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November 6, 1992

To:

Abhay Bang, Anant Phadke, Anil Desai, Ashok Bhargav, Anil Patel, Anil Pilgaokar, Daxa Patel, Lataben Desai, Manisha Gupte, Narendra Gupta, Nimitta Bhatt, Rashmi Kapadia, Ravi Narayan, Sham Ashtekar, Shridhar, Ulhas Jajoo.

Dear friends,

Diwali Greetings !

Apologies for this very belated report of the discussions of the PHC Cell of mfc. I shall not give any excuses for the delay but initially wanted to hand over this personally at the last mfc meeting - which I did to all those present. For the rest this got delayed because on second reading I thought that the first report was too long. So, this is an abridged version.

Sincerely,

Received 17/11/92 (866)

PN 17/11/92 SPT/RF/VB for information We all had sent Comments on Anants paper before the PHC Cell meeting 19/11

PRIMARY HEALTH CARE CELL OF MFC:
REPORT OF THE 3RD MEETING

Venue: Sewa - Rural, Jhagadiya
Dates: 22nd and 23rd of June 1992
Present: Abhay Bang, Anant Phadke, Anil Desai, Anil Pilgaokar, Ashok Bhargava, Dhruv Mankad, Dileep Mavlankar, Lataben Desai, Manisha Gupte, Pankaj Shah, Rashmi Kapadia, Sham Ashtekar, Shridhar and other friends from Sewa - Rural, Ulhas Jajoo

Before beginning the first session, some views were exchanged on the issue of defining Primary Health Care from mfc's perspective. This was thought to be important by some because

A) the Alma Ata definition was considered by them to be too broad and encompassing issues of wider concern like nutrition

B) CHV - or as one participant felt better to call her a Village Level Health Worker (VHW) in order to differentiate the idea from the now rejected government's CHV - is only a part of PHC strategy and his/her scope differ under different conditions and from different perspectives.

Finally it was agreed to shelve the discussion for the purpose of this meeting and proceed to more concrete issues.

DAY 1 SESSION 1: EXPERIENCE OF VILLAGE LEVEL WORKERS IN MANAGEMENT OF CHILDHOOD PNEUMONIA.BY ABHAY BANG

Abhay Bang related the major findings of the study done by SEARCH, Gadchiroli, which were that TBAs are the best persons to reach out to and treat neonatal pneumonia. Also that the VHWs are the most effective of the three in managing childhood pneumonias.

Discussion centered around the issue of relative merits and demerits of CHVs and TBAs and on the effects of successful treatment of pneumonia on other causes of death.

DAY 1 SESSION 2 : IN SEARCH OF APPROPRIATE LEADERSHIP AT VILLAGE LEVEL BY ULHAS JAJOO.

Narrating the experience gained at Sevagram, Ulhas raised the issue of people's participation in selection of and control over a VHW.

Following were the main points discussed:

1. Since the poor were more involved with the struggle for their existence, it was the middle farmer who had the time, opportunity and also the need to take on a leadership role.

2. The curative role of the VHW was not perceived to be important either because there was a hospital nearby for indoor care or patients preferred private practitioners. This is also a new emerging scenario : the peri-urban social set up having an easy access to both private and government health facilities .

3. For outdoor treatment for minor or moderate illnesses people preferred going to a private practitioner even if the costs are higher. This cannot be considered to be society's comment on VHWs potential when the the full potential of the VHWs is not uti-

lised. It is wiser to ask as to what is more desirable, if one wanted to progress towards a more rational health care system.

DAY 1, SESSION 3: LEGAL STATUS OF VHWS BY SHAM ASHTEKAR

Sham Ashtekar shared the various legal view points he had gathered from some legal expects. The main point are summarised below :

1. There is a plethora of statutes covering practice of medicine in India and any meaningful discussions on the legal status of VHW can take place only after correlating the various Acts.

2. A medical practitioner of whatever kind is liable for three kinds of legal action : Criminal (negligence etc.) civil (compensation cases), action under the Acts under which they are registered.

3. The question of practice without registration begs clarification on various issues:

a) What constitute medical practice ? Does only giving advice constitute practice ?, Does free treatment and advice exempt one from being called a medical practitioner ? What about registering under one Act and practicing under another i.e. Cross-practice ?

b) What about practising as a part of a team? Who carries the legal liability of the members of the team ?

What constitutes "acting under standing instructions "? Can an ANM working in a remote area giving injection or a mother assisting a delivery be said to be acting under standing instructions ?

While arguing for some sort of legal status to VHW, protection of consumers from irrational practices needs to be ensured.

Following were the main points of discussion:

1. Does heØshe be seen as only a part of team not having the right of practising outside of a team or as a para professional governed by rules formed by its own body and having the right to practice independently ?

View 1: Part of a team as there is a need for protection of consumers from the potential of malpractice by practising VHWs. It was suggested tentatively that a VHW could be seen to be a part of the village panchayat team.

View 2: As a para professional as the scope for VHWs is enhanced if allowed to practice independant of a government or NGO's control.

2. The norms for a VHW's practice as well as the curriculum needs to be standardised .

There is a concrete proposal from the Population and Adult Education Cell of UGC situated in the Pune University. They have requested Sham Ashtekar to identify centres where second year college student can be trained as VHWs - Arogyamitras.

3. Some form of recognition similar to one accorded to the Emergency Medical Technicians in USA should be asked for.

This issue should be followed up with vigour and speed. Dileep Mavalankar and the Seva rural team volunteered to do it with legal exports of CERC, Ahmedabad. Sham Ashtekar also agreed to continue his efforts. They both agreed to report at the mfc meeting in September 1992.

DAY 1, SESSION 4 : A.SEWA RURAL EXPERIENCE OF WORKING WITH 3 LEVELS OF VHWS - ANGANWADI WORKER (AWW), CHV AND TBA

Pankaj Shah briefly recapitulated the history of collaboration between SEWA Rural and the Govt. He recounted how in the early days, having male multipurpose workers (MMPWs) and the ANMs created duplication of the roles. CHV's role was only marginal and included the curative role for patients above 6 years. TBAs were only called during delivery. Thus all of them worked in isolation.

In 1984 when the Govt. abolished the CHV Scheme, SEWA began integrating their roles. Thus, now,

AWW gives curative treatment and looks after the children.
ANMs and TBAs look after Maternal and Neonatal care.
Male MPWs and ANMs both have a curative and supervisory role and share responsibility of immunisation.
MMPW looks after control of communicable diseases and male contraception.
FMPW takes care female contraception.

In their experience, CHV was not a very useful functionary. But they felt that this was also because their curative role had become more generalised . The paramedics and the AWW also gave treatment for minor illnesses. However, the Sewa Rural experience certainly highlighted the role of a VHW, in their case the TBA and the AWW.

DAY 1, SESSION 5 : B. NIROG'S EXPERIENCE WITH HEALTH EDUCATION MATERIAL

Ashok Bhargav reported on the activities of Nirog and narrated the process through which the Health Education materials - posters and booklets - undergo before they are published for wider dissemination.

He felt that since most of the HE material prepared so far by even the voluntary agencies had been written by clinical doctors. it suffered from several weaknesses:

a. a large amount of unnecessary detail.
b. Use of the language as it is written and **not as it is spoken** .
c. Shaded diagrams and photographs were not understood by the people.

Thus the amount of information, the use of language and finally the type of visuals used, together made the material uninteresting and often incomprehensible to the people at whom the it was directed.

The specificity of Nirog's material:

i. The large proportion of those to whom the HE materials address are either illiterate or with primary level of school education.

ii. The information communicated through Nirog's material is brief and uses concrete ideas. Ability to comprehend abstract ideas and concepts - that which cannot be experienced by the five senses is a skill that comes at a fairly late stage in the process of learning. Only a VLHW who has had 8 years of formal school education can learn abstraction. his view was however contested.

Ashok announced that Nirog will be organising a workshop on this theme for those involved in using or developing HE materials, some time before the end of this year.

DAY 2, SESSION 1:ROLE OF PHC CELL: IDENTIFYING GREY AREAS IN THE SCOPE OF CHVS.

Anant briefly recounted the main points of his paper arguing on the relevance and scope of CHVs.

1. This issue has to be discussed not only in reference to the national situation but more so with the grass root situation.

a) In areas where a good hospital is available, a CHV may not have a major role but for an activist group not having a doctor and wanting to do meaningful medical/health work, a well trained CHV can provide a curative service for problems like malaria, scabies.

b) Till now health planners have considered only two areas - urban and rural but with a rapid urbanisation a third area is emerging i.e. a peri-urban rural area around an urban area. Medical practitioners have reached this area. It is necessary to define the scope of VHW in such an area.

c) The role of CHV should be limited to provision of curative service, health education. To expect him/her to organise people for health action is unrealistic.

d) There may be some compromise in quality of the curative work of CHV but even then a well trained and supported CHV can do equally good work as compared to a conventional doctor.

2. It was pointed out here that the following 5 points broadly cover CHV's role :

A) providing treatment for minor and moderate illnesses
B) referring serious illnesses
C) participating in preventive and promotive health programmes
D) health education
E) preservation of traditional remedies

To this was added a sixth point -

F) maintaining record of vital events

However, it was proposed that the minimum role of CHV be laid down. In addition to a minimum role there could be programme specific roles.

3. At this point several related issues were raised:

1.What is the scope of a CHV in an inaccessible area ?
2.Wouldn't the minimum role of CHV depend on the project?
3.How does the role of HW change with external development ?
4.How do you determine such a minimum role?
5.Does the CHV only act as a 'screen' or get upgraded as technology of diagnostics and treatment improves.

Here it was pointed out that an NGO may upgrade to the highest possible level but if system does not accept such a person ,then it is of no use. This also raises the issue of a patient's choice.

4. It was argued that a CHV's scope in an inaccessible area has problems when team support is not adequate :

1) Knowledge of system of medical care should be there in order to refer patients.
2) Supply of drugs
3) isolation
4) Legal problems.

5. Following points were made regarding the role of a CHV:

1.A CHV should be seen as a decision maker, an implementer and as a person doing liaison,

2.A CHV's role as Health educator , the level of literacy required, the legal position and the tasks expected to be performed, all these are is demanding challenges for a CHV programme in a remote area. To meet the challenge and to use full potential of a CHV, she should be part of team.

3. Fresh problems which CHVs should be trained to tackle could be: ARI, AIDS and STD, Neonatal care, Asthma and so on.

6. Some issues identified for further exploration include,

1. What is the role of health education by CHV
2. Remuneration of a CHV

DAY 2, SESSION 2:ROLE OF PHC CELL: ISSUES FOR FUTURE MEETINGS

1. Education role of CHV? kind of support required ?
2. Legal status
3. Developing curriculum for CHV
4. Upgrading of VHW : Changing role
5. Developing a community approach to STD, Scabies, neo-natal care, alcohol.
6. Diff. members of PHC cell - causes of child deaths

It was decided that at the next meeting of the PHC Cell at Wardha on the 15th of September, papers will be presented by

1. Abhay : Verbal Autopsy
2. Dileep Mavalankar and Sham Ashtekar : Follow up on Legal Status of CHV

The Meeting of the PHC Cell of mfc closed after thanking Drs Anilbhai and Lataben Desai and others at Sewa-Rural for the excellent hospitality offered.