this profession are the problems of the women. So through their own issues it is possible to make them aware about the problems and exploitation of the women in our society; and then they can be organised and activised to fight against this. Nurses have two strong levers for this purpose.

i) ANMs will have close contact with female VHWs, Dais and the women of the rural areas. They will have an entry point like health work. These two advantages they can utilise to work among the rural women to help them understand the problems of women in the society and to fight against them.

ii) General Nurses are the arteries of the hospitals. During the crucial moments in the women's fight for justice, the GNs can utilise their unique power to paralyse the most essential service and turn the balance in the favour of women.

Thus nurses as a profession have emmense potentials to play the key role in the struggle of woemn for justice and emancipation.

It is high time the activists and the organisations in the feminist movement realise this and concentrate on the nurses than on the urban middle class women alone.

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REFERENCES:

1. Unless mentioned otherwise, all the figures are based on - Cahp - Tnai (The Co-ordinating agency for health planning and Trained nurses association of India) Nursing Survey in India,1975.

Com H 11.2

COMMUNITY HEALTH SEMINAR

(E C C January 29th - February 1st, 1981)

(Notes for possible development for talk on "Community Health & Development - Perspectives and Problems". These are notes jotted at various times - snatching minutes as thoughts passed through as they came along monthly, with some rearrangement on 29.1.1981)

The Dictionary definition of "Perspective" says: "apparent relationships between different aspects of a problem without exaggerating or neglecting one aspect - i.e. with proper attention to all points". I shall try to keep this definition in mind as proceed to think on this. It is not easy to give "equal attention" to " all points".

I. It is necessary to start with some definitions of terms any way :

1. Community Health is that area of concern and activity which deals with health of groups of people (communities) as district from health of individuals (though the latter cannot be in any way ignored) and one where the Community takes responsibility for its own health care.

2. Community Development is that area of concern where the material and non-material aspects necessary for the wholesome and all-round development of Persons (human) -in- Community. It is more than improvement in the Gross National Product (GNP). It has to do more with qualitative improvement than with Quantitative aspects, though the latter cannot be ignored.

It may be better to consider the processes involved as a process of "transformation", rather than one of quick or violent "revolution".

II. LOOKING BACK TO GO FORWARD

1) Concepts and levels of understanding the processes of being healthy, and losing health and falling sick have changed immensely; such changes vary from culture to culture, and within a same nation or culture, varys with levels of "tradition- bounded-

"the" cause and eliminate it.

3) Soon the above hopes were shattered.

Better understanding dawned. It become increasingly clear that multiplicity of factors - including social, economic, cultural (including religious or "quasi-religious) and political factors as important determinants, in addition to the already well-understood physical and biological environmental factors.

4) In providing services helpful for maintenance of health - "Technocrats" with their Technologically determined power, often recided on the health care strategy. It was improved.

5) "Technocracy", it was realised is fact of the preventing political system or "ideology".

6) Thus, Health Care delivery systems could be seen to have district differences and characteristics depending on the political ideologies of Countries.

7) Many societies (Nations, cultures) got over-influenced by the fast moving, and developing "Western technology" and these tended to determine and condition the health delivary systems which are now being increasingly recognised to be "inappropriate" and"irrelevant".

III. SO WHAT?

a) If we are to go back to our own ideal requirements, attaining a "high quality life" (healthy life), though Community Health and Development Programmes, where there is genuine community participation, and all rural human transformation is likely to result, then we have to examine our own (several) situations, existing programmes.

b) Further critical examination of existing situations, shows that there has been (Ref.D.Bannerjee : Community Health in Asia Ed.Susan Rofkin p. 27)

i) "Mystification" of Scientific Technology - Needs De-mystification

ii) Undue "Professionalisation" - " De-professionalisation

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the "Democratisation Process" as of now in India requires a careful look.

If one of the key factors in Community Health and Development is Genuine Community Participation, then their special efforts are needed to ensure this -

How far is this effective in Societies where centuries of a feudal system has made large masses apathetic and indifferent.

It can be shown that in general there are three basic types of participation:

1) Local "elites" often making decisions - very common
2) People acting in an advisory capacity to "elites" in authority. Eg. Planners, or community organisers (outsiders) in "post facto" consultation with people groups.

3) People sharing in, or controlling, local political decisions affecting their lives. (Genuine people's participation) (Ref: Peoples Power : Community participation in Planning of Human Settlements - by Mary Racelis Hollnsteiner - in contact Spl. series No. 3 chapter V).

David Warner has analysed situation which can be either Community Supportive (i.e. where genuine community participation occurs) or Community oppressive (where authoritarian styles prevail. This is given in the appendix.

IV. P RO B L E M

i) Genuine Community Health includes Human Development in a "holistic" sense.
Is it possible to achieve this with Medical Technocrates as leaders of the team.
What is the model that should emerge.

ii) Is Genuine Community Participation "desirable" in "Immutrate" (so-called) Caste-ridden societies, where splinter "power-groups" vitiate genuine community participation.

iii) Ultimately, "change" has a political dimension

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HEALTH CARE SYSTEM IN INDIA

AN ANALYTICAL STUDY

- Ajit Muricken -

This article seeks to identify and analyse the major socio-economic and political constraints on the health care system in India, and to project an alternative approach in which the majority of the Indian masses will have equal share and participation in ensuring their better health.

The division of mankind into rich and poor brings about inequality in health care just as sharply as it does in any other aspect of life. The reality and depth of the problem arises because the few rich appropriate the benefits of every advance in medical science. It is their needs the medical system caters to. The Health Ministry acknowledges that 3/4 of the state Budget for health is spent on Elitist needs while only 1/4 is directly used for the rural masses. There are no sustained efforts to tackle the prevalent diseases among the poor or provide minimum maternity and child care facilities. This is the general pattern that exists in all the developing countries. Patients are poor with all that this entails in terms of nutrition, education, employment, housing etc. and are reckoned to be hungry or undernourished or both.

The decisive factor effecting health in developing countries is poverty rather than tropical climate. The diseases that are mainly due to poverty were at one time universal. Many countries in the temperate zone have undergone industrial revolution, which has enabled them to conquer poverty and thereby control diseases. Diseases resulting from poverty have since retreated to the countries which remain poor and these happen to be in the tropics. Thus anaemia, communicable diseases, T.B. etc. which were common in developing countries prior to the industrial revolution, are now largely confined to the tropics and are labelled tropical diseases. Actually these should be called the "diseases of the poor" because they are less a result of climate than a consequence of the social and economic conditions prevailing in the tropics. "At most climate is an intervening variable. In fact, the tropical diseases have become endemic or epidemic in large areas as a result of colonicalism and the ecological disturbances indirectly brought about by this process". Poverty thus plays a double role in

malnutrition, diseases and health perpetuated by existing socio - economic and political structure and culture.

TABLE

THE VICIOUS CIRCLE PERPETUATING LOW SOCIO - ECONOMIC STANDARD WITHIN THE SYSTEM

MALNUTRITION

GALORIC GAP
ILLITERACY
UNSADITARY CONDITIONS

LOWER STANDARD OF LIVING

ILLNESS - TUBERCULOSIS
ANEAMIA
INFECTION

LOW PURCHASE POWER

UNEMPLOYMENT
UNDEREMPLOYMENT

POOR EARNING CAPACITY

Since Independence the Indian Government has pursued health politics which give priority to the training of medical personnel, construction of hospitals. and extension of medical services to the country side through "primary health centres". The number of doctors increased from about 50,000 in 1947 to more than double in 1968 - 69 with a consequent increase in the doctor - population ratio from 1:6300 to 1;5100. Further expansion was planned in the Fourth Year Plan which envisaged a rise in the number of doctors to about 1,40,000. This would bring down the ration to 1:4300, which is still above the WHO norm of 1:3500.

INFRASTRUCTURE FOR HEALTH CARE (AS AT THE END OF PLANS)

	I plan	II Plan	III Plan	IV Plan (anticipated)	V Plan (targeted)
Hospitals & dispensaries	10,000	12,000	14,000	N.A.	N.A.
Hospital beds	123,000	185,000	240,000	281,000	321,000
Primary Health Centres (PHC)	725	2,800	4,900	5,250	5,351
Sub-centres of PHC's	N.A.	N.A.	N.A.	33,000	44,026

	I plan	II plan	III plan	IV Plan (anticipated)	V plan (targeted)
Auxiliary nurses midwives	12,780	19,900	35,000	64,600	N.A.
Health visitors	800	1,500	4,200	N.A.	N.A.
Nurses - aids	6,400	11,500	28,000	N.A.	N.A.
Sanitary inspectors/ Health inspectors	4,000	6,000	18,000	32,000	N.A.
Pharmacists	N.A.	42,000	48,000	66,000	N.A.

These data concern only "Western Medicine". If we take traditional medicine into account, we must add 195 hospitals, 9 dispensaries and 1,55,831 institutionally and non-institutionally qualified ayrvedic practitioners. These statistics show a striking progress. There has been a similar, though less pronounced, increase in the number of nurses, midwives and other medical personnel. Since Independence, 54,000 auxiliary nurses have been trained. The institutional network has been extended and more or less every panchayat now has its primary health centre (5200 as of March, 1974 with 32,000 sub-centres).

Health Service system: India has developed a referral system to meet health needs. This system is based on the idea that patients are to be treated as close to their homes as possible in the smallest, most simply equipped, and most humbly staffed unit that will still look after them adequately. Only when a particular unit cannot care for a patient adequately is he to be referred to a unit higher up in the chain. The chain consist of the health centres the district hospital and the national hospital. The basis unit is a primary health centre with 10 beds. The next unit is a divisional hospital with about 50 beds staffed by specialists in surgey and gynaecology. Next there is a district hospital with 300-500 beds and more specialist staff. At the top of the ladder is the teaching hospital.

Does the referral system function? Often it fails because few hospitals have health centres close enough that referred cases can be admitted. Lack of transportation facilities greatly impede the working of the system.

Many communicable diseases have been eradicated. The death rate has come down from 27.4 per thousand in 1949-50 to 15 per thousand in 1971, while life expectancy has increased from 32 to 50 years. This has resulted in rapid expansion of population with 2.5% annual growth

Among priorities in National Health programme are:

1) Control of communicable diseases 2) Water supply
3) Sanitation programme 4) Nutrition & 5) Family planning.

The rural health services in India are carried out through more than 5200 primary health centres with their sub-centres, at the rate of one of every 10,000 population. Each primary health centre provides health services for people of one community development block of about 100 villages and each sub-centre for 10,000 people. "And yet, our health standards are still extremely low and great majority of our population, very vulnerable. The mortality rate is 15.1 per 1000 and Infant mortality rate 122 per 1000. Life expectancy and birth is much greater for the rich than for the poor. Inspite of all our health campaigns, communicable diseases remain rampant. In 1973 for example, we had 1,498,961 cases of Malaria, 34,972 of Cholera and 75,904 of smallpox. Out of the 15 million people in the world who are affected by blindness on account of trachoma 4 million are India. 60 to 80% of these cases were preventable. In our country, there are moreover 9 to 10 million victims of goitre and about 20 million of filaria, while the cases of active T.B. and leprosy are numbered to 8 and 3 million respectively". (Manorama Year Book 1975. pp.425-27).

Some 450 newly built primary health centres were without doctors in 1970 and many more had only one doctor instead of two. An approx 80% of the doctors practise in towns where 20% of the population lives. Since Independence about 25,000 doctors left India to work abroad. The rest who remained prefer to work in cities or as private practitioners, set up practise where they can find patients who can pay them well enough for their services. The government posts are of necessity poorly paid, and doctors used to town finds it difficult to put up with the deprivation associated with work in rural areas. As a result there has not been any significant progress in health care, at least in the rural area.

Great Paradox. Most of our people still live in a rural environment, where they are deprived of many basic goods and apportunities which are normally found in urban settings. The most blatant form of deprivation is in respect of health care. 80% of our doctors and 90% of our hospital beds are at the disposal of the urban population which represent only 20% of the total population. These institutions have grown in total disregard of the needs of the country. A simple

In rural areas the rate is even higher, being 110-120 per thousand.

According to the ministry of health, most of the investment in our Five Year Plans is meant for building sophisticated hospitals and training doctors, both of which hardly serve the rural population. Besides, 3/4 of the state budget for health is spent on the running more or less the elitist institution while only 1/4 is directly used to meet the real needs of the masses. In the Fourth Plan, for example, only a sum of 700 million rupees was allocated for rural hospitals and health care of out of a total outlay of 3610 million rupees. This is out of proportion to the population and their needs. Less than 1/5 of the total was budgeted for the less favoured 4/5 of our population. Consequently, majority of our rural population remain without basic medical facilities.

UNEQUAL DISTRIBUTIONS OF MEDICAL SERVICES

POPULATION	600 Millions	Distribution RURAL 80%	URBAN 20%
MAN - POWER	Tot.Ratio		
Doctors	136,000	20%	80%
Doctor-people ratio		1:5000	1:20.700 1:1.300
Nurses:G.N.	72,000	10%	90%
A.N.M.	44,000	82%	18%
L.H.V.	6,000	92%	8%
practioners of other medical systems	300,000	1:2000	
Field workers (Health inspectors Health Asst. for M.C.H., F.P. etc)	204,000	1:2700	

THE BIAS IN favour of sophisticated urban hospitals with specialists at the cost of rural areas reflects the structural dualism inherent in the Indian Society. The dualism consists in the generally growing economic desperities between the urban and the rural areas, between regions within countries, between the minority who enjoy full remunerative employment and the vast majority who lack adequate (or any) means of earning a living. It is within this structure that the economic, political and ideological aspects of health

to that of the economic system where the rich urban sector gets more health service than the depressed rural sector. Moreover, the concentration of wealth and political power in the hands of transnational coroprations and industrial monopoly houses explains the health care system's orientation towards Western drugs, and advanced medical technology. Development of local medicine and of local technique is a threat to the profitable medical-industrial monopoly of the Western drug companies.

Pills against poverty: Prevalence of the 'germ' theory of disease has brought about the discovery of wonder drugs and subsequently the emergence of the drug industry. "Instead of the medical profession responding to the needs of the people with drugs geared to help in this process, it is the drug industry which dictates to the medical profession WHAT' to prescribe. Profit and the class interests of the members largely determine the nature of the service provided - it is the case of the tail wagging the Dog".

Alternative approach: The Health problem is not a technical problem which can be solved through improved techniques or by providing hospitals, medical experts and medicines. Many facilities introduced under governmental or private auspices in India fail to reach the toiling masses. They tend to be appropriated by a privileged minority with social influences, economic power and political pull. Thus efforts, in themselves praiseworthy, for the good of the 'common man' tend to benefit the existing power groups, and not the people they are meant to serve. Therefore the demand for health is a political problem. For quality of access to health care the masses will have to be organised for struggle against economic and political domination. Otherwise the majority in the country will remain on the margin of health services.

The most dangerous disease sweeping Asia today is poverty, and medical science has no miracle drug to eradicate it. Poverty has been considered as the vicious cycle of small income, malnutrition, disease and death perpetuated by existing social system. Problem of health care is therefore, linked with the socio-economic problems. Certain social relations are responsible for the poor continuing to live in conditions of ill health. They are the relationship of property, ownership, and power.

A "purely clinical"therapeutic biological approach to illness

can provide adequate health care, that medical care can be divorced from preventive measures and that 'hospital centred systems' are without reservation the most appropriate means for solving the problem of a community's health.

As against the purely clinical approach there is the non-clinical one which perceives the peoblem of health not as one of disease alone. The health of a community is more significantly determined by social and economic factors. Poor health is because of poor living. Consequently, only by changing the living pattern i.e. the socio-economic and political life of the people that improvements in health can be brought about. Structural and institutional changes in society are an essential proroquisite not only for achieving freedom from disease or the threat of disease, enable one to live healthily. The indices therefore to measure health in the present system is not in the nature of weighing death loads and disease but they are:

1. A genuine redistribution of land.
2. Removing of social and economic injusties
3. Elimination of highly monopolistic control over industries and in general, a redistribution of assests in favour of the base of the social pyramid.
4. Proper agricultural production and marketing.
5. Promoting primary health care of all.
6. Easy acess to curative medicine.

You will note that I have listed curative medicine as the last criterion because health is determined by overall economic development and good health cannot be maintained in an economic and social vaccum. A clinical view of health would have used "curative" as the main criterian because it tries to "eradicate" disease by curing the sick, and forgets the fact that no sooner is the patient cured than he sinks back into the mire of poverty and falls ill once again, often within days of his treatment.

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THE ECUMENICAL CHRISTIAN CENTRE, WHITEFIELD, B'LORE-16

Seminar on Community Health - 29 January - 1 Feb 1981

REPORT AND RECOMMENDATIONS

The seminar on Community Health, sponsored by the Ecumenical Christian Centre in January - February was attended by 40 men and women -- doctors, nurses, para-medical workers, representatives from medical colleges, hospitals and community health workers involved in tribal, slum and rural areas from all over India. The seminar affirmed that community health work should be 'self destructive' and that it should not be institutionalised. The community health workers should be prepared to move to fresh areas at a stage when their services are not required for the people.

PERSPECTIVES:

The ultimate aim of the community health work should be structural changes where in each person's dignity is honoured and his/her physical, mental, social and spiritual well being is taken care of. It should function as a catalyst creating awareness for structural change at the grass root level as well as conscientising or even pressurising the power structures. The poor people should be made aware of the extent of the exploitation and oppression and should be motivated to fight for their rights.

APPROACH:

Health work should not be done in isolation from other development activities. Otherwise it will turn out to be a hap hazard patch work which postpones the radical change required. Genuine participation of the people in the health programmes should ensure decision making by the people at all levels, in planning and implementation. Community health programme should be preventive rather than curative. Periodical evaluation of the work will ensure effectiveness.

COST:

It is high time that community health workers should resort to cheaper medicines which the community can afford. Indegenous medicines should be encouraged as far as possible. Awareness should be created among the medical personnel not to be biased

PERSONNEL AND TRAINING ;

The content of the training of the community health worker should be the simple medical knowledge. Apart from the medical education they should be trained how to educate the community about their rights and about the exploitative nature of the society at the micro level. The trainee should be a person who accept the basic perspectives of the programmes. He/she should have leadership qualities. The community health worker who undergoes training should be acceptable to the community. They should be paid a fair wage.

There is dire need to change the present system of education of the doctors and other medical personnel to make it relevant to the realities of the country.

GOVERNMENT AND OTHER AGENCIES:

The community health workers should help people to obtain the maximum benefit from the government. In the actual health services their work should complement rather than compete with the government or other agencies. It is highly essential that duplication should be avoided at all levels. Co-operation and common programmes should be encouraged with groups having the same perspectives.

RECOMMENDATIONS:

I) Bring down the cost of health care and drugs.

II) Indegenous medicine especially the use of herbal medicine should be encouraged.

III) The Christian Medical Association, the Catholic Hospital Association and the Voluntary Hospital Association should work together in dealing with the problem of community health especially in--

1. manufacturing low cost medicines in bulk for the use of non-profit making service organisations.
2. Central purchasing and distribution of drugs.
3. Research and publications.

IV) A forum should be formed to educate people about the false propoganda, promotion and use of unnessary drugs and tonics.

HEALTH - MEDICINE & UNDER DEVELOPMENT

adapted from L. Doyal & I. Pennell

There is a great disparity between the state of health of the population of developing countries and that of the industrialised countries.

The tropical climate of most developing countries is only a minor factor for this disparity.

The health problems of these countries cannot be considered and tackled only as technical problems. We cannot properly understand them and try to overcome them without analysing their socio-economic context - and taking into account the real nature of contemporary underdevelopment.

UNDER DEVELOPMENT OF HEALTH :

The major diseases in the third world fall into 2 basic categories :

1. diseases associated with malnutrition.
2. infectious diseases.

Malnutrition and infection are responsible for the majority of deaths and illnesses in underdeveloped countries, particularly in children under five, who account for at least half of all deaths.

Malnutrition is a common feature of underdevelopment and has a crucial influence on patterns of death and disease. In India it is estimated that 70% of the people i.e. 420 million live below the subsistence level, that means "the minimum required diet for a moderate activity" (2,250 calories per day).

Malnutrition can constitute a primary cause of death, especially among babies and young children - and there are at present about 60 million children in India who are malnutrished.

It is also a major contributing factor in infectious diseases because it reduces initial immunity and chances of survival.

Infectious diseases can be subdivided into 3 groups, according to their method of propagation.

1) Faecally - related diseases are transmitted through contacts with human faeces, the most common being the intestinal parasitic and infectious diarrhoea diseases. They also include polio, typhoid and cholera. These diseases are a major cause of death, especially among children, or chronic debilitating conditions.

Such diseases are a consequence of inadequate sanitation and contaminated drinking water.

There is little evidence that progress is being made in providing such fundamental necessities of life for the masses.

2) Air-borne diseases are largely spread by breathing the respiratory secretions of infected persons, and include T.B., diphteria, whooping cough, meningitis, flu, measles, small pox, chicken pox and others.

The spread of these diseases is greatly facilitated by the over-crowded and inadequate living conditions, common to expanding cities.

3) Vector-borne diseases are caused by parasites which are transmitted to human beings through disease carriers such as mosquitoes (Malaria and Filariasis).

As for the infectious diseases many of them have spread through colonial conquest, slave trade and even by the environmental changes, consequence of technology.

At the same time, the socio-economic relations between the industrialised countries and the developing ones have so far prevented these last ones from adopting the solutions that were available to meet similar health problems in last-century Europe (the provision of public health measures and better general living standards): the necessary capital for these measures was achieved largely at the expense of their underdeveloped satellites, whose economic wealth was pumped out to finance the development of the West.

To the extent that such exploitation continues, it is clear that the mechanisms of imperialism, preventing autonomous economic development in the third world, are part of the obstacle to the solution to these problems.

In this context, there has been a widespread export of "Western medicine" to the third world.

It started with medical facilities for the European staff in the colonies, and with the penetration of the Christian missions. In the context of continuing economic dependence, and consequent constraints on independent national development, throughout the capitalist dominated third world there has been a growing acceptance of the "western medical model" as a way of mediating between man and disease. This implies a hospital-based high technology curative medicine dispensed on an individual basis.

Scientific medicines with its associated drugs and technical equipment tends to be seen as one of many attractive goods on the international markets.

This has particular appeal for the local bourgeoisie, whose patronage has contributed greatly to the adoption of private Western medical care.

The expensive of such a system restricts medical services to the urban areas where the rich are concentrated. The majority of the people in the developing countries, on the other hand, live in small scattered rural communities and cannot afford medical services even where they are accessible. In India 80% of the doctors and 90% of the nurses work in urban areas where 20% of the population lives.

In addition, the practice of Western medicines, with its individualistic curative bias, is inadequate to deal with the problem created by the underdevelopment of health. We are not underestimating the very substantial benefits of Western medicine. However, few of these benefits can be mobilised for the global alleviation of suffering and disease when the economic relations under which they are produced perpetuate conditions which give rise to the suffering and disease in the first place.

The expensiveness of allopatic medicine in the third world, for example, has less to do with its real costs than with the nature of technological dependence, and the profitability to mulnational firms of maintaining it.

1. The most important example of this is found in the drug industry where a small number of powerful corporations based in Europe and the US dominate the international market.

2. Other profitable areas of medicine are related to hospital development. Apart from the vast capital outlay required for hsopital construction, running costs are very high because of the technical installations which can only be restocked through imports. Prestige hospital developments distort the whole balance of health expenditure while being totally inappropriate to meeting real needs. Though

Approved curricula demand a long and expensive training, and the selected candidates come from a small elite with good secondary school. Morover, the medical socialisation they receive inculcates "trained incapacity for rural practice, which is itself the product of the British system of medical training within large centralised hospitals". Instead, they are encouraged to adopt 'professional' ambitions which can only be satisfied by urban-based private practice or by emigration, both of which contribute to the distorted pattern of health care in the third world.

Control over medical education by the internationally organised madical profession, in conjunction with economic command on the market by capitalist states, had added skilled man-power to the drain of resources from the third world to subsidise high-cost health care in the rich countries.

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Code No. 52.

From "HEALTH CARE AND HUMAN DIGNITY"

by David B. Werner.

I would like to summarize a few of the steps that economy being taken, or might be taken, to implement a regional or country-wide approach to rural (or periurban) health care which is more genuinely community supportive.

1. Decentralization. This means relative autonomy at every level. Advice and coordination from the top. Planning and self-direction from the bottom.

2. Greater self-sufficiency at the community level. This is, of course, implicit in decentralization. The more a community itself can carry the weight of its own health activities, both in cost and personnel, the less paralyzed it will be by break-downs in supply and communications from the parent agency.

3. Open-ended planning. For all the talk about "primary-decision-making by the community," too often a program's objectives and plans have been meticulously formulated long before the recipient communities have been consulted. If the people's felt needs are truly to be taken into account, program plans must be open-ended and flexible. It is essential that field workers and representatives from the communities - not just top officials - attend and actively participate in policy planning and policy changing sessions.

4. Allowance for variation and growth. If a program is to evolve, alternatives must be tried and compared. Substantial arrangements for conceiving and testing new approaches, methods and points of view should be built into the ongoing program. Also, private or non-government projects should be observed and learned from, not forced to conform or stamped out.

5. Planned obsolescence of outside input. If self-sufficiency at the community level is indeed to be considered a goal, it is advisable that a cut-off date for external help be set from the first. All input of funds, the earliest possible date when such assistance is no longer needed. Thus the outsider's or agent-of-change's first job, whether he be a medic or an agronomist, should be to teach local persons to take his place and, in so doing, make himself dispensible. Outside funding, likewise, should not underwrite ongoing activity, but should be in the form of 'seed' money or loans to help launch undertakings

be far fewer than is usually supposed. Most of the common health problems could be handled earlier and often better by informed people in their own homes. Health care will only become truly equitable to the extent that there is less dependency on professional or institutionalized help and more mutual self-care. This means more training, involvement and responsibility for and by the people themselves. It should include continuing education opportunities for villagers which reinforce their staying in and serving their communities.

7. More curative medicine. For a long time, health care experts have been pushing for more preventive medicine at the village level -- and with good reason. But too often this has been used as a convenient excuse to keep curative medicine completely -- or almost completely - in professional hands. Clearly, preventive measures are basic. However, the villagers' felt needs have consistently been for curative measures (to heal the sick child, for instance). If primary health workers are to gain the respect and confidence of their people, they must be trained and permitted to diagnose and treat more of the common problems, especially those when referral without initial treatment increases the danger to the sick.

I should point out that when I say "more curative medicine," I don't mean "more use of medicines." Overmedication, by both physicians and villagers, is already flagrant. I mean more informed use, which in many cases will mean far more limited use, of medications. But this will require a major grass roots demystification of Western medicine which can only happen when the people themselves learn more about how to prevent and manage their own illnesses. To promote such a change, the village health worker must have a solid grasp of sensible medicine and, in turn, help reeducate his people.

It is, of course, doubtful whether such a metamorphic awakening to sensible medicine can ever happen outside the medical institution until there has been some radical rethinking within it.

8. More feedback between doctors and health workers. When health workers refer patients to a doctor, the doctor should always provide feedback to the health worker, explaining in full clear detail and simple language about the case. This can and should be an important part of the health worker's and the doctor's continuing education.

9. Earlier orientation of medical students. From the very beginning of their training, medical students, should be involved in community health, and be encouraged to learn from experienced village health workers and paramedics.

10. Greater appreciation and respect for villagers, their traditions, their skills, their intelligence, and their potential. Villagers, and especially village health workers, are often treated like children or ignoramuses by their more highly educated trainers and supervisors. This is a great mistake. People with very little formal education often have their own special wisdom, skills and powers of observation which academicians have never acquired and therefore fail to perceive. If this native knowledge and skill is appreciated, and integrated into the health care process, this will not only make it more truly community oriented and viable, but will help preserve the individual strnegths and dignity of the health worker and his people. I cannot emphasize enough how important it is that health program planners, instructors and supervisors be "tuned in" to the capabilities and special strengths of the people they work with.

In Costa Rica there is a regional program of rural health care under the auspices of the Health Ministry which differs in important ways from the rural health system in the country as a whole. It has enthusiastic community participation and a remarkable impact on overall health. It may well have the lowest incidence of child and maternal mortality in rural Latin America. Its director is a pediatrician and a poet, as well as one of the warmest and hardest-working people I have met. The day I accompanied him on his trip to a half-dozen village health posts we didn't even stop for lunch, because he was so eager to get to the last post before night fell. He assumed I was just as eager. And I was; his enthusiasm was that contagious !

I will never forget our arrival at one of the posts. It was the day of an "under-fives" clinic. Mothers and patients were gathered on the porch of the modest building. As we approached, the doctor began to introduce me, explaining that I worked with rural health in Mexico and was the author of Donde No Hay Doctor. Frantically, I looked this way and that for the health worker or nurse to whom I was being introduced. As persons began to move forward to greet me, I suddenly realized he was introducing me to all the people, as he would to his own family. Obviously he cared for the villagers, respected them, and felt on the same level with them.

This, I must confess, was a new experience for me. I was used to being marched past the waiting lines of patients and being introduced to the health worker, who was instructed to show me around and answer my questions, while the patient, whose consultation we had interrupted, silently waited.

"This man is an exception!" I thought to myself. In our visits throughout Latin America, we found almost invariably that the truly outstanding programs have at least one or two key people who are exceptional human beings. These people attract others like themselves. And the genuine concern of people for people, of joy in doing a job well, of a sense of service, and the sharing of knowledge permeates the entire program clear down to the village worker and members of the community itself.

People are what make health care work.

Who are served?

few most privileged → majority in accessible areas → all the people

Who provides the key services ?

professionals (a few outsiders at high cost with long inappropriate training) → sub-professionals → local persons, traditional healers (many insiders at low cost with short, practical training) → health "team"

Where are training and services provided ?

large hospitals → modest health centre → small post or dispensary → home

Primary concern:

sickness (of individuals) → health (of individuals) → health, well-being and future of the community

Focus of action:

Curative → Preventive (water sanitation hygiene, vaccination, nutrition mother/child care family planning early Dx-Rx) → Integrate Development (health education, leadership, agriculture communications) Intermediate technology (conscientizacion land reform social reform)

Geographic coverage of outreach programs:

small, arbitrarily defined areas of great need (or beauty) → entire regions or countries

Sponsoring agencies:

many small pilot projects { private, foreign, religious } → national → international, centralized, decentralized

RURAL HEALTH PROGRAMS IN LATIN AMERICA

TWO APPROACHES

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Initial objectives	Open-ended. Flexible. Consider community's felt needs. Include non-measurable (human) factors.	Closed. Pre-defined before community is consulted. Designed for hard-data evaluation only
Size of progress	Small, or if large, effectively decentralized so that sub-programs in each area have the authority to run their own affairs, make major decisions, and adjust to local needs.	Large. Often of state or national dimension. Top-heavy with bureaucracy, red tape, filling out forms. Superstructure overpowers infrastructure. Frequent breakdown in communication.
Planning, priorities, and decision-making	Strong community participation. Outside agents-of-change inspire, advise, demonstrate but do not make unilateral decisions	Theoretically, community participation is great. In fact, activities and decisions are dominated or manipulated extensively by outsiders, ofter expatriate "consultants"
Financing and supplies	Largely from the community. Self-help is encouraged. Outside input is minimal or on the basis of "seed funds", matching funds or loans. Agricultural extension and other activities which lead to financial self sufficiency are promoted. Low cost sources of medicine are arranged.	Many giveaways and handouts: free food supplements, free medicines, villagers paid for working on "community projects" Village health worker (VHW) salaried from outside. Indefinite dependency on external sources.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Way in which community participation is achieved	With time, patience, and genuine concern. Agent-of-change lives with the people at their level, gets to know them, and establishes close relationships, mutual confidence and trust. Care is taken not to start with free services or giveaways that cannot be continued.	With money and giveaways. Agents-of-change visit briefly and intermittently, and later on discover that, in spite of their idealistic plans, they have to "buy" community participation. Many programs start with free medicines and handouts to "get off to a good start", and later begin to charge. This causes great resentment on the part of the people.
Data and evaluation	Underemphasized. Data gathering kept simple and minimal, collected by members of the community. Includes questions about the people's felt needs and concerns. Simple scheme for self-evaluation of workers and programs at all levels. Evaluation includes subjective human factors as well as "hard data".	Overemphasized. Data gathered by outsiders. Members of the community may resent the inquisition, or feel they are guinea pigs or "statistics". Evaluation based mainly on "hard data" in reference to initial objectives.
Experience and background of outside agents-of-change	Much practical field experience. Often not highly "qualified" (degrees).	Much desk and conference room experience. Often highly "qualified" (degrees).
Income, standard of living, and character of outside agents-of-change. (MD's, nurses, social workers, consultants, etc.)	Modest. Often volunteers who live and dress simply, at the level of the people. Obviously they work through dedication, and inspire village workers to do like-	Often high, at least in comparison with the villagers and VHW (who, observing this, often finds ways to "pad" his income, and may become corrupt). The health professionals have often

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Sharing of knowledge and skills	At each level, from doctor to VHW to mother, a person's first responsibility is to teach - to share as much of his knowledge as he can with those who know less and want to learn more.	At each level of the preordained medical hierarchy (health team) a body of specific knowledge is jealously guarded and is considered dangerous for those at "lower" levels.
Regard for the people's customs and traditional folk healing, use of folk healers	Respect for local tradition. Attempt to integrate traditional and Western healing. Folk healers incorporated into the program.	Much talk of integrating traditional and Western healing, but little attempt. Lack of respect for local tradition. Folk healers not used or respected.
Scope of clinical activities (Dx, Rx) performed by VHW	Determined realistically, in response to community needs, distance from health center, etc.	Delimited by outsiders who reduce the curative role of the VHW to a bare minimum, and permit his use of only a small number of "harmless" (and often useless) medicines.
Selection of VHW and health committee	VHW is from and is chosen by community. Care is taken that the entire community is not only consulted, but is informed sufficiently so as to select wisely. Educational prerequisites are flexible.	VHW ostensibly chosen by the community. In fact, often chosen by a village power group, preacher, or outsider. Often the primary health worker is himself an outsider. Educational prerequisites fixed and often unrealistically high.
Training of VHW	Includes the scientific approach to problem solving. Initiative and thinking are encouraged.	VHW taught to mechanically follow inflexible, restrictive "norms" and instruction. Encouraged <u>not</u> to think and not to question the "system"
Does the program include "conscientization" (consciousness raising) with	Yes (if it dares).	Issues of social inequities, and especially land reform are often avoided or glossed over.

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Manual or guidebook for VHW	Simple and informative in language, illustrations, and content, Geared to the user's interest. Clear index and vocabulary included. All common problems covered. Folk beliefs and common use and misuse of medicines discussed. Abundant illustrations incorporated into the text. The same time and care was taken in preparing illustrations and layout as villagers take in their artwork and handicraft.	Cookbook-style, unattractive. Pure instructions. No index or vocabulary. Language either unnessarily complex or childish, or both. Illustration are few, inappropriate (cartoons), or carelessly done. Not integrated with the text. Useful information is very limited, and some of it inaccurate. Many common problems not dealt with. May use misleading and/or incomprehensible flow charts.
	Manual contains a balance of curative, preventive, and promotive information.	Manual often strong on preventive and weak on curative information; overloaded with how to fill out endless forms.
Limits defining what a VHW can do	Intrinsic. Determined by the demonstrable knowledge and skills of each VHW, and modified to allow for new knowledge and skill which is continually fostered and encouraged.	Extrinsic. Rigidly and immutably delimited by outside authorities. Often these imposed limits fall far short of the VHW's interest and potential. Little opportunity for growth.
Supervision	Supportive. Dependable. Includes further training. Supervisor stays in the background and never "takes over". Reinforces community's confidence in its	Restrictive, nitpicking, authoritarian, or paternalistic. Often undependable. If supervisor is a doctor or nurse he/she often "take over", sees patients, and lowers community's confidence

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Feedback on referred patients (counter-reference)	When patients are referred by the VHW or auxiliary, the M.D. or other staff at the referral center gives ample feedback to further the health worker's training.	Doctor at the referral center gives no feedback other than instructions for injecting a medicine he has prescribed.
Flow of supplies	Dependable	Undependable.
Profit from medicines (in programs that charge)	VHW sells medicines at his cost which is posted in public. (He may charge a small fee for services rendered). Use of medicines is kept at a minimum.	VHW makes a modest (or not so modest) profit on sale of medicines. This may be his only income for services, inviting gross overprescribing of medicines.
Evolution toward greater community involvement	As VHWs and community members gain experience and receive additional training, they move into roles initially filled by outsiders - training, supervision, management, conducting of under-fives clinics, etc. More and more of the skill pyramid is progressively filled by members of the community.	Little allowance is made for growth of individual members of the community to fill more and more responsible positions (unless they graduate to jobs outside the community). Outsiders perpetually perform activities that villagers could learn.
Openness to growth and change in program structure	New approaches and possible improvements are sought and encouraged. Allowance is made for trying out	Entire program is standardized with little allowance for growth or trial of ways for possibly

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
RESULTS:	Health worker continues to learn and to grow. Takes pride in his work. Has initiative. Serves the community's felt needs. Shows villagers what one of their own can learn and do, stimulating initiative and responsibility in others.	Health worker plods along obediently - or quits. He/she fulfills few of the community's felt needs. Is subservient and perhaps mercenary. Reinforces the role of dependency and unquestioning servility.
	Community becomes more self-sufficient and self-confident. Human dignity and responsibility grow.	Community becomes more dependent on paternalisatic outside charity and control. Human dignity fades. Traditions are lost. Values and responsibility degenerate.
If outside support fails or is discontinued	Health program continues because it has become the community's.	Health program flops.
TACIT OBJECTIVE	Social reform - health and equal opportunity for all.	"Don't rock the boat." Put a patch on the underlying social problems - don't resolve them !
SPONSORING AGENCIES (There are notable exceptions)	Often small private, religious, or volunteer groups. Sometimes sponsored by foreign non-government organizations.	Often large regional or national programs co-sponsored by foreign national or multi-national corporate or government organizations.

Position Paper on Health Care and Justice*

When the Christian Medical Commission was formed in 1968, its first major activity was to evaluate the existing patterns of relationship between church medical institutions and the people they served. We are deeply conscious of the tremendous dedication and selfless service that have made church-related hospitals unique symbols of the proclamation of Christian love in action. Continuing contributions have been made in changing whole systems of service, providing pioneering approaches to ew geographical areas, opening new educational perspectives, and in all of this in demonstrating a high quality of concern. *Problems have now arisen which require new adjustments to changing conditions,* without derogating in any way the contributions of the past.

Ineffective Health System

One sign of trouble has been our inability to keep up with the progressive effort to match in the overseas setting the qualitative improvements in hospital care which have characterized the scientific surge in world medicine. This has required *a rapidly escalating investment in both facilities and personnel* so that increasingly specialized physicians can work with more elaborate and expensive equipment. Hospitals are doing more and more for the same limited number of patients.

The comments which follow are directed to those in all parts of the world who share our concern. The Commission's studies of the past five years have shown that the traditional hospital-based approaches have been both ineffective and inefficient.

Our approach has been ineffective in meeting the total needs of populations for both physical and spiritual healing. Community surveys show that we reach only a fraction of the people in a hospital's orbit It is no longer enough to say that our responsibility is only to provide a facility and then it is up to the people to come. Rather, the service personnel must take more initiative. The fact that the most intolerable health conditions are perpetuated immediately around our hospitals is scarcely a Christian witness. Deplorable health conditions cannot be casually blamed on prevailing social and political conditions. When we did not have effectual measures for health improvement, it may have been justifiable only to practise curative medicine. Now that we have increasingly pot-

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*The following statement on health care and justice represents a position paper adopted by the Christian Medical Commission at its 1973 annual meeting.
The Titles and italics are ours.

ent tools for both curative and preventive services, we must apply a whole new standard of priorities, based on careful analysis of those approaches which are most effective in improving health. Almost all hospitals are doing something about prevention, but no effort has been made to use a cost/effectiveness approach in getting a more appropriate balance between curative and preventive activities. A common response is that we will get around to prevention after we have taken care of immediate medical needs and emergencies. The seen sick patient before us has an emotional imperative that draws us away from such activities as caring for the unseen thousands of children around us who need better nutrition. But a concern for effectiveness will require *a better balance of preventive activities.*

The hospital-focused health care system is also inefficient. A clinica' condition that requires massive investments–especially in the most precious commodity of personnel time-could often have been prevented at a fraction of cost. This is especially true of the health problems that crowd the wards in poor communities. Our inefficiency is also evident *in the way we use time* within the hospital. Because of archaic medical prejudices about clinical care being the doctor's preserve, we do not turn routine treatment over to auxiliary personnel, although it has been abundantly demonstrated that they can care for 90 percent of illnesses as effectively as physicians. Patients must invest inordinate amounts of wasted time in waiting while nothing is done–both as inpatients and outpatients-while the harassed doctor is trying to get through a phenomenal daily burden, most of which could be handled just as well by others. The fact is that elaborate hospital facilities are designed more to serve the professional convenience of overly busy physicians than the well-being of patients. Most seriously, *the people are not given the education* that would permit them to take care of their own health problems. They are also not given *the compassionate listening* time needed to unburden their psychological problems and fears.

Unjust Health System

The Christian Medical Commission has shared with others increasing attempts to publicize these areas of concern. The generally favourable response has been most encouraging. Our further deliberations have now brought us to an additional insight, which we are planning to explore in more depth. We communicate our thinking at this time with the hope that we will get the widest possible participation in our exploration.

For Christians the most serious indictment of a primarily hospital-oriented health care system is that it is not only ineffective and inefficient but that it is also unjust. In fact, it is unjust partly because it is ineffective and inefficient. The technical inefficiency and ineffectiveness we must be sensitive to professionally, but those with Christian concern must be especially sensitive to the injustices of the health system.

The definition of injustice here starts with the conviction that *basic morality requires equitable distribution.* The greatest moral dilemma of medical care is to find the least unjust way to allocate scarce resources. We cannot just open facilities and wait for the centripetal and spontaneous inflow of patients. Our concern must be centrifugal in reaching out to all those in need. Accessibility has three sorts of constraints :

- geographical - and this means that we must decentralize services;
- socio-cultural - and this requires the removal of real or imagined barriers especially those that are culturally misinterpreted because the impersonal environment of the hospital tends to frighten the ordinary patient; we must also be prepared to help patients understand the root causes of their disease so as to promote prevention; and to help them adjust to questions such as, "Why did this disease happen to me?" 7
- economic - and here we need innovative ways of avoiding the dehumanizing aspects both of expensive private care and of free treatment through providing a mix of financial arrangements for care that is inexpensive while still being good.

Towards a More Just Health System

The primary requirement then is that *there be no discrimination* in the way we assume responsibility for total populations around our institutions. This does not imply forcing services on anyone but rather seeing that their needs are recognized and taken into account, and then reaching out to make services available to everyone in the area. Two steps are involved. First, instead of spending all our precious resources on those who come spontaneously, we must work out new ways of defining and providing a basic minimum of *services for all.* The definition of this basic minimum must be locally derived and strictly limited to ensure coverage. The second part of providing equitable distribution is to set and follow *priorities in care.* The purpose is to focus on the measures that will do the most for particularly vulnerable groups. This exercise must combine technical understanding with community participation in planning. A major result is that people are helped to solve their own problems.

Another pattern of differential deprivation of care is built into the institutional structure of the large modern hospital. Traditional village communities provided multiple *mechanisms for social and psychological support for the sick and their families.* Modern institutional organization becomes depersonalized, partly because size demands routines and these tend to be dehumanizing. As Christians we can try to compensate by being loving.

However, the institutional environment itself often discriminates against the families most in need of support. The provision of health care, particularly in a prestigious hospital, may combine technical excellence with procedures which are destructive of family and social relationships. Ill health in itself places great strains on personal relationships, and the way that problems are handled can be healing in strengthening bonds of caring, or grossly disruptive in callous unconcern for subtle relationships which form the fabric of life.

An important element in the effort to reduce injustice through better health care is to relate health deliberately to the *total development of the whole person.* Attention must be given to the needs of Individuals, families and communities. This requires real collaboration of health workers with those working *in the economic and political sectors of communit life.* It involves especially an awareness and willingness to do something about such problems as environment, malnutrition and the balance between population growth and development. An exciting possibility is to learn whether a simple, auxiliary-based programme of integrated health and family planning can be an entering wedge in the process of development, both through changing personal attitudes and expectations about the future and also by providing a community-based channel through which felt needs can be expressed.

We speak here mainly of discrimination in the distribution of services available to the communities surrounding hospitals. The same principles apply with even greater force *in the planning of regional and national health services.*

A truly community-based approach in health care offers a whole new range of involvement and potential renewal for the church. Showing love in action through healing can be a corporate service activity of Christians. With professional guidance, many community activities can be best done by simply trained auxiliaries and volunteers. But church involvement must not be exclusive, it must be inclusive of all who want to serve.

Conclusion

In summary, injustices arise because of:

1. inequitable distribution of scarce resources. This requires a basic minimum of services for all and priority arrangements to provide special services for vulnerable groups.
2. Communities and individuals do not have opportunities to participate in health care decisions, especially as they relate to total development.
3. the health care system does not promote the wholeness of individual, family and community life through its tendency to

depersonalize individual care and disrupt interpersonal relationships, with those who suffer most often being those most in need.

This leads us to present three challenges to policy makers and funding agencies, to health workers and educators, and to all who share our concern. We reiterate that these challenges represent a new recognition that we hope to explore with many. The Commission commits itself to respond to these challenges and to the further insights that will come out of continuing efforts to improve our understanding and perception.

1. We share in a call to openness, to new vision and insight and *a daring readiness to explore* complex relationships at the interface between science and human values.

2. The challenge to individuals is that in our daily working setting and relationships we must make our part of the action more just *in allocating more equitably* those resources we control. But we have to start where we are and use what we have as we move incrementally to innovation.

3. The corporate challenge is that *we review critically the justness of the health system a as whole.* This does not mean condemning or discarding the means and understanding that have contributed so much in the past. We can now build on the past with our new insights, just as those in the future will build more just systems as to-day's justice becomes tomorrow's injustice. We justify this call in the belief that there is no force as aggressive yet as healing as love.

Health System in India*

Our health standards are still extremely low and the great majority of our population, very vulnerable. The mortality rate, 15.1 per thousand, is considered high, and life expectancy at birth is much greater for the rich than for the poor. In spite of all our health campaigns, communicable diseases remain rampant. In 1973 for example, we had 1,498,961 cases of malaria, 34,972 of cholera and 75,904 of smallpox. Out of the 15 million people in the world who are affected by blindness on account of trachoma, 4 million are Indian; 60 to 80% of these cases were preventable. In our country, there are moreover 9 to 10 million victims of goitre and about 20 million of filaria, while the cases of active T.B. and of leprosy are numbered to 8 and 3 million respectively. But, why does such a situation still prevail after all our efforts and investments in men and money?

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*An extract from Duarte Barreto, "The Indian Situation", in "India's Search for Development and Social Justice" series, CSA Publications, Bangalore, 1976. PP. 24-25.

It should, first of all, be pointed out that the miserable health standards of our masses actually reflect the overall conditions of life which we have previously described. How can we expect people who subsist below the poverty line and suffer from malnutrition, to be in good health? How can the illclad, the homeless, those who live without safe drinking water and proper sanitation, avoid diseases? Miserable health standards almost unavoidably constitute a part and parcel of the life of the poor. To be born poor usually means to be born or to become unhealthy.

The very orientation of our health system also explains the poor health conditions of the masses. 80% of our doctors and 90% of our hospital beds are at the disposal of the urban population which respresents only 20% of our total population. Since Independence, about 25,000 doctors lef. India to work abroad, while 25,000 others remain more or less unemployed in our cities. According to the Ministry of Health, most of the investments of our Five Year Plans go for the building of sophisticated hospitals and the training of doctors, both of which hardly serve our rural population; 3/4 of the state budget for health is also spent on the running expenses of more or less the elitist institutions, while only 1/4 is directlmade use of the real needs of the masses. In the Fourth Plan, for example, only Rs. 700 million, out of the total Rs. 3,610 million for health, was allocated for rural areas. Less than 1/5 of our total health outlay was budgeted for the already less favoured 4/5 of our population! As a result of such factors, 50-60% of our rural population remains without basic medical fecilities. How much can each of our 5,200 Primary Health Centres, most often poorly staffed, financed and equipped, serve about 100,000 villagers? and how much can each of our 32,000 sub-centres, still worse off, serve a population of more than 15,000 people?

The general standards of life of our people and the overall organisation of our health system, therefore, explain, to a great extent, the miserable health standards of our people.

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NOT BISHOPS, BUT BUSINESSMEN

Drug multinationals have been sharply criticised in recent years for excessive overpricing and for their callous disregard of human needs.

But do they, after all, have something more to offer the developing countries than expensive remedies of little value. The New Internationalist arranged a debate between George Teeling-Smith, Director of the Office of Health Economics and spokesman for the British pharmaceutical industry and Sanjaya Lall an outspoken critic. GRAHAM HANCOCK watched from the sidelines.

The Office of Health Economics (OHE) occupies a plush suite in a building off London's Regent Street. The rent is paid out of an annual budget that has been voted for the last 15 years by leading pharmaceutical multinationals to enable the OHE to "look at the economics of health care in general". George Teeling-Smith, who directs the Office's business, describes himself as "a great believer in the market mechanism" - the best way, he says, to guarantee cheap and efficient drugs to the least developed countries, providing that there is an appropriate structure of domestic purchasing and health care delivery.

"There are two ways of distributing resources. One is the market mechanism where people are allowed to choose how they distribute their own resources. The other is distribution of resources by a bureaucracy. That is the Eastern European controlled economy system. An I think myself it has greater disadvantages than the market economy system."

Doctor Sanjaya Lall, a Research Fellow at Oxford University and author of a controversial report on the drug companies for UNCTAD IV, takes a rather different view. In his opinion the poor countries will never get the pharmaceuticals they need at the right prices unless they very firmly rationalise their drug imports.

He cites the example of Sri Lanka "which has basically no local drug industry at all but is just buying on the open market". Sri Lanka has set a rare example amongst the developing countries, says Lall, by drawing up a list of essential drugs and then setting out to buy these on the world market through a state corporation at the cheapest available price.

"The whole idea of setting up a priority list of drugs based on need is to encourage more rational prescribing and to reduce the number of drugs on the market. The idea is not that there are only 100 drugs for the least developed countries, but that there are 100 or so in the first-line list (mostly anti-infective) which are very widely distributed for use in the villages. The list should be decided upon by the appropriate health authority in consultation with pharmacologists, doctors, WHO and so on."

Lall would like to see every developing country with "a special committee to deal with "a special committee to deal with the whole rationalised drug list, to review new drugs coming every year, to update the list and to provide the necessary information to the country's doctors". He feels that the money spent by the drug companies on promotion of their products is altogether excessive and argues that "an alternative system could provide the same information to doctors at much lower cost".

Teeling-Smith: "But I think you would accept that if you rely purely on the bureaucrats and official government sources of information you will enormously stifle innovation....."

"Quite honestly, I just don't see the connection between innovation and promotion.

on older and less expensive products for which promotion doesn't really apply..... Pharmaceutical sales promotion applies to modern, innovated drugs. New drugs don't get used unless doctors are told about them and the only person who is likely to tell the doctors is the innovator: the manufacturer.

"Government interests, after all, are to keep costs down, so no government body is going to draw attention to new, better and more expensive drugs if there are older, cheaper ones that will do. Unless a manufacturer promotes the new innovation which, providing it is an important innovation, will be more expensive, nobody will. And I believe that the companies should probably decide what is the right level of expenditure from their own commercial experience."

Teeling-Smith accepts that the prices of drugs are not set in relation to production costs - "when you are buying a medicine what you are buying is the cure, and the technological know-how behind the cure. So, you can't reasonably relate the chemical ingredient cost to the selling price. You have to look at something much more complex, and that complex thing is the cost of innovation."

Once a new drug has been formulated, patent laws prevent other companies from copying and selling it themselves. So the innovator alone can set the price and reap a considerable reward. Return on investment in the drugs industry is higher than in almost all other manufacturing sectors; but, Teeling-Smith argues, this is something that the world must be prepared to accept if it wants the Research and Development (R and D) to go on, the new and better pills to continue rolling off the production line.

Lall concedes that the pharmaceutical companies do carry out important research and development but cannot accept this as a justification of high prices: "In the case of other consumer products - for example motor cars - you can see that a Rolls Royce is very different from a Mini. But when one branded drug sells at 20 times the price of another chemically identical one sold under a generic name you have to ask why? The answer is that doctors believe one drug to be more effective than the other because they have been led to do so by promotion.

"Of course the present market system does support a fantastic amount of R and D, and brings forth a lot of new drugs. But my problem is that it does so in a very costly and inefficient way. This is particularly so where poor countries are concerned. My argument is that at the moment they pay too much because the market mechanism encourages duplication of drugs, through promotion of brand names and produces a lot of drugs which developing countries don't need - what I would call 'rich men's' drugs.

"But there remain a number of new drugs which the developing countries really do need. So I would say, for the older drugs the answer is to buy as cheaply as possible. For the new drugs what is required is a preferential system that allows developing countries to pay less than the rich countries do. So how do you react to this proposition? A preferential system of pricing for useful 'rich men's' drugs so that the poor countries can pay less for drugs that they need but that were not developed primarily for them?"

"But that happens already on a national scale. Take Valium, for example, which might be used by one person in ten in the US and one person in a thousand in Pakistan."

"But I would say that the price of Valium in India and Pakistan should be substantially lower than the price in the US."

"This brings us back to the fundamental difference. You are again trying to move away from the market and into bureaucracy and I am saying that from my own viewpoint I have never been convinced that a bureaucratic solution necessarily reaches

drug industries was concerned: "Countries that try to develop only an indigenous industry are going to seriously disadvantage themselves because the best way to get technology transfer is very often to accept and welcome the activity of a multinational company."

Lall's position here was that the transfer of technology from rich to poor, the setting up of indigenous drug industries, was both desirable and inevitable. Groups of poor countries close to one another geographically, or sharing the same health problems, should, he felt, pool their resources to establish laboratories and initiate research. But he did not see them inevitably turning to the multinationals for help: "The developing countries are very keen to set up their own industry and this is something you can't deny. They want to promote domestic industry, domestic entrepreneurship, domestic ownership."

Teeling-Smith: "If you look around the world at countries where they have offered very favourable terms to the multinational pharmaceutical companies you can see the same pattern in different situations. Both Ireland and Malaysia for example, saw the advantage of transfer of technology in the sense of the substantial investment by the multinational companies in production and research. And they have made an economic climate which has attracted this investment..... The more stable the climate for the industry in the country, the more likely the company is to retain earnings in the local country. But if you think that your subsidiary may be nationalised next year you take all the profit you possibly can by every legal route out of the country. If you are perfectly confident that you have a firm base in a country you are prepared to not only take no money out but to put more and more money in."

Transfer pricing provided a good opportunity for the multinationals to take out their profits. By upping the cost of intermediary materials "sold" to the subsidiary they could reduce the apparent profitability of the subsidiary and therefore and therefore reduce the amount of tax paid to the local government. Lall: "The price of intermediate raw materials charged by a multinational to its subsidiary contains an overhead for research and development but it also contains a transfer pricing element designed to avoid the payment of taxes. Now if the aim is to ensure the best possible health care for the least developed countries surely the thing to do would be to cut out transfer pricing - or at least to have such an exchange of information between governments that a right transfer price could be established?"

"I don't think there is a right transfer price. You must understand that the reason the multinational companies try to grab back as much profit as possible out of the less developed countries is frankly because they are suspicious of the future stability of their operations there."

Another major problem discussed was the practise of labelling drugs differently in different countries. Dangerous side effects listed in the rich nations are often not mentioned on packages in the developing countries where consumers are less sophisticated. This enables the drug companies to sell drugs that might not otherwise have found buyers, but can mean the buyers die from perfectly preventable complications. What do the drug companies have to say to that?

Teeling-Smith argued that there was often a different balance of costs and risks for the more and the less developed countries: "I would just be talking rubbish if I were to say that the multinational companies were operating in the less developed countries primarily for the welfare of those countries. You seem to be saying that they should be setting an example but quite honestly, that is nonsense. They are not bishops. They are businessmen."

DOCTORING EVIDENCE

PEOPLE IN WESTERN COUNTRIES MAY BE HEALTHIER NOW. BUT ENVIRONMENTAL FACTORS HAVE PLAYED A MUCH GREATER PART THAN MEDICAL THERAPY IN DEFEATING DISEASE - AND ARE PROBABLY STILL THE MOST IMPORTANT CONSTRAINT ON HEALTH. YET THE MEDICAL PROFESSION ABSORBS MORE AND MORE OF OUR CASH. THE AUTHOR LOOKS AT SOME OF THE EVIDENCE FOR ITS EFFECTIVENESS AND ASKS WHETHER IT REALLY DESERVES ALL THIS TRUST AND MONEY.

"There is considerable difference between a good doctor and a bad one but hardly any difference between a good doctor and none at all."

This ungenerous reference to the medical profession by Francis Galton was made in the 17th Century. But it sums up the assessment of many critics of medicine today. The writings of Thomas McKeown and Ivan Illich among others have served to deflate the medicine men to the size of normal human beings (in some case below) and thrown into question much of our reliance on medical prowess and wisdom.

Such reliance, if in retrospect unwise, was at least understandable. When it comes to the crunch we know that we have just one weak vulnerable package of flesh and bones to last out our lives. So it is conforting to believe that, although the structure may be weak, there are people who understand such things who can tinker with the machine when it starts to stutter, and pour in some health.

From the earliest days doctors have seized and retained the role of professional dispensers of health, establishing it as a commodity which we all want and which they say they can supply.

The severest critics like Illich however, argue that they don't supply us with health and that such control over our bodies that they do have has been wrongly taken from us. Indeed his overall message is that doctors are a menace - an alarming conclusion but one with more truth to it than we care to admit.

You may find that difficult to believe because, compared with previous generations, we all seem healthier and brighter-eyed and live much longer. Over the last century or so death rates in the UK for example have been reduced by about 75%. But how much of the credit can the medical profession take ? The answer is : not much.

Thanks to the diligence of the Registrar General for Englant and Wales, we can see which diseases declined sufficiently to produce that cheering statistic. The figures given against the list below are the percentage of the reduction in death rate for which each disease is responsible.

Tuberculosis	18%
Bronchitis, Pneumonia, 'flu	10%
Cholera	11%
Convulsions, teething	8%
Typhoid, typhus	6%
Diptheria, scarlet fever	6%

But the really interesting point is that all these diseases had been falling away long before the medical profession had discovered the cures. The most significant fall, that of tuberculosis, is

The same was true of most of the other infectious diseases. Their decline was partly due to improved standards of nutrition which made the body better able to resist attack and partly to improvements in the treatment of sewage and the handling of food which restricted greatly the movements of the micro-organisms responsible for disease. Wide-spread drug treatment did not become available until the invention of sulphonamides in the 1930's and the antibiotics in the 1940's by which time many of the enemy had quit the field. And even since then it is doubtful that medical intervention has been the major factor in disease decline.

That is not to say that research has not had an important role to play in identifying the micro-organisms responsible. But the real heroes physically defeating disease have been the engineers and the sanitary inspectors although the medical profession is one which bathes in the reflection of our glowing health and tends to walk off with much of the credit.

History apart, you might think that today with our environment so much improved, doctors would now be the major influence on health. That is at least very unlikely. There are yet more factors to take into account. It has been calculated for example that, for the mature male, smoking wipes out for him half the advantage gained from the improvement in Western health over the last century. And it is likely that diets of low fibre and lack of exercise can similarly be major influences.

And one should not assume that poverty as a cause of ill-health has been wiped out in the rich countries. No-one would be surprised to learn that Harlem is not the healthiest place to live in New York. But even in Britain where everyone has roughly equal access to health care, there are disturbing discrepancies in health between social classes.

Figure 2 illustrates the point. The brutal fact is that if you are a manual worker in social class V you are twice as likely to die before 65 years old than if you are a well-heeled professional in social class I. And although over the past thirty years there is a tendancy for all social classes to live longer, the differences between them are, if anything, increasing.

Figure 3 shows the pattern for some of the major causes of death. Even heart disease is more likely to hit the lower classes before 65 and of course bronchitis, associated with dirty jobs and pollution, is seven times more likely to kill the manual worker. Motor vehicle accidents are more lethal to the poor partly, it seems, because more of them ride motor bikes, and also because they are more likely to be the vulnerable pedestrian. But whatever the reason - bad housing in areas of high pollution, poor food, dangerous jobs - the fact remains that in health terms as in so many others, it just does not pay to be poor.

Having read this far you may be willing to concede that the medical profession will probably come second to environmental and social factors as a determinant of health. The human body, it seems is not just an independent machine buzzing around the world, with occasional break-downs, but responds continually to environmental and social pressures. You may still feel, however, that doctors have a useful if comparatively minor role to play.

ignorance, or say there is nothing wrong with us, they will dish out a meaningless pill of sugar called a 'placebo'. This is Latin - a useful means of mystification - for "I will please" (although a rather more unkind translation might be "I am a Quack).

The willingness of doctors to accept this kind of role encourages many spurious and expensive contacts with their patients. A quarter of consultations in the UK, for example, are for the untreatable common cold.

The fact is that medicine is an inexact science, but doctors have sensed that this is something we don't want to know. If in doubt, they say something is wrong (we seem to prefer authorised sickness to uncertain health) and then claim to be curing it. And since as a result the connection with reality can at times be tenuous, there is often quite a wide discrepancy between what one doctor and another will do in the same situation. Prescriptions for vitamins for example are seven times more common in Britain than in Scandinavia and American doctors on the average will operate twice as often as in Britain.

Take the case of tonsillectomy (removal of tonsils). A fifth of children in the US undergo this operation despite the fact that in 90% of cases, it is technically unnecessary. In one memorable experiment back in 1934 from a sample of 1,000 children in New York City, 61% were found to have had their tonsils removed. The remainder were examined by a group of doctors who recommended removal from 45% of these. Those who survived this hurdle were passed on to another group who recommended tonsillectomy for 46%. Yet another group selected a similar percentage from the previous groups' rejects. In the end, only 65 children out of 1,000 had been advised to keep their tonsils. The number might have been even less had the experimentors not run out of doctors to examine them.

DISEASE CAUSED BY DOCTORS

This result would be laughable, but for the fact that 1 in 1,000 children die as a result of the operation and 16 in the 1,000 suffer serious complications. Scientific inexactitude can easily drift into actual bodily harm and indeed there is a medical term to cover it. This time the unpleasant concept is mystified into Ancient Greek as 'iatrogenesis' (iatros = physician: genesis: = origin) and means 'disease caused by a doctor.'

Iatrogenesis is a charge which Ivan Illich wields with particular ferocity. Indeed to cover the kind of activity involved for example with the dishing out of placebos he uses the term 'cultural iatrogenesis', saying that it destroys the individual's ability to suffer life and death with dignity.

But he reserves particular venom for clinical iatrogenesis: "It has been established that one out of every five patients admitted to a typical research hospital acquires an iatrogenic disease, sometimes trivial, usually requiring special treatment. Half of these episodes result from complications of drug therapy; amazingly one in ten comes from diagnostice procedures. Despite good intentions and claims to public service, a military officer with a similar record of performance would be relieved of his comand, [illegible] would be closed by the police."

Even if the conclusion is less extreme, one is bound to admit that the medical profession has become a focus of finance and influence and influence that has absorbed much of our own decision-making power and uses a disturbing proportion of it in its own interest. The worship of high-technology professionalism channels health resources in directions that we ourselves, were we in possession of the information, might not choose.

Did you know for example that a comparison of the recovery rates of people with heart conditions who stayed at home, with those in hospital in a cardiac intensive care unit (which requires three times the equipment and five times the staff needed for a normal patient) showed that there was absolutely no difference at all. Similarly for terminal-cancer patients there is no difference in life expectancy between those who die at home and those who die in hospital.

Doctors tend to vote for the glamorous (usually curative) activities which interest them with only secondary regard for society's needs. Recent surveys amongst UK medical students for example showed that despite the vital importance of community medicine, only 2% of students selected this as their first choice of career.

And disturbingly it is this kind of ethos which is being transmitted from rich countries to poor. Third World medical schools reflect Western attitudes and aspirations, give much the same kind of training, and make many of the same mistakes.

A recent study of five Latin American countries showed them to be spending ten times as much on medical case as on the provision of water and sewerage systems. Scarce resources can be directed in this way because some of the most influential and persuasive members of the health system are the doctors. When this is the quality of the decision one can only say that the safest way to treat medical pronouncements is with a healthy scepticism.

RUNAWAY TRAINING

TRAINING DOCTORS IN POOR COUNTRIES FOR HIGH TECHNOLOGY MEDICINE DIVERTS SCARCE RESOURCES AWAY FROM THE POOR. OVER-QUALIFIED PERSONNEL DON'T WANT TO WORK IN POOR AREAS - WHAT THEY WANT TO DO IS MIGRATE OVERSEAS. MILA LAHOZ REPORTS FROM THE PHILIPPINES ON THE FRUSTRATIONS OF ONE YOUNG DOCTOR ANXIOUS TO GET AWAY.

Cristina Agustin is an angry young woman - one of 1,200 Filipino physicians who received their medical licenses last year. And the source of her anger is the restriction on the entry of foreign medical personnel into the US, imposed by the US Congress last year.

"I'm so frustrated," Cristina stormed, "Here I am with 9 years of medical school behind me, and I feel all that schooling is inadequate to make a good doctor out of me." Cristina studied medicine at the University of the Phillipines, and interned at the Phillipine General Hospital. Both are generally con-

To support her conviction, Cristina pointed out the leading specialists in Manila. "Practically all of them are US-trained. I know of very few doctors who have made it to the top of the profession without benefit of foreign training."

Cristina's father is an afluent businessman, willing and able to support her financially for as long as she needs it. Her older brother and sister are both doctors in the US, working there for 5 and 2 years, respectively. At present, both have no concrete plans to return to the Philippines.

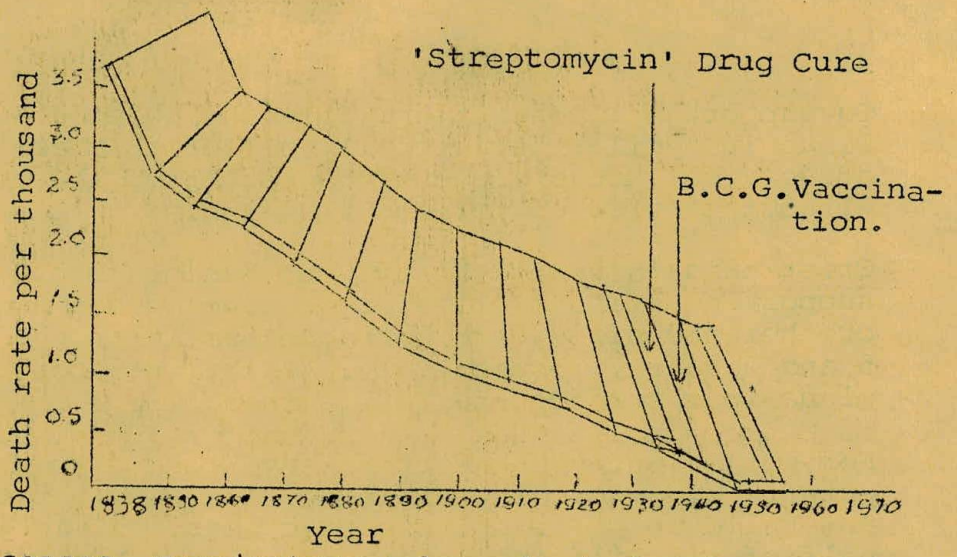
For while most young doctors have gone abroad with the express purpose of undergoing training, it is a fact that many stay on and build up their private practices. It is estimated that around half of all Filipino medical graduates are working abroad. And while there are around 10,000 active nurses in the Philippines, 20,000 Filipino nurses are abroad, most of them in the US.

And although young Filipino doctors cry out for more extensive and sophisticated training the most pressing health problems of the Philippines (respiratory ailments, tuberculosis, gastro-enteritis and parasites) do not require sophisticated technologies. Nor are the doctors in the right place. A third practice in Metro Manila, where 12% of the populace live: one doctor for every 600 people. But there is only one for every 9,000 citizens in the provinces and rural areas. Around 70% of Filipinos in the rural areas dies without seeing a d#ctor.

The Philipine government has realized the inadequacy of its public health care system, but has done little to correct it. There have been efforts at training 'paramedics' to deliver basic health care in the remote villages. But health priorities still have to be rationalized. In 1975, the health budget was US $ 91 million. That same year, the Heart Centre for Asia was constructed at a cost of US $50 million! The Heart Centre serves a few hundred cases each year. The only response of the Department of Education to the need for medical personnel in the rural areas took the form of an additional requirement in the form of 6 months of rural practice by graduating doctors and nurses. This was initiated in 1974, but many found the experience frustrating and demoralizing. One doctor said that he was unable to function in the rural health unit, without the medicines and equipment that he was accustomed to.

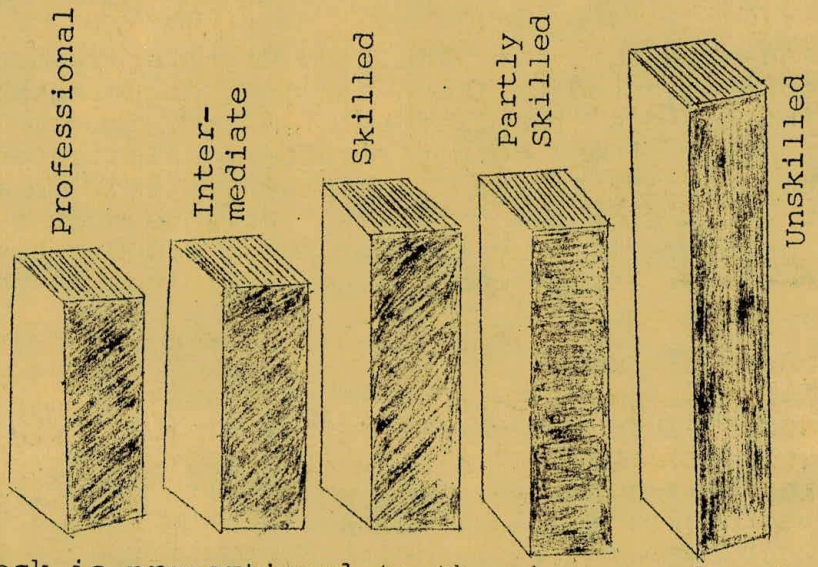
The restriction on the immigration of foreign doctors and nurses to the US is expected by many to benefit health services in the rural Philippines. But, these expectations may not be met. Philippine medical education almost exclusively attracts urban-oriented, upwardly-mobile students like Cristina who may be unwilling and unable to serve in the rural areas. "They talk to us about service and sacrifice, and exhort us to serve our countrymen. But I intend to serve them, when I return from America. And sacrifice ? I've sacrificed 9 years in medical school, sacrificed 6 months of rural practice, which I thought was a complete waste of time, and then we'll sacrifice 4 more years of unrealistic residents' wages. Those sacrifices I can take. But I'm not willing to sacrifice my professional growth,

1. DECLINE IN TB BEFORE DRUGS



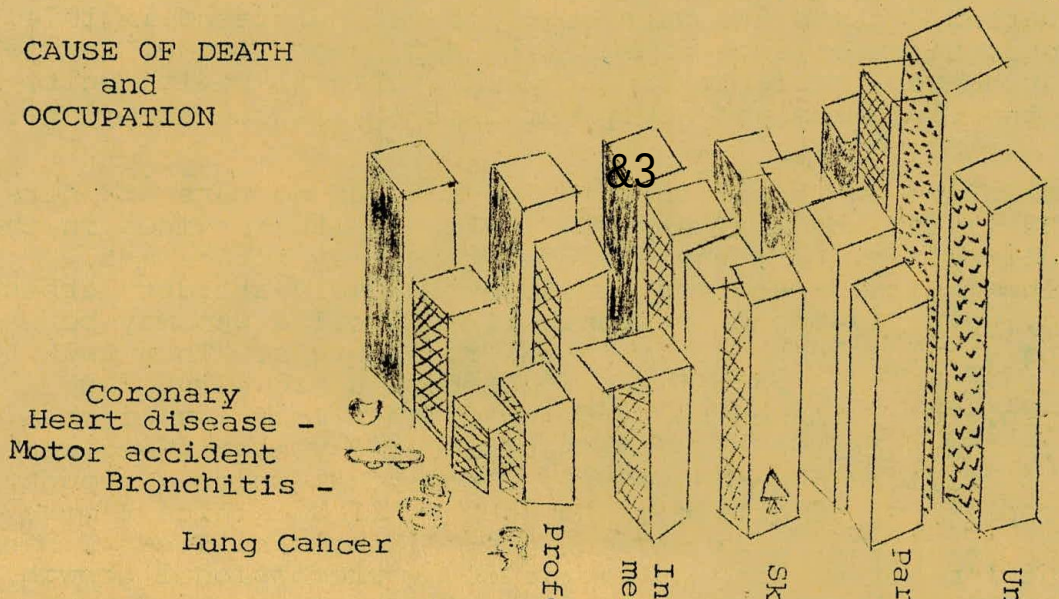
Like many other diseases, respiratory tuberculosis had been declining in rich countries long before the introduction of the 'miracle drugs' of the 1930's and 1940's

2. EARLY DEATH and OCCUPATION



The height of each block is proportional to the chances of members of that occupational class dying before the age of 65. So an unskilled worker is twice as likely to die early as a professional. 1959-63 England and Wales. Based on Registrar General figures.

3. CAUSE OF DEATH and OCCUPATION



DRUG JARGON

MUCH CRITICISM OF THE DRUG COMPANIES IS LOST IN THE JUNGLE OF TERMINOLOGY SURROUNDING THEIR MULTINATIONAL OPERATIONS. BELOW, THE NEW INTERNATIONALIST EXPLAINS SOME OF THE KEY CONCEPTS. ON THE FACING PAGE A DEBATE IS STAGED BETWEEN AN INDUSTRY GOLIATH AND A RADICAL DAVID.

Research and Development:

New drugs come from four directions :isolation from natural products, adaption of existing drugs, application of the theory of human biological processes and from random screening of chemical substances. Most of the important new drugs now in use have been developed from research undertaken by the pharmaceutical industry. Academic medicine played no part for example in the origination of tranquilisers, anti-malarials, anti-histamines, hypotensives, oral contraceptives and most vitamins and anaesthetics.

One of the most important dimensions of pharmaceutical research and development is the safety testing of new drugs on animals and, ultimately, on people. Many promising preparations have to be rejected because they fail to achieve acceptable levels of safety and in some cases preparations have to be withdrawn from the market when unforseen and damaging effects come to light. Nevertheless it is estimated that some 30,000 persons die annually in the US from adverse drug reactions about 80% of which are preventable.

Promotion :

In the market characterised by innovation the commercial life of most drugs is limited. Therefore, when a company produces a new and useful product it must advertise to doctors to ensure that it comes to be used as rapidly as possible. And, indeed, genuine informative advertising does perform a valuable function by drawing doctors attention to latest developments.

Unfortunately, the great bulk of pharmaceutical promotion is designed less to be informative than to inculcate 'brand preference'. Only five or six out of 40 or so new branded products put on the US market each year are real improvements on existing products.

On the average the drug companies spend twice as much on sales promotion as they do on research and development, vastly exceeding in the US and UK, the cost of continuing education for doctors in every aspect of practise. With the same money in the UK,for example it would be possible for each General Practitioner to have a teacher of medicine or therapeutics spend about a month a year working with him in his practice and giving him advice.

Patents and Brand Names :

Multinational companies dealing in pharmaceuticals protect the market for each of their new products by taking out patents. In addition, products are protected by brand names - which are normally different from and simpler than the 'official' generic names given by the World Health Organisation. Brand names provide market protection for a product simply because doctors are induced by advertising to use the brand name rather than the generic name when writing a prescription.

The pricing policy has induced Italian firms to copy other companies' products, as Italy is the one Western developed country which does not recognise pharmaceutical patents. Some Eastern European countries operate in the same way.

There are thus two world markets for the main pharmaceuticals - the patent market with prices set by the multinational companies and the non-patent market where prices are much more competitive. In the latter section of the world market however there is a greater risk of purchasing products of unreliable quality.

Transfer of Technology :

In the Third World in general more than 90% of drug patents are held by foreign firms. Once a patent is registered, neither a national nor a foreign competitor can enter the market it covers, normally within 3 years, even if it is not being exploited by the patent holder. This inhibits the transfer of drugs technology from the developed to the developing countries by effectively retarding the growth of indigenous pharmaceutical industries. Thus, while the drug multinationals maintain that their presence in developing countries is helpful the truth is very different. Ideally, the Third World should aim to ignore international patent laws, as the Eastern European countries have done, to cooperate in the manufacture of drugs and to set up technology-centres to conduct research and disseminate information. Some developing countries, notably India, do have indigenous pharmaceutical industries on which cooperative schemes might be based.

Transfer Pricing :

Transfer pricing is used to a greater or lesser degree by all multinational companies to increase their profitability. Where drug multinationals are concerned the procedure is as follows : the parent company sells the drug ingredients to an overseas subsidiary at a vastly inflated price. The subsidiary then manufactures the drug and markets it at a price related to the cost of purchasing the ingredients from the parent company. Thus the declared profits of the subsidiary are artifically reduced and the real profits transferred to the parent company. This particularly useful when the tax on company profits is greater in the overseas country than at home.

Transfer pricing is, primarily an international tax dodge and is the economic area in which the drug companies are able to use their multinational character to best advantage

COMMUNITY DIAGNOSIS

Community diagnosis serves to discover a community's health problems and to evaluate measures instituted for their solution. Any community health programme drawn up without a systematic attempt at a community diagnosis is likely to fail. In order to ascertain whether a Community Health programme has made any difference to the health of the people served, baseline surveys are necessary so that the most appropriate programme is introduced in the region.

Community diagnosis is essential to ascertain to what extent maternity services have been responsible for any decline in maternal and infant mortality rates. One may want to know whether such services have been responsible for the increased rate of population growth. Have school health services improved the health of school children ? In developed countries infectious diseases have been replaced by chronic diseases such as hypertension, ischaemic heart disease and various types of neoplasia are similar phenomena taking place in developing countries ? Have health programmes to be altered to meet these changing circumstances ? These are examples of some of the issues that make scientifically based community diagnosis mandatory in the development and organisation of all health programmes.

Epidemiology is an important tool of community diagnosis. It has been concerned traditionally with the distribution and determanants of disease and disorder in populations. The relationship of cholera to contaminated water, of malaria and yellow fever mosquitoes and of pellagra to a deficient diet, are classic examples of the contribution made by this approach.

The scope and role of epidemiology has been expanded to include an ever widening range of conditions - chronic disease, mental disorders, congenital anomalies, accidents, alchoholism and health aspects of population dynamics, and has further expanded to include studies of the behaviourial correlates of disease and variations in health statut - cigarette smoking, utilisation of health services, compliance and co-operation with medical advice etc. The strategy and findings of epidemiological inquiry can be applied to the organisation and evaluation of health services.

An adequate diagnosis requires answers to seven major questions:

(1) What are the Magnitudes and Extent of Community Health Problems?

Requires to be assessed not only by professional health workers but such an approach has to be augmented by information concerning the importance of the health problems from the perspective of the community to be served.

(2) What is the Extent of Current Attempts to Alleviate the so Community Health Problems ?

Information should be obtained about services available (including indigenous medical services) the extent and patterns of utilisation, the barriers to utilisation of the services and the community's perception of the services and its participation in the same.

(3) What are the correlates of Community Health Problems ?

It is necessary to identify segments of the population at highest risk-is it more common in the young or the old, in males or

(5) What data are needed for programme Management and Evaluation ?

These include data necessary for clinical management of cases and data required for accounting purposes in terms of activities and data gathered for the evaluation of the programme.

(6) What methods of Data gathering, Recording and Processing are needed ?

Answers to these questions come from a knowledge of epidemiological methods.

(7) To what extent is the programme accomplishing its objectives?

Aim of this question is to ascertain whether the programme is accomplishing its objectives (a) have the changes postulated is necessary for improvement in the health status been brought about. For example, if certain agricultural practices and culturally determined beliefs were responsible for a poor nutritional status in pregnant women (based on answers to question 3) have these beliefs and practices been changed ? If a high incidence of trachoma was due to poor personal hygiene and non attendance of the clinic, have the behavioural change been made in the right direction. (b) If the answer to question (a) above are positive, have corresponding improvements been effected in the health status, i.e. has the nutritional status of pregnant women improved. (c) Finally, if answers to questions (a) and (b) are both in the affirmative, it would be necessary to determine the extent to which these changes have been brought about by the programme rather than having occurred spontaneously. Answer to this question would be difficult unless a comparison of the results of the programme area are compared with a similar area without such a programme. Many claims of programme or treatment successes in halting an epidemic are made but experience beyond the programme area has shown that the epidemic declined for reasons quite unrelated to the intervention programme, i.e. natural history of the disease or decline due to other reasons.

Source of information : 1. WHO Technical Memorandum.

2. Community Medicine - What is in a a Name by Robert L. Kane.

3. Community Diagnosis by John C. Cassel.

4. WHO Monograph Series 34.

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Changing Concepts in Community Health Care

Definition of Health

WHO - Health is a state of complete physical, mental and social wellbeing not merely the absence of disease and infirmity.

In their 1962 review of the teaching of Preventive Medicine, Shephard and Roney listed 20 different titles for such departments, commencing from Hygiene to be present concepts of Community Medicine.

"Hygiene"(named after "Hygeia" the Greek Goddess of health) refers to the body of knowledge relating to the promotion and preservation of health. It is a very comprehensive term which includes Public Health and Preventive Medicine.

"Preventive Medicine" is a science and art of preventing disease, prolonging life and promoting physical and mental health and efficiency.

"Social Medicine" is a comprehensive term used to embrace research into social factors which affect health or incidence of disease by means of surveys, case studies and statistical investigations.

Medical Sociology, Social Psychology and Social Psychiatry are all branches of Social Medicine.

"Clinical Social Medicine" applies to the application of social medical principles in the diagnosis and treatment of industrial patients.

"Public Health" may be considered as a branch of knowledge or as a practice i.e. its specialised character as an academic subject and its breadth as a practice. It is essentially a post graduate study of a vocational character although fundamentals of the same are taught at the undergraduate level. Public Health includes sanitary and water engineering, housing construction, town and country planning, large scale food production and veterinary control. It is a practice of environmental and personal hygiene, preventive medicine and epidemiology and includes also legislations and administrative provisions and certain organised medical care and social services which are provided by the executive Public Health Departments.

With so many terminologies of this particular discipline, one may be justified in saying that he is "the speciality of ?" The struggle to define this new speciality goes on.

A definition which allows for flexibility and scope in both teaching and research is, "Community Medicine is the academic discipline that deals with the identification and solution of the health problems of communities or human population groups". We also accept the definition of community as "a group of individuals or families ~~bring~~ living together in a defined geographic area, usually comprising a village, town or city; these may represent only a few families in a rural area or may include heavily populated cities.

Even Abraham Flexner noted that "the physicians' function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and moral well being".

The medical and dental practitioners look after individuals, and may be families, which is the "General Practice" of preven ive medicine.

The "Community Medicine Practitioner" looks after groups and communities.

Both the above mentioned two agencies, practice preventive medicine "through intercepting disease processes by community and individual action". It has now been accepted generally that Community Medicine may be perceived as a distinct third area in medical education, producing a trio of laboratory, hospital ward and community. Its particular relevance to the study of the community has been aptly brought out by an expert committee of WHO "The education of every physician should.....enable him.....to understand how factors affecting health can be examined and measured and to discern the practical steps that can be taken to counteract hazards; he should know enough about the economics and priorities of public health programmes at both the local and national levels, to recognise when the local community must make important decisions and when the national cost of health services must be balanced against those of other community services. He should understand how health services operate and are related to one another, the principles governing the delivery of medical care, what parts are played by auxiliaries and other health workers, and the effects of culture on the demands for services and of the use made of them when they are provided".

Community Medicine is by no means limited to the activities of physicians alone. It draws upon a number of disciplines for its tools. The tools include community diagnosis (which draws on such diverse fields as sociology, political science, economics, biostatistics and epidemiology) and health services research (the application of epidemiologic techniques to analysing the effects of medical care on health).

It is ironic that a profession which began in the Community, should suddenly need to rediscover it. Several centuries of gradually institutionalised medicine followed by technological revolution progressively moved medical science farther from the people to be served and closer to the artificial life support system of the hospital centre. Sometime in the last 15 years, medicine rediscovered the Community at large. The academicians have become aware of the wide gap that exists between knowledge acquired and the implementation of that knowledge. War was declared on poverty, ignorance and disease. Medical educators have gradually descended from their ivory tower and recognised flaws in the cult of our specialisation. The era of revelation has given way to the era of relevance. Amidst these rites of passage, a new discipline, community medicine, has emerged.

The most important tools of Community Medicine, which include community diagnosis, are epidemiology and biostatistics. Community diagnosis is the attempt to identify as fully as possible what health problems and the health care resources are, it enables the practitioner of community medicine to implement solutions, e.g. John Snow's investigations of cholera in England before the bacteriological era. This was an example of pure epidemiological research, in understanding the determinants of disease-agent, host and environment.

The tools of epidemiology have now been gradually turned to newer tasks. Methods for delivery of care and containment of disease became increasingly important as prevention and cure became increasingly difficult to achieve. Studies of chronic degenerative diseases have led to an appreciation of the multifactorial determinants of disease. The behavioural sciences have also emerged as important tools of Community Medicine for predicting the occurrence of disease through knowledge of phenomena such as social stress, as well as the

Community Diagnosis

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Information should be obtained about services available(including indigenous medical services) the extent and patterns of utilisation, the barriers to utilisation of the services and the community's perception of the services and its participation in the same.

(3) What are the correlates of Community Health problems ?

...nts of the population at highest risk-is

knowledge of resources available - finance and personnel - A multi disciplinary approach will be necessary.

(5) What data are needed for Programme Management and Evaluation ?

These include data necessary for clinical management of cases and data required for accounting purposes in terms of activities and data gathered for the evaluation of the programme.

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Source of information

1. WHO Technical Memorandum
2. Community Medicine - What is in a Name by Robert L Kane
3. Community Diagnosis by John C Cassel
4. WHO Monograph series 34.

Biostatistics, the black bag of Community Medicine has expanded fast beyond the stage of dry manipulation of complex mathematical procedures. The computer has opened up exciting areas for medical diagnosis, simulation models of health situations and rapid processing of large volumes of data. Environmental health has risen from the privy to worldwide ecological concerns with over abendance of people and their waste products.

The social revolution has produced a philosophy that health care should be readily accessible and that consumers of health services should participate in planning and decision making. It has often been said that "Health is a right and not a privilege" and"Health by the People". Medical care which fulfills the three C's - continuous, coordinated and comprehensive - is being sought but at a price society can afford. Departments of Community Medicine will in future have to play an active role in developing effective delivery systems.

While the science of medicine is forging ahead, the social setting of medicine is caught up in its own revolution. Medical schools have been challenged to restructure their position in the community. The pressures for medical schools to get involved are real and powerful. Communities themselves have indicated in forceful ways that they expect medical schools to respond to their demands for service. No longer will people accept charitable crumbs of medical care; they now accuse the institutions of exploitation and demand a reckoning. In the USA, 64 medical schools have been forced to restructure their curriculum.

In our own country the recent report of the group on medical education and support manpower has enjoined, that during the last 30 years sustained efforts have been made to implement the health sector objectives laid down by important committees like Bhore Committee, Mudalior Committee and so on. Inspite of substantial investments made and impressive results obtained, particularly in the production of medical manpower, the health status of our people, be it in rural areas or plantations, is far from satisfactory. The medical profession itself, which is noted more for its conservatism and individualism, has to accept its share of blame. They obstinately cl[illegible] one Western models of easy medical practice, based on hospitals. [illegible]is therefore, but natural that medical colleges have now been challenged to restructure their position in the community. They are required to accept a major service responsibility for a segment of the adjacent community. The potential for meaningful innovation in modes of delivering and organising health services falls within the'Community Medicine', area of competence, for example, the variety of alternatives to the neighbourhood health centre, should be developed in response to the social forces calling for increased community involvement. Introduction of regional medical programmes through medical colleges has provided one potential means by which we can directly influence the health care delivery systems.

Such changes have great relevance to plantation industries, for questions of rural health care and primary health care delivery systems, are of the utmost importance in plantation settings. The plantation doctor has an important role to play in bringing about his change with the help of the employer and worker. Within limited resources of money and manpower, primary health care in remote and inaccessible areas, has to be provided by him. He has to be a good "Managerial Physician" and"Leader of a health team".

It is essential that in order to appreciate the community, its social systems and their interactions with the medical care system, he must become part of that community.

Community Medicine represents a bridge between medicine and society. The ultimate test of this discipline lies not in its ability to consolidate a multiplicity of theoretical frameworks but in its application to actual problem solving situations. It is a discipline which requires a precise definition of health problems and a specific commitment to examine them and treat them in the full scope of their implications.

Community Medicine has a vast umbrella. They start with communities analysis and the basic skills of epidemiology as a tool for applying the scientific method to medical problem - solving, and build to encompass a variety of different but often overlapping disciplines including medical economics, behavioural sciences, environmental health and ecology, health services research and demography. The synthesis of these multiple techniques and concerns represents the methodology and body of knowledge that we recognise today as Community Medicine.

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1. The challenges of Community Medicine, edited by Roher L.Kane
2. Alternatives in Development Health, Health Services and Medical Education. A programme for Immediate Action
3. Community Medicine in Developing Countries edited by Abdel R Omran
4. WHO Tech-Memoranda
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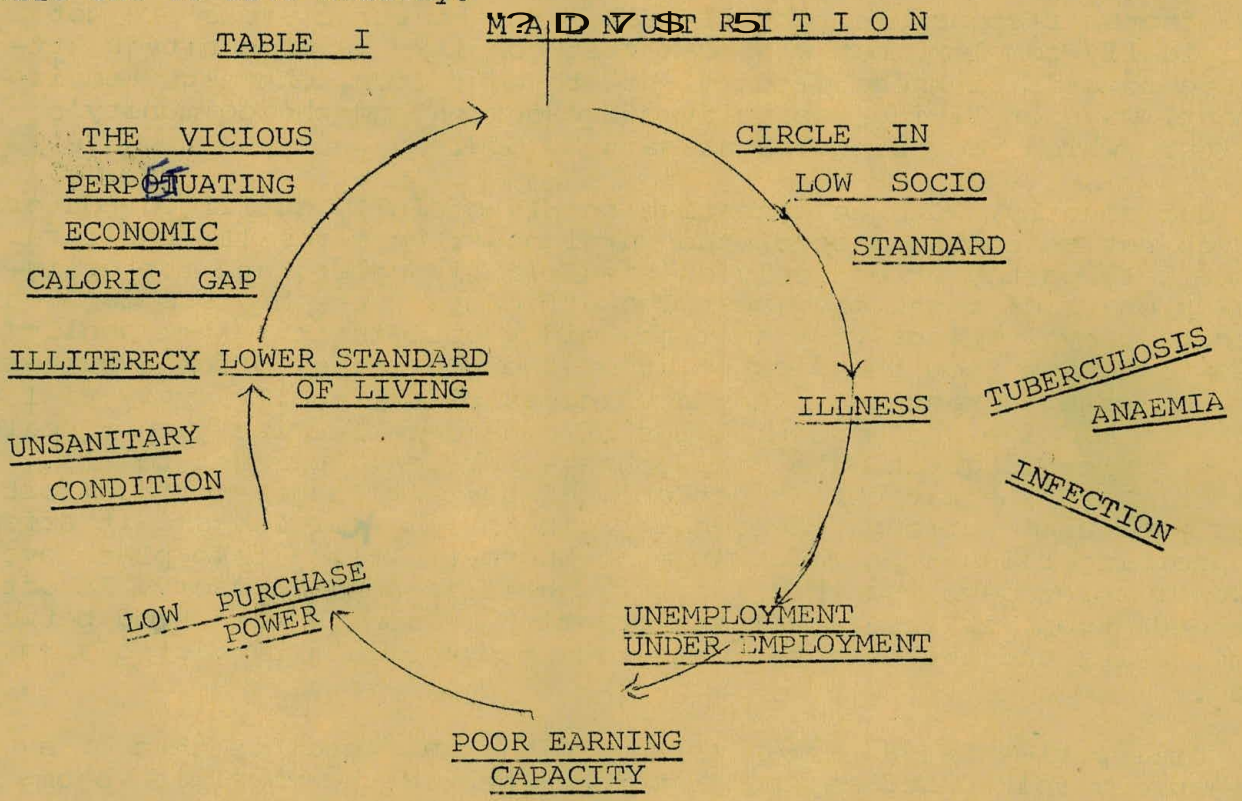
NON CLINICAL APPROACH

Ajit Murickan.

Non-Clinical approach to community health is based on the view point that a community's health is the expression of community living. Poor health is because of poor living. Thus it follows that only by changing the living pattern i.e. the socio-economic and political life of the people that improvements in the community's health can be brought about. Health cannot be considered in isolation from many other central issues which affect the development of the community. Problens of structural and institutional changes are intimately connected with the achievement of good health, which means not only to achieve freedom from disease or the threat of disease, but in a more positive way, to create the conditions and atmosphere which enable one to live healthy.

TABLE I



STATE OF HEALTH RURAL - URBAN INEQUALITY

There is a considerable disparity in the state of health between rural and urban areas in India. In the real of clinical treatment itself, there is a bias in favour of the most modern and expensive medical technology. There are two options, on the one hand, building up a few large hospitals in metropolitan cities with expensive equipment, and staffed with highly qualified physicians and specialists, and providing sphisticated treatment, which only a few can afford, and on the other hand, providing appropriate health care for the rural masses, i.e. 80% of the Indian population which has hardly any access to moderate health facilities.

In India the accent, even of the voluntary agencies, continues to be in building large hospitals, and centres of medical excellence,

Minister of Karnataka. In a frank speech delivered at the All India Medical Association, he focussed the attention of the conference on the ridiculous state of affairs in the health sector and said that three fourths of the health bedget funds were being used in urban areas, where as the majority of Indian population lived in rural areas. Besides a great majority of Doctors were found practising in urban centres. He pointed out that of the state's total bed strength of 24,229 a m8re 4,165 bed had been provided in rural areas (Deccan Herald Dec 29, 1976).

STATE OF HEALTH IN THE RURAL AREA

The poor state of health in the rural area calls for higher priority to the provision of medical cars in rural areas. The nature of the prevalent diseases and the constraints of resources, warrant a less sophisticated treatment High priority given to preventive measures and to medical care in the rural areas have come to constitute the basic principle underlying the health services in rural areas.

The factor responsible for ill-health in the rural areas are not clinically complex, but what makes it complex, is community's attitude towards sickness, lack of health education, unhealthy environment, ways of living, scarcity of resources and the community's culture which sees sickness as sent by God.

In our country, with an excessive supply of fully qualified Doctors we do not reach the mass of the rural poor. As a result, the rural poor rely partly or entirely on traditional healers and for deliveries on traditional midwives. The efficacy of the healers is much debated, evaluations vary from the midly optimistic to the wholly negative. But from the view point of the poor, they offer a number of important advantages. They are accessible-virtually every village has the midwife and most villages of considerable size have a healer. The service is quick. The healer has a personal approach to his clients and the patient is not obliged to wait in great discomfort for prolonged periods. The consultation is not hurried and it offers supporting roles to a wide range of kinsmen. It may take place over two or three days, so that instant recall is not necessary. It often depends upon, or results in the creation of some social bond between the healer and the patient. This may be sympolised by gift giving etc.

A rural patient whose image of the role of a Doctor is that of a leasurely folk curer may be disturbed because the physician seems anxious to hurry him out of the office. For all these reasons the traditional healer may be preferred by the rural poor even if a free government service is available. At best they would regard the service as an occasional supplement to the traditional healer to be consulted when the traditional medicine has not proved effective. The disease pattern in the rural area is predominantly communicable diseases transmitted by human faces such as intestinal, parasitic and infectious, diarrheal diseases, air-borne diseases like tuberculosis, pneumonia, dyptheria, measles, chickenpox etc.

The cause of these diseases in the village is due to inadequate supply of pure and controlled water, low standards of environmental, sanitation and personal hygens, low levels of nutrition and poor housing. The most appropriate remedy seems to lie in preventive measures and health promoting activities.

Social and economic injustice

Land tenure

Agricultural production and marketing

Population control

Malnutrition

Health training

Curative medicine

You will note that we list curative medicine as our last priority, because health is seen as only one component of overall community improvement and good health cannot be maintained in an economic and social vacuum. A clinical view of community health would have listed "curing" first because it tries to 'eradicate disease by curing the sick' and forgets the fact that no sooner than the patient is cured than he returns to a slough of poverty that once again felled him within months, often within days of his treatment.

"The physician in the spectrum of comprehensive health care has to function not merely as a clinical therapist but also partnership between him, other co-worker and the community. He must consider the various factors which bear on health and not just those of organic disease, maintaining a realistic contact with the scientific basis of all that he does. He must view each patient not as a pathological curiosity but as an individual in the family and community and consider his feelings, behaviour, way of living, habit, family situation, job, belief, income and other factors influencing his illness and health. He must know the wide range of facilities and resources available for the health and welfare of the community and work with his team towards integrated rather than piecemeal health service". (Dr. B.N.Lingaraju).

Health is not just a matter of providing hospitals, medical experts and medicines. Many facilities introduced under governmental or private auspices in developing countries fail to reach the needy sectors. They tend to be appropriated by the groups with social influences, economic power and political pull, by the privileged minorities. Thus, potentially praiseworthy efforts for the good of the 'Common man' remain limited to the existing power groups, and the people they are meant to serve are often excluded. Unless ordinary people can be motivated and mobilised to act together and resist the domination of traditionally powerful, the majority in developing countries will remain at the margin of social services. Problems of health care in developing countries are, therefore, linked with the socio-economic problems of that society and are linked with the power structures which exist in the society."

(Health care in the Context of Self-reliant Development
by Dr. Samuel L. Parmar)

When we talk about people and their poverty and ill health, we have to ask fundamental questions such as 'why are these people ill fed, ill clothed, ill housed, under educated, and prey to preventable diseases?'. Are these inevitably ? Are there really so many people and such scarce resources that all cannot have enough?. Or is it

change. On the contrary since these will fall into the control of those who have power they will only increase the hold and dominance of such groups. That is why the new understanding of development emphasises structural change, the need to change existing property relationships and the power structure related to it. Resources are important but unless a new pattern of social relationships is established they will keep the poor in conditions of misery.

COMMUNITY HEALTH AND COMMUNITY'S PARTICIPATION

In order to define the 'Community health' it is perhaps best to define first its two component parts. Health is defined as the physical, mental and social well being of the individual. By community we mean a collectivity of people who can be identified geographically and have general sense of belonging to this geographical entity and who have the collective capacity to make decisions commit resources and take responsibility for the conduct of activities which are carried out in this collectivity. This concept of health and community given by the W.H.O. widens the concept of health and community and shows the social, economic and political implications of it. Secondly, it is clear that the medical profession cannot be the sole motivator, instigator and/or provider of health in a community. The present system of medical education has not prepared the doctor to deal with the social, economic and political implications of the W.H.O. denititions. They are trained essentially as technicians well versed in the causes and treatment of many disease, but they know practically next to nothing about the causes and treatment of many basic problems such as ignorance and poverty, which breed ill health in a community.

It is widely recognised that the present system of undergraduate medical education is far from satisfactory to meet the need of the country. Despite the recommendations made by numerous Committees and conferences, improvements in the quality and relevance of medical education have been tardy. Although the seeting up Department of Preventive and Social Medicine in the medical College over 15 years ago was a step in the right direction, this by itself has not met with significant success as it lacked scholary foundations and the field practice areas were not adequately prepared. The strangle hold of the inherited system of medical education, the exclusive orientation towards the teaching hospital (five years and three months out of five years and six months of the total period of medical education being spent within the seeting of the teaching hospital) the irrelevance of the training to the health needs of the community, the increasing trend towards specialisation, the acquisition of post graduate degree, the lack of incentive and adequate recognition for work within the rural communities, and the attraction of the export market for medical man power are some of the factors which can be indentified as being responsible for the present day aloofness of medicine, from the basis health needs of our people. The relation of medical education to the social framework of the community is largely brought out towards the end of the student period of formal training and medical education continues to postpone, rather than prepare the doctor for the practice of medicine in the community. A vaccum separates the health centre and the doctors from the village and the people and the critical health needs of the people remain largely unmet. The greatest challenge to the Medical Education in our country therefore into design a system that is deeply rooted in

In their tebhnical skills are to be of any use in helping a community to obtain 'total physical, mental and social well-being then it is certainly important from them to work very closely with those who have skills in community development, education and economic planning.

Community health is not identical to community medicine Health to most people still means medical expertise and big hospitals or established mobile clinics or sending medical personnel and staff to a health centres of some distance away from the hospital. This approach to community health holds the same attitudes and uses the same approach that is used in relative medicine the community is made passive receptient of health services. Further more the concept of health is narrowed down to physical well-being and underplaced the socio-economic and political implications of the W.H.O. definition of health.

To care for the physical, mental and social well-being of all people is a task that goes far beyond what the physicians can accomplish. It is a task that involves political and social activities planning and a great number of highly skilled persons outside the health field. If physicians technical skills are to be of any use in helping a community to obtain total physical mental and social well-being then it is certainly important for them to work, very closely with those who have skills in community development, education and economic planning. The present and future health care can only be effective if we take the team approach. The challange to the physicians is that he/she can no longer be the health authority, but needs to be an effective team leader to mobilise and organise the community.

I believe Community health is having the people of a community make the decisions and take the responsibilities for the improvement of their own health. The W.H.O. referred to their definition as health by the people in contract to health for the people and stated it as its priority in their executive committee meeting in January 1975.

The entire community's participation is essential in bringing about community health. If a community is not encouraged to present discuss, improve their environment and develope good health habits by themselves the chances of helping the total health of the community which remain virtually untapped. These resources of which the potential manpower is the largest and most obvious, can be mobilised to change the poor health conditions as well as bring about the much needed economic improvement.

CONCLUSION

The achievement of good health is intimately connected with the problems of structural and institutional changes. To overcome poverty, illhealth and injustice, we have to change the social system. No amount of resources will bring about change in the present health care system. That is why non-clinical approach to community health emphasis structural change. By structural I refer to the transformation, historic pattern of concentration of economic and political power in the hands of small elite groups who exploit their position to maintain the status quo and ensure that they and their descendents continue to enjoy the good things of life at the expense of the poor.

NEEDED CHANGE IN PHILOSOPHY AND ORIENTATION OF THE HEALTH TEAM.

Alina Cattani.

With the phenomenal growth of medical science and techniques in this century, the cost of medical treatment has also increased many-fold.

According to the different social systems, health has become either a commodity (in capitalist countries) or it is handed out from above (in social imperialist countries.

In Western countries large capitals are invested in sophisticated hospitals, over-specialised, where the aim is provision of the highest possible quality care to the individual to satisfy the need of the affluent society. This has required a rapidly increasing investment in both facilities and personnel so that increasingly specialised doctors can work with more elaborate and expensive equipment. Hospitals are doing more and more for the same limited number of patients. At the same time many health problems of the past centuries have been solved by the provision of public health measures and mainly by better general living standards.

In India health services reflect the socoi-economic and political forces at work in the country. They are very much patterned on those of Western countries, they reflect the neo-colonial influences still prevailing in Indian society. The medical and nursing education is a striking example of this : students who have gone through medical or nursing education in India find themselves better equipped to function in a sophisticated hospital in our cities or abroad than in our Indian villages. Yet it is becoming more and more evident that the Western medical model is inadequate to answer to the needs of less developed countries like India.

This mainly because the socio-economic conditions are different. On the one hand, in the national budget, the portion for health expenditure is limited by other priority needs of development. And on the other, the vast masses living below the poverty line cannot afford expensive medical #afe.

The vital statistics show a remarkable progress in health standards in the country since the beginning of this century.

	1901	1950	1970
Life expectancy	23 years	37 years	52 years
Death rate	42%	27%	17%
Infant mortality rate	215%		113%

But like all global statistics, they do not reveal the disparities in different sections of the population. (different strate of the society, different states, urban and rural areas).

The institutional growth of our health system is impressive and has undoubtedly contributed to these improved health standards.

	1947	1971
Doctors	46,000	116,000
Nurses and midwives	12,000	68,000
A N M	-	42,000
Health Inspectors	750	32,000
No. of hospital beds	113,000	300,000
No. of dispensaries	1,807	5,195
No. of Primary Health		

The deaths of children below 5 years amounted to 58% of total death in 1970.

And it is estimated that proper disposal of human excreta alone, notyet in practice in the rural areas, could cut down the incidence of disease in India by 20 - 30 per cent.

A closer analysis shows a very unequal distribution of medical services - both in personnel and resources such that about 50% of our rural population remains without basic medical facilities. (see chart)

It is evident therefore that the present health system is ineffective in meeting the total needs of the population.

The Government has been aware of this, and set up, since Independence, several study committees, but their findings and recommendations had no real impact on the existing trends. Inequalities in the health field reflect and have their root in the unjust socio-economic system.

If the share of the rural areas has to increase, then at the very least a halt must be called to the extension of services in the urban areas - But this would go against the interests of powerful groups :

1) the rich who can afford the best medical care and therefore demand it.
2) the doctors who are interested in specialisation and clinical skills, attractive remuneration and urban living facilities.
3) the pharmaceutical firms who thrive on the urban market for the 'latest' brand drugs, tonics, imported medicine, and fancy packaged preparations.

Health has been recognised, though only quite recently, as a basic human right : a right of each and every man. In our endeavours in health work and in chosing our priorities we are morally obliged to give serious thoughts to the situation and the needs of our people.

We have seen that the health scence in India is characterised by

1) An inequitable distribution of scarce resources.
2) High incendince of preventable fatalities and diseases.

<u>The causes</u> for the unfavourable situation are many !

1) The concentration of services in the urban areas.
2) Inadequate preventive approach and neglect of environmental hygiene in which the community has a basic role to play.
3) Inadequate accessibility of rural services, and no proper referral services.
4) The sophistication of medical education : over-professionalisation increases costs and reduces the autonomy of the individual.
5) Practically, money is needed to obtain medical care both from Government and private institutions, and the low income group cannot afford it.
6) Over-emphasis of provisions ofhealth services "from above" - It was assumed that "health" is something to be "given" to the people through institution and medicines - under state control.
   This led 1) to devaluing and destroying the old tradition of indigenous part-time service-professional workers, close to the people. 2) to neglecting to include participation of the people in health care planning and implementation.
7) Huge cost of the western model, unsuited to our socio-economic conditions :
8) Neglect by the medical profession of any consideration for the socio-economic dimension affecting health in general, and the situation of

A new programme of health services is to be built with the community itself as the central focus. This implies the creation of the needed health services within the community, by utilizing all local resources available, and then supplement them through a referral service. The new model will have to place greater emphasis on human effort (for which we have large potential) rather than on monetary inputs.

A cost/effectiveness approach based on careful analysis of those approaches which are more effective in improving health must bring about a more appropriate balance between curative and preventive activities.

Often a clinical condition that requires great investments, especially in personnel-time, could have been prevented at a fraction of the cost.

The social aspect of the health problems should be an intrinsic preoccupation of the health workers. It is important to help the patients to understand the root causes of their diseases - so as to promote prevention.

And we need innovative ways of avoiding the dehumanising aspect both of expensive care and free treatment, through providing a mix of financial anaugements for care that is inexpensive while still being good.

All this demands basically a change in philosophy and orientation of health team, from provision of : the highest possible quality care to the individual To : "the basic minimum health care for the community." The need for a new approach demands a change :

From hospital care	to community care.
From institution based curative medicine	to greater emphasis on preventive measures.
From the urban bias	to higher priority to health care in rural areas - close to the people. Decentralisation of services.
From the clinical approach	to an integrated approach, involving immunisation, health education, nutrition and medical care.
From a health service system imposed from above.	to health services truly of and for the community - securing active participation of the people.

The greatest moral dilemma of medical care is to find the least unjust way to allocate the resources at our disposal. Two steps are involved.

First, instead of spending all our precious resources on those who come spontaneously to us, our concern must reach out to all those in need, and we must work out new ways of defining and providing a basis minimum service for all. (Within a delimited area, to ensure #övs$r<(ge).

The second part of providing equitable distribution is to set and follow priorities in care. The purpose is to focus on the measures that will do the most for particularly vulnerable groups. This effort must combine technical understanding with community participation in planning, a major result is that people are helped to solve their own problems.

APPENDIX

UNEQUAL DISTRIBUTION OF MEDICAL SERVICES

		distribution	
		RURAL	URBAN
POPULATION	600 millions	80%	20%

BUDGET - Central : according to the Ministry of Health, most of the investments of our Five Years Plans go for the building of sophisticated hospitals or training of doctors, both of which hardly serve our rural population.
ex: IV Plan : Rs. 3.610 millions, out of which only Rs.700 millions for the rural areas.

- State : 3/4 of the state budget for health is also spent on the running expenses of the more or less elitist institutions. $\frac{1}{4}$ is directly made use of for the needs of the masses.

	total	rural	urban
HOSPITAL BEDS	300.000	10%	90%
PRIMARY HEALTH CENTRES	7.500	5.400	2.100
& sub-centres	32.000		

- About 5000 P.H.C. for about 500.000 villages
  ⟶ 1 P.H.C. for 100 villages
- Centres and sub-centres are most often ill-equipped, under-staffed and poorly supplied with drugs.
- They are able to give more or less effective service to abo 1/3 of the population, in the vicinity of their headquarters.

By consequence ⟶ some 300 millions neglected people in the rural areas.

THOSE WHO NEED MEDICAL AID THE MOST, GET THE LEAST

	rural	urban
VITAL STATISTICS		
Death rate ('70 -'71)	17.53%	10.06%
Infant mortality rate	114.50%	79.93%

UNEQUAL DISTRIBUTION OF HEALTH SERVICES (II)

		All INDIA average	KERALA
HOSPITAL BEDS ('75) per 1000 population		0.5	1.05
BIRTHS IN HOSPITAL ('65)	rural	2.96%	12.91%
	urban	29.96%	31.95%
DEATHS IN HOSPITAL ('65)	rural	2.27%	7.69%
	urban	11.76%	25.80%
DEATH RATE per 1000: ('74)	rural	15.8	8.0
	urban	9.1	6.8
INFANT MORTALITY RATE per 1000 ('70)	rural	136.4	55.9
	urban	89.9	39.7

KERALA

		LOW LAND	HIGH LAND
HOSPITAL BEDS ('71) per 1000 population		1.42	0.46
DELIVERIES with medical assistance ('73)	(Rural)	59.	36.
INFANT DEATHS per 1000 live births ('73)	(Rural)	46.6	78.
DEATHS with medical assistance ('73)	(Rural)	80.	53.
DEATH RATE per 1000 population ('73)	(Rural)	8.8	9.3

ALL INDIA

DISTRIBUTION OF DOCTORS

Public sector employment	45,000
Self-employment	73,000
Private sector	8,000
Abroad	13,000
Remainder	10,500
	160,000

DISTRIBUTION OF NURSES

	G.N.	A.N.M.	L.H.
Government Institutions	56%	85 %	97%
Church-related "	30%	7.5%	-
Private Institutions	13%	7.5%	3%
Abroad	-		

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Community Health - Where do we begin?

by

J A McGilvray.

While it is increasingly recognised that the individual patient should be involved in a partnership therapy with his doctor and nurses because this frequently speeds recovery, so it is essential that communities, particularly the deprived, should be involved in their own health care. I want to give you two examples of how this has been done.

The first comes from a project we are sponsoring in India. The objective was to provide health care to a total population of 80, 000 distributed in one small town and ten outlying villages and the programme is to be compatible with the resources of this community. In addition to a general curative programme it is hoped to reduce the birthrate from 40 to 30 per 1, 000; reduce infant mortality by 50%, identify and bring under regular treatment leprosy and TB patients and train village health workers. No other health facilities are available in the area.

For the first six months, the health team visited the villages and sat down with the people each evening when most of them had returned from their agricultural work in the fields. Various possible services were discussed and the choice depended on the willingness of the villagers to cooperate in a joint plan whereby they provided the buildings, improved the access roads and registered their own patients.

In many cases, the villagers did not place a high priority on health care. Their main concern was lack of food and so this was where the discussion began but soon it led to a discussion of malnutrition in the children and its consequences. In some cases, the priority was to dig wells in and near the village for better irrigation and, in return, the villagers would cooperate in providing a common meal for all the children to supplement their diet.

The village school teachers were involved to help with immunizations and keep a regular check on the children's weight. Thus all the resources of the community were

The normal practice is to design health centres in some engineer's office of the capital city and then a decision is made in the Ministry of Health concerning the location of these health centres. Then someone has to be trained and persuaded to live in this rural environment which requires a higher motivation than most people possess. Meanwhile, the health bureaucrat. In this project, I have described the villagers themselves have provided the facilities and it is they who choose the village health worker for training. The project has successfully proved that where the community is intimately involved in the creation of its own health care system, it works.

The other example is from Guatemala in Central America. Two-thirds of the population is Indian with a very low per-capita income. In fact, Guatemala has the lowest GNP in Latin America. Only 10% of the children attend school and only 2% finish the primary level. They have serious health problem with 80 - 85% of the children moderately to seriously malnourished. The death rate is high and approximately 50% of the children die before they are five years of age. Another problem related to health is land tenure for 2% of the population own 80% of the land. This has a definite impact on the TB incidence because it results in overcrowding in small residences. The programme began when a doctor was assigned to direct a district hospital but he found that most of his patients were suffering from illnesses fostered by their way of life in a very unjust economic society. He broke away from the hospital and spent several months visiting villages and simply listening to people who described their own problems. He became convinced that any medical programme must be given to people on their own terms and at their speed if it was to be successful. The doctor might think that the people needed triple vaccine and more protein in their diet but they were probably much more interested in other things altogether.

In a recent visit by the health team to a village in the mountains several meetings with the villagers elicited the information that their major concern was for their chickens. They had all died. They were worried about this because chickens were their only source of meat and they knew that the eggs were good for their children. They then went on to say that they would like to grow apples. They grew well at that altitude and could be sold profitably in the market about 16 kilometres away. These were the things they believed they needed - not immunization and not a clinic - but chickens and apples. So it was on that basis that the health programme began. People were being helped on their own terms

course and is judged by his ability to recognise symptoms. He is not taught diagnosis because that is where most people, even doctors, go wrong. He takes back with him a stock of medicines and then is allowed to charge for these but, because the village health committee know their cost, he cannot overcharge or he is out of a job. The training is very simple and very practical. They spend a good deal of time in the hospital making rounds and seeing actual clinical cases. Then they are taught to recognise symptoms which means that they must spend a good deal of time listening to people while they describe them. You will be surprised to know that a careful evaluation of their work showed that 90% of their patients were treated properly. If a well trained doctor does as well then he has an excellent record.

On the basis of these two projects which involve the community in decision-making and participation in their own health care we can recommend the following steps :-

1. There must be a complete orientation to those who are to be served. Health care must be delivered on their terms. This is the first essential step.

2. If you do a demographic survey you must include questions like "What do you think your needs are," Avoid offering services on our own professional terms.

3. A committee of local village people must first be organised a health group before the first medications or immunizations are given.

4. These committees should select the person who is to be trained as their health worker. Then they can supervise them and discipline them.

The above examples will indicate that the first need in community health care is to instill a sense of self-confidence and self-reliance in those who are to be helped. For it is not enough to motivate people; they should also be organised so that their will and their eagerness to act will become most effective.

Excerpts from

RURAL HEALTH PROGRAMMES

TWO APPROACHES

	COMMUNITY SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPPLING)
Initial Objectives	Open-ended, Flexible. Consider community's felt needs. Include non-measurable (human) factors	Closed. Pre-defined before community's is consulted. Designed for hard-data evaluation only.
Size of Programme	Small, or if large, effectively decentralized so that sub-programmes in each area have the authority to run their own affairs, make major decisions, and adjust to local needs.	Large. Often of state or national dimension. Top-heavy with bureaucracy, red tape, filling out form Superstructure. Frequent breakdown in communication.
Planning, Priorities and decision making	Strong community participation. Outside agents-of-charge inspire, advise, demonstrate, but do not make unilateral decisions	Theoretically, community participation is great. In fact, activities and decisions are dominated or manipulated extensively by outsiders, often expatriate "consultants"
Financing and supplies	Largely from the community Self-help is encouraged. Outside input is minimal or on the basis of "seed funds" matching funds, or loans. Agricultural extension and other activities which lead to financial self-sufficiency are promoted. Low-cost sources of medicine are arranged.	Many giveaways and handout free food supplements, free medicines, villagers paid for working on "community projects" village health worker (VHW) salaried from outside. Indefinite dependency on external sources.
Way in which community participation is achieved	With time, patience and genuine concern. Agent-of-change lives with the people at their level, gets to know them and establish close relationships, mutual confidence and trust. Care is taken not to start with free services or giveaways that cannot be continued.	With money and giveaways. Agents-of-change visit briefly and intermittently and later on discover that inspite of their idealistic plans, they have to "buy" community participation. Many programmes start with free medicines and handouts to "get off to a good start", and later

	COMMUNITY SUPPORTIVE	COMMUNITY-OPPRESSIVE (CRIPLLING)
Data and evaluation	Underemphasized Data gatherring kept simple and minimal collected by members of the community. Includes questions about the people's felt needs and concerns. Simple scheme for self-evaluation of workers and programme at all levels. Evaluation includes objective human factorsas well as " hard data".	Over emphasized. Data gathered by outsiders. Members of the community may resent the inquision, or feel they are guinea pigs or "statistics". Evaluation based mainly on "hard-data" in reference to initial objectives.
Experience and background of outside agents-of-change	Much practional field experience. Often not highly "qualified" (degrees)	Much desk and conference room experience often highly "qualified" (degrees)
Income, standard of living and character of outside agents of change (MDs, nurses, social workers, consultants, etc)	Modest, Often volunteers who live and dress simply at the level of the people Obviously they work through dedication and inspite village workers to do likewise.	Often high, at least in comparision with the villagers and VHW (who observing this, often finds ways to "pad" his income and may become corrupt) The health professionals have often been drafted into "social service" and are resentful.
Sharing of knowledge and skills	At each level, from doctor to VHW to mother, a person's first responsibility is to teach to share as much of his/her knowledge as possible with those who know less and want to learn more	At each level of the preordained medical hierarchy (health team), a body of specific knowledge, is jealously guarded, and is considered dangerous for those at "lower" levels.
Regard for the people's customs and traditional folk healing, use of folk healers.	Respect for local tradition. Attempt to integrated traditional and Western healing. Folk healers incorporated into the programme	Much talk of integrating traditions and Western healing, but little attempt. Lack of respect tradition. Folk healers not used or respected.
Scope of clinical activities (Dx, Rx) performed by	Determined realistically in response to community needs, distance from	Delimited by outsiders who reduce the curative

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESIVE (CRIPPLING)
Selection of VHW and health committee	VHW is from and is chosen by community. Care is taken that the entire community is not only consulted, but is informed sufficiently so as to select wisely. Educational prerequisites are flexible	VHW ostensibly chosen by the community. In fact, often chosen by a village power group, preacher, or outside. Often the primary health worker is an outsider. Educational prerequisites fixed and often unrealistically high.
Training of V H W	Includes the scientific approach to problem solving. Initiative and thinking are encouraged.	VHW taught to mechanically follow inflexible, restrictive "norms" and instructions. Encouraged not to think and not to question the system.
Does the programme include conscientization (consciousness raising) with respect to human rights, land and social reform?	Yes, (if it dares)	Issues of social inequities and especially land reform are often avoided or glossed over.
Mannual or guidebook for V H W	Simple and informative in language, illustrations and content. Geared to the user's interest. Clear index and vocabulary included. All common problems covered. Folk beleifs and common use & misuse of medicines discussed. Abundant illustrations incorporated into the text. The same time and care was taken in preparing illustrations and layout as villagers take in their artwork and handicraft. Manual contains a balance of curative -preventive and promotive information	Cookbook-style, unattractive. Pure instruction. No index or vocabulary language either unnecessarily complex or childish, or both. Illustrations are few inappropriate (cartoons) or carelessly done. Not integrated with the text. Useful information is very limited, and some of it inaccurate. Many common problems not dealt with. May use misleading and or incomprehensitive flow charts. Manual often strong on preventive and weak on curative information overloaded with how to fill out endless forms
Limits defining	Intrinsic. Determined by	Extrinsic. Regidly and

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
Supervision	Supportive. Dependable. includes further training. Supervisor stays in the backgrounds and never "takes over". Reinforces community's confidences in its local workers.	Restrictive, nit-pickin authoritarian, or paternalistic. Often undependable. If supervisor is a doctor or nurse he/she often "takes over" sees patients, and lowers community's confidence in its local worker.
encouragement of self-learning outside of norms	Yes. VHW's are provided with information and books to increase knowledge on their own.	No. VHW's are not permitted to have books providing information outside their "norms".
feedback on referred patients (counter-reference)	When patients are referred by the VHW or auxiliary, the MD or other staff at the referral centre gives ample feedback to further the health worker's training.	Doctor at the referral centre gives to feedback other than instructions for injecting a medicine he/she has prescribed.
Flow of supplies	Dependable	Undependable
Profit from medicines (in programmes that charge)	VHW sells medicine at cost which is posted in public. (He/she may charge a small fee for services rendered) Use of medicines is kept at a minimum	VHW makes a modest (or not so modest) profit of sale of medicines. This may be his/her only income for services, inviting gross over-prescribing of medicines.
Evolution towards greater community involvement	As VHWs and community members gain experience and receive additional training, they move into roles initially filled by outsiders-training supervision, management, conducting of Under-fives clinics, etc. More and more of the skill pyramid is progressively filled by members of the community	Little allowance is made for growth of individual members of the community to fill more and more responsible positions (unless they graduate to jobs outside the community) Outsiders perpetually perform activities that villagers could learn.
Openness to growth and change in programme structure	New approaches and possible improvements are sought and encouraged. Allowances is made for try-	Entire programme is standardized with little allowances for growth or trial of ways for possible doing

	COMMUNITY SUPPORTIVE	COMMUNITY OPPRESSIVE (CRIPPLING)
R E S U L T S	Health worker continues to learn and to grow. Takes pride in the work. Has initiative. Serve the community's felt needs. Shows villagers what one of their own can learn and do, stimulating initiative and responsibility in others community becomes more self-sufficient and self-confident. Human dignity and responsibility grow.	Health worker plods along obediently, or quits. He/she fulfills few of the community's felt needs. Is subservient and perhaps mercenary. Reinforceps the role of dependency and unquestioning servility. Community becomes more dependent on paternalistic outside charity and control. Human dignity fades. Traditions are lost. Values and responsibility degenerate.
If outside support fails or is discontinued	Health programme continues because it has become the community's	Health programme flops
T A C I T OBJECTIVE	Social reform :health and equal opportunity for all	"Don't rock in the boat" Put a patch on the underlying social problems - don 't resolve them!
SPONSORING AGENCIES	Often small, private religious or volunteer groups. Sometimes sponsored by foreign non-governmental organisations.	Often large regional or national programmes cosponsored by foreign national or multi-national corporate or governmental organizations.

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TWELVE GROUPS OF AXIOMS ON MEDICAL CARE

(MAURICE KING)

MAJOR AXIOMS

One The medical care of the common man is immensely worthwhile.

Two Medical care must be approached with an objective attitude of mind which is free as far as possible from preconceived notions exported from industrial countries.

Three The maximum return in human welfare must be obtained from the limited money and skill available:

a) In estimating this return means must not be confused with ends.

b) Medical care must be adapted to the needs of an intermediate technology.

THE PATTERN OF A MEDICAL SERVICE

Four A medical service must be organized to provide for steady growth in both the quantity and the quality of medical care.

Five Patients should be treated as close to their homes as possible in the smallest, cheapest, most humbly staffed and most simply equipped unit that is capable of looking after them adequately.

Six a) Some form of medical care should be supplied to all the people all the time.

b) In respect of most of the common conditions there is little relationship between the cost and size of a medical unit and its therapeutic efficiency.

c) Medical care can be effective without being comprehensive.

Seven a) Medical services should be organised from the bottom up and not from the top down.

b) The health needs of a community must be related to their wants.

THE ROLE OF THE DOCTOR AND THOSE WHO HELP HIM

Eight The role a doctor has to play in a developing country differs in many important respects from that he plays in a developed one.

Nine The role played by auxiliaries is both different and more important in developing countries than in developed ones.

Ten All medical workers have an educational role which is closely linked to their therapeutic one.

a) Skilled staff members have a duty to teach the

Twelve: Medical care and the local culture are closely linked.

a) Medical care must be carefully adapted to the opportunities and limitations of the local culture.

b) Where possible medical services should do what they can to improve the non-medical aspects of a culture in the promotion of a 'better life' for the people.

Essential Elements of Good Medical Care

The fundamental goal of the medical care complex is to make medical care available to the community.

What are the elements which distinguish good medical care from other kinds of care? Basically there are four elements:

1) accessibility
2) quality
3) continuity
4) efficiency

These are the objectives which the medical care complex must incorporate to achieve the goal of good medical care.

1. Accessibility

Good medical care must be accessible to the individual at the time and place where he needs it.

The professional must have access to a comprehensive range of services from other professionals, facilities, equipment, drugs and other services necessary for his patient's needs.

The community must ensure that the necessary services will be available in adequate supply.

The 3 determinants of accessibility therefore are:

a) personal accessibility - involving many different points of entry into the complex being available.

b) comprehensive services - community programmes and adequate referral systems

c) quantitative adequacy - this involves the concept of planning with collection and analysis of data and information, forcasting needs, and the development of strategies to provide a comprehensive range of services as may be required at any given time.

2. Quality

Care of high quality is that which implements the most up-to-date knowledge and techniques available to the health services.

The following factors must be present:

a) professional competence - incorporating the need for supervision and in-service training.

3. Continuity

Care must be patient orientated and not disease orientated. Continuity implies planned and co-ordinated relationships among services within the community.

a) person centred care - orientated toward the promotion and maintenance of health in the individual and so must integrate preventive and curative services.

b) centre - source of care - best demonstrated by health centres.

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4. Efficiency

Efficiency administration of medical care programmes promotes the economical use of health resources and provides a means for achieving good medical care for the community. It involves:

a) equitable financing - by N.H.S. or insurance

b) adequate compensation - for the professional component

c) efficient administration - organises the use of resources in the most effective and economical way.

* * *

THE WORK OF THE HEALTH CENTRE

(REX FENDALL)

The activities of a health centre can be summarized like this:

Personal services:

General curative outpatients services
Maternity Care
The care of the under-fives - immunization
The care of school children
Consultative clinics
Clinics for special diseases, e.g. tuberculosis and malnutrition
Dental Care
Mental Care
Home visiting
Case work
Limited inpatient care
Family Planning

Community services:

Health education
The improvement of water supplies
The improvement of excreta disposal
The supervision of

AN APPROACH TO PUBLIC HEALTH - Professor Sidney Kark

Method: Making a community diagnosis

Choose a defined area limited by convenient natural boundaries from which data can be collected. This area should include the hospital or health centre itself and not be too big -- say 2-4,000 people.

Mark out this defined area on a map with a 'felt pen', fasten it to a piece of 'softboard' that easily takes pins and hang this up on the wall.

See if any basic data on the population of the villages in the defined area is available from the records of the provincial administration or the tribal headquarters.

Make arrangements to add to this information by recording births and deaths within the defined area, and, if possible, encourage the population to come up and register these events themselves.

Distinguish the records of patients from within the defined area by the use of cards of a special colour, some distinguishing mark or a special prefix to their record numbers.

Choose one or two diseases of particular interest or importance, think about them and decide what data would be of greatest value in studying their behaviour in the community, or might most usefully point the way to effective community health action.

Explain the idea to the record clerks, and get them to collect the required information by questioning the patients, and recording their data for analysis, preferably after the manner suggested in 26:12. Where relevant, record the location of the cases being studied by sticking coloured pins into the map.

Plot the data obtained in graphical or tabular form and pin it on the wall.

When sufficient data has been collected, analyse it carefully, form some judgement as to its accuracy, see if it needs amplifying or extending, and see what conclusions it leads to.

The plan the necessary health action accordingly.

* * *

HEALTH EDUCATION - John Bennett

Method

A start with health education

Resolve to undertake some health education, however little may be possible at first, and plan what is done. See that some interested person is in charge of the educational drive.

Try to base the

If there is a choice of villages in which to work, choose that with the most co-operative headman. Approach the most senior man in the area first, the 'Area Commissioner' for instance, and, having secured his co-operation, then seek the aid of his subordinates.

Endeavour to follow these seven points:

1. Decide how much of the available knowledge on a particular subject should be passed on to the community and to specific groups within it, mothers and adolescents for instance.
2. See how these ideas can best be expressed in the vernacular.
3. Determine which beliefs, customs and attitudes, are likely to either help or hinder the acceptance of this knowledge. See what can be done to circumvent any hindrances.
4. Try to discover which individuals or groups of people in the community are in a position to help or hinder the acceptance of this knowledge. See if it is possible to minimize the effect of the potential hinderers.
5. Make the most of a variety of teaching methods.
6. Make the most of teaching aids, having first determined that they are understood.
7. Endeavour to measure success or failure and make this evaluation an integral part of the educational programme.

* * *

THE CROSS-CULTURAL OUTLOOK IN MEDICINE

MAURICE KING

I. Method: A start in the study of a strange culture

The family. What are the common patterns of family composition? What is the age of marriage and how stable is it? What are the strongest emotionalities within it? What are the obligations towards the extended family of uncles, aunts and cousins? What is the status of women?

After the family, what other important associations are there? Political parties? Guilds? Agricultural co-operatives? Initiation groups? Religious communities?

What are the influential members of the community? Chiefs? Party officials? School teachers? Ministers? Hospital assistants?

What accords status in the community? Cattle? Wives? Children? Land? Money? Education?
What are the values of a community? Leisure? Conformity? Happiness? Fulfilment of the personality?

What are the customs of the community over the use and ownership of land and money? How is the land inherited? What is the income of the average family? Is money the common property of the family? Is there money available in the community for medical expenses?

What are the attitudes and practices of the community in matters

II. Method: Obtaining a "Cross-cultural outlook' in medicine

Observe the society closely. Use what is visible to lead to what is invisible in terms of attitudes, values and goals etc.

Read some anthropology

Read what novels and plays may be relevant

See if there have been any specific studies of the tribes in the area and read them.

Make the acquaintance of an anthropologist working in the vicinity.

Obtain an insight into the local culture by carefully questioning some of the more educated members of the local community.

Follow this up by obtaining more information in routine case histories taken from the patients.

Take at least some steps to learn a local language, even if it is only the greetings and the necessary clinical questions and imperatives.

* * *

COMMUNITY HEALTH CELL
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MEDICAL CARE ADMINISTRATION.

Organization of health services is both a cause and effect of specialisation. Some of the advances in modern medical care have occurred as a result of improved methods and skills in organization which make possible the division of labour and the co-ordination of specialised tasks. At the same time, technological advances have produced a high degree of specialisation which generates the need for organisation.

When patients encounter difficulty in finding and using medical care from numerous independent specialised sources, organisation becomes a necessary means for co-ordinating services and focusing on the total patient.

Medical Care Complex - embraces the personal relationships and organised arrangements through which health services are made available to the public.

Components - It consists of 3 major components.

1) Personal Component - People needing Health Services
2) Professional " - People providing Health Services
3) Social " - Private and public organisations (which make personal Health Services available to the population) for performing medical care functions.

Structure: The inter-relationship and inter-actions among the 3 components provide the structure for the medical care complex giving it form and outlining its functions.

The principal interaction is between the people needing the services and those providing them. This interaction may be intimate and personal as in the relationship between a patient and his physician or it may be indirect and impersonal as in a man in immunization programme conducted by a local health department.

The combined efforts of the personal and professional components to achieve mutual and social goals is the social component which provides the organised arrangements for performing medical care functions.

Boundaries: The boundaries of the complex, its scope and direction are determined by the goals, values and expectations each of the components brings to its participation in the medical care process.

What are some of the personal, professional and social goals, values and expectations which act as the boundaries

a) Personal Component:

There will of course be considerable variation in the individual goals and expectations and differences in culture, education, economic status, geographic location and other individual characteristics contribute to this variation.

In genral, however, the principal goals of the individual's participation in the medical care complex are the relief of pain and symptoms and the prevention of future pain and disability. In addition, a less clearly definable goal is the psychological benefit of peace of mind when the fears and forebodings of present or potential illness are alleviated.

b) Professional Component:

Their collective goal is to provide the best medical care possible within the limits of their own abilities and of scientific technology. In return for their contribution they expect to be reasonably compensated in an amount commensurate with their responsibilities and with relative cost of their education and training.

C) Social Component:

The community participates in the medical care complex in order to promote, protect and restore health of individuals in its population. It recognises that expenditures of money, manpower and material in the field of health represents investments in the total structure of a community and cannot be considered only on the consumption side of the ledger.

Society's goals are to reduce as far as possible mortality and morbidity in all segments of the population, to ensure everyone access to personal health services of high quality; to remove or reduce unnecessary social or economic consequences which the population may suffer as the result of disease or disability.

The principle of equity and equality should prevail. Attempts are made to ensure that health services of an acceptable standard of quality are made universally available. It is hoped that the resources allocated will be used in the most efficient manner possible, consonant with humanitarian goals. Society demands that the knowledge gained through research should be radily and widely applied, that unmet needs or duplication of services should be minimised and that the use of services should be appropriate in quantity and quality to the need of them.

Essential Elements of Good Medical Care:-

The fundamental goal of the medical care complex is

1) accessibility.
2) Quality.
3) Continuity.
4) Efficiency.

These are the objectives which the medical care complex must incorporate to achieve the goal of good medical care. They must obviously be intimately related with each of the 3 components of the medical care complex we considered above - personal, professional, social.

1. Accessibility:

Good medical care must be accessible to the individual at the time and place where he needs it.

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2. Quality:

Care of high quality is that which implements the most up-to-date knowledge and techniques available to the health services.

The following factors must be present:

a) Professional competence - incorporating the need for supervision and in-service training.

b) personal acceptability - this may require U.A.P. studies and education of the public.

c) qualitative adequacy - standards of education

3. Continuity:

Care must be patient orientated and not disease orientated. Continuity implies planned and co-ordinated relationships among services within the community.

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14.5.1979.

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Family Planning

Community services

Health education

The improvement of water supplies

The improvement of excreta disposal

The supervision of housing conditions

The regulation of food shops and markets

Campaigns against communicable diseases

The collection of statistics.

COMMUNITY DIAGNOSIS.

Community diagnosis serves to discover a community's health problems and to evaluate measures instituted for their solution. Any community health programme drawn up without a systematic attempt at a community diagnosis is likely to fail. In order to ascertain whether a Community Health programme has made any difference to the health of the people served, base-line surveys are necessary so that the most appropriate programme is introduced in the region.

Community diagnosis is essential to ascertain to what extent maternity services have been responsible for any decline in maternal and infant mortality rates. One may want to know whether such services have been responsible for the increased rate of population growth. Have school health services improved the health of school children? In developed countries infectious diseases have been replaced by chronic diseases such as hyper-tension, ischaemic heart disease and various types of neoplasia are similar phenomena taking place in developing countries? Have health programmes to be altered to meet these changing circumstances? These are examples of some of the issues that make scientifically based community diagnosis mandatory in the development and organisation of all health programmes.

Epidemiology is an important tool of community diagnosis. It has been concerned traditionally with the distribution and determanants of disease and disorder in populations. The relationship of cholera to contaminated water, of malaria and yellow fever to mosquitoes and of pellagra to a deficient diet; are classic examples of the contribution made by this approach.

The scope and role of epidemiology has been expanded to include an ever widening range of conditions - chronic disease, mental disorders, congenital anomalies, accidents, alchoholism and health aspects of population dynamics, and has further expanded to include studies of the behavioural correlates of disease and variations in health status - cigarette smoking, utilisation of health services, compliance and cooperation with medical advice etc. The strategy and findings of epidemiological inquiry can be applied to the organisation and evaluation of health services.

An adequate community diagnosis requires answers to seven major questions:

(1) <u>What are the Magnitudes and Extent of Community Health Problems</u>?

Requires to be assessed not only by professional health workers but such an approach has to be augumented by information concerning the importance of the health problems from the perspective of the community to be served.

(2) <u>What is the Extent of Current Attempts to Alleviate</u> these Community Health Problems?

Information should be obtained about services available (including indigenous medical services) the extent and patterns of utilisation, the barriers to utilisation of the services and the community's perception of the services and its participation in the same.

(3) What are the correlates of Community Health Problems?

It is necessary to identify segments of the population at highest risk-is it more common in the young or the old, in males or females, is the problem selected to educational level of other factors?

(4) What procedures or techniques will be needed to effect the desired changes?

Based on the answers to the previous 3 questions, one could lay down priorities for new health programmes and the segments of a population to be covered. Procedures and techniques have to be evolved which require a knowledge of resources available - finance and personnel - A multi disciplinary approach will be necessary.

(5) What data are needed for Programme Management and Evaluation?

These include data necessary for clinical management of cases and data required for accounting purposes in terms of activities and data gathered for the evaluation of the programme.

(6) What methods of Data gathering, Recording and Processing are needed?

Answers to these questions come from a knowledge of epidemiological methods.

(7) To what extent isthe programme accomplishing its objectives?

Aim of this question is to ascertain whether the programme is accomplishing its objectives (a) Have the changes postulated as necessary for improvement in the health status been brought about. For example, if certain agricultural practices and culturally determined beliefs were responsible for a poor nutritional status in pregnant women (based on answers to question 3)have these beliefs and practices benn changed? If a high incidence of trachoma was due to poor personal hygiene and non attendance of the clinic, have the behavioural change been made in the right direction. (b) If the answer to question (a) above are positive, have corresponding improvements been effected in the health status, i.e. has the nutritional status of pregnant women improved. (c) Finally, if answers to questions (a) and (b) are both in the affirmative, it would be

spontaneously. Anser to this question would be difficult unless a comparison of the results of the programme area are compared with a similar area without such a programme. Many claims of programme or treatment successes in halting an epidemic are made but experience beyond the programme area has shown that the epidemic declined for reasons quite unrelated to the intervention programme i.e. natural history of the disease or decline due to other reasons.

Source of information:

1) WHO Technical Memorandum.

2) Community Medicine - What is in a Name by Robert L Kane.

3) Community Diagnosis by John C Cassel.

4) WHO Monograph series 34.

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C-55

BEFORE AND BEYOND OBJECTIVES AND GOALS: THE VISION

by

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It is not the stated goals and objectives of a community program that make it vital or viable- -but rather the vision, unwritten and evolving, shared by the members of the program and community as they change and evolve together.

In the planning and evaluation of health programs, often a a great deal of discussion is devoted to "objectives" and "goals." Goals tend to be more general, objectives more specific, but both are- -or, it is commonly agreed, should be- -clearly defined. They become the fixed landmarks toward which the ship sets sail.

But there is something bigger and more subjective that precedes objectives and goals and that contributes to both their formulation and the strategy of their pursuit. This is the dream of where we would like to go: the vision.

The difference is figuratively- -and too often literally- -a matter of life and death. Goals and objectives lie "out there," fixed and defined. They are static, like rocks or ports. But a vision is boundless, fluid and evolving. It is both inside us and beyond us. It is the human response of past and present trailing into the future and beyond. It can be noble or selfish, and is often a mixture of both. It cannot be objectified or tried down in time and space. It changes and grows constantly. It soars!

This may sound very abstract and philosophical, scarcely meat for a ministry of health. Yet such considerations are ultimately pragmatic. For it is the vision of man that shapes and distorts his "objective" choices- -and which leads him to both his gas chambers and cathedrals.

Whether the vision of those behind a government or community health program is the shared vision of many or the elite vision of a few, whether it is basically authoritarian or humanitarian, will have a lot more to do with the practical reality or the program than will its stated goals and objectives.

The World Health Organization (WHO) has set as its overall goal "the provision of basic health care to all the world's people by the year 2000."

An admirable goal- -or a frightening one!- -depending on how it is interpreted and by whom. As has already been demonstrated, it means radically different things to different people, even among the top experts within WHO's palatial headquarters overlooking Lake Geneva.

--Does it mean extending our existing professionally

--Does it mean increasing the dependency of the poor on existing institutions that would keep them both poor and powerless?...Or does it mean helping the poor to organize at the family and community level to take greater control over their lives and health?

- -Does it mean "fertility control" through payment of women to take (or pretend to take) the pill, and raids by "health police" to sterilize women and adolescent boys by force to meet required quotas (as we know has happened)? ...Or does it mean facilitating social and political changes that will permit the poor to improve their economic base and so discover for themselves- -as have the rich- -the benefits of a small family?

- -Does it mean modifying (yet preserving) a social order that produces increasingly poor health among the rich as it perpetuates poor health among the poor, because it is fundamentally unfair and corrupt?...Or does it mean working together toward a new social order that is sensible, just, and kind?

- -Does it mean preserving our "human right" and inalienable "freedom" to exercise unlimited greed while one third of mankind goes hungry?...Or does it mean struggling to overcome human selfishness through human understanding and love?

- -Does it obstruct, or does it open the way, for more equitable distribution of power?

DISEASES OF MODERN ECONOMIC DEVELOPMENT

DISEASE AND ENVIRONMENT

Most disease is the result of some factor or factors in the environment. All infections, whether caused by bacteria, viruses, or various parasites, come into this category. Injuries and poisons of all kinds are also environmental hazards, and it has been estimated that over 80 per cent of cancer is due primarily to some environmental factor. Examples of the latter are the relationships between lung cancer and smoking, between skin cancer and sun or X-rays, and between oral cancer in the east and chewing a 'quid' containing tobacco, lime, and other ingredients.

Even malformations present at birth may be the result of some intrauterine environments, as tragically exemplified by thalidomide poisoning or infection with rubella during pregnancy. Very few diseases are, in fact, solely the result of genetic factors.

In view of the environmental dependence of disease, a search for the cause of a particular malady is, infact, usually an attempt to identify the responsible factors in the environment. Many examples could be cited. Snow, in his classic mapping of cases ina cholera outbreak in London, identified contaminated water as the responsible factor much earlier than the cholera vibrio was discovered. The relationship between fever and the presence of mosquitoes was recorded by David Livingstone long before Rose and his colleagues demonstrated the mode of transmission and life cycle of the malaria parasite. Sleeping sickness was seen to occur in the presence of tsetse flies before Bruce described the transmission of the responsible trypanosome.

In the realm of non-infectious disease, Pott's observation that chimney sweeps were particularly prone to skin cancer preceded knowledge of the carcinogenic action of hydro-carons and skin cancer was associated with exposure to sun when little was known of the carcinogenic effects of radiation.

Such examples could be multiplied in almost every field of medicine.

THE SIGNIFICANCE OF RELATIONSHIPS

The different effects of any one cause will always tend to be associated with one another. Conversely, if two or more diseases tend to be rare or common together in different communities, common or related causes may be suspected. Diseases due to a common cause will all tend to occur more commonly in individuals most exposed to that causative factor, and as a result these diseases will be found together in individuals more often than otherwise expected. Conversely, the tendency fortwo or more diseases to occur concurrently in individual patients suggests that they have a common or related cause (Burkitt, 1970).

It is thus evident that studies of the geographical distribution of particular diseases not only help to identify possible causative factors in the environment but also enable the recognisation of relationships between one disease and another.

DISEASES WITH A PARTICULAR AND WITH A COMMON GEOGRAPHICAL DISTRIBUTION

Different diseases may have a particular and distinctive geographical distri-

Some of the diseases which have a common distribution resulting from a common causation are:- Various skin conditions, (including cancer) associated with excessive exposure to sun; bronchitis, lung cancer and nicotine-stained fingers, all caused by cigarette smoking; and liver cirrhosis, delirium tremens and obesity, all resulting from excessive indulgence in alcohol.

Another group tending to have the same geographical distribution comprises many of the most common and serious diseases of the western world (Trowell, 1960; Cleave et al., 1969). It includes:

Coronary heart disease, the commonest cause of death, killing one man in four;

Cancer of the large intestine, the second commonest cause of death from cancer, after tumours of the lung;

Appendicitis - the commonest abdominal emergency.

Diverticular disease of the large bowel - the commonest disease of the intestine;

Gallstones - which are present in some 10 per cent of the adult population.

Over a third of a million gallbladders are removed annually in the USA.

Varicose veins - affecting some 10-15 per cent of the adult population.

Venous thrombosis - one of the major hazards of any serious sickness.

Pulmonary embolism - one of the commonest causes of post-operative death.

Diabetes - the commonest endocrine disorder.

Obesity - the fear of which is now a nationwide obsession; and

Dental caries - so prevalent that it is scarcely regarded as a disease.

These , together with some less well known maladies, can be considered as diseases of modern economic development.

GEOGRAPHY OF DISEASE OF MODERN ECONOMIC DEVELOPMENT

All the diseases listed above are rare or unknown in communities little touched by Western civilization, and Western dietary customs in particular. They are all most prevalent in Europe and North America, and it is particularly significant that in the latter situation they now have a comparable incidence in both the white and coloured communities. In India, Pakistan and the Middle East and, as far as can be ascertained, in rural areas of South America, their incidence is intermediate to that of Africa and America Japan also has had an intermediate incidence, but in the case of most of this has been rising, particularly in large cities, since the Second World War, and has risen rapidly in Japanese who have emigrated to California and Hawaii. The situation among the New Zealand Maoris is much closer to that of the population of European descent than it is to the less westernized Polynesian islanders who remain almost free of these diseases.

TIME OF EMERGENCE IN DIFFERENT SITUATIONS

Obesity, diabetes, dental caries and possibly gallstones were well recognized early in the last century, but have become very much commoner during the present century. Coronary heart disease, appendicitis (Short, 1920), diverticular disease (Painter and Burkitt, 1971) and venous thrombosis only emerged as important clinical entities in the first quarter of this century. Experience in developing countries suggests that thesame applied to varicose veins (Burkitt 1972), but their incidence was not recorded before they became common.

These conditions were much more common in white than in coloured Americans 30 to 40 years ago, a gap which in most instances has now been bridged. This suggests a causative factor which appeared in the environment of the Caucasians before that of Negroes, but which has increased relatively more quickly in the environment of thelatter than of the former during the past 40 years.

When one turns to the situation in developing countries, of which Africa will serve as an example, these diseases appear to follow the impact of Western civilization, some coming soon after the introduction of sugar, and others only after further dietary changes, particularly those which accompany urbanization.

Diabetes, dental caries and obesity appear relatively early, appendicitis, varicose veins, and femoral thrombosis some what later, and intestinal cancer gallstones, coronary heart disease and diverticular disease only long after a high degree of adoption of western habits.

ASSOCIATIONS IN INDIVIDUALS

In the Western World many of these diseases have been observed to occur together in the same individuals more often than would be expected by their incidence in the community as a whole.

As has been explained above, this further suggests that they have a common or related cause.

RELATIONSHIP TO DIETARY CHANGES

The environment responsible for the intestinal diseases enumerated above is most likely to be dietary and therefore changes in food which coincided with or preceded the rise in incidence of these diseases, deserve special attention. The incrimination of the factor or factors responsible for these diseases will suggest possible ~~x~~causes for the associated diseases. One must therefore consider dietary changes:

a) that occurred in North American and Northern Europe shortly before the turn of the century;
b) that affected the white before the coloured population in the USA;
c) that take place in the diet of African villagers when they become educated or urbanized;
d) that occur in the diet of Japanese on emigration to America.

~~x~~)

The main changes that occurred in western diet in the last quarter of the last century and the early years of this century were:

a) some rise in fat consumption, probably not more than 25 per cent (Antar et al., 1964);
b) a greater rise in sugar consumption, possibly up to 200 per cent (Antar et al., 1964; Walker, 1971a);
c) a reduction in cereal fibre, in the region of 5- to 10-fold (Walker, 1971a).

Japanese, emigrating to America, eat less rice and potatoes than when living in Japan, and increase their consumption of meat, eggs and butter, with consequent loss of fibre relative to calorie intake.

CAUSES SUGGESTED BY EPIDEMIOLOGICAL EVIDENCE

It has already been indicated that the similar geographical distribution of the diseases enumerated above and the tendency for them to occur together in individuals suggests common or related causes.

Examination of changes in food habits suggest that sugar excess and fibre depletion might be important causative factors.

Cleave (1956) was the first to point out the sugar excess and fibre depletion tend to be reciprocal to one another. Removal of unabsorbable fibre from natural carbohydrate foods results in concentration of the starch and sugar with consequent over-consumption. When food is diluted with fibre, satiety precedes over-consumption.

This is not the place for a detailed discussion of possible mechanisms whereby carbohydrate excess or ~~xxxx~~fibre lack may cause disease but suggested mechanisms may be summarized as follows:

Deficiency of dietary fibre results in

(a) Delay in transit of intestinal content through the gastrointestinal tract (Walker, 1961, 1971 b; Burkitt, 1971 a, Burkitt et al., 1972). This results in small formed stools contrasting with the large soft unformed stools characteristic of communities on a high-residue diet.

This constipation, a feature of Western life, results in:

(i) raised pressures within the lumen of the bowel which are believed to be the cause of diverticular disease (Painter, 1970) and appendicitis (Burkitt, 1971b);

(ii) altered bacteria in the stools which are believed to form substances that cause an increased incidence of bowel cancer (Aries et al., 1969; Hill et al., 1971);

(iii) increased pressures within the abdomen during straining at stool, which result in back-pressure in the veins of the legs and may be in part responsible for varicose veins and venous thrombosis (Burkitt, 1972). The latter is the cause of pulmonary embolism.

(b) Diminished excretion in the stools of substances formed from cholesterol, together with increased absorption of cholesterol in the diet through the wall of the intestine. This raises the cholesterol level in the blood, which is believed to predispose to the development of coronary heart disease (Trowell, 1972a,b). It seems likely that in a similar way it influences the formation of gallstones which are largely formed of cholesterol.

(c) Over-consumption of refined carbohydrate, especially in the form of sugar and white flour.

This is largely responsible for the appalling rise in the incidence of dental caries, probably plays a significant role in the causation of obesity and diabetes, and may also contribute to coronary disease and gallstones (Cleave et al., 1969).

CONCLUSION

The geographical distribution and historical development of many of the diseases characteristic of economic development suggests that the most important single factor running through them is the removal of unabsorbable fibre, without which over-consumption is almost impossible.

Because it has no nutritive value, fibre has been the neglected factor, the Cinderella of dietetics. Its retention once again in our flour could make an incalculable improvement in the health of any Western nation, which would be an ultimate fruit of geographical investigation.

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DISEASES OF MODERN ECONOMIC DEVELOPMENT

DISEASE AND ENVIRONMENT

Most disease is the result of some factor or factors in the environment. All infections, whether caused by bacteria, viruses, or various parasites, come into this category. Injuries and poisons of all kinds are also environmental hazards, and it has been estimated that over 80 per cent of cancer is due primarily to some environmental factor. Examples of the latter are the relationships between lung cancer and smoking, between skin cancer and sun or X-rays, and between oral cancer in the east and chewing a 'quid' containing tobacco, lime, and other ingredients.

Even malformations present at birth may be the result of some intrauterine environments, as tragically exemplified by thalidomide poisoning or infection with rubella during pregnancy. Very few diseases are, in fact, solely the result of genetic factors.

In view of the environmental dependence of disease, a search for the cause of a particular malady is, infact, usually an attempt to identify the responsible factors in the environment. Many examples could be cited. Snow, in his classic mapping of cases ina cholera outbreak in London, identified contaminated water as the responsible factor much earlier than the cholera vibrio was discovered. The relationship between fever and the presence of mosquitoes was recorded by David Livingstone long before Rose and his colleagues demonstrated the mode of transmission and life cycle of the malaria parasite. Sleeping sickness was seen to occur in the presence of tsetse flies before Bruce described the transmission of the responsible trypanosome.

In the realm of non-infectious disease, Pott's observation that chimney sweeps were particularly prone to skin cancer preceded knowledge of the carcinogenic action of hydro-carons and skin cancer was associated with exposure to sun when little was known of the carcinogenic effects of radiation.

Such examples could be multiplied in almost every field of medicine.

THE SIGNIFICANCE OF RELATIONSHIPS

The different effects of any one cause will always tend to be associated with one another. Conversely, if two or more diseases tend to be rare or common together in different communities, common or related causes may be suspected. Diseases due to a common cause will all tend to occur more commonly in individuals most exposed to that causative factor, and as a result these diseases will be found together in individuals more often than otherwise expected. Conversely, the tendency fortwo or more diseases to occur concurrently in individual patients suggests that they have a common or related cause (Burkitt, 1970).

It is thus evident that studies of the geographical distribution of particular diseases not only help to identify possible causative factors in the environment but also enable the recognisation of relationships between one disease and another.

DISEASES WITH A PARTICULAR AND WITH A COMMON GEOGRAPHICAL DISTRIBUTION

Different diseases may have a particular and distinctive geographical distri-

Some of the diseases which have a common distribution resulting from a common causation are:- Various skin conditions, (including cancer) associated with excessive exposure to sun; bronchitis, lung cancer and nicotine-stained fingers, all caused by cigaretter smoking; and liver cirrhosis, delirium tremens and obesity, all resulting from excessive indulgence in alcohol.

Another group tending to have the same geographical distribution comprises many of the most common and serious diseases of the western world (Trowell, 1960; Cleave et al., 1969). It includes:

Coronary heart disease, the commonest cause of death, killing one man in four;

Cancer of the large intestine, the second commonest cause of death from cancer, after tumours of the lung;

Appendicitis - the commonest abdominal emergency.

Diverticular disease of the large bowel - the commonest disease of the intestine;

Gallstones - which are present in some 10 per cent of the adult population.

Over a third of a million gallbladders are removed annually in the SSA.

Varicose veins - affecting some 10-15 per cent of the adult population.

Venous thrombosis - one of the major hazards of any serious sickness.

Pulmonary embolism - one of the commonest causes of post-operative death.

Diabetes - the commonest endocrine disorder.

Obesity - the fear of which is now a nationwide obsession; and

Dental caries - so prevalent that it is scarcely regarded as a disease.

These , together with some less well known maladies, can be considered as diseases of modern economic development.

GEOGRAPHY OF DISEASE OF MODERN ECONOMIC DEVELOPMENT

All the diseases listed above are rare or unknown in communities little touched by Western civilization, and Western dietary customs in particular. They are all most prevalent in Europe and North America, and it is particularly significant that in the latter situation they now have a comparable incidence in both the white and coloured communities. In India, Pakistan and the Middle East and, as far as can be ascertained, in rural areas of South America, their incidence is intermediate to that of Africa and America Japan also has had an intermediate incidence, but in the case of most of this has been rising, particularly in large cities, since the Second World War, and has risen rapidly in Japanese who have emigrated to California and Hawaii. The situation among the New Zealand Maoris is much closer to that of the population of European descent than it is to the less westernized Polynesian islanders who remain almost free of these diseases.

TIME OF EMERGENCE IN DIFFERENT SITUATIONS

Obesity, diabetes, dental caries and possibly gallstones were well recognized early in the last century, but have become very much commoner during the present century. Coronary heart disease, appendicitis (Short, 1920), diverticular disease (Painter and Burkitt, 1971) and venous thrombosis only emerged as important clinical entities in the first quarter of this century. Experience in developing countries suggests that thesame applied to varicose veins (Burkitt 1972), but their incidence was not recorded before they became common.

These conditions were much more common in white than in coloured Americans 30 to 40 years ago, a gap which in most instances has now been bridged. This suggests a causative factor which appeared in the environment of the Caucasians before that of Negroes, but which has increased relatively more quickly in the environment of thelatter than of the former during the past 40 years.

When one turns to the situation in developing countries, of which Africa will serve as an example, these diseases appear to follow the impact of Western civilization, some coming soon after the introduction of sugar, and others only after further dietary changes, particularly those which accompany urbanization.

Diabetes, dental caries and obesity appear relatively early, appendicitis, varicose veins, and femoral thrombosis some what later, and intestinal cancer gallstones, coronary heart disease and diverticular disease only long after a high degree of adoption of western habits.

ASSOCIATIONS IN INDIVIDUALS

In the Westerm World many of these diseases have been observed to occur together in the same individuals more often than would be expected by their incidence in the community as a whole.

As has been explained above, this further suggests that they have a common or related cause.

RELATIONSHIP TO DIETARY CHANGES

The environment responsible for the intestinal diseases enumerated above is most likely to be dietary and therefore changes in food which coincided with or preceded the rise in incidence of these diseases, deserve special attention. The incrimination of the factor or factors responsible for these diseases will suggest possible ~~ex~~causes for the associated diseases. One must therefore consider dietary changes:

a) that occurred in North American and Northern Europe shortly before the turn of the century;
b) that affected the white before the coloured population in the USA;
c) that take place in the diet of African villagers when they become educated or urbanized;
d) that occur in the diet of Japanese on emigration to America.
e)

The main changes that occurred in western diet in the last quarter of the last century and the early years of this century were:

a) some rise in fat consumption, probably not more than 25 per cent (Antar et al., 1964);
b) a greater rise in sugar consumption, possibly up to 200 per cent (Antar et al., 1964; Walker, 1971a);

HISTORICAL DEVELOPMENT OF HEALTH CARE IN INDIA *

Considering that the topic for today's workshop is on 'Front Line Workers', it should only be natural, before we go into the details of development of health care in India, to state that the implementation of the Community Health Workers Scheme in India since October 2nd, 1977 in 777 Primary Health Centres, marks two major departures from past attempts at organisational reforms in rural health programme.

First for the first time, the scheme attempts to transfer the administrative control of a health programme to the community and second, it strikes at the root of medical profession's monopolistic attitude towards health care functions. The success of the whole scheme is shrouded by a cloud of 'if's' and 'but's' and perhaps this would be obvious as we look back at the development of health care in India.

It would be important to note at the outset that 'Health Services' are one of the components that influence the health status of a population. Health of a population is influenced as much if not much more by other social and economic factors as nutrition, water supply, waste disposal, proper housing, education, income, employment,etc. Besides these factors the existing political system plays a dominant role in shaping of health services in a community, through decisions on resource allocation, manpower policy, choice of technology and the degree to which the health services are to be available to the population.

The British had their own health policy in India, and so did our leaders after independence, and it is sometimes difficult to determine which has been more exploitative to our masses.

A pattern of approach to health emerges as a logical product of a given political, social and economic system. Even if a health policy is not spelled out in all its comprehensive details, the political economic and social forces themselves generate an 'unwritten' policy frame for action which influences the health of a population.

The neglect of the indigineous system of medicine,neglect of the health needs of the vast majority of the population and active promotion of dependency on British Medical Institutions can be expected as a logical outcome of the British colonial system of Govt.in India. The spectular rise in the output of doctors, principally from the priveledged class and urban orientation of growth and development of health services in post independent India cannot be called a mere random phenomenon - as unforseen or unintended outcomes.

Development of Health Care in India can be best described under the following headings :

1 - Pre - British Period.
2 - British Period
3 - Post Independence Period.

Pre-British Period :

House hold remedies, quacks, astrolegers, magicians, priests, Gods and Goddeses, unregistered and unqualified prac-

Most of the dwellings in these cities contained latrines water closets and protected wells. But with the decline of the civilisation, there was a general decline in the standard of sanitation and town planning as the Aryan invaders became mainly Agrarian and pastoral people[4].

The next few centuries saw rapid development of the Indian systems of Medicines starting with the Ayurvedic system of medicine.

Medical education was imparted from the university of Nalanda, Taxila, Kashi and Sushurta school.

Emperor Ashoka was particularly responsible for the spread of social medicine, manifest in a public health care system which included hospitals and sanatoria for men, women and children.[4]

Ayurveda or the religion of life was thought with other Vedas namely the Rigveda, Yajurveda and Athanaveda.[5]

Charaka and Shusruta are known the world over for their contribution to the Indian Systems of Medicine which has contributed to the Arab Medicine and modern medicine.

With the onset of the Muslim rule the physicians of the Middle East trained in the then flourishing Unani system which was largely Galenic in influence and curative in approach, began to translate Ayurvedic texts and in the 10th Century Kakim Yusuffi a physician in the courts of Babar and Humayum is said to have synthesised Arabian, Persian and Ayurvedic thought and composed an Integrated Medical System.[7]

Some people believe that the advent of the Unani system, led to the decline of the Ayurveda and modern medicine completely undermined it.

The colonial policy of exploitation, expropriation and plunder created widespread disruption in the way of life of the Indian people.[2]

Djurfeldt and Lindburgh feel medical care offered by these physicians could not keep pace with the actual health problems in the community, which were in turn created by extremes of poverty and decline of environment.

High infant mortality, child and maternal mortality rates, rampanging epidemics etc. overwhelmed the tools of traditional practicioners.[8]

Content of the Indian system of Medicine: (I.S.M.)

Indian System of Medicine besides Ayurveda in the course of time adapted Umani, Yoga Natunopathy.

Various attempts have been made to develop the I.S.M. but in the process it suffered various setbacks. Various importtant committies like C.G.Pandit, Dave and Uduppa committee have studied problems facing I.S.M. in great debt and suggested remedial measures but obviously political will was lacking and this led to absolute neglect of the I.S.M.[9]

With increased attempts at integrating I.S.M. with allopathic system the VI Plan allocation has been raised to Rs.60 crores (2.04% of total health budget).

There are signs of increasing interest and integration at various levels is being tried.

A blatant disparity is the fact that about 2 lac practioners of I.S.M. have till now never formed part of the health service infra-structure.

British Period :

The British introduced Western Medicines in India in the later half of the 18th century mainly to serve their #olonial settlers and armed forces.[11]

The British had only two aims in mind :

1. To establish a health service to back up the colonial rule,

2. Extension of health services to the native population because of extremely poor physical conditions of the sepoys.[4]

The missionaries had already introduced western medicines in South India in early 16th century. European doctors employed in East India Company had an important role to play in introduction of modern medicines in India. As the work load increased the European doctors felt the need for assistance in their duties, so they trained local inhabitants as compounders and dressers, who were designated as 'Native Doctors.'

These services initially meant for the colonial settlers, started being utilised by the elite of the Indian population and this was perhaps the beginning of the disparity that is perpetuated till today. The remaining 90% of the population relied on the indigenous practitioners and perhaps on the little medical care that overflowed from charitable hospitals and dispensaries and missionary organisations.

The National Planning Commission states that medical assistance and living conditions had to be improved if the Indian Army and Civil Administration were to be worthy of the money spent on them.[12]

However, what looked like genuine interests of the British had profound influence on the system of Medicine in India, because of the infra-structure laid down, the beliefs and the value system which supported it, constituted an important legacy left behind by the British to Independent India's System of Medicine.

With various attempts at developing a Public Health system and inspite of the much acclaimed Act of 1935, the problems of the rural masses remained unresolved. The National Planning Commission clearly states that ' The problems of health remained in all its intensity and complexity almost untouched, upto the

The legacy of education, technology, lifestyles value systems and aspirations of the west were readily imbibed by our elite which closely identified with the colonial rule. It is to be noted that many from this class also found their way into our Planning Commissions, and this had major implications in so far as it radically altered the parameters by which any problem would be studied and the methodology used to solve it.[1]

This is particularly manifest in Medical and Nursing Education. The irrelevance of the Indian Medical Education is the result of the outcome of adoption of the British pattern and value system. It is important to recognise that there was a simultaneous decline in the Indian Systems of Medicine.

The British public health system never went beyond sanitation and public health work in large cities and towns and poor control of epidemics in the rural areas. However, taluka dispensaries were set up, but these again served the government staff rather than the rural masses.

The missionaries also tried their hand at providing health care but this was too haphazard and uncordinated.

The British however did one good thing - they laid down the foundation for a very important concept neglected from the time of Ashoka, and that is - that health care is the responsibility of the state. In the course of two hundred years of colonial rule, almost every facet of life in India was subordinated to the commercial, political and administrative interests of the ruling power. The country was very backward in the field of agriculture as well as in industry. Caste, class and religious considerations had divided the society into a very tiny minority of highly priveledged persons at one extreme and a large mass of underpriveledged people who constituted an overwhelming majority on the other.

Both medical education and health care services were available to those in the priveledged uppermost class of society, not basically because of lack of technological know-how, but mainly because of lack of political, economic and social will.[2]

DEVELOPMENT OF HEALTH CARE IN INDEPENDENT INDIA :

The British Government in due course of time thought of rendering Comprehensive (Intensive and Extensive) Health Services to the rural masses and with this objective in mind, the government appointed a historical committee headed by Sir Joseph Bhore in 1943.

The committee submitted its report in 1946. This report is one of the most rational and far sighted documents of its kind which largely remained unfulfilled.

Although the Committee shows continuous awareness of the realities of the Indian situation, the British influence is clearly seen in certain areas.

Decentralisation of services suggested by Sir Joseph

The Committee suggested a ' Short ' and a ' Long ' Term Plan as a blue-print for the development of comprehensive services for the country, the short term plan covering two first five year plans and the long term plan stretching for twenty to forty years. The country side was the focal point of the recommendations made.

As early as 1946 the recommendations of the Bhore Committee were accepted as the guidelines for the provision of health care services to independent India.

The aim according to Shri Nehru was to develop a 'National Plan' which would supply free treatment and advice to all those who required it.

An important flaw of the Bhore Committee however was the fundamental role assigned to the allopathic doctor in the proposed health structure. There was no room anywhere for the Indian systems of Medicine.

It as rightly pointed by Dr. Vishwanath and Dr. Bhat of the Committee, that the basic doctor envisaged will not willingly fit into the scheme, except under conditions of destitution. This is exactly what happened, though attempts at producing the so called basic doctor have been and are still being made in some institutions. Generally speaking the so called ' Basic Doctor' that was envisaged is still elusive!

Various Committees like the Mudaliar Committee, Chadah Committee, Jumgalwalla Committee, Kartar Singh Committee and the Shrivastava Committee, have reviewed medical education and existing health system. Besides a large number of international conferences, and an inumerable number of national conferences have been organised to discuss the malady of our medical education and health care system. Many of the changes suggested have been implemented and as usual, most of them have been shelved for posterity!

The changes which have occured in our infrastructure in the Primary Health Centres and sub-Centres, from the time of their inception have been shown in Fig.I.

The outlay on health during the various plans have been shown in Fig.II. The outlay on health declined with each plan from 3.3% in the first plan to 1.7% in the Fifth Plan. The Sixth Plan shows a minimal increase to 2.02% of the total budget. There has undoubtedly been an increase in the total amount allocated, but this has not grown proportionately with increased allocations to other items in our budget.

Needless to say that all along major share has been taken up by medical colleges and superspecialities in health care.

Two important changes which have occured recently need special attention.

First is the conversion of unipurpose workers to multipurpose workers, and together with this the idea of increasing the number of sub-centres per primary health centre. This is expected to decrease the population to be covered from 10 to

THE COMMUNITY HEALTH WORKER SCHEME :

This scheme was launched on Oct. 2nd in 777 development blocks out of the 5,400 community development blocks in the country. To date about 120,000 community health workers have been trained in different primary health centres already.

It is important to note that though our Govt. has introduced this scheme now, various International and National Agencies both Govt., voluntary and different philantrophic organisations have since long shown how primary health care could be delivered through front line workers, thus solving the two main problems our country has been facing, namely outreach and active community participation.

The community health worker can be drawn from either sex, should be permanently resident in the area where he/she is going to work in, be from any vocation, be able to read and write, be social service oriented, preferably below 30 and physically active and should be able to spare 2-3 hours daily and be acceptable to the whole community.

Following these guidelines, the village community nominates 2-3 persons and the final selection is eventually made by the Medical Officer in consultation with the Block Development Officer and the field staff from various government organisations.[15]

The initial training lasts for 3 months and is carried out mainly in the primary health centres and partly in the field. The workers are paid a remuneration of Rs.600 during the 3 months of training, and then the worker is paid Rs.50/- month.

The scheme may or may not be a success. However, there arefew things one has to analyse.[16]

The social structure in the Indian villages and experience with the community development programmes and other rural programmes, has clearly shown that the upper strata and affluent few in the villages utilise most of the resources meant for the development of the village. Personal experience during my study of front line workers in different projects in rural India corraborates these findings, especially in the Govt. Sector. The community seldom really participates in the selection and the services are largely rendered to the elite. There is lot the Govt. has to learn from the work being done by the community health workers in Jamked, Mandwa, Kunkuri,etc.

The training includes teaching of homeopathy, yoga and indigeneous systems of medicine. Which of our staff in the primary health centres have any knowledge of the Indian systems of medicine themselves, leave alone being able to teach this to a group of barely literate people ? This leads one to think that the government is taking the whole scheme very lightly.

' People's Health in People's hands ' is being envisaged. This cannot survive in a millieu where the superstructure continues to be highly professionalised and consumes the lions share of the health budget. To quote Dr. Bannerjee " Leaders exhortations for promotion of indigenious systems of medicine, naturopathy and urine therapy, do not carry any

Nevertheless the scheme as mentioned earlier is an attempt at democratisation of health services, and though it has a large number of drawbacks, it could still be very useful, if there is proper supervision, and financial assistance. The community health worker could be the change agent in the community and also provide an entry point to other change agents who could make use of this opportunity to work with the people to initiate social and economic changes.

The community health worker's scheme marks the sad and late realisation of the fact that health to the masses cannot be delivered by building ever increasing number of medical colleges and sophisticated hospitals in the urban areas, but that health of the people has also to be in their own hands.

Let us hope that this scheme does not meet with the same faith as most of the other schemes, but instead that it can be indeed a tool to improve the status of our masses which since long have remained neglected.

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HEALTH CARE SYSTEM IN INDIA

AN ANALYTICAL STUDY

- Ajit Muricken -

This article seeks to identify and analyse the major socio-economic and political constraints on the health care system in India, and to project an alternative approach in which the majority of the Indian masses will have equal share and participation in ensuring their better health.

The division of mankind into rich and poor brings about inequality in health care just as sharply as it does in any other aspect of life. The reality and depth of the problem arises because the few rich appropriate the benefits of every advance in medical science. It is their needs the medical system caters to. The Health Ministry acknowledges that 3/4 of the state Budget for health is spent on Elitist needs while only 1/4 is directly used for the rural masses. There are no sustained efforts to tackle the prevalent diseases among the poor or provide minimum maternity and child care facilities. This is the general pattern that exists in all the developing countries. Patients are poor with all that this entails in terms of nutrition, education, employment, housing etc. and are reckoned to be hungry or undernourished or both.

The decisive factor effecting health in developing countries is poverty rather than tropical climate. The diseases that are mainly due to poverty were at one time universal. Many countries in the temperate zone have undergone industrial revolution, which has enabled them to conquer poverty and thereby control diseases. Diseases resulting from poverty have since retreated to the countries which remain poor and these happen to be in the tropics. Thus anaemia, communicable diseases, T.B. etc. which were common in developing countries prior to the industrial revolution, are now largely confined to the tropics and are labelled tropical diseases. Actually these should be called the "diseases of the poor" because they are less a result of climate than a consequence of the social and economic conditions prevailing in the tropics. "At most climate is an intervening variable. In fact, the tropical diseases have become endemic or epidemic in large areas as a result of colonicalism and the ecological disturbances indirectly brought

malnutrition, diseases and health perpetuated by existing socio - economic and political structure and culture.

TABLE

THE VICIOUS CIRCLE PERPETUATING LOW SOCIO - ECONOMIC STANDARD WITHIN THE SYSTEM

MALNUTRITION

GALORIC GAP
ILLITERACY
UNSADITARY CONDITIONS

LOWER STANDARD OF LIVING

ILLNESS - TUBERCULOSIS
ANEAMIA
INFECTION

LOW PURCHASE POWER

UNEMPLOYMENT
UNDEREMPLOYMENT

POOR EARNING CAPACITY

Since Independence the Indian Government has pursued health politics which give priority to the training of medical personnel, construction of hospitals. and extension of medical services to the country side through "primary health centres". The number of doctors increased from about 50,000 in 1947 to more than double in 1968 - 69 with a consequent increase in the doctor - population ratio from 1:6300 to 1;5100. Further expansion was planned in the Fourth Year Plan which envisaged a rise in the number of doctors to about 1,40,000. This would bring down the ration to 1:4300, which is still above the WHO norm of 1:3500.

INFRASTRUCTURE FOR HEALTH CARE (AS AT THE END OF PLANS)

	I plan	II Plan	III Plan	IV Plan (anticipated)	V Plan (targeted)
Hospitals & dispensaries	10,000	12,000	14,000	N.A.	N.A.
Hospital beds	123,000	185,000	240,000	281,000	321,000
Primary Health Centres (PHC)	725	2,800	4,900	5,250	5,351

	I plan	II plan	III plan	IV Plan (anticipated)	V plan (targeted)
Auxiliary nurses midwives	12,780	19,900	35,000	64,600	N.A.
Health visitors	800	1,500	4,200	N.A.	N.A.
Nurses - aids	6,400	11,500	28,000	N.A.	N.A.
Sanitary inspectors/ Health inspectors	4,000	6,000	18,000	32,000	N.A.
Pharmacists	N.A.	42,000	48,000	66,000	N.A.

These data concern only "Western Medicine". If we take traditional medicine into account, we must add 195 hospitals, 9 dispensaries and 1,55,831 institutionally and non-institutionally qualified ayrvedic practitioners. These statistics show a striking progress. There has been a similar, though less pronounced, increase in the number of nurses, midwives and other medical personnel. Since Independence, 54,000 auxiliary nurses have been trained. The institutional network has been extended and more or less every panchayat now has its primary health centre (5200 as of March, 1974 with 32,000 sub-centres).

Health Service system: India has developed a referral system to meet health needs. This system is based on the idea that patients are to be treated as close to their homes as possible in the smallest, most simply equipped, and most humbly staffed unit that will still look after them adequately. Only when a particular unit cannot care for a patient adequately is he to be referred to a unit higher up in the chain. The chain consist of the health centres the district hospital and the national hospital. The basis unit is a primary health centre with 10 beds The next unit is a divisional hospital with about 50 beds staffed by specialists in surgey and gynaecology. Next there is a district hospital with 300-500 beds and more specialist staff. At the top of the ladder is the teaching hospital.

Does the referral system function? Often it fails because few hospitals have health centres close enough that referred cases can be admitted. Lack of transportation facilities greatly impede the working of the system.

Many communicable diseases have been eradicated. The death rate has come down from 27.4 per thousand in 1949-50 to 15 per thousand in 1971, while life expectancy has increased from 32 to 50 years. This

Among priorities in National Health programme are:

1) Control of communicable diseases 2) Water supply
3) Sanitation programme 4) Nutrition & 5) Family planning.

The rural health services in India are carried out through more than 5200 primary health centres with their sub-centres, at the rate of one of every 10,000 population. Each primary health centre provides health services for people of one community development block of about 100 villages and each sub-centre for 10,000 people. "And yet, our health standards are still extremely low and great majority of our population, very vulnerable. The mortality rate is 15.1 per 1000 and Infant mortality rate 122 per 1000. Life expectancy and birth is much greater for the rich than for the poor. Inspite of all our health campaigns, communicable diseases remain rampant. In 1973 for example, we had 1,498,961 cases of Malaria, 34,972 of Cholera and 75,904 of smallpox. Out of the 15 million people in the world who are affected by blindness on account of trachoma 4 million are India. 60 to 80% of these cases were preventable. In our country, there are moreover 9 to 10 million victims of goitre and about 20 million of filaria, while the cases of active T.B. and leprosy are numbered to 8 and 3 million respectively". (Manorama Year Book 1975. pp.425-27).

Some 450 newly built primary health centres were without doctors in 1970 and many more had only one doctor instead of two. An approx 80% of the doctors practise in towns where 20% of the population lives. Since Independence about 25,000 doctors left India to work abroad. The rest who remained prefer to work in cities or as private practitioners, set up practise where they can find patients who can pay them well enough for their services. The government posts are of necessity poorly paid, and doctors used to town finds it difficult to put up with the deprivation associated with work in rural areas. As a result there has not been any significant progress in health care, at least in the rural area.

Great Paradox. Most of our people still live in a rural environment, where they are deprived of many basic goods and apportunities which are normally found in urban settings. The most blatant form of deprivation is in respect of health care. 80% of our doctors and 90% of our hospital beds are at the disposal of the urban population which represent only 20% of the total population. These institutions have

In rural areas the rate is even higher, being 110-120 per thousand.

According to the ministry of health, most of the investment in our Five Year Plans is meant for building sophisticated hospitals and training doctors, both of which hardly serve the rural population. Besides, 3/4 of the state budget for health is spent on the running more or less the elitist institution while only 1/4 is directly used to meet the real needs of the masses. In the Fourth Plan, for example, only a sum of 700 million rupees was allocated for rural hospitals and health care of out of a total outlay of 3610 million rupees. This is out of proportion to the population and their needs. Less than 1/5 of the total was budgeted for the less favoured 4/5 of our population. Consequently, majority of our rural population remain without basic medical facilities.

UNEQUAL DISTRIBUTIONS OF MEDICAL SERVICES

POPULATION	600 Millions	Distribution RURAL 80%	URBAN 20%
MAN - POWER		**Tot.Ratio**	
Doctors	136,000	20%	80%
Doctor-people ratio		1:5000	1:20.700 1:1.300
Nurses:G.N.	72,000	10%	90%
A.N.M.	44,000	82%	18%
L.H.V.	6,000	92%	8%
practioners of other medical systems	300,000	1:2000	
Field workers (Health inspectors Health Asst. for M.C.H., F.P. etc)	204,000	1:2700	

THE BIAS IN favour of sophisticated urban hospitals with specialists at the cost of rural areas reflects the structural dualism inherent in the Indian Society. The dualism consists in the generally growing economic desperities between the urban and the rural areas, between regions within countries, between the minority who enjoy full remunerative employment and the vast majority who lack adequate (or any) means of earning a living. It is within this structure that the economic, political and ideological aspects of health

to that of the economic system where the rich urban sector gets more health service than the depressed rural sector. Moreover, the concentration of wealth and political power in the hands of transnational coroprations and industrial monopoly houses explains the health care system's orientation towards Western drugs, and advanced medical technology. Development of local medicine and of local technique is a threat to the profitable medical-industrial monopoly of the Western drug companies.

Pills against poverty: Prevalence of the 'germ' theory of disease has brought about the discovery of wonder drugs and subsequently the emergence of the drug industry. "Instead of the medical profession responding to the needs of the people with drugs geared to help in this process, it is the drug industry which dictates to the medical profession WHAT' to prescribe. Profit and the class interests of the members largely determine the nature of the service provided - it is the case of the tail wagging the Dog".

Alternative approach: The Health problem is not a technical problem which can be solved through improved techniques or by providing hospitals, medical experts and medicines. Many facilities introduced under governmental or private auspices in India fail to reach the toiling masses. They tend to be appropriated by a privileged minority with social influences, economic power and political pull. Thus efforts, in themselves praiseworthy, for the good of the 'common man' tend to benefit the existing power groups, and not the people they are meant to serve. Therefore the demand for health is a political problem. For quality of access to health care the masses will have to be organised for struggle against economic and political domination. Otherwise the majority in the country will remain on the margin of health services.

The most dangerous disease sweeping Asia today is poverty, and medical science has no miracle drug to eradicate it. Poverty has been considered as the vicious cycle of small income, malnutrition, disease and death perpetuated by existing social system. Problem of health care is therefore, linked with the socio-economic problems. Certain social relations are responsible for the poor continuing to live in conditions of ill health. They are the relationship of property, ownership, and power.

can provide adequate health care, that medical care can be divorced from preventive measures and that 'hospital centred systems' are without reservation the most appropriate means for solving the problem of a community's health.

As against the purely clinical approach there is the non-clinical one which perceives the peoblem of health not as one of disease alone. The health of a community is more significantly determined by social and economic factors. Poor health is because of poor living. Consequently, only by changing the living pattern i.e. the socio-economic and political life of the people that improvements in health can be brought about. Structural and institutional changes in society are an essential proroquisite not only for achieving freedom from disease or the threat of disease, enable one to live healthily. The indices therefore to measure health in the present system is not in the nature of weighing death loads and disease but they are:

1. A genuine redistribution of land.
2. Removing of social and economic injusties
3. Elimination of highly monopolistic control over industries and in general, a redistribution of assests in favour of the base of the social pyramid.
4. Proper agricultural production and marketing.
5. Promoting primary health care of all.
6. Easy acess to curative medicine.

You will note that I have listed curative medicine as the last criterion because health is determined by overall economic development and good health cannot be maintained in an economic and social vaccum. A clinical view of health would have used "curative" as the main criterian because it tries to "eradicate" disease by curing the sick, and forgets the fact that no sooner is the patient cured than he sinks back into the mire of poverty and falls ill once again, often within days of his treatment.

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HEALTH SYSTEM IN INDIA - A CRITICAL REVIEW

Reena Fernandes

Health services are one of the main factors influencing the health status of a population. The health of a population is also influenced by such social and economic factors as nutrition, water-supply, environmental sanitation, housing, education, income and its distribution, employment, communication and transport and the social structure. In general we can say that health in any community is product of interaction between its way of life on the one hand and its environment on the other. In the pre-dindustrial society, the helath culture was in harmony with the total culture. But urbanisation slowly led to the disruption of this equilibrium. The industrial revolution brought about drastic changes in this equilibrium affecting social, economic and political relations as well as health culture. This caused wide spread suffering due to such health problems as under-nutrition, mal-nutrition, high infant and maternal mortality rates, high incidence of small pox, typhus, cholera, disentry, T.B. and other communicable diseases.

Dr. Louis Baretto in his paper on health system in India ..."In India health is more than a problem, it is a challenge that has to be met by the mojority of the population. The most obvious short coming of the health system in India is that it caters to the few at the cost of the majority. It tends to concentrate in urban areas and in particular for the wealthy section of the big cities so much so the rural masses are deprived of adequate health care. Some of the important reasons for this disparity are:

- the vast majority of the people, for whom the services are run, are left out of the process of planning of the goals.

- increased dependance on the doctor and lack of encouragement to the community to cater to their own health care.

- Health planners and policy makers from the urban elite. and naturally have vested interests.

- our elite has been greatly influenced by western models inappropriate and unsuitable to our country. As such the health situation today is a reflection of a system founded on an urban bias or reversal of priorities benefitting the elite. The lion-s share of funds goes to medical colleges, out of which come out sophisticated doctors, professionally incompetent and unprepared to work in the rural set up. The present system of education for the health personnel is hospital based, sophisticated, curative -oriented and results in trained helath personnel whose main concern cannot be identified with health needds of the majority of the people ....."

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The doctor-population ratio in India of 1 : 4200 does not seem to fall much short of the Mudaliar Committee's expectation of 1 : 3500. However this figure is very misleading because of the difference in such a ratio in the urban and rural areas.

" People are sick because they are poor ; they become poorer because they are scik and the become sicker because they are poorer." This quotation of B.R. Bloom is very true of the Indian context today. Hence,neither is cure of bodily deseases so much medical nor treatment to psychological disorders so much clinical. The sickness is beyond where it is manifested. The problem of the health system is a reflection of the problem of the larger society. Today, we are living in a form of society where the basic relationship of human beings has come to be exploitation of large number of people only to favour a few. The key factor of imbalance is the control of an insignificant minority over the vast majority. The deprivation of the masses, the forms of wealth and power owned and controlled by a handfull of people. This is the economic base on which all other forms of relationship is built such as culture,religion, education and the medicine system is no exception. Therefore the medical system could be seen from this broad perspective of a super structure imitating the base.

While diseases in humans appear symptomatically in various deathly forms as T.B., cancer, neurosis, psychosis, the origins of it is rooted in the social life of the individual. Humans can exist and live only in society. Therefore all bodily illness both biological and psychological though in form, individual, in essence, are social. The environment and material conditions in which the individual lives, determining the state of mind and body ... the health of the person.

Modern medical science views the human organism mechanistically . The health professionals advanced training permits the recognition of only specific cause and treatment of disease. This view diflects attention from the multi-factorial origin of disease, especially from the environment, work process or social stress. It focuses on the individual rather than on the illness-generating conditions of society. It traces the sources of the illness to the individual life-style. It assumes that responsibility for disease and cure rests at the individual rather than at the collective level. Some instances from the reality would make the situation clear

.... a remote village in Quillon, Kerala, produces a number of elephantisia patients mostly from the poorer classes. Along with their legs, their numbers their numbers also swelled indicating the spread of the disease. Any amount of clinical treatment did not seem to help. The doctors were forced to leave the clinic and examine the village condition. Stagnant filthy water sheets developing the most unhygenic conditions were found which were the breeding ground for the filariasis. Clearing out these pools eradicated with the anopheles mosquito and put an end to the production of elepantisis.... Here is a clear example to show where the problem lies. The question before us is - where is the disorder ? A correction in the social environment of the elephantises-prone people

seems to be the closes answer. The question that plunges us deeper into the malady is why the poorer classes, by themselves are not able to maintain the environment clean and control the spread of the disease? Is it because they are lazy and lack the will ? or more tragically that they do not have the means ?

Probing into the Indian situation again, the bidi-workers are a typical example. At the recruitment of Beedi-rolling an individual of 15-20 years of age is able to obtain optimum production of 1500-1800 beedies per day. But gradually this comes down to 700, to less than 500 at 35 to 40 years of age. What is the reason ? Constantly inhaling the beedi small in the ill ve tilated huts makes them predisposed to cancer, T.B., asthma which plagues them at an early age, drastically reducing their efficiency and quality of life. Here again we have a s cial problem. For better health, they need good ventilation, better housing conditions. A little closer look would show that these beedi rollers are in the hands of a very powerful gang of middle men who squeeze the maximum and leave nothing but subsistence wages ... that they may tomorrow continue production.

In such a situation, with such starvation wages being the tribute for 12 to 15 hours of work per day, can the beedi rollers maintain their health at the cost of decrease in production which directly means starvation. In this sense, medical science offers no critical appraisal of class structure and relation of production, even in their implications for health and illness.

We need to relate patterns of death and disease to the social, economic and political structure of society and specific material circumstances under which people live and work. The level of analysis has to be shifted from the individual to the stressful forms of social organisation.

Diseases of today can be directly linked to the capitalist system. In the capitalist profit-industries, we see the contradiction between profitability and improved health conditions which generates and creates conditions conducive to disease of various kinds.Common examples are the chemical and dye factories, cigarette factories where no production gloves are given in production. The reason is simply b ecause when the hads loose their sensitivity through indirect contact of handling with gloves, it means reduction in speed of operation and hence decline in production and profit .

... in Iron and steel industries, it is not unusual for workers in the casting section to work withou t protective garment exposing naked bodies the the fluctuations of very hot and very cool temperature. What is the result ? ... the disintegration of the human body.

Where profit is the motive, the maintenance of production level is paramount ; the working conditions and the health conditions of the worker are relegated to irrelevancy.

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The exploitation of illness for private profit is a primary feature of the health system in advanced capitalist societies. Multinationals play such an exploitative role to a great extent. One thrust of imperialism is the creation of new markets for products manufactured in dominant nations and sold to the Third World. Because of their monopoly character, maultinational corporations are well rehearsed, yet little known for manipulation in their advertising and marketing preactices, price and patent collusion, marketing of drugs in the third world before their safety is tested, or those banned in the first world countries. This is evident if we recall that recently 30 important drugs have been totally withdrawn from further prescription, because of their dangerous ill effects. Novalgin, a popular pain killer has been proved to be harmful when consumed in tablet form. This is known only after years of usage ?

The dynamics of exploitation of the system we are in today works in such a way as to enrich a few , while impoverishing the majority. The disparity is nakedly exposed in the 320 million of our population (perhaps the current census would reveal more) living below poverty line. What does this mean in concrete terms ? A per capita income of less than Rs. 40 per month. Whereas the WHO fixed the minimum intake at 2400 calories per day, the actual calorie consumption of an Indian in this category is less than 1400 calories per day. Far below subsistence. A high ratio of children in this category makes them all the more vulnerable to diseased conditions and disease. From birth malnutrition and undernourishment haunts the Indian child. Sequal to this is infant mortality as high as 49 %. With 40 % the quality of life has come to be of a negative nature. What can 40 rupees buy today ? How to spend it % on health care ? definitely no !

Economically speaking these 32o million people do not have any purchasing power and therefore access to medical care is a remote possibility. Of what use then, is medicine and the whole organisation of this science ? Further because their ineffectual position in the economic strata, this bulk of our people are isolated and redered impotent. They cannot compel the state to render any form of medical care or any other care, unlike, other dominant sections of our society. We can no longer accept the state as a "neutral" body , for now we know very well that it represents the interests of the rulin g class. And being in a position of vital importance, generally acts as a repressive body of any change that alters the basic tenets of the exploitative system and all other relationships sustained by it. In this light, we see ,that if at all, any medical care is bestowed, the logic of it is to keep alive this mass of "working force" to produce wealth for the ruling class.

In such retrograde conditions, the reasons for most medical and psychological illness is social and the solution necessarily political. In such a situation that exists today, the role of the doctor becomes only reactionary or one who tackles the problem only at the manifestation and symptomatic level. Here , we could show a relevant case of a

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woman with a sceptic leg . The diagnosis (clinical) showed advanced gangrene ... leg to be amputated. The doctor addedly remarked, Amma, if you had come three days earlier, we could have saved your leg, you are too late. Why did you not come on time ? -- the famous question of most doctors.... The woman, wife of landless labourer related the economic conditions of her family and her problem. " I have come from 15 miles, the bus charge is Rs. 1,50, my husband daily wage labourer has to work everyday if we are to eat and live. He could not come with me earlier. Everyday we had to save enough money to come here. "The woman is perpetually tied to man, and the man shackled to'wage slavery'. If he has to feed his family he cannot leave his work and go. He is caught between the devil and the deep sea.

What would have been the treatment three days earlier ? What is it now? ...'cut out the leg' ... a simple answer to a threatening social problem?

Health workers concerned about progressive social change face difficult dilemnas in their day to day work. Clients' problems often have roots in the social system. Clinical treatment alone will not sufficed or work in stress-related or occupational diseases,because inspite of everything, the situation worsens, upon return to the illness-generating working conditions. This explains much of the relapse in repeated patients. In responding to the expressed needs of the patients, health-workers engage in "patching ". Victims of unemployment (part of the 14 million unemployed) .... who are frustrated from competition for survival, clashing moral and social values ...have agonising mental breakdowns! ....What solution does the psychiatrist/counsellor have to offer ? .... on the individual level, it implies an adjustment to the social system in which lies the source of the problem. At the societal level, it amounts to 'patching' of oppressive social pattern causing disease.

The contradictions of patching have no simple resolution. Health workers cannot deny services to clients even when and if it implies the latter's continuation and participation in perpetuating illness-generating social structures!

We cannot any longer dis-illusion ourselves into believing in the present system of health and medical practice. It is now imperative to expose its unhealthiness. As doctors, medical professionals, students paramedicos, and as people concerned about humanity and its future, we sh ould not be silent spectators to this evil system.

The task before us right now is to make a through study of the present health system, the philosophy of medicine and medical practice. It is important to draw connection between social issues and personal troubles. Health practice should link clinical activity to efforts aimed directly at basic socio-political change. FUNDAMENTAL SOCIAL CHANGE HOWEVER COMES NOT FROM LEGISLATION BUT THROUGH DIRECT POLITICAL ACTION

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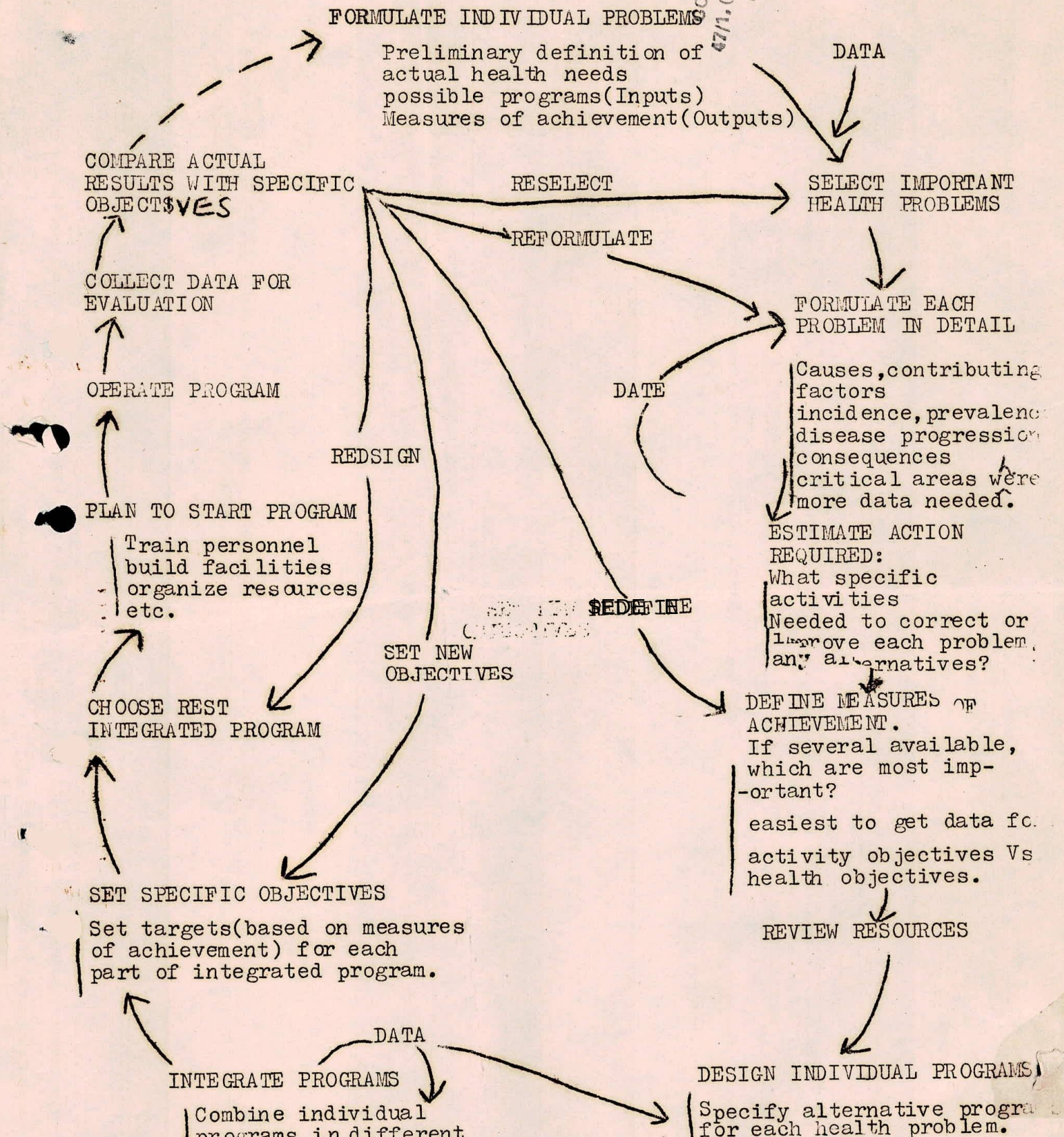

HEALTH - Concept, Priorities and Social Obligations

1. The Meaning of Health: "Health is a state of complete physical, mental a nd social well-being, and not merely the absence of disease or infirmity." (WHO Charter)

a) Health is more than physical fitness. It is a VALUE, a commodity worth having. It is therefore related to other values (like, justice, truth, peace) and must help the individual to live out these other values. It must liberate man's spirit and spiritualize his vitality. In other words, health is an enabling value.

b) Health has a social finality. It is that which helps a person to actualise his role in society - in the family and the community. We cannot divorce the concept of health and disease from the understanding of the purposes, and therefore of the nature of health, of the community to which the individual belongs. In other words, we must look at man in his total vocation and final destiny. Health has something to do with the wholeness of man.

c) "Illness belongs to the human condition" - It is an evil to be eliminated; but, there can never be a human condition in which all illness is eliminated. Illness is a result of heredity, environment, unhappy experiences, stress of life, misbehaviour of our fellowmen, and our own personal sins. (We must not lose sight of this last aspect viz. health and sin. Each 'sin' is an attack on health, for "the burden of sin weighs heavily upon man's life centre, affecting that innermost part where all his faculties experience either a saving unity or a crushing disunity"-B. Haring)

d) Health is a gift from God. The doctor is a steward of a task - he does not pass on health, but enables it, so that the Giver of health may give it. A doctor, who is himself a man of faith, will enkindle this faith in his patients and thus help them to form correct attitudes towards health, life and death.

2. Health and justice - the question of priorities.

Is it justice that the wealthy, or that those who live in towns close to where the doctors live for their convenience, should gobble up the health-care available? Is is just that our exclusive interest, in medical care, should be only in individuals, in particular in those individuals who come to us, with a resultant neglect of many times that number who could have been helped if sufficient attention was paid to the health of the community? How does one fix priorities when we know that needs will always exceed resources? How is one to reconcile the "non-choice approach (i.e., we will serve all those who come to our hospital, selflessly) and the "excellent medicine" approach (i.e. the very best attention and latest facilities, and perhaps the costliest, are available here) with the real needs of the community?

It is obvious that , in fact, the practice of medicine is an ethico-political art, for in fixing one's priorities one has to ma ke ethical choices: " whom to serve, whom to deprive".

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A HEALTH MAP

PEOPLE'S PARTICIPATION AND ECONOMIC SELF RELIANCE IN COMMUNITY HEALTH

ABHAY BANG, GOPURI, WARDHA.

Irene Peter said, "Today if you are not confused, you are just not thinking clearly. "In the field of community health, one often sees workers, who have no confusion, no questions. They know all the solutions and a stereotyped implementation of that solution will solve all the people's health problems. But fortunately, one meets some other workers who think, who are full of questions and hence appear confused. These are the people who are going to take community health ahead. Hence their confusions are important.

The reality is so complex that it is natural for any 'thinking' person to get confused. However, some of the confusions do not arise out of these complexitise but are created by our own muddle. I shall try to discuss two such myths which are commonly harboured by such thinking community health workers, and which cause unnecessary confusions.

Today, we are forced to believe that people's participation and economic self-reliance are some of the most important objectives of a community health project and those who cannot achieve these are 'poor', unsuccessful projects'. A time has come when we should question the validity of these two criteria in the context of Community Health work. We should first try to understand how these criteria came to be accepted unconditionally.

WHAT IS PEOPLE'S PARTICIPATION?

Some decades ago, development of undeveloped communities meant doling out food clothes, medicines and money to the poor who were just passive recipients. Gradually a realisation came that this was a bottomless pit which would never fill. So came the concept that 'people' should work for their own improvement. However it was soon realised that people could not be made to work unless they were involved in the process of development. Thus came the idea of people's participation.

I am all for people's participation in development processes, but want that it's meaning and the limitations, when applied to the field of community health be understood properly.

There are three questions I want to ask.

1) What do we mean by people's participation?
2) Who are the 'people'.
3) Is people's participation possible in community health?

Different people have different meanings for people's participation. Some project workers say that there is overwhelming peoples participation in their projects; thereby meaning that the people are taking benefits from their programme. Does merely taking benefits of the programme or participating as beneficiaries mean people's participation?

IF THIS IS PEOPLE'S PARTICIPATION, THEN.....

Some call it people's participation when the people are receiving benefits not as charity but are paying or rather are forced to pay for the benefits. Does such payment for services mean people are participating? Then people are very actively participating in the whole of the commercial system today where everybody pays for whatever he or she gets. Then can compulsory payment for the benefits, which is

A very successful community health project claims that "the villagers collectively constructed a rood from our hospital to the village so that our health team would reach the village", and foreigners are much impressed by this 'people's participation'. One however finds that the road was constructed by the labourers of the village in 'food for the work' programme and the villagers were mainly paid labourers.

The same community health project says "our village health workers have been selected by the people of the village and our project has a people's committe as advisory board". Through this is meant to be participation by the people in decison making, on closer enquiry, one finds that almost every V.H.W. was selected by the head of the village and two or three influential persons and the project staff. The people's committee consists of established leaders and the rich people of that area. Does the decision making power given to the few rich and established leaders of the village and mutely followed by the rest of the villagers mean people's participation By this definition the whole political system today has very wide people's participation.

Obviously all these are examples of people's participation.

The last point takes us to the next question, 'who are the people'? This is quite a tricky and political question. A big power invades a small nation and puts its 'yes man' in power and says 'people of this nation have invited us to liberate them'. Do mere heads of the government mean people? A rich man who also heads the Gram Panchayat takes a decision as to who should be the VHW from that village. Is he the people?

The male head of the family says "the tradition of our family requires women to remain in purdah and all people approve this tradition". Is he the whole family or are the males alone the people ?

NO! In all these instances decision making does not represent the desire of all the people, definiely not of those who have no voice and freedom to speak but but who very badly need an opportunity to take part in the decision making to ensure that it is in their interest and not to oppress them.

Thus I have tried to show what is not people's participation and who are not 'the people': If this is not people's participation then what is it? Who are the people?

Probably everybody born as a human being has a right to be included in the 'people', be it the oppressed or the oppressor.

But for operational purposes, we will have to say that the oppressed, the expoited and the needy should have priority in the comprehensive definition of 'the people'.

When these people understand the situation and issues by criticial consciousness and take part in decision making, implementation and evaluation of programmes and take the responsibility of the work as well as share in the benefits..... it becomes people's participation,

There cannot be genuine people's participation without a proper political atmosphere and educational process. Even then true people's participation may be a distant goal.

THE PREREQUISITES OF PEOPLE'S PARTICIPATION:

Today's political and socio-economic system is directly opposed to real people's participation. How can there be a true people's participation when

life of the poor in the undeveloped (exploited) countries, a concept has born that people should be given such economic programmes which can generate income for themselves and hence they don't have to depend, on outside help enternally.

THE LOGIC OF ECONOMIC SELF-RELIANCE:

Fine! Good policy! But then this has to be an objective of economic programmes to be achieved through economic activities. This has been implicitly accepted in the field of community health also. This has caused tremendous diversion and confusion and a time has come to challenge this assumption. There are many reasons. When a community health project tries to become economically self reliant, it adopts two methods.

a) It starts charging the rich to gain more income. (the so called 'Robinhood' method). Ultimetely this results in the community health project becoming dependent or rich clientele for its economic self-reliance. To satisfy this clientele comes the sophistication, X-rays, E.C.G., more indoors, more specialization, and more and more workers and time to cope with all this. Also come in the unscientific, unethical practices like giving unnecessary injections, tonics, mystifying the symptomatic relief etc., to draw and retain the paying patients.

The rich class is much more shrewd than community health projects. It is almost never dependent on this community health project alone for its own health care; (though occasionally individuals may need and seek such curative services, such examples don't prove that the whole class is dependent on community health project). They almost always get their health need fulfilled through the commercial private health system, Only in very remote places, persons from such class might depend on community health projects. Thus the community health project becomes dependent on the rich class for its income and survival rather than otherwise. This brings gradual changes in the priorities, strategies, methods, behaviour, and relationships of the community health project and it ends in serving primarily the needs and priorities of the rich.

An analysis of the clientele of most of the mission hospitals, who in an attempt to become economically self reliant started charging the cost of the treatment to patients shows that ultimately they ended with two maladies. They are underutilized and underutilized, and are utilized predominantly by the rich class.

Sathyamala from VHAI has described (Health For the Millions, Bulletin February 1980) how she saw at many places voluntary hospitals half empty, beds occupied by the rich who only could pay the charges and the next door Government hospitals and dispensaries-inefficient, low quality, corrupt but still overburdened, full of poor patients. What an irony! Then why should the dedicated missionaries run such hospitals? Even private commercial health care system (eg. Jaslok Hospital) can do and does the same role. Then where is the difference?

b) To raise income, the second strategy adopted is to charge the poor more and more in an attempt to them pay at least the cost of the treatment. We have already seen how it results in elimination of the poor from the curative health care. 60% of admissions in a hospital of a famous community health project which claims to be economically self reliant are from the rich coming from the area

It is obvious that the real people's participation is a distant dream to be achieved by a process of economic-political and cultural liberation.

When one views the objectives and the claims of people's participation in community Health projects one can not help but laugh. The present system is antiparticipatory. Moreover there are more vital fields in which people would prefer to participate first. Health is a low priority issue.

The expectation that people will participate in a real sense in a mere community health programme is unrealistic. This conclusion is also supported by the experience of numerous workers in community health who have learnt it the hard way that people cannot be mobilised and organised through and for health work. It does not mean that there should be no afforts towards people's participation in health programmes. All afforts to involve the people, expecially the needy and the opporessed in making decisions and their implementatio should be made. This will marginally help a participatory culture to be created. But it must be realise that peoples participation is essentially an objective of political and educational process, and health work, has only week political implication, If community health work is a part of political activity, it will get it's backing and advantage but without a proper political context, not much of genuine people's participation can be achieved in community health work alone. Hence people's participation perse cannot be a primary objective of community health programmes.

If people's participation is real and genuine, one should not talk of people's participation in the project's health programme but of the project's participation in the people's health programme. But realistically this cannot happen through the health process alone.

Some workers use another misquiding term, 'community participation' in community health programmes. There are two obvious fallacies. One, there is no organised entity as 'Community' in the villages today. There are individuals, families castes, classes, political groups and one cannot create communities out of such individuals and groups for the purpose of and through mere community health work (though community health work might marginally help this process.) Seeondly, though claims are made of having achieved community participation, in reality only the existing social organisations (Panchayats etc) and established leadership are involved in decision-making. We have already seen that such leaders alone are not the people and hence they cannot replace the community.

ECONOMIC SELF-RELIANCE: WHY?

Another popular fashion-word is 'economic self reliance', commonly used as a criterian of evaluation and boasting feature by many agencies and projects in community health. How did this come to be given such an importance that it has almost become an important objective of community health programme? The workers keep on desperately running after this objective forgetting that economic self-reliance is not the purpose of their work and they cannot afford to sacrifice their original purpose of their work and they cannot afford to sacrifice their orginal purpose that is to improve the health of the vulnerable people.

An argument forwarded is that the poor are given primary health care through V.H.W.S. financed by the income generated from the rich in the hospital. It means the V.H.W.s given elementary care in the village for the poor and rich also but doctors and hospitals are mainly for the rich. Such discriminatory strategy becomes inevitable when community health project accepts the objective of economic self reliance and tries to raise the income through health programmes.

It is true that the poor also should be charged a little for health care so that they do not become objects of charity and pity. Also, if they are charged they feel that they have paid for health care and so the care must be of some quality, earned by them. It is common experience that the poor also value such treatment and advice for which they have paid. But this logic is then taken to its extreme that the poor also should pay the whole cost of treatment, which is pretty high in the present system. The poor, already exploited by the present economic system has very little resources, on which community health project further puts its claim.

An argument is often put forward that 'that poor also have the capacity to pay for curative services. They manage to mobilise the resources when you make it compulsory for them to pay'. This is the philosophy of the private doctors. Once, when I put this argument before a poor man, he said "Look Doctor Saheb, If I am ill and dying and if you press me for charges I shall sell my house, my family shall starve and then only I will be able to pay your maney. But if I do it does it mean I had the capacity to pay you"?

When this objective of economic self reliance is almost thrust on the community health projects in the voluntary sector by funding agencies let us ask few questions.

WHO IS SELF-RELIANT TODAY?

Is the government self-reliant in the sense it generates all its necessary incomes by productive activity? NO! It depends on squeezing the people by taxes, direct and indirect. None of the welfare programmes of the government are self sufficient.

Are the funding agencies-self feliant? In spite of decades of working, all of them continually depends on donations from people in the developed countries. They do not generates their own income by an economic programme run by themselves even though, theirman field of work is fund raising.

Funding agencies can raise money through Western capitalism. However this capitalistic system depends, at leasst partly on the developing countries for its markets and remember, the market is the source of income for capitalism.

I have thus, tried to show that true people's participation and economic self-reliance, though good objectives in themselves, cannot realistically become the objectives of community health programme itself. They can and should become objectives of political or economic programmes. This is why a community health programme if possible, should not be run in

marginal contribbution to political, economic development).

When community health programmes accept people's participation and economic self-reliance as their objectives and are evaluated against these criteria it will fail miserably. It creates a schizophresic dichotomy between what you aim to do and what you can do through your tool of health work. No community health programme can achieve these unrealistic aims. Acceptance of these objectives for health programmes creat as deep frustration, sense of guilt and confusion in those who honestly see and admit the failure to achieve them and lot of hypocrisy and faleshood in those who claim to have achieved it. The earlier we get out of these illusions, the better it will be for us.

Com H 11.26

HEALTH SITUATION IN INDIA

To understand the health situation in our country, we need to look at some facts.

We are a population exceeding 800 million. With a growth rate of 2.2% and a Birth rate of 32 per thousand population, we are likely to cross the 1 billion mark by the turn of the century.

We are a young population. Around 40% of us are below 15 years of age, and only 6.5% are over sixty. As per the 1981 census, we also have an adverse sex ratio, that is, 935 females per 1000 males. Also, about 77% of the population lives in villages, and our literacy rate continues to hover around 36%.

Now, to consider the health problems in this population.

Malnutrition is of prime importance. Surveys of the National Institute of Nutrition, Hyderabad, show that 4 out of 10 rural households consume diets which do not meet their calorie needs. The situation is no better in urban slums, where a majority of urban population resides. This problem is acute in certain social groups, like agricultural labour, tribals and other marginalised populations. It is also prevalent in the so called 'vulnerable' groups like children under 5 years of age and pregnant and lactating mothers. Iron deficiency anaemia affects 50% of the under fives and 30 to 40% of females in the reproductive age group.

The Green revolution and bumper crops have raised our food stocks, and we have even been able to survive droughts in the recent past. The food distribution systems have yet to make square meals an affordable reality to the common man.

Provision of safe drinking water has been raised to the level of a Technology Mission. Yet, over 60% of our villages have to walk for more than 3 kms for this. As for sanitation, hardly 14% villages and 34% urban areas have sound excreta disposal systems.

It is no wonder that (with problems of Malnutrition, lack of safe drinking water and proper sanitation) around 60% of hospital admissions

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are due to infective and parasitic diseases. What are these major diseases? Tuberculosis (affecting over 8 million) Leprosy (over 4 million), Malaria (showing an increasing trend), Filaria, worm-infestations, Amoebiasis, Diarrhoeas and Dysnteries. Even the sickness rate with minor illnesses is high. 7 to 13% of us are ill at any point of time. Each of us has 2.6 to 3.9 new episodes of sickness every year. If any one of us has not been sick over the past year, it only means that some one else had double this quota of illness.

Is all of this because of our large population?
When we look at Europe and North America in the 19th Century, their population and sickness trends were the same as it is now here. Infact, their sickness rates dropped even before their population size stabilized and even before antibiotics or anti-bacterial drugs were discovered!

Is it because of our abject socio-economic conditions? Is it poverty? Examples of better health standards in China, Srilanka, Cuba and even in a State of our country - Kerala debunks this myth.

Then, what is it? It can only be pinned down to the common f ctor in the above examples, that is, AWARENESS. Awareness of health, and all factors which affect health. It just means that the common man does not know any of these, or at least, many of these.

We are a country who started on the Independent path with a blue-print for health - viz - the Bhore Committee report and subsequent modifications based on it. Even then the recommended health budget amounted to 13.4% of the total plan, which was scaled down to 3.1% in practice. We are a country - one of the earliest in the world - who committed to population planning. We were one of the earliest signatories to the Alma-Ata declaration of 'Health for All by 2000A.D'. How are we going to achieve what we want, or need?
What is health? It is defined by the W.H.O as a state of physical, mental, social and spiritual well being, and not just the absence of disease of infirmity. There are five levels at which health can

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be tackled.

1. Health promotion viz., good food, water, rest, play and the like
2. specific protection - by immunization for dangerous diseases (we plan immunization for all by 1990!)
3. Early diagnosis and treatment
4. Disability limitation, and
5. Rehabilitation.

In the above, we seem to be concentrating more on physical health, and that too at level 3, viz., early diagnosis and treatment. Considering the need for cost-effectiveness and rationality, the Hathi Committee in 1975 had formulated a Rational Drug Policy, which recommeded 116 essential drugs, setting up of a National Drug Authority and other measures, which Dr Prakash will be telling you about.

Now, to lead to the theme of the Workshop, this state of affairs has promoted a Pharmaceutical Industry which does not seem to be responsive to our needs for enough drugs to treat Tuberculosis, Leprosy etc, at an affordable price. Dr Dabade will be talking to us about the commercial view-point of this industry which has managed to find enough place to promote tonics and vitamins to a malnourished population.

Lastly, the most important question which will be dealt with by Dr Vanaja Ramprasad is the role of women in this health situation, and drugs which affect them. Considering the crucial role of women as mother, nurse and even first aider in the family situation, it seems that she is under a heavy burden indeed. Anyway, you will hear more when she speaks next.

As for the role of a Drug Action Forum in this milieu, we believe that awarenass in health matters can be achieved if one concentrates on key issues, the more important of which in the present context is DRUGS.

Shirdi Prasad Tekur

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Com H 11.27

HEALTH INFO. OF INDIA -1991

Table 2.02 p-41/42.

Kar. at a glance

– Estimated Annual Birth rates - 1986-89

		1986	87	88	89	31/3/92
Karnataka	Combined	29.0	28.9	28.7	27.9	27.8
	Rural	29.9	29.9	30.1	28.9	28.8
	Urban	26.8	26.6	24.9	25.0	24.8

Table 2.03 - p-44 Estimated Annual Deaths rate '86-'89

		1986	87	89	89	31/3/92
Kar	Combined	8.7	8.7	8.8	8.7	8.1
	Rural	9.4	9.7	9.5	9.5	8.8
	Urban	6.8	6.1	7.0	6.5	6.1

HEALTH INFO. OF INDIA 1991 / KAR & INDIA AT A GLANCE 31/3/92

Table 2.02 p-41/42

– Estimated Annual Birth rates 1986-89

		1986	87	88	89	31/3/92 Kar	(Prov 1990) India
Kar.	Combined	29.0	28.9	28.7	27.9	27.8	29.9
	Rural	29.9	29.9	30.1	28.9	28.8	31.5
	Urban	26.8	26.6	24.9	25.0	24.8	24.5.

Gradual decline - just below National figures.

Table 2.03 p-44-45. Estimated Annual Deaths rate, (Prov-1990)

		1986	87	88	89	Kar	India
Kar.	Combined	8.7	8.7	8.8	8.7	8.1	9.6
	Rural	9.4	9.7	9.5	9.5	8.8	10.4
	Urban	6.8	6.1	7.0	6.5	6.1	6.7.

Comparative 1986/89 Gradual decline - below Nat.

Comparative Birth rates 1986/89

	India	Kar	AP	Kel	Mah	TN
Combined -	32.6/30.5	29/27.9	31.6/25.6	22.5/19.8	30.1/28.3	23.8/23.1
Rural -	34.2/32.0	29.9/28.9	32.4/26	22.4/19.7	31.7/30.4	24.1/23.5
Urban -	27.1/25	26.8/25	28.7/24.1	23/20.2	27.4/24.4	23.1/22.2

Rate of decline less than in A.P., comparable to other neighbouring states. Urban ~~birth~~ rates higher than neighbours – on par ∑ national figures.

Comparative Death rates 1986/89

	India	Kar	AP	Kel	Mah	TN
Combined	11.1/10.2	8.7/8.7	9.9/9.3	6.1/5.9	8.4/7.9	9.5/8.6
Rural	12.2/11.1	9.4/9.5	10.7/10	6.0/5.9	9.7/8.9	10.7/9.7
Urban	7.6/7.1	6.8/6.5	7.1/6.5	6.9/6.0	6.1/6.1	7.1/6.6.

Rate of decline ~~steady and comparable to neighbours~~ marginal ~~(Tn & AP) on East~~, while it is higher than Kel & Mah, our northern & southern neighbours on the West coast.

(Male/Female Ratio / Rate of Urbanisation / Popn by. below poverty line (district-wise) (Communication links) & Hosp: Beds: Pop. ratios. Refer SPT – Kar Pop., F.P. & Women's Health.

Table 2.05 p. 49 Estimated IMRs – 1989 / per 1000 live births.

	India	Kar	AP	Kel	Mah	TN
Combined	91	80	81	22	59	68
Rural	98	89	87	23	66	80
Urban	58	53	53	15	44	43

Below natl. avgs. Comp. to AP. Rest below Kar.

		Kar	Ind
★ IMR – Prior 1990	Comb	71	80
	Rur	81	86
	Urb	39	51

Table 2.12 P-58 Expectation of life at births: – check on 1991 census

			Kar	India
KAIG →	(1991-96 projected)	Male	64.15	60.6

Table T.08 p-102

No. of Doctors & Avg. population Served (1990)

	Kar	AP	Ker	Mah	TN
Total doctors	31,028	33,283	4163	62,770	48,291
Population served per Dr.	1:1457	1:1924	1:1213	1:1179	1:1165
Period to which data relate	31/12/90	31/12/90	31/12/90	31/12/89	31/12/90

Better than A.P./Kerala. - Worse than Mah/TN.

Table 8.01 p-117

No. of Hospitals & beds ~~acc. to ...~~ / as on 1/1/91.
according to urban/rural areas.

State	Rural		Urban		Total	
	Hosp.	beds	Hosp.	beds	Hosp.	beds
Kar	25	2526	263	31951	288	34477
AP	165	3716	450	32684	615	36400
Ker	2328	37859	596	32490	2924	70349
Mah. (1/1/90)	345	12120	1759	99300	2104	111420
TN (1/1/90)	89	4235	319	44545	408	48780

All states better than Kar.
Very low in Rural areas.

~~Table 8.02 p-118~~

No. of Hospitals & Beds according to ownership as on 1/1/91.

Government		Local bodies		Pvt. & Vol. org		Total		Population served per	
Hosp.	Beds	Hosp.	Beds	Hosp.	Beds	Hosp	Beds.	Hosp	Bed
09	26424	28	714	51	7339	288	34477	157,000	1311
45	25251	4	46	266	11103	615	36400	95,416	1612.
37	26474	0	0	2787	43875	2924	70349	10,269	427.
93	62684	92	10955	1319	37781	2104	111420	35,184	664.
82	37935	7	479	119	10366	408	48780	136159	1139.

Mah / AP. / TN. — comparable bed strength.

Next to Mah. in Hosp & Bed strength

Least of all states

Max in Kar. i.e. less hospitals Comp. to AP/TN in Beds vs pop.

p-119 No. of Dispensaries & beds acc. to Rural / Urban as on 1/1/91

Rural		Urban		Total	
Disp	Beds	Disp	Beds	Disp	Beds
610	355	232	242	842	597
549	171	244	106	793	277
1243	95	509	64	1,752	159
796	452	8406	1966	9202	2418
147	138	365	140	512	278

~~Next to Kerala - much better than other states.~~

Table 9.02 p-126

Primary Health Centres – progress of Establishment as on 01/4/90.

No. functioning	Kar	AP	Ker	Mah	TN.	
As on 1/4/85	365 ×3	555 ×2.5	199 ×4	1539	436 ×3	Good progress in est. PHCs comp. to neighbouring state.
As on 1/4/90.	1133	1283	886	1646	1386	

Table - 9.03 p-128/129 Sub-centres - progr - as on 1/4/90

No. functioning	Kar	AP	Ker	Mah	TN	
as on 1/4/85	4964	6129	2270	6391	5860	Comparable
as on 1/4/90	7793	7894	5094	9248	8681	

Table 9.04 p-130/131 Community Health Centres --- 1/4/90.

No. functioning	Kar	AP	Ker	Mah	TN	
as on 1/4/85	98	27	4	147	30	Comparable, except Kerala.
as on 1/4/90	146	46	54	283	72	

p-136 Table 10.02 Reported cases & deaths due to Cholera & Diarrhoeal dis. during 1990.

		Kar	AP	Ker	Mah	TN	
Cholera	-Cases	412	69	174	546	812	High. Less than Mah./TN
	-Deaths	14	0	9	22	4	
Ac. diarrh. dis	-Cases	310682	1086233	871369	496099	257848	Except TN. higher deaths. AP - higher cases & deaths
	-Deaths	218	424	422	121	382	

p-139 Table 10.05

Table 10.06 p-140 (Meningococcal)

Reported cases & deaths due to Meningitis in States - 1987-1990

	1987 C/D	1988 C/D	1989 C/D	1990 C/D
Karnataka	11/1	128/12	0/0	0/0
AP	0/0	1476/98	1313/80	1516/75
Kerala	55/2	134/23	325/7	166/8
Maharashtra	4427/664	3226/611	3090/674	2171/468
TN.	0/0	0/0	19/3	140/10.

Better than Mah/AP - - Good control.

Table 10.07 p-141 K.F.D.

Disease prevalent to Karnataka?

	1986 C/D	1987	1988	1989	1990
Kar. cases/deaths	780/14	228/10	322/6	1550/22	1282/31

for Taluk-wise break-up — table gives details.

Table 10.08 p-142

State-wise positive cases of Malaria 1987-1990.

	1987	1988	1989	1990
Karnataka C/D	88505/0	127008/8	106683/0	56980/0.
AP	53010/1	62535/1	82510/2	81,366/5
Ker	3772/1	5147/1	6126/1	6,411/1
Mah	60557/2	84030/5	122314/8	109,806/6
TN	55523/0	75953/0	90,478/0	117,428/0.

Worse than Kerala. Better than rest.

Table 10.10 p-144/145

N. & C+P -1990-91 Population at risk.

	Prevalence rate per 1000	
	Estimated 1981	Recorded March 93
Karnataka	5.98	1.88.
A.P.	11.72	4.0
Ker	2.95	2.15
Mah	6.37	2.21
TN	15.14	3.56.

Table 10.12 p-147

Total STD cases seen & treated in STD clinics 1986-90.

	1986	1987	1988	1989	1990
Karnataka	72285	74493	75572	7963	87114
AP	75548	77328	79038	83121	86316
Ker	19483	20517	21347	24278	26201
Mah.	423794	425387	425631	426107	227822
TN	223746	226820	227328	22947	243871

Filaria Table 10.14 & 10.15 pg 149/150.

p-157 to 161

Table 10.22 Reported cases & Deaths due to Communicable Diseases during 1990 (Cases/deaths)

	Diphtheria	Polio	Tetanus (Neonatal)	Tetanus (others)
Kar	460/7	204/8	393/54	499/104
AP	1515/24	1987/23	814/61	1081/123
Ker	66/4	68/1	41/8	37/11
Mah	219/11	413/11	259/65	968/167
TN	22/1	730/4	102/25	473/54

Better than AP

Comp-TN better than AP/Mah

	Whooping Cough	Measles	ARI	Pneumonia ~~Enteric Fever~~
Kar	3906/1	2230/3	423803/186	4369/59
AP	11966/17	6377/36	864618/253	20923/105
Ker	3648/3	13400/4	1894788/98	8661/33
Mah	257/0	2110/3	276790/54	5745/253
TN	311/0	9815/74	163400/157	7359/17

AP

Low comp to Mah better than rest

Better than AP/Kerala though deaths high.

	Enteric Fever	Viral hep	Rabies	Syphilis
Kar	8062/15	2441/89	1345/40	7439/2
AP	48019/46	15433/120	680/91	20465/3
Ker	6092/9	9010/16	409/33	480/0
Mah	8368/55	10750/570	96/80	3066/0
TN	11500/34	232/3	255/18	2271/0

	Gonococcal Infec	Tuberculosis
Kar	8085/6	79459/821
AP	59939/20	216192/1250
Ker	2017/0	49288/236
Mah	1986/0	79363/905
TN	1753/30	75796/649

	Morbidity	Mort
D →	morbidity lesser than AP	mortality AP & Mal&
P —		
T		
Polio		
Measles.		

	Morbidity	Mortality
Polio	↑ Ker	↑ Ker/TN.
Diphth	↓ AP	↓ AP/Mal
Pertussis	↓ AP.	↓ AP/Ker.
Tet (N)	↓ AP.	↓ AP/Mal.
Tet (O)	↑ Ker/TN	↑ Ker/TN.
Measles.	least	least.
ARI/Pneum	↓ AP/Ker	↓ AP/Mal.
Ent/Viral hep.	↓ TN.	↑ TN/Ker.
Rabies	Highest	↓ AP/Mal.
Syph. & Gonoc	↓ AP	↓ AP/TN
~~Gonococ~~		↓
TB.	comp Mal/TN	↓ AP/Mal.
Guinea worm	↓ AP highest.	

SOCIAL SECURITY

Social Security :- is defined as that security or help furnished by the society to an individual or family; through appropriate organisations, against certain risks like accident, illness, invalidity, maternity, old age and death.

Social Security :- helps to alleviate ~~povity~~ poverty and to interfere with the vicious cycle of poverty - disease - poverty.

Social Security :- is a comprehensive term and includes in it social insurance, social assistance as well as some schemes of commercial insurance.

Social Legislation :- falls into 2 classes -

Social Insurance :- e.g. Employee State Insurance Scheme.

Social Assistance :- Mostly voluntary organisation very little in India

Social security measures are those which the society provides to its members against the circumstances of loss of working and earning capacity, and ensures a minimum income and other necessary amenities during the periods of disability and distress due to certain contingencies.

The security measures may be provided either through the state or through voluntary organisations - employees' organisation like their union of employer's organisation or by their combined efforts and aided by the State.

In short social security services an measure which provide the citizen with benefits designed to prevent or cure disease, to support him when unable to earn and to restore him to gainful activity. It is security of employment

Security of income

Security of power to work

These measures are therefore indispensible for promoting social welfare in industrial economy.

Coming back to the two main classes of Social Security.

Social Insurance :- covers sickness, maternity, employment injury, unemployment, old age, dependents, and widows benefits retirement pension etc.

Social Assistance :- includes children's allowance, unemployment assistance, care of the handicapped and old etc.

Both these systems of Social assistance and insurance are close to one another till they merge into a system of social security

The Main features :- of a comprehensive plan for social security are the following :-

a) carriage of the whole population
b) carriage of all principal contingencies
c) adequate medical and allied services
d) benefits - adequate to replace lost earnings
e) contribution - from employer and state.

Generally social security measures are contributory. This means that these

This medical care service organised under the social security should be comprehensive in character, unlimited in availability should meet the needs of every member of the community and should be integrated with the general health services. Restoration of health, rehabilitation, prevention medical care and promotion of health comprise the total objection.

Social security in India :- the following acts are in existence in India for the social security of the working population.

1. The workman's Compensation Act 1923 (C.A.)
2. The Employers State Insurance Act 1948 (C.A.)
3. The Labour Welfare Act, the Coal Miners (Provident Fund and Bonus Schemes Act 1948)
4. The Employers Provident Fund Act 1959
5. Maternity Benefit Acts (Central and States)
6. The Family Pension Scheme (1971)

ESI ACT 1948 :- Scope - 1. extends to the whole of India except the State of Jammu and Kashmir

2. It applies to all factories - other than seasonal, running at power, employing 20 or more persons. It covers all the persons including clinical staff whose remuneration does not exceed Rs. 400/-.

The benefits are both in cash and kind

1. Sickness Benefit :-(in cash) - provide payment at ½ daily rate for maximum 56 days in any continuous period of 365 days.

   - Persons getting bebefit shiuld remain under treatment.

   - For TB patient extended benefit for 18 weeks.

2. Maternity Benefit :-(in cash) consists of periodic payment for 12 weeks of which not more than 6 weeks should precede the expected date of confinement.
3. Disablement Benefit :- (in cash) or Workman's Compensation Act
   - payable for temporary or permanent
   - partail or total disablement as a result of employment, injury (including certain occupational diseases)

Rate of Benefit :- is equivalent to ½ of assured average wage for 52 weeks. This is called'full rate'

Temporary disability - at full ratr during disability.
Permanent partial disability - at the fulla rate
Permanent total disability - throughout life.

4. Dependants benefit (in cash) or Family Pension Scheme :-

   Periodical payments are paid at the following rates to the following dependents of an insure person dying as a result of employment injury

   i. to widow - during life or until remarriage - 3/5 of full rate
   ii. to each legitimate or adopted son - 2/5 of full rate (until he

Inpatient R_x and attend
Special drug as per approved list
Visits by Dr. to his home

Provision of Beds :- general bed for 800 employees
general bed for 1600 employeers exclusively for TB cases
maternity bed for 500 women employed in all centres when the scheme is in force.

Administration and Finance :- Called ESI Corp. consist of Minister of Labour
Minister Proffen and M.P's
Refer State and Centre
Employees
Employee

Under the corp. there is a standinf committee and
D.G. as the Chief Executive Officer.

Contribution :- E.S.I. Fund = By State
Centreal
Employers
Employee

C.G. 2/3 administration expenses
S.G. - share of cost of medical R_x proportioned divided SG and C.
Employer 3/4 % total wage bill
1 million out of 2.5 million.

Limitation of ESI Scheme :-
1. Scope restricted to factory worker only if not agricultural and other workers.
2. Benefit are very restricted
3. Unemployment is not covered
4. Old age and retirement benefits do not exist
5. Standards of Medical benefit is restricted to Rs. 6/- per year
6. Benefits are primary certain per and rehabilitation n not paid for.

OXFAM GUIDELINES FOR HYGIENE PROMOTION IN EMERGENCIES

SUZANNE FERRON: FEBRUARY 1998

TABLE OF CONTENTS

INTRODUCTION

Diarrhoeal diseases are a major cause of mortality and morbidity in emergencies and some studies have shown that they contribute to between 25-50% of all deaths.

Whilst there is little available data from emergency situations, studies conducted by Esrey et al (1985, 1991) in a development context have shown that whilst improvements in water quality alone can produce limited reductions in childhood diarrhoea by 15-20%, the greatest reduction was attributable to safer excreta disposal (36%) and hand washing, food protection and improvements in domestic hygiene (33%).

However, providing water and sanitation facilities does not necessarily ensure that people will use them effectively or even at all as complex factors affect how people behave. Many water and sanitation projects have failed in the long term because pumps or other facilities have not been maintained. Hygiene Promotion aims to ensure that the potential benefits of such facilities are maximised and sustained.

These guidelines have been compiled primarily for use by field workers setting up hygiene promotion projects (either from engineering or health backgrounds). However they will also be of use to project and programme managers who have the responsibility of ensuring an integrated approach to water and sanitation provision.

Oxfam is committed to integrating Hygiene Promotion with the engineering aspects of its work. However, there is very little literature or systematic research available on Hygiene or Health Promotion in emergencies and therefore all attempts to assess effectiveness are vital. Feedback on project activities and on the use of these guidelines will allow Oxfam to adapt and revise them as necessary.

Feedback to
Annie Lloyd, Public Health Team, Emergencies Department
alloyd@oxfam.org.uk

HYGIENE PROMOTION

- Is the planned and systematic attempt to enable people to take action to prevent water and sanitation related illness and to maximise the benefits of improved water and sanitation facilities

- Combines insider/beneficiary knowledge (what do people know, do and want) with outsider knowledge (e.g. the causes of diarrhoel diseases, communications and learning strategies and evaluations of previous water and sanitation projects)

- Includes, but is not exclusively, the provision of information and learning opportunities regarding aspects of personal and environmental hygiene, including water provision, excreta disposal, drainage, solid waste disposal and vector control (more commonly known as Hygiene Education)

- Makes better hygiene possible in an emergency by providing essential items that may be in short supply such as water and food storage containers, soap and sanitary protection

- Provides the crucial link between people in the community and the technical interventions

Hygiene Promotion has a narrower focus than Health Promotion but both aim to promote positive health. and to enable people to take action to prevent illness.

OXFAM'S APPROACH TO RELIEF

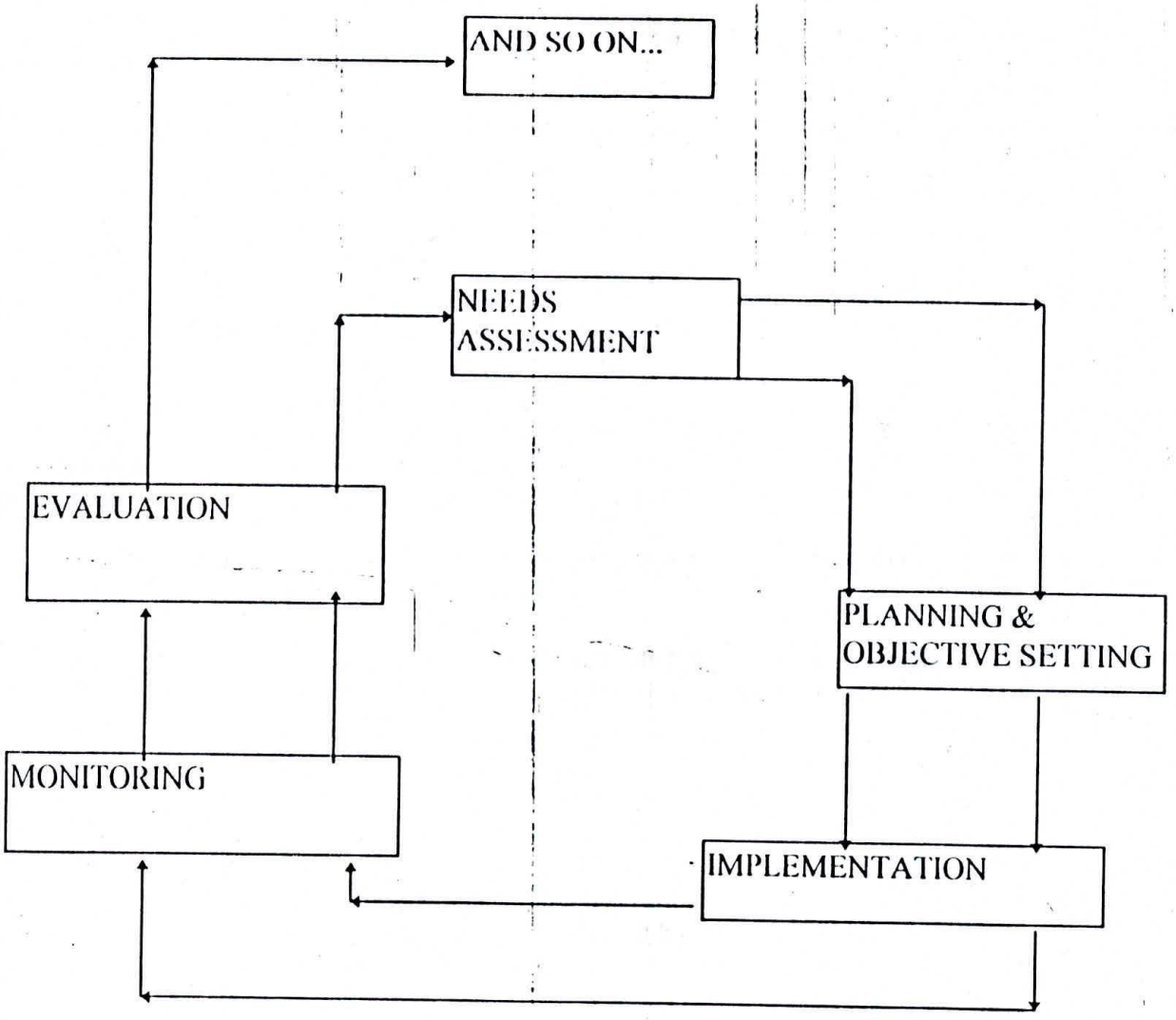
'It is Oxfam's experience that relief programmes are significantly enhanced if the people affected are actively involved in all aspects of planning, implementation and evaluation of those programmes. This is especially the case where aid workers are unfamiliar with the customs and culture of those they are assisting. It should always be remembered that the beneficiaries in any programme are the most valuable resource and that agencies must utilise their knowledge and learn from them. While it may not be easy to institute effective consultative and participative mechanisms in the initial stages of an emergency, an attempt should be made to establish the principle of consultative planning and then build on imperfect beginnings.... Oxfam also recommends that wherever possible relief programmes work with the existing local structures in order to support and enhance their longer term capacity to respond to emergencies.... Programmes should be made to reflect the diverse concerns of women as well as men, of older as well as younger people and of those who risk becoming marginalised because they belong to a minority group,'(Oxfam Handbook on Development and Relief 1996).

HOW DO YOU GO ABOUT IT?

It is not possible to provide a blueprint for setting up a hygiene promotion programme in emergencies as situations will vary greatly. Work may be undertaken in a camp situation, or an urban or rural environment as a response to a mass exodus of people, flooding, drought or other calamity and each situation will present specific challenges.

Despite a sometimes rapidly changing situation it remains important to include all the stages of the project cycle as far as possible.

(Taken from SCF Tool Kits)



1. ASSESSMENT

- The processes of assessment, planning, monitoring and evaluation are as essential in relief as in development work but in an acute emergency do not wait to find out all of the available information before responding

- In an acute emergency an initial assessment can be done in 2-3 days. Not all projects will commence in an acute emergency and the time available for data collection should thus be adjusted accordingly.

- Briefly assess the key areas of possible intervention which epidemiological common sense tell us are major risk factors: 1) excreta disposal (including that of young children and babies) and usual sanitation practices, 2) hand washing practices

- If water sources are to be rehabilitated try to assess existing or possible mechanisms for future maintenance such as water committees or user groups.

- Use rapid assessment methods initially: exploratory walk; focus groups (men, women and children), discussions with key informants and opinion leaders (e.g. leaders: religious and secular, elders, teachers, TBAs etc.)

- In the initial assessment period try to identify the camp or community organisation and leaders, if any. Community structures may have become severely disrupted during an emergency or may be non existent. Mobilising the community to regroup and elect new leaders if necessary will facilitate any future work with them.

- Outreach workers may already exist and their initial training may simply need to be supplemented- try to identify them. It is also useful to try and find out what media of communication are most common in the community and whether there are existing tools and visual aids that might be used by the outreach workers.

- There may also be people available with expertise in public health or community development - try to identify these people

- During the initial assessment try to identify other potential people to work with who might be involved in a campaign or who could be water point or latrine attendants.

- Continue with a more detailed assessment as you design and implement your campaign or the first phase of your project. Other participatory methods of assessment such as pocket charts and mapping may be used once the facilitators have received appropriate follow up training in how to use these techniques.

- A structured observation period (see appendix 2) may be useful in order to provide some quantitative data for monitoring and evaluation purposes. Aim to have completed this within three months. Always make sure that feedback is provided to the community.

- Large questionnaire surveys are time consuming, expensive and require specialised knowledge of survey design to provide valid information. When discussing hygiene people may also often give the answers they think you want to hear making the results unreliable. Only use a survey if you are confident of your design and sampling methods and the relevance and validity of the data you hope to obtain.

SAMPLE CHECKLIST

This sample checklist provides a list of key information that can be gathered during an initial assessment

- population
- mortality and morbidity
- community organisation
- key informants, opinion leaders
- household size
- community organisation & structures (women's groups, water committees, religious institutions, social societies, youth groups, schools, health service etc.)
- existing outreach workers (Community Health Workers, Social development extension agents etc.)
- child/infant defaecation
- adult defaecation
- anal cleansing
- child bottom cleaning
- child stool evacuation
- hand washing after anal cleansing
- hand washing after cleaning children's bottom
- water collection
- water storage
- source of drinking water
- management of domestic animals
- breast feeding practices

(Consider who is involved, what they do and with what)
Observe for stools on the ground and any other high risk practices

See appendices 1 & 2 for a detailed checklist and sample structured observation form

2. PLANNING AND OBJECTIVE SETTING

- It is very important before any implementation to define your objectives and the means by which you will assess your intervention
- Initially it will be the team which sets the objectives but as the project progresses there will be the opportunity to allow different community groups to set their own objectives e.g. the digging of a specified number of latrines by a certain date
- Set short and long term objectives to ensure that a longer term perspective for the project is considered

Below and on the following pages is a set of objectives for a water and sanitation project. In order to provide a concrete context a camp situation of 50, 000 refugees has been envisaged.

The following priorities are recommended in an acute emergency:

- **provide a minimum amount of water for drinking, cooking and washing**
- **ensure people have enough water containers to collect and store water cleanly**
- **provide facilities for people to dispose of excreta safely**
- **protect water supplies from contamination**
- **ensure that people have key information to prevent disease**
- **ensure that people have soap for hand washing**