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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 new 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.

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 characterised the scientific surge in world medicine. This has required a rapidly escalating investment in both facilities and personnel so that increasingly specialised 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 be justifiable only to practice curative medicine. Now that we have increasingly potent 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 clinical condition that requires massive investments - especially in the most precious commodity of personnel time - could often have been prevented at a fraction of the cost. This is especially true of 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 per cent of illness as effectively as physicians. Patients must invest ordinate 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.

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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.

The Christian Medical Commission has shared with others increasing attempts to publicise 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 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 decentralise services;

-socio-cultural -and this required 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?";

-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.

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 recognised 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.

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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 of 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 strain 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 community 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.

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 decision, 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 depersonalise individual care and distrupt interpersonal relationships, with those who suffer most often being those most in need.

This leads us to prevent three challenges to policy makers and funding agencies, to health workers and educators, and to all who share our concern. We reiterate that challenge 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.

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1. We share in a call to openness, to new vision and insight and a daring readiness to explore - comples relationships at the inter-face 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 have as we move incrementally to innovation.

3. The corporate challenge is that we review critically the justness of the health system as a 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 today'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.

THE FOREGOING STATEMENT ON HEALTH CARE AND JUSTICE REPRESENTS A POSITION PAPER ADOPTED BY THE CHRISTIAN MEDICAL COMMISSION AT ITS 1973 ANNUAL MEETING.

HEALTH - MEDICINE & UNDER DEVELOPMENT

Duplicate

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).

...2.

Most of the so-called "tropical" diseases fall into this category. They have extremely debilitating effects on a large number of patients.

These diseases of underdevelopment were wide spread in Europe in the past. They have been overcome there not so much by the medical discoveries, but mainly because of the general amelioration of the standard of living as a result of improvements in sanitation (housing, drainage, refuse-disposal) and in education.

This indicates that the diseases which concern us here are a direct consequence of the wretched condition of material life for most people in the third world.

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.

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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 hospital 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 capitalist medical technology may alter the effects of some diseases (if the sufferer can afford it) it cannot lessen their incidence.

3. One of the consequence of the adoption of the Western medical model and its technology, is the expansion of Western model medical education. The recognition of medical degrees from developing countries was for long conditional on the approval of curricula and "standards" by the colonial powers, and this was a major contraint on innovations necessary to meet local health needs.

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 medical 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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CHANGING CONCEPTS IN COMMUNITY HEALTH CARE

Duplicate

Definition of Health

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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.

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

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"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 haalth problems of communities or human population groups". We also accept the definition of community as "a group of individuals or families 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".

Community Medicine (its erstwhile cousing being Preventive and Social Medicine) is therefore, a science and art of preventing disease, prolonging life and promoting physical and mental health and efficiency.

The medical and dental practitioners look after individuals and may be families, which is the "General Practice" of preventive 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 thirdarea in medical education, producing a triad 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

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that can be taken to counteract hazards; he should know enough about the economic 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. Sometimes 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 socialisation. 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 dpidemiology 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 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 factors associated with compliance with prolonged medical regimens.

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 date. Environmental health has risen from the privy to world wide ecological concerns with over abundance 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 "Health is a right and not a privilege" and "Health by the People". Medical care which fulfills the three C's - continuous, co-ordinated 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.

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In our own country the recent report of the group on medical education and support man power 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 man power, 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 cling to the Western models of easy medical practice, based on hospitals. It is therefore, but natural that medical colleges have noe 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 man power, 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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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 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".

Community Medicine (its erstwhile cousing being preventive and Social Medicine) is therefore, a science and art of preventing disease, prolonging life and promoting physical and mental health and efficiency.

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

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

..2.

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 triad 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 economic 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. Sometimes 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 educator have gradually descended from their ivory tower and recognised flaws in the cult of our socialisation. The era of relelation 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 opidemiology 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 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 factors associated with compliance with prolonged medical regimens.

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 date. Environmental health has risen from the privy to world wide ecological concerns with over abundance of people and their waste products.

..3.

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 "Health is a right and not a privilege" and "Health by the People". Medical care which fulfills the three C's - continuous, co-ordinated 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 man power 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 man power, 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 cling to the Western models of easy medical practice, based on hospitals. It is therefore, but natural that medical colleges have not 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 man power, 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.

...4.

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.

Sources of information:

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.

5. Preventive Medicine for the doctor in the Community - Leavell and Claike.

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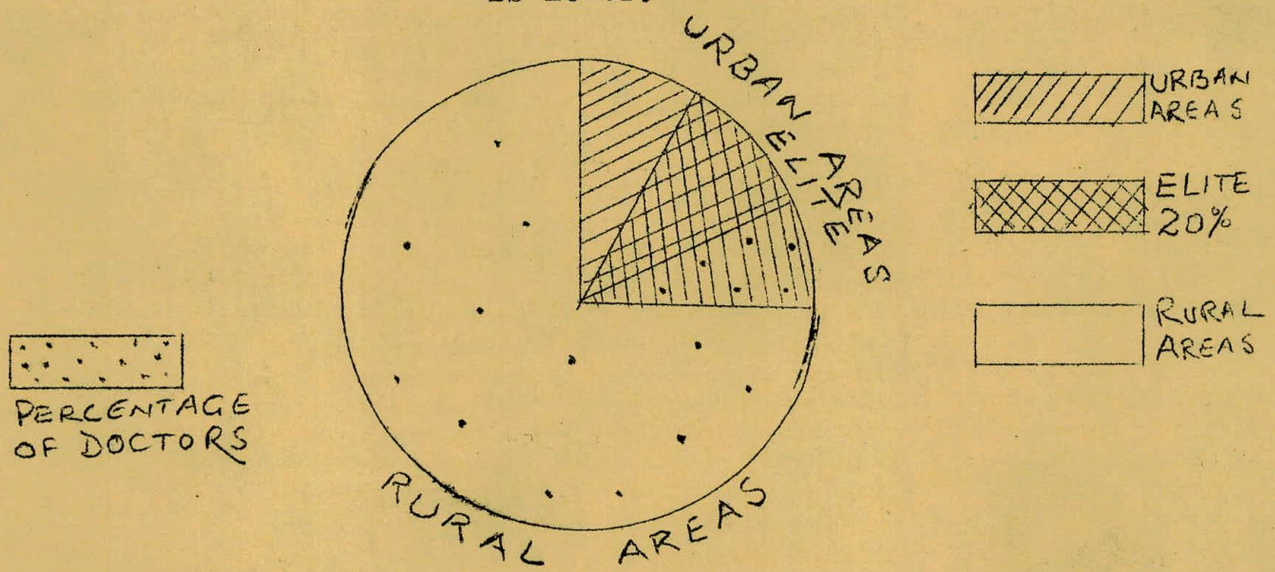
Duplicate

MEDICAL CARE ACCESSIBLE TO THE MASSES

GUIDELINES IN PLANNING

Based on awareness of:

- effective demand (minority) : reflects the ability of powerful groups in society to influence the allocation of resources to produce certain types of goods and services to meet their needs.
- voiceless needs (majority) : of the relatively poor and unskilled rural majority, where the index of health is lower.



Health Services should be:

1) ACCESSIBLE: 3 elements of accessibility:

- geographical: within walking distance (maximum 5 to 7 miles)
  → study the area, its map, transportation facilities, existence of other facilities (avoid overlapping)
- financial: low-cost (strive for self-sufficiency)
- psychological: acceptability, familiarity, confidence.

2) COMPRENHENSIVE: integrating - curative
- preventive
- promotive

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The provision of even basic health services is met with minimum effect unless:

a) the community is motivated for the necessary changes in the socio-cultural environment.

b) the community is provided with adequate nutrition, safe drinking water and a reasonably sanitary environment.

..2.

3) - COMMUNITY-BASED :- we must seek and encourage people's participation in different aspects of the programme.

- new perspective : viewed in the whole process of human development, we are partly responsible for the whole, not wholly responsible for a part.

- many of the health problem of the rural villages are of a nature which cannot be solved by individuals but require the combined effort of many or most of the inhabitants.

4) - accompanied by continous EVALUATION.
and modifications according to the findings, (objectives, data and statistics, records, cost-effectiveness).

DECIDE OBJECTIVES AND PRIORITIES considering :

- socio-economic development of the people
- patterns of disease : identify health conditions in the community and problems causing them.
- what people think of health and disease
- local needs, particularly the needs of special groups and areas
- degree of support from the community
- resources available in money, man-power and materials
- need for co-ordinated and joint action of different service agencies (voluntary and governmental) for a total and integrated community development.

INTEGRATED HEALTH PROGRAMME

Health services (whether hospital, dispensary, health centre or community health programme) need be integrated in the overall effort of human, community and national development.

For too long the interaction between the health services and the community they serve was ignored or denied.

New perspective :

I - as "health workers", we are partly responsible for the whole not wholly responsible for a part.

Health planning belongs to society (not only to specialists)
Health action needs to be linked with the broader community goals.

The socio-economic situation of the patient and the community must concern the health team.

The importance of the health service as an information service should be clear: informations about the symptoms and signs of what is going wrong in a society may be more important than treating the symptoms which, in the long run, could conceal the real trouble.

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II - Many of the problems of the rural villages cannot be solved by individuals, but require the combined efforts of the inhabitants, the health workers and the government services.

ex: environmental hygiene is the responsibility of the community.

To make a contribution to the equitable distribution of the health services to the masses of India, all hospitals should give priority to the planning and development of primary health and community care, taking into account government and civic programmes, and chiefly the people themselves.

1) Basic health education to the people

2) Work on some preventable diseases (ex: blindness, T.B., leprosy, etc.)
   - camps
   - special clinics (also pre-school childr-en, F.P., etc.)

3) Organisation of rural health zones and health centres.

4) Promotion of auxiliary personnel (para-professionals)

COMMUNITY-BASED PROGRAMME

Considering the local needs,

A - select a community of a defined and accessible geographical area.

B - study the community characteristics :

- demographic dynamics : birth rate - death rate - age pyramid
  causes of death, of disability, of incapacity to work, of distress.

- structure of the community : groups, leaders.

- socio-economic life : sources of income,
  income range
  employment pattern or occupation
  pattern of expenditure
  educational level

  assessment of local resources for the programme

- felt needs

- local customs regarding health
  - what it means to be sick ?
  - what people do to avoid sickness ?
  - what people do to cure sickness ?
  - to whom people turn when they are sick ?
  - who gives them advices ?
  - what is the importance of different foods, food-rituals, births, deaths, marriages, etc.

- other health facilities.

C) identify and analyse the community's health problems
(diagnose the cause of the ill-health)

D) set the priorities and goals for the programme

- health care facilities
- specific health improvement objectives
- health-related development work

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- Curriculum proposed in "the new health plan for the nation" (Raj Narain)

  - fundamentals of health sciences
  - measures for maintaining good health
  - hygiene - personal environmental
  - treatment of common infectious diseases
  - maternity and child care
  - treatment of common ailments
  - first aid.

- The sponsoring centre should provide referral service and extend all professional help needed.

HEALTH PROMOTION

Let us look at medical care not from the standpoint of illness, but of health. In the past we have lost sight of the primary objectives : to keep people healthy and out of the hospital in the first place. We have organised for sickness.

In the future we must organise for health.

Fundamental questions :

If the concept of health is = non-illness
then health care = cure of disease (curative medicine) or eradication of disease (preventive medicine)

Isn't health more than non-illness?
Isn't there more to life than keeping disease-free?
Isn't there more to being human than just being well?

The more revolutionary advance in modern medicine is the re-discovery of the wholeness of the human personality. (see Jesus' healings).

It is a well known fact that the overall well-being of a person depends considerably on the quality of the environment and the social relationships.

Better health care requires attention to the total development of the whole person, to the needs of individuals, families and communities.

It includes awareness and willingness to do something about such problems, as environment, malnutrition, balance between population growth and development.

"The primary task of a hospital is to be viewed in terms of human learning :

to enable patients, their families and the staff to learn from the experience of illness and death how to build a healthy society" (Dr.M. Wilson).

A comprehensive view of health demands to relate our hospital system to the process of human development taking place in the country. This implies to aim at self-relaint growth, social justice and peoples participation.

One of the crucial factors in this process is education, not of the formal type, but the type that transforms the minds, and changes attitudes and age-old patterns of behaviour.

A new consciousness is growing of the role of the hospital in health promotion, making use of the existing opportunities of listening, conversations, group discussions.

...7.

community

- Community involvement demands that, before any step is taken, the/
  - must be consulted,
  - their opinion should be considered
  - they should be involved in every decision that is taken.

- A health-action committee should be formed, to secure active co-operation of the people.

- Information about the village and its people will need to be collected, by simple methods and using relatively unskilled workers (ex: school teacher, or even illiterate women - see Rajupeta chart)

- Local leadership must be inspired - and initially it may be up to the medical and nursing profession to provide inspiration and direction.

- the health worker should be selected by the community to be served.

- training should be organised as near as possible to the villages to be served, so that the trainee can keep in contact with his or her family. Exposing the trainee to urban or westernised millieu too often leads to the loss of community identity, and will make the return to the community difficult.

- medical training must enable the trainee to know what ailments he or she can treat, and what he should instead refer for medical treatment - and how urgent the referral is.

- medical training demands some clinical experience in a hospital or dispensary, where the trainees can see patients and understand the clinical picture of diseases.

- "on the spot" training must help the trainee to tackle simple and basic health problems, and to learn basic health promotion and health education.

- supervision of the paramedical worker is necessary and should be carried out regularly with :

  - visits by the supervisor to the paramedical workers site
  - regular meetings and training sessions at the hospital or dispensary.
  - reports from the local community health committee about the health promotor's work, its quality, and the acceptance of the fees charged.

- fee-for-service should be decided locally, so that the community will pay for the services required.

  - if the community provides resources, they will be concerned that these are well used.
  - the health committee should be informed of the price of the basic medicines the health promoter's will be supplied with by the sponsoring centre.
  - the health promoter should continue his or her normal life and work and do the health work on a part time basis (2 - 3 hours daily)
  - the sponsoring centre should work out the training programme considering :
    - what kind of education should be given in the particular situation.
    - what should be the motivation of those who are trained.
    - can some traditional skills and systems be utilised (ex: massage).

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HEALTH EDUCATION

This is a process which effects changes in the health practicies of people and in the knowledge and attitudes related to such changes.

Through health education a nurse should aim at :

a change of knowledge
→ change in attitude
→ change in behaviour
→ change in habit
→ change in custom.

Contents of health education ;

- human biology
- nutrition
- hygiene : personal environmental.
- care of mothers and children
- pretention of communicable diseases.
- use of health services.

Principles of health education :

Interest	: bring about recognition of the needs, to catch people's interest.
Participation	: active learning
From known to unknown	: start where the people are and precede to new.
Comprehension	: communicate in a language people understand
Reinforcement	: repetition at intervals - 'booster dose'.
Motivation	: awakening the desires
Learning by doing	: action-process. "If I hear I forget; if I see I remember; If I do I know" (Chinese proverb).
Communication	: on emotional, cultural and intellectual plane.
Prior knowledge of the people	: customs, habits, taboos, beliefs, health needs.
Good human relations	: people must accept the educator as their real friend.

A nurse's teaching is best done in an informal way, making use of actual situations to impart education :

Home-visits are very opportune times for health education.

We should organise formal teaching sessions.

To be successful communication these should be :

Brief	: 5 to 10 minutes.
Simple	: make one or two points clear. We should not confuse with too much information.
Seen	: use visual aids, or tools when possible.
Heard	: speak aloud to capture interest
Remembered	: use local events to illustrate - it helps to remember.

How to prepare the teaching :

Teaching guids
Visual aids } where to get them from or how to prepare them ourselves and use them.

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Demonstration
As much as possible choose the subject in relation to a situation or an event.

Then : follow-up :
- see what people have understood
- clarify
- repeat occasionally
- advise concretely
- encourage to apply, to change habits.

Every staff member must responsibly include teaching in his/her daily work.

But to stimulate, co-ordinate and follow-up the health education programme it is better to have one person who takes special responsibility for it.

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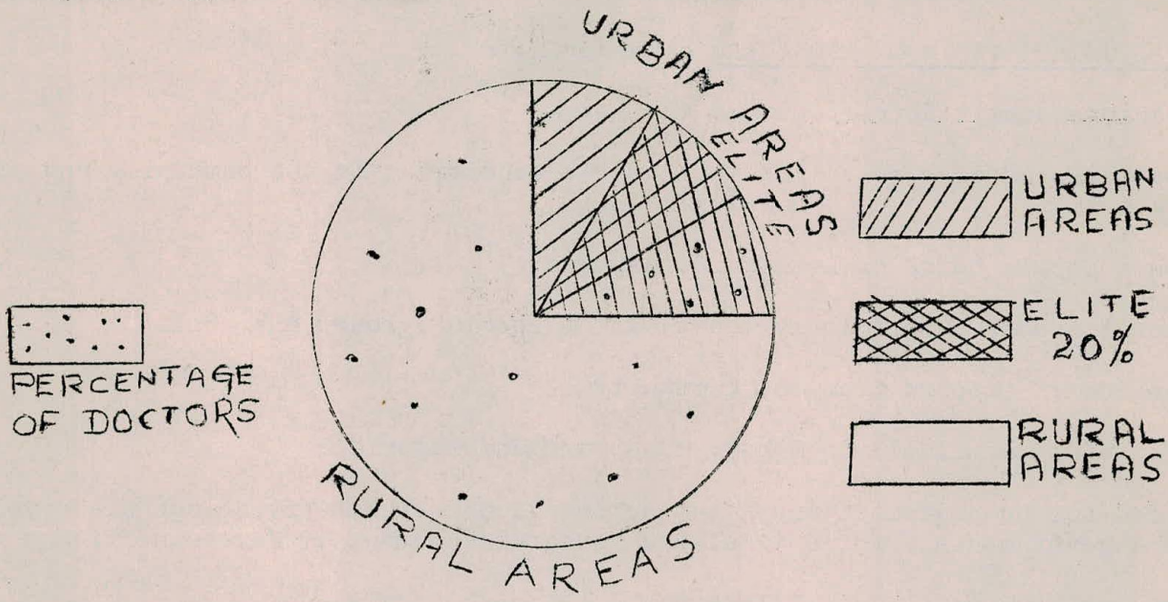

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- specific health improvement objectives
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The community should be actively involved in steps B),C) and D)

There is need for :
- agreement upon the problems to be tackled
- agreement upon the solutions within the village
- a village organisation (ex: health committee)
  -- to gather the village resources
  -- and promote effectiveness action

The potential for health promotion and improvement within the community needs to be awakened and released. It is bound to be more effective than interventions " from outside ".

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Three Principles for financing community health programmes

Community health programmes can be self supporting under certain conditions. The following are some economics which make it possible for a programme to be self-supporting.

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I Obtain community support

Too often we organise our programme without any consultation with the community leaders, then we wonder why we are left to pay for it! Besides meetings with governmental authorities, there should be detailed discussion with village or community leaders. The programme should be a co-operative effort.

II Pedal power is cheaper than motor power

We could buy 120 bicycles for the cost of one Ambassador car: the cost of running a motor vehicle can be equal to the salary of a specialist doctor. Our programmes should be within walking or cycling distance, or accessible by bus travel. We may need to consider skills when making an appointment. Every jawan does not need to ride in a tank!

III Doctors are not needed for routine work

In battle a few officers can command many jawans! Six village level health workers can give simple health to 15.000 people. Their salary will cost the same as one MBBS doctor. This does not mean that doctors are not needed. Far from it. But doctors can train semi-literate or illiterate women health workers to give simple health care.

TRAINING OF PARAMEDICAL COMMUNITY HEALTH WORKERS

hat are the most important assets of a poor country?
its man-power : the people and their skills.
there are many potentialities still to be developed.

In the field of health services, our initiative ways and the eagerness to obtain help from others, without first building up our own potentialities, have brought a help that leads to a new kind of helplessness.

To provide simple medical facilities to the rural areas, the first step is to train and organise paramedical health workers.

- the process of providing medical aid to the village "from outside" must be reversed :
  - local personnel should be enrolled and
  - the village people must be involved in the decision-making.

- Community involvement demands that, before any step is taken, the community
  - must be consulted,
  - their opinion should be considered
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or eradication of disease (preventive medicine)

Isn't health more than non-illness?
Isn't there more to life than keeping disease-free?
Isn't there more to being human than just being well?

The more revolutionary advance in modern medicine is the re-discovery of the wholeness of the human personality. (see Jesus' healings).

It is a well known fact that the overall well-being of a person depends considerably on the quality of the environment and the social relationships.

Better health care requires attention to the total development of the whole person, to the needs of individuals, families and communities.

It includes awareness and willingness to do something about such problems, as environment, malnutrition, balance between population growth and development.

"The primary task of a hospital is to be viewed in terms of human learning :

....6/-

to enable patients, their families and the staff to learn from the experience of illness and death how to build a healthy society" (Dr. M. Wilson)

A comprehensive view of health demands to relate our hospital system to the process of human development taking place in the country. This implies to aim at self-relaint growth, social justice and peoples participation.

One of the crucial factors in this process is education, not of the formal type, but the type that transforms the minds, and changes attitudes and age-old patterns of behaviour.

A new consciousness is growing of the role of the hospital in health promotion, making use of the existing opportunities of listening, conversations, group discussions.

HEALTH EDUCATION

This is a process which effects changes in the health practices of people and in the knowledge and attitudes related to such changes.

Through health education a nurse should aim at :

a change of knowledge
→ change in attitude
→ change in behaviour
→ change in habit
→ change in custom.

Contents of health education :

- human biology
- nutrition
- hygiene : personal environmental
- care of mothers and children
- pretention of communicable diseases.
- use of health services.

Principles of health education :

Interest	:	bring about recognition of the needs, to catch people's interest.
Participation	:	active learning
From known to unknown	:	start where the people are and precede to new
Comprehension	:	communicate in a language people understand.
Reinforcement	:	repetition at intervals - 'booster dose'.
Motivation	:	awakening the desires
Learning by doing	:	action-process. "If I hear I forget; if I see I remember; If I do I know" (Chinese proverb).
Communication	:	on emotional, cultural and intellectual plane.
Prior knowledge of the people	:	customs, habits, taboos, beliefs, health needs.
Good human relations	:	people must accept the educator as their real friend.

A nurse's teaching is best done in an informal way, making use of actual situations to impart education :

In the hospital we come across so many situations raising problems and questions, which can be the starting point for discussing and teaching.

Home-visits are very opportune times for health education.

We should organise formal teaching sessions.

To be successful communication these should be :

Brief	:	5 to 10 minutes.
Simple	:	make one or two points clear. We should not confuse with too much information.
Seen	:	use visual aids, or tools when possible.
Heard	:	speak aloud to capture interest
Remembered:		use local events to illustrate - it helps to remember.

How to prepare the teaching :

Teaching guides
Visual aids
} where to get them from or how to prepare them ourselves and use them.

.....7/-

Demonstrations
As much as possible choose the subject in relation to a situation or an event.

Then : follow-up : - see what people have understood
- clarify
- repeat occasionally
- advise concretely
- encourage to apply, to change habits.

Every staff member must responsibly include teaching in his/her daily work.

But to stimulate, co-ordinate and follow-up the health education programme it is better to have one person who takes special responsibility for it.

Duplicate

TWELVE GROUPS OF AXIOMS ON MEDICAL CARE

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 organized 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 & 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 less skilled ones.
(b) All medical staff have a teaching vocation in the community they serve.

THE ADAPTATION OF MEDICAL CARE TO LOCAL CONDITIONS

ELEVEN In developing countries medical care requires the adaptation and development of its own particular methodology.

TWELVE Medical care and the local culture are closely linked.

(a) Medical care must be carefully adapted to the opportunities & 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.

Duplicate

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:

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THE PATTERN OF A MEDICAL SERVICE.

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... 2

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sspd.
14.5.1979.

NATIONAL INSTITUTE OF ADVANCED STUDIES

BANGALORE

Indian Institute of Science Campus
Bangalore

NATIONAL INSTITUTE OF ADVANCED STUDIES

This is the age of scientific renaissance with explosions of information in all fields of knowledge. While one welcomes this and the new technologies it has given birth to, there is also a growing concern that there is a need to integrate this information and examine the new technologies in the historical, social, cultural, political and economic context of the increasingly complex societies in which the latter will take root. Further, one requires to take into account the values and the psychological propensities of those who will make use of this information. Are they well versed just in their respective field of specialisation or do they approach problems from a broader perspective? Unless all this is done, the very harbingers of human progress can spell its doom. It is this realisation which has inspired the creation of the National Institute of Advanced Studies.

This Institute (subsequently referred to as NIAS) is a Centre for higher learning with twin objectives. The first is to provide an atmosphere in which, through exchange of ideas, exposure to new knowledge in different areas, introduction to nation's socio-cultural heritage and understanding of the strengths as well as weaknesses of human personality, one could move towards that widening of mental horizons, which makes for more accurate and effective decision making. The other is to support and lead multi-disciplinary research on the borderlands of material sciences, social sciences and humanities; helping the researchers from different disciplines work together, understand each other's language and attack complex problems in a comprehensive fashion.

That there was a need for such a commingling of different disciplines was clear to Jamshetji Tata who in 1904, while gifting to the nation first ever Institute of Science and Technology, had clearly remarked that there should be a place for humanities in such an Institute. A reference to this philosophy was made again by Mr. J.R.D. Tata, who while speaking at the Platinum Jubilee of the Indian Institute of Science, said the following:

> "It has been said that education is what makes a man what he is, the way he conducts himself, his interests, his values, his personality. The load of work imposed on young men and women pursuing advanced studies in our Institute is such that they have little time or opportunity to expose themselves to literature, the arts, drama, poetry, music, history, philosophy, which, though unconnected with their study or research work, are important elements in the make-up of a civilized, liberally educated person such as Jamsetji Tata had in mind.
>
> Many of the thousands of young men and women who emerge from our Institute would, I think, appreciate the opportunities to nourish their minds and expand their horizon beyond their immediate course of study. If I am right, may I end my remarks with the suggestion that we consider introducing in the Institute wholly optional programmes of study or discussion in some of the subjects I have just mentioned, and thereby send out into the world better informed and more lively citizens who will, in turn, play a fuller part in making this great but impoverished country of ours a better place to live in?"

National Institute of Advanced Studies, initiated by the Sir Dorabji Tata Trust of which Mr. J.R.D. Tata is the Chairman, has gone further in crystallising the above philosophy, making integrated learning its very *raison d'etre*.

History

While Mr. J.R.D. Tata had the first idea about 25 years ago, it passed through many discussions and elaboration by a number of distinguished scholars, industrialists and administrators before it took its final shape. It was presented as a concrete project at the request of the Sir Dorabji Tata Trust, by a committee consisting of the following:

1. Prof R.D. Choski	Trustee Sir Dorabji Tata Trust
2. Dr. Satish Dhawan	Senior Adviser Indian Space Research Organisation.
3. Mr. L.K. Jha	Former Chairman Economic Administration Reforms Commission and ex-Governor of Jammu and Kashmir.
4. Prof. M.G.K. Menon	Member Planning Commission Govt of India.
5. Prof. Philippe Olmer	Hon. Professor at the University of Paris Formerly, General Director of Higher Education Ministry of Education Paris.
6. Dr. H.N. Sethna	Retired Principal Secretary to the Government of India and ex-Chairman, Atomic Energy Commission.

The project for such an Institute was welcomed by the Prime Minister, Shri Rajiv Gandhi, who also initiated an enquiry with the officials concerned, regarding the possibility of finding a location for it in Delhi. However, the alternate locations available and offered did not meet the requirements of the new Institute. Subsequently, the Governor and the Chief Minister of West Bengal, when informed about the project, also offered a suitable location for it in the city of Calcutta. Finally, the Trustees of the Sir Dorabji Tata Trust and the Director-designate of the Institute, Dr. Raja Ramanna, came to the unanimous conclusion that the aims, ideals and objectives of the Institute could be most effectively achieved by its location in Bangalore in close proximity to the Indian Institute of Science.

The Institute was registered in Bangalore on the 20th of June, 1988 under the Karnataka Societies Registration Act. Dr. Raja Ramanna took over as the Director of the Institute in August 1987. Dr. R.L. Kapur joined as the first Professor on the Faculty in October 1988. The first formal activity of NIAS, i.e. a course of lectures to the senior administrators in Government and Industries was held in Jan-Feb. 1989.

It was in March 1989 that the Council of the Indian Institute of Science gave on license, 5 acres of land within the campus of the I.I.Sc for the NIAS buildings. The Visitor of the Indian Institute of Science, the President of India, gave his consent to this welcome gesture in December 1988. In September 1987, the Government of Karnataka had promised an interest - free loan of Rs. one and a half crores to construct the buildings.

The National Institute of Advanced Studies was formally inaugurated on January 16, 1989 by Mr. J.R.D. Tata.

The Administrative Structure

NIAS is an independent organisation registered under the Karnataka Societies Registration Act. It is financed by the Sir Dorabji Tata Trust and the Government of Karnataka.

There are three Authorities for the overall administration of the Institute. These are the Council of management (subsequently referred to as 'Council'), the Holding Trustees and the Academic Council.

The **Council** has the full powers and authority on overall management according to the Rules and Regulations of the Institute. It has the following members:

a. Two nominees of the Sir Dorabji Tata Trust,
b. Director of the Institute (Ex-Officio),
c. Two nominees of the Government of India,
d. One nominee of the Government of Karnataka,
e. Director, Indian Institute of Science, and
f. Not more than three persons to be co-opted by the above from time to time for a period of five years. No action of the Council shall be invalidated by the mere fact that co-option of the three members as provided above, had not been made.

All nominated members will hold the office for 5 years. Chairman is elected by the Council Members for a period of 3 years.

The **Academic Council** looks after the academic programmes and advises the Council on academic matters. It has the following members:

a. The Director, who is the Chairman of the Academic Council;
b. Members of the Faculty, that is to say, the Director and Professors and any other member of the academic staff of the Institute deemed to be a Faculty Member by the Council; and
c. Not more than five experts in the related fields to be appointed by the Director.

The **Holding Trustees** review the overall functions of the Institute and have the following members:

a. Chairman of the Council
b. The nominee of the Sir Dorabji Tata Trust
c. The nominee of the Government of Karnataka
d. The Director of the Institute
e. The Director of the Indian Institute of Science.

The **Director** is the Executive and Academic Head of the Institute. He is a member of all the three statutory bodies. He shall have the general control over the Institute and shall give effect to the decisions of the authorities of the Institute.

The Programmes of the Institute

As decided by the Academic Council and the Council of Management, the main programmes of the NIAS will be as follows:

1. To conduct 40-day residential courses for persons in senior positions from Government, Industries and Universities. In these courses, a galaxy of renowned scholars and experts from all over the country will acquaint the participants, not only with the new developments in various fields of knowledge but also put them in touch with nation's socio-cultural roots and its experiments towards becoming a modern state without parting with time-tested traditional values.

Besides taking part in the lectures and discussions, the participants will also make their own contributions through talks on subjects of their own interest, presenting critical reviews of selected books, taking part in panel discussions and carrying out specific projects.

The Government participants are expected to be the officers at the level of Joint Secretary and those from Industries will be from senior management cadre. One expects a very creative atmosphere with mature participants from different backgrounds interacting in and out of formal sessions.

During the residential course, the participants will be the guests of the Institute who will arrange their accommodation, food, entertainment and visits.

2. To conduct workshops on developmental policies of national importance. Experts will be called in to spend 8-10 days examining a given policy or a new idea, both in its concept as well as in the details of its application, looking into its successes and failures, the reasons for both and suggesting new directions: thus providing for our legislators and administrators the much needed information and expert opinion.

3. To conduct socially relevant multi-disciplinary research on the borderlands of science, social science and humanities.

4. To invite visiting faculty on long-term basis from six months to a year. During this period, the visitor could put finishing touches to his on-going research and also interact with the permanent faculty in planning and executing new or on-going research programmes.

5. To invite key administrators from the Government and Industries to come as Visiting Fellows for six months to a year. Here they would pursue any new developmental ideas they have, fill in the gaps in knowledge pertinent to their tasks, and test out their ideas with the permanent and Visiting Faculty. Some of these ideas could become foci for the national workshops mentioned in (2) above.

6. To publish books, monographs, periodicals and papers.

7. To co-operate with other Institutions and Organisations and contribute knowledge at inter-disciplinary level.

MEMBERS OF THE COUNCIL

1. Mr. J.R.D. Tata — Chairman
Chairman
Tata Sons Limited
Bombay House
Homi Mody Street
Bombay - 400 001.

2. Mr. J.J. Bhabha — Member
Managing Trustee
Sir Dorabji Tata Trust
Bombay House
Homi Mody Street
Bombay - 400 001.

3. Dr. Ashok S Ganguly — Member
Chairman
Hindustan Lever Ltd
Hindustan Lever House
Backbay Reclamation
Bombay - 400 020.

4. Mr. Keshub Mahindra — Member
Chairman
Mahindra & Mahindra Ltd
Gateway Building
Apollo Bunder
Bombay - 400 039.

5. Prof. M.G.K. Menon — Member
Scientific Adviser to
Prime Minister
& Member, Planning
Commission (Science)
Government of India
Yojana Bhavan
New Delhi - 411 001.

6. Dr. Francis A Menezes — Member
Director
Tata Management
Training Centre
1, Mangaldas Road
Pune - 411 001.

7. Prof. C.N.R. Rao — Member
Director
Indian Institute of Science
Bangalore - 560 012.

8. Dr. Raja Ramanna — Member
Director
National Institute of
Advanced Studies
Indian Institute of Science
Campus
Bangalore - 560 012.

9. Mr. T.R. Satish Chandran — Member
Director
Institute for Economic
and Social Change
Nagarabhavi Post
Bangalore - 560 072.

10. Mr. Manish Bahl — Member
Secretary (Personnel)
Ministry of Personnel, Public
Grievances and Pensions
Government of India
New Delhi - 110 001.

11. Mr. B.N. Yugandhar — Member
Director
Lal Bahadur Shastri Academy
of Administration
Government of India
Mussoorie - 248 179 (U.P.)

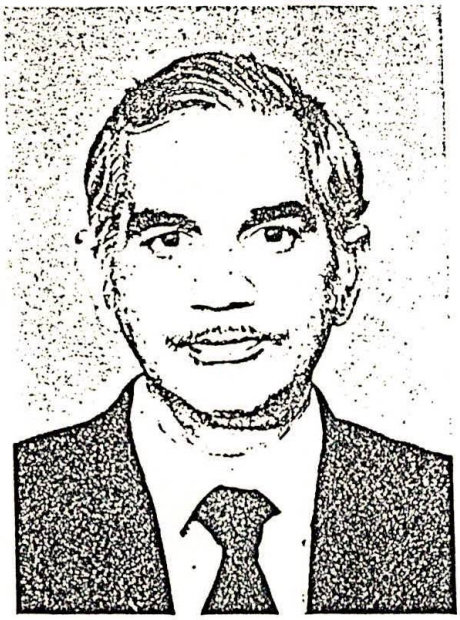
MEMBERS OF THE ACADEMIC COUNCIL

1	Dr. Raja Ramanna Director, National Institute of Advanced Studies Indian Institute of Science Campus Bangalore - 560 012.	Chairman
2.	Shri S.T. Baskaran Postmaster-General Office of the Chief PMG Bangalore - 560 001.	Member
3.	Prof. Andre Beteille Professor of Sociology Department of Sociology Delhi School of Economics University of Delhi Delhi - 110 007.	Member
4.	Shri K.A. Chandrasekaran Joint Secretary (Training) Department of Personnel and Training Government of India New Delhi - 110 001.	Member
5.	Prof R.L. Kapur National Institute of Advanced Studies Indian Institute of Science Campus Bangalore - 560 012.	Member (Ex-Officio)
6.	Prof. N. Mukunda Chairman Division of Physical & Mathematical Sciences Indian Institute of Science Bangalore - 560 012.	Member
7.	Prof. K. Subrahmanyam Nehru Fellow The Institute for Defence Studies and Analyses Sapru House Barakhamba Road New Delhi - 110 001.	Member

THE FACULTY

DR. RAJA RAMANNA is the Director of the Institute. A Ph.D. from London University and awarded the D.Sc *(Honoris Causa)* by many others, he has formerly been Director, Bhabha Atomic Research Centre, Bombay (1972-1978) and (1981-83); Scientific Adviser to the Minister of Defence, Government of India; Director General, Defence Research and Development Organisation; and Secretary for Defence Research (1978-81); Chairman, Atomic Energy Commission and Secretary to the Government of India, Department of Atomic Energy (1983-87). He has also been Chairman, Board of Governors, Indian Institute of Technology, Bombay (1972-78) and is, currently, the Chairman of the Governing Council of the Indian Institute of Science, Bangalore. He is a Fellow of the Indian Academy of Sciences and the Indian National Science Academy and has received various national awards including Shanti Swarup Bhatnagar Award (1963); Padma Shree (1968); Padma Bhushan (1973); and Padma Vibhushan (1975).

Dr. Ramanna also brings to the Institute an abiding interest in Arts and Philosophy. He has a deep knowledge of Music both Indian and Western and is an accomplished Pianist, having performed to many a distinguished audience in various parts of the world.



DR. R.L. KAPUR is the first to join the permanent Faculty of the Institute. He is a Psychiatrist with a Ph.D from the University of Edinburgh. Formerly, he has been the Professor of Community Psychiatry and Head, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore (1975-83); Visiting Professor, Centre for Theoretical Studies, Indian Institute of Science, Bangalore (1983-89); Visiting Professor, School of Medicine as well as the Divinity School, Harvard University, U.S.A. (1985-86). He has also been a consultant to the World Health Organisation. He has received various awards including the Medical Council of India Award for Community Research. He is a Fellow of the Indian Academy of Sciences, the Indian Academy of Medical Sciences and the Royal College of Psychiatrists, U.K.

His research interests include Cross-cultural Psychiatry and Psychological concepts in Ancient Indian Philosophy. He has researched on Yoga, having taken an Indian Council of Medical Research sabbatical in 1981-82 to study under a Guru.

Report on the First NIAS Course for Senior Administrators in Government and Industry

A. Aim of the Course

The first course, designed by the National Institute of Advanced Studies to acquaint the senior administrators both from the Government and Industries with the latest advances in knowledge as well as to remind them of their socio-cultural roots, was conducted at the Tata Management Training Centre, Pune from 16th January to 18th February 1989 (total duration : 5 weeks).

The course did not attempt transfer of any new skills; nor did it aim to provide any information directly pertinent to the participant's current work assignment. Instead, the focus was on the widening of mental horizons in such a manner as would improve the officer's decision-making capacity and give him or her a fresh, broader perspective from which to attack the problems in course of his or her work. It was understood that such a change comes slowly and in a subtle manner and can be gauged only through examination of subjective satisfaction immediately and long-term performance in the long run.

B. Course Formulation

A variety of subjects, from the material sciences, social sciences and the humanities were included in the course. The faculty was carefully chosen, keeping in mind the lecturer's proven scholarship and communication abilities. Each lecturer was told about the overall purpose of the course and then asked to talk about his subject in five half day sessions. The choice of topics was entirely left to each lecturer's discretion. Besides the exposition of some major themes, separate individual lectures on some significant topics were also included.

Besides the lectures, some field visits to scientific organisations as well as some major industries were also organised. 'A highlight of the course was a visit to the National Centre for the Performing Arts, Bombay, where the participants were treated to a lecture, a tour of the Centre and a play in the evening.

C. The Participants

There were seventeen participants from the Government and eleven from the Industries. The list of participants is given on page 20. The Government participants were selected by the Department of Personnel and Training, Government of India, and those from the private and public sectors were deputed by the individual companies in response to communications sent by the Chairman of the Council and the Director NIAS.

The average age of the participants was as follows:
Government candidates : 48.7 years,
Industries candidates : 41.3 years.

D. The Inauguration

There was a brief inauguration ceremony in which Mr. J.R.D. Tata, Chairman of the Council, NIAS, spoke about the history of the Institute, the inspiration from similar institutes of excellence in France, the contribution of various distinguished scholars and experts who had met in various committees to elaborate on the original theme and finally the concretisation of the objectives when the Institute was registered under the Karnataka Societies Registration Act on June 20, 1988. Mr. Tata reminded the audience of the desire of Shri Jamshetji Tata to have material sciences and humanities flourish under the same roof and its realisation now, with NIAS coming up on the campus of the Indian Institute of Science.

The Director, Dr. Raja Ramanna, welcoming the participants and the distinguished guests, explained the overall aim of bridging the gap between sciences and humanities. He also gave a description of the course.

E. The Conduct of the Course

The main method of teaching was a lecture followed by discussions. While each lecture lasted 1-1 1/2 hours, the discussions often went on for 2 to 2 1/2 hours. It was heartwarming to see that everyone participated in discussions. Many participants continued with discussions afterwards and it was common to see small groups meeting the faculty members later in the evening.

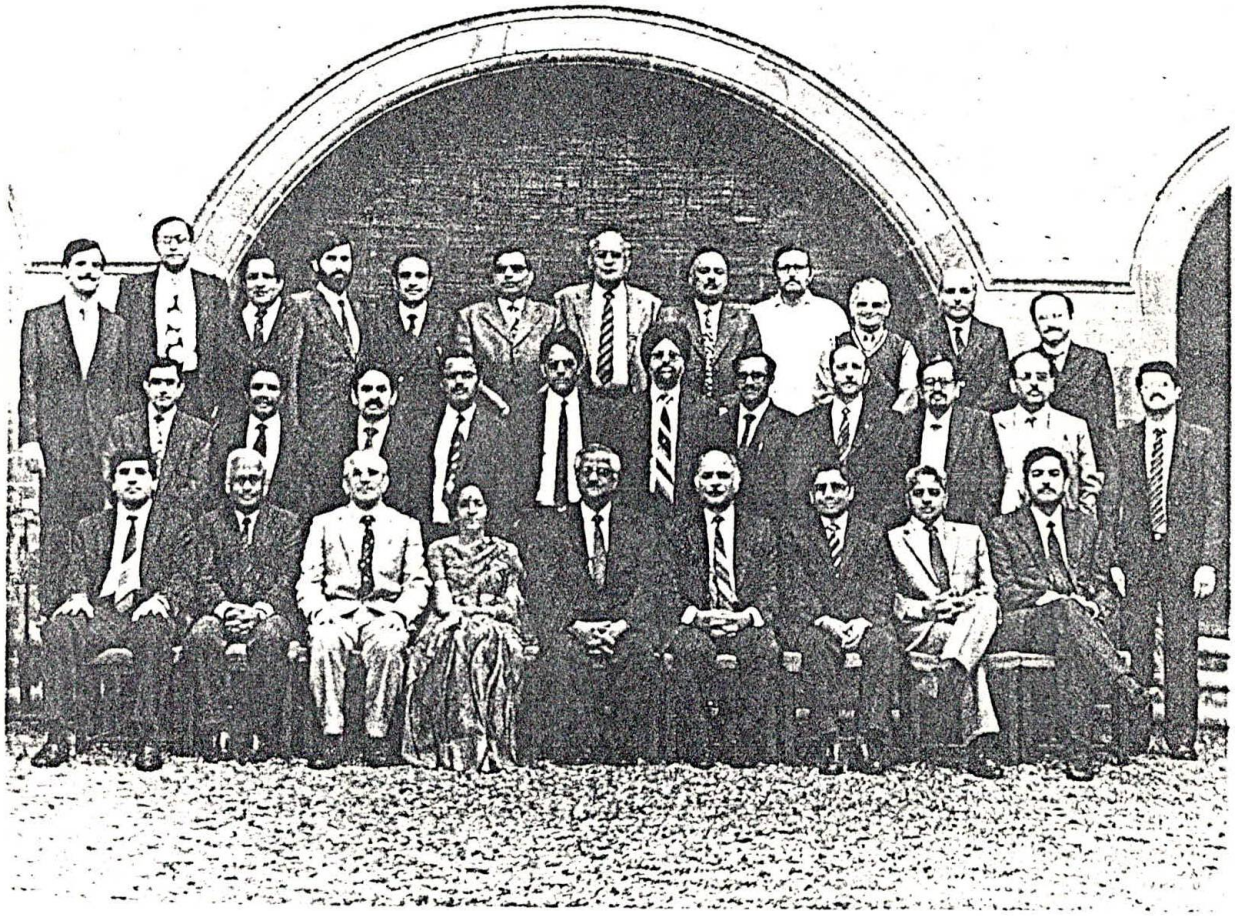
Most teachers used audio visual aids like overhead projector and slides. In the Psychology course, there was an exercise in which the participants assessed their own personality and also a session in which Dr. Kapur took the participants through YOGA-NIDRA.

About 7-10 days after the beginning of the course, the participants had a meeting with the NIAS Director and faculty in which, among other things, they suggested that the participants should give short talks about their own work. This was organised. Half-hour presentations were made by ten participants and were greatly appreciated.

The participants were taken for several visits which were vastly enjoyed. In the visits, there was a judicious mixture of science establishments, industries and entertainment.

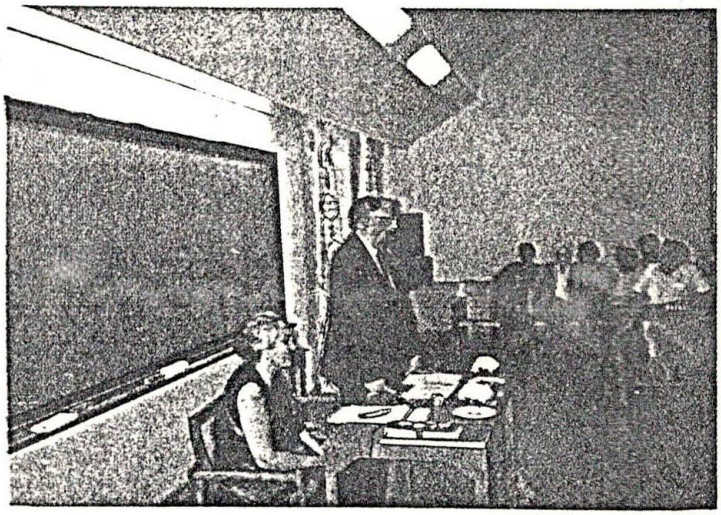
In the T.M.T.C. there were facilities available for croquet, tennis, badminton and table tennis and these were well utilised by the participants. While not available initially, arrangements were later made to provide T.V. and video facilities during week-ends.

Shri J.R.D. Tata signing the Golden Book
at the inaugural ceremony.



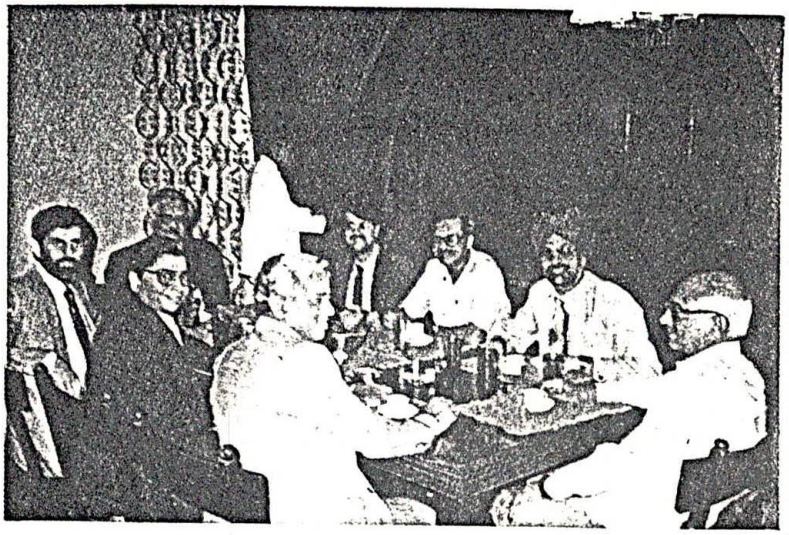
Participants of the first NIAS course with the Director.

Prof. R.L.Kapur, Dr. Raja Ramanna, Shri J.R.D. Tata, and Shri Jamshed Bhabha at the inaugural ceremony.

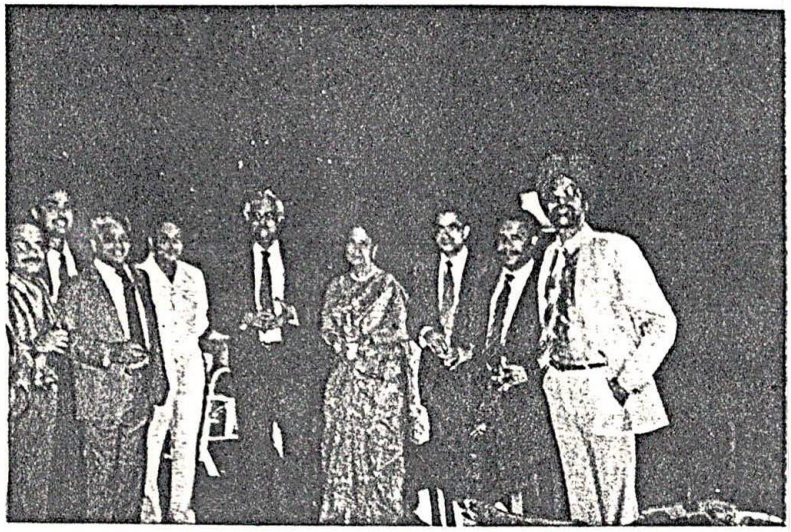


The Director, Dr. Raja Ramanna and Prof. Romila Thapar with the participants.

The participants in an attentive mood.



Participants enjoying dinner time conversation with Prof. Narasimhan.



The participants enjoying the 'End of the Course' celeberation with Dr. Raja Ramanna.

Mrs. Krishna Singh presenting the memento of participants' appreciation to Dr. Raja Ramanna.

F. Evaluation of the Course

Since this was the first course of its kind, special care was taken to make an evaluation through a variety of means. Every week after one lecturer completed his assignment, the participants evaluated his course using a specially prepared questionnaire. Also, there were three meetings during the progress of the course when the participants aired their criticisms and gave suggestions.

On the basis of the evaluation, the following imrpovements will be made in the next course.

1. a. Mutual introductions by exchange of bio-data
   b. "Creative problem solving through group processes" - workshop on the 1st day of the course
   c. Talks by the participants about their own work
   d. Book reviews by the participants
   e. Panel discussions with the panel involving representatives from the participants
2. Additional lectures and discussions on some new subjects, e.g. Advances in Biology and Ecology as well as workshops on Art Appreciation
3. Collective project work.

THE LECTURE THEMES

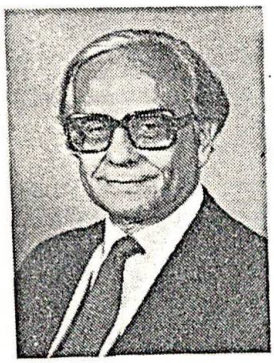
	NAMES	LECTURE THEMES
1.	Prof. Andre Beteille	Sociology
2.	Prof. R.L. Kapur	Mental Health and Human Management
3.	Prof. S.S. Barlingay	Philosophy
4.	Prof. Romila Thapar	The Interpretation of History
5.	Dr. F.A. Mehta	Economics and the Developing World
6.	Mr. Hiten Bhaya	Development Administration
7.	Mr. T.R. Satish Chandran	Development Administration
8.	Prof. K. Subrahmanyam	Politics and Defence
9.	Prof. A. Neelameghan	Informatics
10.	Prof. Renuka Ravindran	Elements of Mathematics
11.	Prof. V.G. Tikekar	Computers and Computing
12.	Prof. N. Mukunda	Philosophy of Science
		SPECIAL LECTURES
13.	Dr. S. Gopal	The National Movement
14.	Prof. R. Narasimhan	Natural Language Development
15.	Prof. John Barnabas	Evolutionary Molecular Biology
16.	Dr. Francis A Menezes	Dreams
17.	Prof. B.V. Sreekantan	Physical Creation

The Visiting Faculty

1. **Prof. Andre Beteille,** Ph.D., Professor of Sociology, University of Delhi. Formerly Jawaharlal Nehru Fellow 1968-70; Commonwealth Visiting Professor, University of Cambridge 1978-79; Visiting Fellow, Wolfson College, Oxford 1978-79; Visiting Professor, Tinbergen Chair, Erasmus University, Roterdam 1984; Visiting Professor, London School of Economics 1986. Research Interests: Social Inequality, Social Justice, Sociological Theory. Publications: Essays in Comparative Sociology; Caste, Class and Power; Inequality and Social Change - Studies in Agrarian Social Structure; Castes: Old and New and several academic papers.

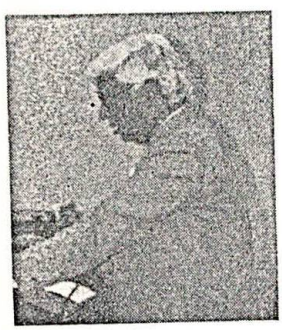
2. **Dr. Surendra Shivdas Barlingay,** Ph.D., Emeritus Professor, Department of Philosophy, Poona University. Formerly Professor, Indian Philosophy and Culture, Zagreb University, Yugoslavia 1962-64; Prof. & Head, Department of Philosophy, Poona University 1970-80. Visiting Professor, University of Western Australia 1968-70; National Lecturer, University Grants Commission 1974; Fellow, Indian Council of Historical Research; Fellow, Indian Council of Philosophical Research; Research Interests: Indian Philosophy and Culture. Publications: Poverty, Power and Progress; Beliefs, Reasons and Reflections; Kala aur Saundarya and many other books and academic papers.

3. **Dr. John Barnabas,** Ph.D., Head, Division of Biochemical Sciences, National Chemical Laboratory, Pune. Formerly Professor, Post-graduate School for Biological Studies, Ahmednagar; Fulbright Fellow, Yale University, U.S.A. 1958-59; Netherlands Government Scholar, University of Groningen, Netherlands 1960-61; Shantiswarup Bhatnagar Award 1974; Jawaharlal Nehru Fellowship 1983-85; Fellow, Indian Academy of Sciences; Fellow, Indian National Science Academy. Research interest Molecular Genetics and Evolution; Publications: many academic papers.



4. **Shri Hiten Bhaya,** Member, Planning Commission, Government of India since 1985. Formerly Chairman, Hindustan Steel 1972-77; Director, Indian Institute of Management, Calcutta 1977-81; Adviser, Government of Ghana and Guyana; Director of several public and private sector companies.

5. **Shri T.R. Satish Chandran,** I.A.S. (Retd). Director, Institute for Social and Economic Change, Bangalore from 1988. Formerly Adviser (Energy), Planning Commission and Secretary, Ministry of Energy, Government of India 1976-83; Chief Secretary to Government of Karnataka 1983-87; Fellow, Indian Institute of Engineers; Member, Indian Institute of Public Administration.



6. **Dr. S. Gopal,** D. Litt. (Oxon), D. Phil (Oxon); Fellow, ST. Antony College, Oxford; Emeritus Professor, Jawaharlal Nehru University; Corresponding Fellow, Royal Historical Society; Sahitya Academi Award 1976. Interests: History , Culture. Publications: Several books and papers including a three-volume book on Jawaharlal Nehru.

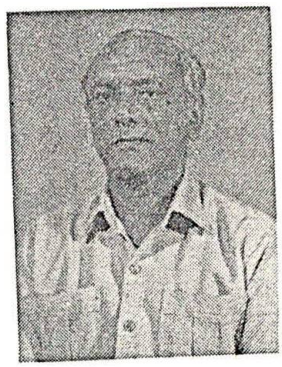
7. **Dr.Fredie A. Mehta,** Ph.D., Director, Tata Sons Ltd; & Chairman, Forbes Group of Companies; Chairman, Investment Corporation of India; Director-in-charge, Tata Economic Consultancy Services; Chairman, Siemens India Ltd; Member, Executive Committee and of the Board of Directors, IDBI: Member, Advisory Board of the Unit Trust of India & Member, Securities & Exchange Board of India. Formerly Director of several multinational companies. Interests: Economic and National Planning.

8. **Prof. N. Mukunda,** Ph.D., Chairman, Division of Mathematical and Physical Sciences, Indian Institute of Science, Bangalore, from 1985. Formerly Research Associate, Princeton University, U.S.A. 1964-66; Research Associate, Syracuse University, U.S.A. 1966-67; Fellow, and then Reader, Tata Institute of Fundamental Research, Bombay 1967-72; Professor, Centre for Theoretical Studies, Indian Institute of Science 1972 onwards; Chairman, Centre for Theoretical Studies, I.I. Sc., 1973-1979; Visiting Professor, Institute of Theoretical Physics, Gotenberg, Sweden 1979 and 1982; Visiting Professor, University of Texas, Austin, U.S.A. 1973 and 1982; Visiting Professor, Duke University of Naples, Italy 1980 and 1983. Fellow, Indian Academy of Sciences; Fellow, Indian National Science Academy; Bhatnagar Award 1980; Jawaharlal Nehru Fellow 1987-89. Research Interests: Classical and Quantum Optics. Publications: 115 Research papers and 2 books.

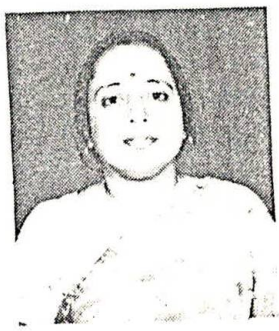
9. **Dr. Francis A Menezes,** Ph.D., Director, Tata Management Training Centre, Pune, since 1970. Formerly Executive Director, Indian Society for Applied Behavioural Science 1971-73; Council Member, Systems Research Institute 1975-78; Director, Indian Airlines. Research Interests: Dreams and Creativity, Motivation, Management Research. Publications: Several books and Academic papers.

10. **Dr. R. Narasimhan,** Ph.D., Senior Professor, Tata Institute of Fundamental Research, Bombay, since 1973. Formerly Chairman, CMC Limited 1976-79; Jawaharlal Nehru Fellow 1971-73; Padma Shree 1976; Dr. H.J. Bhabha Award 1976; Om Prakash Bhasin Award 1988. Research Interests: Computational modelling of behaviour, natural language behaviour modelling, Scientific methodology.

11. **Prof. A. Neelameghan**, Visiting Professor, Indian Statistical Institute/Documentation Research and Training Centre, Bangalore, from 1987. Formerly Professor and Head, Indian Statistical Institute/Documentation Research and Training Centre 1962-78; Chief Technical Adviser, UNESCO 1978-82; Visiting Professor, various U.S. Universities; Consultant (information system) for SIET, HAL, ONGC, CLRI, CMTI, HMT, etc. Publications: over 200 research papers and technical reports, 5 books.

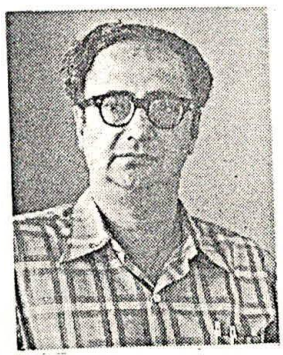


12. **Prof. Renuka Ravindran**, Ph.D., Professor and Chairman of Applied Mathematics, Indian Institute of Science, Bangalore from 1988 Formerly Humboldt Fellow, Gottinghen 1976-77; Visiting Associate Professor, Cornell University, U.S.A. 1983-84. Research Interests: Flows in compressible fluids. Publications: Several academic papers.

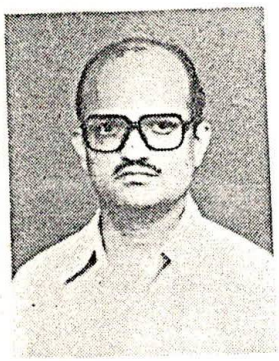


13. **Prof. K. Subrahmanyam,** I.A.S. (Retd). Nehru Fellow from 1988. Formerly Director, Institute for Defence Studies and Analyses, New Delhi 1968-75; Member, UN Inter - Governmental Experts Study Group on the Relationship between Disarmament and Development 1980-81; Jawaharlal Nehru Visiting Professor, University of Cambridge, U.K. 1987-88.

14. **Dr. B.V. Sreekantan,** Ph.D., Indian National Science Academy Srinivasa Ramanujan Professor, Tata Institute of Fundamental Research, Bombay, since 1987. Formerly Visiting Scientist, Laboratory for Nuclear Science, Massachusetts Institute of Technology, Boston, U.S.A. 1954; Visiting Scientist, Centre for Space Research, M.I.T. Boston,U.S.A. 1965-67; Director, Tata Institute of Fundamental Research 1975-87. Fellow, Indian Academy of Sciences; Fellow, Indian National Science Academy; National Lecturer U.G.C. 1981-82. Member, Atomic Energy Commission 1986 - 87; Padma Bhushan 1988. Research Interests: Theoretical Physics Publications: Several books and academic papers.



15. **Prof. Romila Thapar,** Professor of Ancient Indian History, Centre for Historical Studies, Jawaharlal Nehru University, New Delhi. Formerly Distinguished Visiting Professor, Cornell University, U.S.A; Visiting Professor, University of California, Berkely, U.S.A; Directeur des Etudes, Maison des Sciences de L'Homme, Paris. Fellow of the Royal Asiatic Society; President, Ancient South Asia Section, British Assn. of Orientalists; National Fellow, Indian Council of Social Science Research. Publications: A History of India; The Past and Prejudice; From Lineage to State and many other books and academic papers.



16. **Prof. V.G. Tikekar,** Ph.D., Professor, Department of Applied Mathematics, Indian Institute of Science, Bangalore, from 1988. Formerly Visiting Fellow at the Computing Laboratory University of Newcastle upon Tyne (U.K.) 1975-76; Fulbright Fellow, University of Michigan, Ann Arbor (USA) 1987-88. Life Member, Indian Mathematical Society. Research Interests: Linear Programming, Theoretical Computer Science, Numerical Mathematics, Statistics, Mathematics Education. Publications: Several academic papers and books for NCERT and Karnataka Directorate of Text books.

A SHORT NOTE ON THE NATIONAL INSTITUTE OF ADVANCED STUDIES

INDIAN INSTITUTE OF SCIENCE CAMPUS

BANGALORE - 560012

The National Institute of Advanced Studies (NIAS) has been established since August 1988. It is regulated under the Karnataka Societies' Registration Act and is financially supported by the Sir Dorabji Tata Trust. The Institute has been licensed 5 acres of land within the campus of the Indian Institute of Science, where the buildings are under construction. Dr. Raja Ramanna, the distinguished Nuclear Scientist, was the Director till he became the Minister of State for Defence, Government of India, and since then Prof. C.N.R. Rao, Director, Indian Institute of Science, is also the Honorary Director for the National Institute of Advanced Studies.

This Institute is a Centre for higher learning with twin objectives. The first is to provide an atmosphere in which, through exchange of ideas, exposure to new knowledge in different areas, introduction to nation's socio-cultural heritage and understanding of the strengths as well as weaknesses of human personality, one could move towards that widening of mental horizons, which makes for more accurate and effective decision making. The other is to support and lead multi-disciplinary research on the borderlands of Material Sciences, Social Sciences and Humanities; helping the researchers from different disciplines work together, understand each other's language and attack complex problems in a comprehensive fashion. More specifically, the aims are as follows:

1. To conduct 5 weeks residential courses for persons in senior positions from Government, Industries and Universities. In these courses, a galaxy of renowned scholars and experts from all over the country will acquaint the participants not only with the new developments in various fields of knowledge, but also put them in touch with nation's socio-cultural roots and its experiments towards becoming a modern state without parting with time-tested traditional values;

2. To conduct Workshops on developmental policies of national importance. Experts will be called in to spend 8-10 days examining a given policy or a new idea, both in its concept as well as in the details of its application, looking into its successes and failures, the reasons for both and suggesting new directions: thus providing for our legislators and administrators the much needed information and expert opinion;

3. To conduct socially relevant multi-disciplinary research on the borderlands of Science, Social Science and Humanities;

4. To invite visiting faculty on long-term basis from six months to a year. During this period, the visitor could put finishing touches to his on-going research and also interact with the permanent faculty in planning and executing new or on-going research programmes;

5. To invite key administrators from the Government and Industries to come as Visiting Fellows for six months to a year. Here they would pursue any new developmental ideas they have, fill in the gaps in knowledge pertinent to their tasks, and test out their ideas with the permanent and Visiting Faculty. Some of these ideas could become foci for the national workshops mentioned in (2) above;

6. To publish books, monographs, periodicals and papers; and

7. To co-operate with other Institutions and Organisations and contribute knowledge at inter-disciplinary level.

R.L. KAPUR

THE DECENTRALIZATION
AN EXPERIMENT OF BANWASI SEVA ASHRAM IN DECENTRALIZED PRIMARY HEALTH CARE

- Dr. Rajni Bem

We are living in an era, in which the achievements of man in the field of Science and technology, have revealed a lot of wonders, given him power over the nature, offered him a number of luxuries and brought different human habitations in closer contact. All this did contribute to happiness of the man but, at the same time, it has also created problems.

One of the main features of the era is the production of consumer goods on a mass scale, on the basis of the energy (other than human) of the diesel - Petrol, Electricity, Atom, etc. The natural outcome of the policy of mass production with profit motive, has been centralization of the authority regarding accesses to nature's resources and the licencing, the royalties and the taxations on the raw material and the produce.

These industrial production units save their expenditure on anti-pollution measures, find out ways and means to keep labourers in a temporary status to avoid the responsibility of their welfare, try to evade taxes, take every opportunity to raising the prices. These units are not oriented to meeting the needs of the community. Rather, they contribute to the increase in the needs and the cost of living. This industrilization has slowly extended its field and now-even-farming and forestry is also planned and operated on the principles of mass production and treding for the benefit of profit in rupees and in foreign currency. This commercialization of the life has contributed to disruption of local and regional self-sufficiency in basic needs of life. It has also caused unemployment among the rural artizens and initiated their migration to the cities. The townships and cities need these people for the building construction works and other miscelleneous jobs. But, they do not wish to provide space and facilities to them. Thus two worlds, the urban and the slum are seen to exist side by side in the cities.

The present day educational system does not impart skill and

confidence to student to stand on his own. It also does not give the student any abilities to critically study, analyse or understand the present situation. It neither gives him information on his constitutional rights, the laws relevant to his living nor the information on the organisations and services promoted by the Government or available otherwise, for employment opportunities or availing the welfare facility. It contributes nothings to the building of sound personality and a sense of social responsibility. What it contributes to is, the Development of aspirations for a lighter work, desk work, managerial or consulative work - different kinds of jobs with better remuneration and better previleges. There is nothing wrong in aspiring for better living. Only thing is, it should not be at the cost of some others. What is understood is that there is a limit to the possibility of jobs of that nature and the increase in the remuneration. A society which promotes such aspirations can not always provide appropriate opportunities on the same scale. It is not feasible also. It only leads to unhealthy competition, correuption, inflation and breaking down of the economy and social order.

The National Governments are owning the total responsibility of the welfare of their people. There is nothing wrong in owning such a responsibility by the well meaning elected representative body. What is wrong about it is, that it does not envisage any role for the people to share in the responsibility. Actually, the nature of the care and protection has to be such that it simulteneously promotes among people, an understanding of the situation, develops appropriate skills and abilities to face the situation and manage their basic needs of life on a regional self-sufficiency basis. This has not happened. It was not planned. The result is, that there is an increase in the dependence of the people on the Government and also there is an increase in the people's demands. The situation has reached a stage where it seems beyond the means and capacity of the Governments to fulfil the responsibility it owns.

The health has an intimate relationship with the life's situation, the individual's living habits and the facility for treatment of illness in times of need. The health becomes feasible, if the life situation is favourable to health(needs of the body and mind) and the

living habits are oriented to the building-up of health and its protection. The situation to-day is adverse every where, more so in rural areas and worse in tribal areas. As one moves away from city one also notices the lack of proper medical facility.

To-day, the whole thing has become such a mix-up that the common fealing is, that it is difficult to manage living with honesty and sincerety, a sense of social responsibility, or a spirit of service and sacrifice. A break-through out the situation is an urgent need of the time. The important aspect of it is, that it has to be constructive.

Gandhijee talked of a Constructive Programme in the context of an alternative social order to the present one of industrialisation and centralization. His Constructive Programme offered common people, a chance to participate in the action for a change-the constructive revoluation. The programmes offered were such that an average and a genious both could participate, could join hands and experience and visualize the relief it brought to the troubled people and the community. This contributed to the development of a hope and confidence in better future. His philosophy and programmes, inspired some intellectuals to devote all their life to practice, develop and extend the idea and the Programmes. Banwasi Seva Ashram is one such experiment initiated in the year 1954 by the followers of Gandhi. It's programmes are oriented to the development of Gram Swarajya. The decentralized health care is an integral part of the whole programme.

The health project was initiated in 1968. It operates in the tribal area of the Sonbhadra (old Mirzapur) district of Uttar Pradesh and covers the villages in 4 community development blocks, In 1968 the area was such backward, and the people faced a continuing challange of poverty, deprevistion and exploitation. The community had traditions of barter, but was finding it difficult to produce enough for sustainance Many families were already in debts of money lenders and in many instances the land and the man had become bonded for generations, Though there were traditional indeginous practitioners and almost every family used house-hold remedies, these did not seem to help them cure the illnesses. It did provids them relief. Neither the health and medical

care nor the other welfare activity of the Government was functional. Some was the status of the community development blocks. Only the Police and Revenue functioneries were active and alcohal distillation and its illegal and legal sale points helped people to earn as well as get drunk and indebted. In a way, the area was most appropriate for an integrated development pfogrammes. The whole community needed a helping hand on various fronts, to come out of the situation.

The ~~other~~ one compulsion of the situation for the social worker was to orient ~~himself~~ herself to the problems fased by the people and find solutions those which could be implemented banking upon the skill potential of the people before planning on extension activity. This meant having a continuing process of study. Experimentation, evaluation, project formulation, extension of successful experiments and reformulation of action plans from time to time as per the need. It also meant diverting energies for arranging relief in situations of drought every 3rd-year and famine once in 10-years, Industrial invasion, problem of land rights and reserve forest etc.

All this had to be managed with the help of the local people, as possibility of recruiting staff was out of question. Job seekers had no attraction for the place and the remunaration also could not be attractive. The few motivated persons from outside the social workers group was the only resource for implementation of experiment. In a way, this proved to be a boon in disguise because on the one-hand technology and methodology had to be oriented to local skill potential and minimum dependance of markets, organising training in new skills, upgrading the existing ones and on the other hand it also meant participation of the people in their own development the socio-economic and of the personality.

Though, people were in need of health and Medical care, it did not prompt them to immediately believe in the new medical service offered. They took their own time to test the relief offered and believe that the service offered was of some standered. They also had an apprehension, that the motive behind this noble work is either to force family planning or it was just to complete the formality for earning one's own better livelihood. Similarly they had a feeling that they belonged to a different world and the health advice given had no relevance to their situations. Soon, it became clear, that their feeling also was a part of reality. Actually, after studying their living conditions and the degree of poverty

it became clear that under-nutrition and almost absence of fat in diet and not the protein and vitamin deficiency, were the main nutrition problems. It influenced the growth and delayed the puberty and caused early appearance of cataract and aging. It contributed to chronicity of even ordinary illness and infections. Under such conditions, it was a wonder to see clear cases of chronic pulemonary tuberculosis with history of hasmoptysis live an active life to old age. The underfed also could do hard work to earn livelihood. Endemic Malaria manifested more as anaemia and only at times as high fever. When the rapport was built, the people narrated two incidents relating the health care. One was the campaign by a fair, well-built Government doctor who moved in bullock-cart in the area and treated cases of Yaws with injections which also cured as per their version 'Sujak' and 'Garami' (venereal infections) The other was the anti-Malaria drive, the D.D.T spray, They had all admiration for the doctor and credited D.D.T spray with Malaria control. They accepted conjunctivities and night blindness as an yearly happening of a transitory nature. It was true. Because Kerato-malacia was a rarity, Their knowledge about the nursing care and quarenteening of pox cases appeared sound. They did not defecate in the fields from where they picked up leafy vegetables. Though they had not read medical books, they could narrate well the clinical features and the course of the common seasonal ailments and describe the complications that would develop which showed their capacity of self-learning. At the same time, because being out-off from outside world they were ignorant of the advances in medical treatment and refused to take cases to hospitals in neibouring townships.

As the roads and communication facility was non-existant, the people had to find a companion to walk through the forest to reach the clinic and in case the patient was serious they had to wait till a few others could carry him on cot or chair. Going to clinic also meant-making arrangements for the care of the children, the animals and the house. All these circumstances and the poverty conditioned their chances of receiving treatment in time and till they recovered fully. The absence of hospital facility and the constraints in the life of the patients was an excuse for new learning, more dependence on clinical observations and manggement of home nursing. Similarly, out-breaks of conjuctivites, scabies, Gastro-enrritis etc. gave a chance to study the environment and living habits in more detail. The whole situation was a difficult one from the point of

view of scheduled implementation of any pre-planned standard health care programme. At the same time, the situation was most favourable for the trial of a decentralized primary health care.

Banwasi Seva Ashram for achieving its objective of healthy community adopted a strategy of decentralization of responsibilities. The main reasons for doing so were:

(1) To achieve the objective of healthy community, health care services have to be within the reach of the community and within its means.

(2) Health care for each village on the basis of the infrastructure of paid workers is not feasible. It is beyond the means of a voluntary agency to sustain such a structure. It is also beyond the means of the Government.

(3) There is also no likelihood of qualified doctors moving into villages and even if they did, they were bound to exploit people rather than serve them.

(4) If the programme is implemented by involving and arranging proper training of local personnel, there is a fair chance of the continuity in the service created.

(5) The involvement of the local persons will also help proper orientation of the plans and programmes as compared to the ones that are based on the attitude, information and skills of perons belonging to an alian culture and social situation.

After a preliminary rapport building effort, the first health and first-aid training course was organised in February, 1969, for the literacy teachers and others.It was felt that even though they were to treat the ordinary cases it is essential to orient them to clinical history taking and examination. Hence, weekly clases were organized for those persons who opted for voluntary village health friend service. The experience of the experiment in terms of its feasibility, quality and utility was proved within first three years. The only limitation was that it could not be extended to the desired number of villages because of lack of communications. The potential workers could not attend the follow-up classes. It was felt that there will have to be a few full time workers, who would keep a continuity in the contact established with potential village health friends

Though a decision was taken to have an intermediary cadre, it took 4-5 years to motivate the people to join a residential course of 6 months duration. To get over this difficulty, two decisions were taken. The one decision was to organize a programme of health meetings for men and women evrry winter to communicate to them prevention of certain selected ailments and also few tested household remedies. Special health courses were also organized for 3-5 days at the development centres for the village leaders and potential health friends once a year. The other decision was to involve the staff, the persons in charge of village sub-centres of Ashram, looking after the implementation of integrated development programme.

These persons had already attended the health education courses and know a bit about the primary medical care. These people were specifically instructed in treatment of cough and cold, malaria, diarohen, dysentry and vitamin deficiencies. This helped them as well as the villagers. Later, after a period of 3-4 years it became possible to inspire assistant worker, one each from 6 centres to take up the training of gramin doctor (a full time health worker). Here again, the experience has been encouraging. The only thing which was a little disturbing was the need to interrupt the course when farming opprations and household responsibilities demanded their presence at home. Within a period of two years, these trained persons were sent to plains in the north of the district to provide medical relief to the people of the flood affected villages. The services of these village functioneries were much appreciated by the people in comparison to the practitioners of those villages.

The director of the project had to manage ~~all alone~~ the clinic the extension work, ~~and~~ the training of clinic assistants and associates for field work. ~~Though, this~~ added to the strain of difficult living condition and the work load, it also was educative. Starting from simple jobs the skills were gradually upgraded as per the potential and the reliability of the individual. The persons associated with the clinical work were told about the basics of anatomy physiology, pathology, pharmocology, the writing of case history, the clinical examination and the assessment of the seriousness of the illness. The other point that was impressed upon was not to try to treat serious cases and the conditions that they have no knowledge about, but to refer cases in time to proper institutes.

This approach has paid. The clinic is now managed by a locally trained person to the satisfaction of the director of the project(who now plays the role of a consultant) and the people. The people from long distances are attending the clinic.

Thus, the rural health service structure which has evolved over the past years has four links:-

* The first link is the voluntary village health friend
* The second link is the full-time paid worker, the Gramin-doctor giving primary health and medical care to a group of villages.
* The third link is the Ashram clinic , the staff of which is also responsible for the training of the functionaries, study and evaluation and co-ordination of the work of Gramin Doctor.
* The fourth link is the referred Hospitals in the townships and at the district head-quarters.

As the people of the area have shared in the responsibility of implementing the primary health care programmes, they have also shared in the expenditure incurred by way of contribution towards the cost of the medicine. As a rule, every patient is to pay the bill for the treatment received. The bill does not include the cost of establishment and the salaries of the staff. The treatment charges are kept to minimum by avoiding unnecessary injections and other sofisticated medicines. As a rule, every patient is to pay the full amount, if not possible at one time, he can pay the remaining later. No needy patient is refused for want of money. Rather, if felt necessary, food and other help is arranged. When ever possible, an effort is made to rehabilitate the deserving patient. While being generous, there is always a need to be vigilant about recoveries from the clever patients, who proudly pay heavy charges to private lay practioners.

The staff of the project also contributes to funding in an indirect way. The whole staff works on the basis of an honorarium and lives a simple life in hormony with the surroundings. Same is true about the get up of the clinic.

The study of the indeginous medicines and the use of household remedies in primary medical care has helped in many ways. In some cases it has replaced the marketed products, in others instances, specially the

household remedies

digestive, respiratory, heat exposure and skin cases, these have proved to be a boon. The use of these simple remedies have not only contributed to the recovery of the patient to normal but have also contributed to reduction in the charges for the treatment.

The formal structure of primary health care gets the support of the socio-economic development activity of the Ashram. These activities help to motivate the people to receive and use the health information. They also imporve the living conditions in favour of health, thus increasing the feasibility of healthy living.

The project has been in operation for more than 20 years. The idea of decentralized primary health care have proved its worth. But, at the same time, it has not been possible to extend it to the whole area, mainly because of the difficulties in identifying and training the personnel required. The programmes could reach about one third of the villages of the area of operation of Banwasi Seva Ashram.

A regular evaluation of the various aspects of the programmes was undertaken from time to time. In the first evaluation done at the end of second year(1970), it was observed that people felt happy about the health information extended and said that it makes life better. The second evaluation made in 1974, looked into the acceptance of the small family norm and family planning practice. It was seen that an educational approach to family planning extension was effective in introducing it, not only as a means of limiting the size of the family but as a way of life. The third evaluation study done in 1979, looked into the achievements of a comprehensive development programme, including health and medical care, in a sample drawn from the beneficiaries of the economic programme. The findings of this survey are; 1) more people had adequate food, clothing and boarding, 2) functional literacy programme has succeeded to the extent of increasing literacy from 14% to 27%, 3) the percentage of families that owed to money lenders decreased from 42-60% during 1974-75 to 23.47% during 1970-79. The latest evaluation has been conducted in the year 1987. The sample for this study has been based on random sampling of the villages and that of families in sample villages of the area of operation of Banwasi Seva Ashram. This study evaluated the overall impact of problem oriented action plans like mobilization of bank finance, land

and irrigation development, tree plantations, obtaining land ownership rights etc. The other component of this study was the reassessment of the random sample of families from the sample of 1979 study, on the points elicited earlier. The information obtained from the data of both these samples is presented here:

TABLE NO. 1 :

Benefits from health education activity in the sample families of 1979 survey as expressed in the year 1979 and 1987:

Benefits	No. of families in 1979.	No. of families in 1987
1) personal cleanliness	111	113
2) compost making	48	107
3) Use of trench latrine	6	9
4) Safe drinking water	92	108
5) Right cooking methods	50	97
6) Use of indigenous nutrition supplements like Til & Muhua.	90	127
7) Improved child care	70	107
8) prevention of disease	91	107
9) Use of household remedies	74	110

Health benefit shows a satisfactory improvement on all points except that related to the use of laterines. The availability of sufficient and safe drinking water and nutrition supplements still seems to be a problem for a significent number. This must have influenced the possibility of getting benefitted from the information on the child-care and prevention of illness.

In the 1987 survey - the respondents were asked to narrate their nutrition information, in relation to the health of the mother and child , the seasonal special dietetic needs, and proper cooking and the source of information. They were asked to give their opinion about the seasonal prevalence of illness and their cansative factors. The questionaire also included questions on attitude and practice of family planning. The objective was, (1) to assess the impact of nutrition

education, 2) to know about the common prevelant illnesses suffered and have a comparison with the findings of the clinic, 3) to know how such thought they have given to knowing the cause of illness and its prevention and, 4) to assess the attitudinal change in favour of family planning.

It was observed that out of the total-1706 respondents had ~~received information on diet~~ 1066 had knowledge about nutrition of the child, 990 new about the nutrition and care of the mother, 520 possessed knowledge related to proper cooking and 435 knew about the special seasonal food requirements. The major source of information has been Ashram in general followed by elders in the family and friends and then the published literature. What is seen to corroborate with the clinical experience is the lack of knowledges in the family about proper feeding of the child. Only 20 respondents said that they received information from the elders. ~~Similar~~ corroboration is seen in the respondents opinion and the clinic records about the seasonal prevalence of illness. The understanding of the people about seasonal prevalence of illnesses and their cansative factors as reflected in ~~the~~ the samples is as given below:

TABLE NO. 2

The opinion of the respondents about common illnesses, their seasonal prevalance and their information on the cansative factors:

Illness	Favoured seasons.	CANSATIVE FACTORS	
		Relevant answers % of total opinion.	The most important factors emerged % of relevant opinion.
1) Malaria	Rainy-Winter	81	Mosquito - 63
2) Gastro entreaties Diarrohia, Dysentry.	Summer	95	Contamina- ted food and water. 39
3) Fever	Summer-Winter	54	Mosquito- 53 Exposure to heat. 44
4) Cold & Cough	Winter	79	Exposure to cold. 62
5) Eye Diseases	Summer	80	Exposure to heat & inf. 100 100

1	2	3	4	
6) Pox	Summer	29	Change in the weather.	75
7) Skin diseases	winter	79	unhygienic conditions.	69
			Infections.	31
8) Tuberculosis	Whole year	77	Infections diseases.	70

The people have mentioned weather condition as one of the cansative factors in a few instances. It can be interpreted as the untoward influence of weather conditions or increased suseptability to the infections. At the same time, it is also true that if these illnesses are to be prevented one needs to know when and under what conditions weather has an adverse influence on health. At Ashram clinic, a constant effort is made to analyse these factors, base preventive know-how on the findings and incorporate it in the instructions to patients given in the clinic, in the literature produced and in the regular health talks given.

The data on the family planning attitudes and practice revealed that out of 1206 respondents, 1170 have given their opinion. Those who said that family planning is very essential were 366, those who favoured it were 416 and those not in favour were 388. About two-third respondents had a favourable attitude to family planning. Absolute silence on the topic observed by one-third of the total sample (536 respondents) is also significant. Out of the 782 who favoured family planning 395 had adopted it. The method of choice was Tubectomy in 45% cases, vassctomy in 25% cases, indigenous medicine in 15% cases, self-control in 12% and other contraceptives in 7% cases. A significant number 28.8% of the acceptors had adopted family planning for spacing the child birth.

The information on medical care was elicited in both the surveys, i.e. 1979 and 1987. The cange that has come over in the attitudes regarding treatment can be seen in the sample of 1979 which was also interrogated in 1987.

TABLE NO. 3

Medical services availed by the sample families of 1979 survey in the year 1979 and 1987:

Services availed	in 1979		in 1987	
	often	some times	often	some-times.
Charms & Amulets.	27	51	6	15
Indigenous medicine	13	67	15	65
Government Hospitals	00	02	13	23
Ashram's health centres	44	07	102	14
Ashram's clinic	62	34	88	44
Private practioner	0	0	0	12

It can be seen that now there is reduced faith in charms and amulets, that the Government services have become available and that the private practioners ~~(III-trained-persons)~~ have started operating.

In the survey of 1987 which had a wider sample(served and not covered by Ashram's primary health care), information was sought on the source of medical treatment for various common illnesses and its beneficiary effect. The following picture has emerged:-

TABLE NO. 4

The source of medical treatment and its beneficiary effect as expressed by the sample families of 1987 survey:-

Source of Medical treatment	No. of persons who availed.	No. of persons benefitted.
Home remedies	1516	670 (44%)
Ashram's medical centres	1067	1040 (97%)
Government Hospitals.	1674	1593 (95%)
other Doctors.	47	19 (45%)

It is seen that in terms of obtaining relief the diagnosis based treatment has been more effective than that based purely on symptomatic relief.

On the whole, it can be said that Ashram's efforts to promote health have yielded results. It has contributed to increased awareness and practice with regard to healthy living, family planning and medical

care of the diseased.

The participation of the local community as a functionary of primary health care has also been successful. Among the staff of 15 only three persons have had their training in regular teaching institution, the Director, a Homeopath and a mid-wife. The rest are trained at Ashram. There are about 250 village health friends, who have taken initiative in helping the villagers. An evaluation of their turnover was done on two occasions, once in the year 1974 and recently in the year 1986. In 1986 survey a total of 46 health friends were interviewed. Out of these 24 were working for more than 5 years. The findings have been encouraging with respect to their contribution and the potential. But, at the same time it is observed that in the early years, when the life was less complex and the contact was more regular, their turnover and social contribution was better. Out of 46 health friends interviewed, 38 were willing to give 5 to 10 days a year, and 25 were willing to give one-day every 2 months for gaining more knowledge about health and medical care. Twenty five were willing to use literature as a source of information (11 health friends were just literate and 18 were upto primary). All-together, with some variation health freinds were able to treat simple manifestations of about 15 common illnesses with home remedies. They were able to extend to community the knowledge gained about clean living habits, safety of drinking water, improved methods of cooking rice, Roti, green vegetables, milk and the use of nutrition supplements like gingilly seed, edible oil, Amla, milk, Mahua flower. Fifteen health friends out of 46 expressed their desire to gain more knowledge to improve the health standard of the community. The feed bake obtained from the study is, that there has to be a continuous effort to identify and train health friends, as a few would be loosing interest in social work for various reasons. This is actually true about the training of personnel to work full-time in the project. Three senior staff persons left the job, two of them have started private practice. About 10 persons of the level of Gramin Doctor also left the job. In early days, it was difficult to find persons willing to undergo training, now many come not with the idea of serving the community, but with the idea of easy learning for remunerative private practice. Thus, even today very few get selected for training and even in that sometimes either the trainee drops out or he needs to be discontinued. A few continue to train and get trained over a period of 3-5 years

As regards the illness pattern manifested in the records of the clinic and the health centres, Malaria is the most common illness (nearly 50% patients), then comes the upper respiratory infections and vitamein deficiencies, followed by the gastro-intestinal disturbances and then the protein calorio deficiency. These findings and the opinions of the respondents in 87 about prevalent illnesses makes it clear that the immunization programmes has very little to offer by way of prevention of morbidity and mortality.

The gramin doctors and doctors at the clinic feel, that the illness pattern is showing changes with the change in living and working conditions and change in living habits. This means, reorientation of the contents of health education. There is also the problem of treatment by the less-trained private practitioners. The cases get complicated because of their interventions in illnesses about which they know very little. The road accidents, and injury cases, and respiratory and gastro intestinal have increased in certain groups of villages which are near to the industrial projects. Thus, there is always a new food for thought.

The experience with regards to home remedies is encouraging. It has made village health friend service more meaningful, its incorporation in routine prescriptions has helped to reduce other medication and helped recovery of the patient to normal health.

On the whole, one feels happy and satisfied while working with the community and for the benefit of the community, in a way that helps them improve upon their own abilities to resolve their problems.

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People's Perception of Health Care

By Kalpana Sharma

The question of health touches everyone. It is a subject that no one can ignore. Yet the aspect from which health care is viewed differs greatly amongst different classes of people and between urban and rural dwellers.

A mirror of people's perception of health care is the media, especially the print media. It plays a dual function in that it provides an avenue for people to voice their views and complaints about the health care system and it also plays a role in determining people's perceptions towards health-related issues. It does the latter by the choice of subjects it covers, thereby determining an order of priorities which does not necessarily coincide with that of the majority of readers.

From letters to the editor and other feedback from readers, one can deduce some of the health care issues that interest at least the city dweller. These range from personal health questions, which newspapers answer through columns by medical practioners, to complaints about the public health system, over-prescription and malpractice by private practioners and the sale of adulterated and sub-standard drugs.

These issues are covered by the press. At the same time, newspapers introduce subjects which would interest only a small readership, yet to which an inordinate amount of space is devoted.

Take, for instance, the issue of euthanasia. In a country like India, where the choice whether to live or die is taken out of the hands of the vast majority of our people because of poverty, the lack of an adequate diet and almost non-existent health care, whether some people should have the right to end their own lives hardly qualifies as the burning health subject of the day. Yet, if you look through a file of newspaper clippings on health, you will be amazed at the number of major and minor items on this issue.

Another current media obsession, which is, perhaps, a little more justifiable than euthanasia, is the fitness fad. Almost every newspaper and magazine now considers it essential to carry a column on "Total Fitness", which includes tips on how to exercise and how much, what to eat and what to avoid and the state of mind one should adopt to remain fit!

On the other hand, sufficient information on over-prescription by doctors, on the poor quality of drugs, on banned and harmful drugs as well as useless ones that continue to be dispensed in India, is found wanting. There is sporadic writing on these issues but journalists engaged in such exposes have

often encountered difficulties from their own managements who are anxious not to displease some of their important advertisers who just happen to be pharmaceutical companies.

Similarly, although all newspapers undertake sporadic exercises in assessing the state of public hospitals and health facilities, especially after a scandal or deaths through neglect, not enough attention is paid to private hospitals and nursing homes. While the majority of the poor do frequent the public institutions, we overlook the fact that because people perceive the quality of health care in these institutions to be inadequate, even poor people skimp and save to go to private nursing homes and clinics, little realising that the conditions here are often worse than in the public facilities because of the almost total absence of accountability. Consequently the problems that arise in these places are rarely publicised.

While there are occasional stories about malpractice or of wrong medication being prescribed, there is inadequate information given on patients' rights, on safe drugs, especially for children, on questions patients must ask their doctors.

From my personal experience as an editor, I know that when we introduced a column called Medisense in Express Magazine, in which we attempted a kind of health education and consiousness-raising, the response was very positive from the readers.

The problem editors face is the lack of specialised writers in these issues. One cannot always ask practising medical doctors to write as this can be construed as free publicity for the particular medical practitioner. And unfortunately, there are only a handful of journalists who have made health their business and endeavoured to keep abreast of the latest developments so that they can write with insight and authority on the subject. The need for such specialisation has become increasingly evident as the possibilities that new technologies and medical discoveries open up for curing what was considered incurable or for prolonging life.

Similarly, information about occupational health hazards is now available from groups around the world who have specialised in this issue. We require people who will investigate the conditions in this country, write about them, and inform and warn people so that those who are able to can avoid these hazards. Here again a certain amount of specialisation is required. Badly researched articles written from half knowledge can either result in unnecessary panic or a cover up of a potentially dangerous situation. Only an informed journalist can sift through the mountain of information and actually draw authoritative conclusions.

A word on women's health. Newspapers seem to have decided that the only aspect of women's health worth mentioning is that which is connected to the reproductory system. Therefore contraception, pregnancy, sex-determination tests etc form the

bulk of the writing on women's health. Although one does not doubt that these do constitute the major health issues confronting women, they do not represent the complete picture. Working women, for instance, have a set of special health problems which directly relate to the nature of their work. These are rarely addressed.

Also, subjects such as the need for safe contraception, or the post-operative problems women face due to lack of after care, are also rarely investigated. One finds routine items about abortion deaths. Yet no one seems to be asking the obvious question, namely that if women die after a routine operation like an abortion, then isn't there something seriously wrong with our health care system?

An issue like sex-determination, on the other hand, has grabbed a great deal of media attention as also infertility and in-vitro fertilisation techniques and the test tube baby. These interest a relatively small, better-off minority of readers. Yet both English and regional language newspapers have devoted a considerable amount of attention to these subjects.

Some of the coverage on sex-determination tests may have contributed to popularising the misuse of this technology. For instance, in Express Magazine, when I decided to invite two writers critical of sex-determination tests to describe a new technique that was being introduced in India, although their perspective came through the article very clearly, we received calls from distant places asking us the name and address of the doctor who would perform such a test. One wonders, therefore, whether the press can play any role in shaking the beliefs that people already have on these issues.

However, there have been some instances where the press has played an exemplary role in informing the public on health issues. For instance, the coverage of the proceedings of the Lentin Commission set up to investigate the death of 14 people in J. J. Hospital in Bombay through adulterated glycerol, was such an example. The Times of India and the Indian Express carried detailed daily reports on the proceedings of the commission, thereby serving an important public function. Through these reports, people could understand the system of drug administration, the manner in which hospitals obtain their supplies, how the manufacture of adulterated or sub-standard drugs takes place and who is responsible for such gross negligence.

A possible indication that more people are now turning away from allopathy to traditional and alternative system can be gauged from the increase in the number of columns in various newspapers on homeopathy and ayurveda. This could indicate a possible loss of confidence in western medicine caused by the increasing incidence of over-prescription by allopathic doctors which have adversely affected patients.

While for most ordinary people, health care basically revolves around the state of their own health, the press should intervene at the level of policy. There is precious little discussion on health policy, on budgetary allocations, on the desirability of decentralisation, and on laws relating to health issues and how they can be made more efficacious, including laws that protect the rights of patients. These are issues that should be accorded a much higher priority than they are at present and should engage people's attention as much as the recent debate on media autonomy. Unfortunately, this is an area where the media's perception of the importance of health care is sadly deficient and could do with some urgent medical attention.

Peoples Perception of Health Care

Paper to be presented in Session III
on Thursday 20th 1990, in the Workshop
'Towards a Decentralised Health Care;
A fresh look at the National Health Policy

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PEOPLE'S PERCEPTION OF HEALTH CARE .....

Human health is a complex entity. It has several connotations and meanings. In this paper I make an attempt to view people's perception of health care. Being a physician, it is necessarily impossible for me to view this subject from the layman's angle, and what follows is my own perception of what people at large think and do as regards health. The comments are applicable to urban setting in contemporary India and perhaps apply to most large cities.

WHAT IS HEALTH ?

When asked thus, most people would answer, 'Freedom from illness'; a few would perhaps further qualify and add, 'Freedom from physical and mental illness'. One can hazard a confident guess that most people do not view health as a POSITIVE concept. Nor do most lay people think of health as a holistic entity with physical, emotional, sociocultural, ethical and spiritual dimentions. Thus it follows that mostly people perceive health as a restricted phenomenon, as something that is appreciated only when some of it is lost. Perhaps the remark attributed to an Eastern philosopher is apt in this context. When asked to define health, he stated, ' Health is the crown on a well man's head, which only an ill man can see! ' In more serious terms, this is the bane of contemporary society which seems to take little interest in participating in health planning and care.

WHEN DO PEOPLE SEEK MEDICAL HELP ?

There are many variables which determine when a given 'Person' becomes a 'Patient' and seeks medical attention. Some of the more important of these are :

Nature and intensity of illness
Sociocultural aspects
Level of anxiety
Situational factors
Awareness
Educational background
Coping ability
Stoicism etc.

In other words, given the illness of the same nature and intensity, different patients seek help at different times. But the underlying dominant theme would be one of anxiety; anxiety about becoming dysfunctional, disabled, dependent or dead. Needless to say, the inherent nature of the disease plays a major role. In a majority of cases, there appears to be a lag period from symptom formation to the decision to seek medical opinion; this lag is again conditioned by factors inherent in the human personality.

WHERE DO PEOPLE SEEK MEDICAL CARE ?

Once the patient decides to seek help, he has many options. Perhaps the most readily available source of help would be the general practitioner or at times the family physician. Familiarity, geographic proximity and convenient timing often make the G P the first line of contact. The G P is ideally situated to deliver initial health care; he often knows the patient and his family well and established rapport makes it easier. However, for a variety of reasons, the role of the GP is being eroded, an unfortunate development.

Often, a nearby nursing home or hospital serves many people as the initial care provider; the advantage for the patients being the availability of help at night when a GP may not be readily available. Previous contacts at nursing homes or community hospitals prompt people to use these frequently. It is also seen that many a patient referred by a GP for a particular purpose to a hospital often continues to return to the latter, perhaps with a belief that the care is better.

In recent times, consultants and even specialists in various branches of medicine may be called upon to serve as initial care givers. Many patients 'bypass' the GP or their family physician and consult an internist, for instance. Often this is needless and tends to strain the specialist and dilute his practice. A more formal and orderly system of referral and return would be welcome; but many people seem to believe that no matter what they suffer from, they need the 'senior' opinion. This necessarily erodes the relationship with a GP or family physician who would be otherwise taking care of most problems.

In more recent times, medical centres, both diagnostic as well as treatment centres incorporating modern and state of the art technology have started functioning in metropolitan cities. These are centres capable of offering complex procedures such as renal transplants and coronary surgery. They are essential for tertiary care of patients who need care with methods developed at considerable cost in more recent times. Needless to say, these centres are very expensive and hence can cater only to a fraction of the society which is affluent enough to afford them. It must be emphasised that while these centres are needed, they are relevant only to small segents of the large patient population. A matter of concern has been that these centres often provide so called Health Checkups in attractive packages and attract people to avail of them. While such screening evaluations are good, there must be a proper followup by the primary doctor who refers the patients for checkups. Perhaps one salutary effect of these high-tech centres is that they make people more aware of the need for periodic medical examinations. Yet one gets a strong impression that most people do not have a clear concept as to what a screening programme means and how to use it to advantage with the aid of their personal doctors.

General practitioners, consultants, nursing homes, community hospitals as well as teaching hospitals all serve the community in terms of primary care. This is not the ideal situation as a lot of the time of more senior professionals is taken up at the cost of patient's time for more complex cases. This is essentially because the people at large do not clearly understand the stratification of levels of medical care.

PEOPLE'S PERCEPTION OF PREVENTIVE MEDICINE

In theory it is accepted that the members of the community should take an active part in health matters, particularly in aspects of preventive medicine. But in reality this is rarely seen. Most people relate to health in a stance of individuality and can rarely approach problems with a general stand. Partly this is because most people think of medical care as curative one and not the other aspects. It is rather curious and pathetic that large sections

of people take an intense and persistent interest in matters such as politics, religion and territorial imperatives; yet when matters of health are involved, it is difficult to find community participation in an active and aggressive manner. Even a cursory look at the history of medicine has clearly shown that the standards of medical practice are dictated more by the demands of the public than by the plans of the profession. Until this happens in our own context, dertain anomalies and major deficiencies in the existing system will not be corrected.

OBJECTIVE KNOWLEDGE ABOUT ILLNESS:

Optimal management of any illness demands that the patient understands the essential nature of the disease as well as the role of the therapeutic measures advised. This is all the more important in chronic diseases,such as diabetes, hypertension, asthma etc. But it is seen that most lay patients are not very keen to appreciate the need for educating themselves. Compliance on the part of the patient is largely a matter of the understanding of the nature of a given illness and the implications of poor control of the illness. We have a long way to go in this direction; mass media have made some initial inroads in this regard but the Himalayan task is still ahead. The reasons for poor patient education are multifacted and form a rich field for future studies.

WHAT DO WE CONCLUDE?

Health of an individual is a complex concept and is not restricted to the physical realm. Most people at large do not seem to think of health in preventive terms and are rather passive in this context. Lay people think of health in somatic terms and are generally not very keen to acquire objective and scientific knowledge about their diseases and the treatment modalities. This leads to poor compliance in disease management and followup. The community at large does not seem to be aggressively involved in health matters, particularly as regards preventive and promotional aspects. General improvements in health care seems to demand an active participation from the community with regard to both preventive as well as curative care.

Future trends should appreciate these facts and ensure that the lacunae are corrected to the extent possible. The experiences of developed countries are before us and the developing countries can ill afford to repeat the errors of the past.

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"TOWARDS A DECENTRALISED HEALTH CARE:
A FRESH LOOK AT THE NATIONAL HEALTH POLICY"

WORKSHOP

ORGANISED BY
THE NATIONAL INSTITUTE OF ADVANCED STUDIES
INDIAN INSTITUTE OF SCIENCE CAMPUS, BANGALORE
ON 20-23 SEPTEMBER, 1990

VENUE: RUSTUM CHOKSI HALL, IISC CAMPUS

PROGRAMME

20 September, 1990
Thursday

09.00 - 9.30 A.M. **REGISTRATION**

09.30 - 10.30 A.M. **SESSION I**

INAUGURATION

Welcome and Introductory Remarks : Prof. R.L. Kapur
Deputy Director
National Institute of Advanced Studies

Inaugural address: Dr. M.N. Srinivas
Chairman
Board of Governors
Institute for Social and Economic Change
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Address by : Mr. M.Y. Ghorpade
Minister for Rural Development and Panchayat Raj
Information and Publicity
Government of Karnataka

10.30 - 11.30 A.M. Registration (contd.)

Coffee

11.30 - 1.30 P.M. **SESSION II**

Current Status of India's Health

Coordinator: Prof. R.M. Varma

Speaker : Dr. K. Ramachandran

Discussion

1.30 - 2.30 P.M. Lunch

2.30 - 5.00 P.M. (with tea break) **SESSION III**

People's Perception of Health Care

Coordinator : Prof. Madhav Gadgil

Speakers : Dr. Om Prakash
Ms. Kalpana Sharma
Ms. Manisha Gupte

Discussion

21 September, 1990
Friday

09.00 - 11.00 A.M. **SESSION IV**

Decentralised Health Care in Karnataka

Coordinator : Mr. B.N. Betkerur

Speakers : Mr. T.R. Satish Chandran
Topic : Problems of Decentralisation

Ms. Anisha Shah
Topic : A report on Workshop: Panchayat Raj and Health Care

Dr. C.M. Francis
Topic : Role of Secondary & Tertiary Hospitals in a Decentralised set up

Discussion

11.00-11.30 A.M.	Coffee
11.30- 1.30 P.M.	**SESSION V**
	Pluralistic Approach to Health Care
	Coordinator : Dr. N.H. Antia
	Speakers : Prof. R.L. Kapur Topic: Redefining Health
	Dr. Darshan Shankar Topic: Role of Ayurveda in Decentralised Health Care
	Dr. A.V. Balasubramanyan Topic: Role of Folk Medicine in Decentralised Health Care
	Dr. N.N. Mehrotra Topic: A Strategy for Involvement of Local Health Traditions in Primary Health Care
	Discussion
1.30 - 2.30 P.M.	Lunch
2.30 - 5.00 P.M. (with tea break)	**SESSION VI**
	Some Innovative Experiments in Decentralised Health Care
	Coordinator : Dr. Prem Chandran John
	Speakers : Dr. H. Sudarshan Dr. Abhay Bang Dr. Thangappan
	Discussion
7.00 P.M.	**Public Lecture** by Dr. Harcharan Singh Adviser Health and Family Welfare Planning Commission Government of India
	Topic: **My Vision of Health Care in India**

22 September, 1990
Saturday

09.00 - 11.00 A.M.

SESSION VII

Models for Decentralised Health Care

Coordinator: Prof. Ashish Bose

Speakers : Dr. N.H. Antia
Dr. Meera Chaterjee

Discussion

11.00 - 11.30 A.M. Coffee

11.30 - 1.30 P.M.

SESSION VIII

Education for Health

Coordinator : Dr. S.K. Lal

Speakers : Dr. R.M. Varma
Dr. Ravi Narayan

Discussion

1.30 - 2.30 P.M. Lunch

2.30 - 5.00 P.M.
(including tea break)

SESSION IX

Research Issues in Decentralised Health Care

Coordinator : Prof. R.L. Kapur

Speakers : Dr. (Mrs.) Thelma Narayan
Topic : Medical Issues

Dr. Ravi Duggal
Topic : Economic Issues

Prof. A.V. Shanmugam
Topic : Managerial Issues

Discussion

7.00 P.M.

Valedictory Address by : Prof. L.C. Jain
Member
Planning Commission
Government of India

Topic : **Panchayat Raj and the Welfare Programmes**

23 September, 1990
Sunday

09.00 - 11.00 A.M. **SESSION X**

Recommendations: Dr. N.H. Antia

Rapporteurs: Ms. Anisha Shah
Dr. Meera Chatterjee

11.00 - 11.30 A.M. Coffee

Role of Secondary and Tertiary Care Hospitals in a Decentralised set up

Dr. C.M. Francis

Whatever be the political system, hospitals (secondary and tertiary) need great attention, because they

1. are the most visible part of the health care system,
2. are centres of excellence (?),
3. have large budgets,
4. make use of a large number of personnel, exp., the highly trained professionals, and
5. are prestigious.

Health services at the secondary and tertiary levels are typically organised as bureaucracies characterised by

1. division of labour based on specialisation, according to jobs and tasks,
2. hierarchical structure of authority,
3. systems of rules and procedures for employees and the work to be performed; rules, procedures and activities often become the goals,
4. selection based on qualifications and technical competence, and
5. resistance to change.

1.1. Pyramidal structure

We have accepted a pyramidal structure as the model for providing health care services. Successive levels of care (?) are provided.

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They are expected to meet effectively the needs of the people with appropriate combinations of personnel and facilities at each level.

1.1.1. Primary health care has been defined exhaustively including the one given at the Alma Ata conference. For our purpose (organisational; institutional), it is care provided by the community, health guides/workers, daia, multipurpose workers and similar health care workers and care provided by the Primary Health Centres. It is the first line of health care services.

1.1.2. Secondary and tertiary health care provides specialised (specialist) care. It is provided by community health centres, subdivisional or taluka hospitals, district hospitals, medical college hospitals and specialised centres and institutions. The number of beds may vary from the 30 bedded Community Health Centre Hospital to 1000 beds or more.

The dividing line between the secondary and tertiary levels is not clear cut. Divisions can be made on the basis of more specialised care (subspecialities) or greater attention focussed on the problem by way of investigations, management and research, utilising the advances in medical science and technology. Most of the hospitals, irrespective of size, are secondary care institutions. Among the tertiary care hospitals will be many of the medical college hospitals, advanced

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centres, and institutions dedicated for single speciality care. Many of them are urban, may be of an All-India character or serve the entire state. They will not come under the Zilla Parishad. Some of them may be autonomous.

For our present purposes, we will club secondary and tertiary care hospitals together, though some of the implications can be different, administratively and politically.

2. Decenteralisation

There is no doubt that for more effective functioning of any activity, decentralisation is necessary. The Alternative Strategy for Health for All (ICSSR/ICMR-1981) had suggested that all the integrated health services upto and inclusive of the District Health Centre should be placed under the Panchyati Raj Institutions.

> "6.19. We believe that such decentralisation is essential and that the people should be placed in effective charge of the health services at these levels".

In and by itself, the setting up of local bodies at two or more levels will not necessarily create a decentralised order. There is need to develop ~~to develop~~ democratic decentralisation with local self-reliance and self-regulation. Decentralisation should enable decision making power closer to the level of action, with the full realisation of responsibility and the necessary analysis of information. This is particularly true about health care. There is no doubt that people's health must be in people's hands. But there are many factors which may counter the situation. Legislation by itself is not enough. There is need for social awareness and action arising therefrom.

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2.1. Decentralisation and hospitals

With the people who have the authority and who are affected by the activities being on the spot or closeby, better monitoring can be expected of the work done by the staff and utilisation of the facilities. There is likely to be greater accountablility. The community can monitor the extent to which their needs have been met, tasks fulfilled and resources promised made available.

The needs of the people are likely to be met better, whether they be in the quality of care provided, use of drugs or procedures undertaken. Can we expect a more rational use of drugs in our hospitals? Can we expect a more appropriate use of science and technology to improve the health of the people, being aware of the resources and the economic and social implications? Can we get an ethical answer to the question "who shall receive what health care?" It depends on whether the people's representatives are sensitive to the issues, are knowledgeable and have the will to take decisions and implement them.

We have to evolve a system which will avoid conflicts with respect to the relative authorities of the Panchayati Raj leaders and the Directorate of health services regarding supervision of the duties of the district health officers and other staff. We need not worry very much about "serving two masters", as long as they are not opposed to each other.

2.1.1. Need for better appreciation of the roles

With Panchyati Raj and decentralisation, there is need to appreciate the changes. Knowledge should precede action. In fact, there should have been a process of building up awareness:

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i. On the part of the people's representatives, an awareness of the current concepts of health, as also of the many programmes sponsored, financed and administered by the Centre and the State. It is not that they should become proficient in health care. But they must have sufficient knowledge and the attitude to understand, when explained, why particular activities are important. They must also be enabled to understand the organisation and structure of the health services. They have to be given brief training in the essential components of the health development and the objectives of the hospital.

ii. On the part of the health professionals and the personnel of the hospital, an understanding of how to interact with the peoples' representatives in the changed situation. They must understand that doctors, nurses, and other personnel are there to help the people achieve and maintain health.

Alma Ata Declaration (1978) states:

> "45. Health personnel form part of the Community in which they live and work. A continuing dialogue between them and the rest of the community is necessary to harmonize views and activities relating to primary health care".

Such dialogue is probably even more important when dealing with the secondary and tertiary care hospitals.

A major problem is that the people's representatives and the health professionals use different "languages", leading to misunderstanding. There is need to come together in a few "understanding" sessions.

Politicians often defer to medical opinion, especially if the doctors are specialists with big images. At the same time, doctors may give in to pressures from politicians for a variety of reasons. It is necessary that the major objectives of health care be always kept in view, to improve the quality of life.

Orientation programmes for members of the Zilla Parishad and Mandal panchayats and the health professionals and personnel are needed to avoid friction. Suitable methods, including audio-visuals and literature, could be useful.

2.2. Some questions

With decentralisation, if improvement is to take place, the people's representatives will have to ask a number of questions: What are the hospitals doing at present? What should the hospitals be doing? How can they be enabled to do so?

1. Are the services rendered by the hospital coping with the needs of the people? Are the services adequate?

   An answer to this question can probably be given by simple surveys of the patients referred to the hospital. But there may be patients not referred because people know that the particular hospital does not have the facilities necessary to provide the kind of intervention required. It will be necessary to get information from the periphery.

2. Are the people utilising the services?

   In our country, the quantitative utilisation of the large majority of the hospitals is most often more than complete. There are a few exceptions. Such hospitals are sickly and likely to die soon.

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3. Is there adequate quality of care?

Many hospitals fail to pass this test. Various explanations are given. Main problems are a lack of commitment and motivation on the part of the personnel at all levels. Added to it are the lack of resources, esp., financial.

4. Are the services provided by the hospital relevant to the health problems of the people? Are they able to deal with the major health problems effectively?

A new orientation and a new way of managing hospitals are needed to make the hospitals relevant to the urgent needs of the people. The hospitals must be re-oriented to increasingly participate in comprehensive health care.

Can decentralisation help? It must. The people's representatives have the responsibility to make the services relevant and adequate with good quality care and utilised fully by the people.

2.3. Involvement of the people

Decentralisation must mean full involvement of people. It is not only a question of transferring authority. There must be responsibility. The failure of many of our schemes, like the Community Development Blocks, has been because we are not willing to shoulder responsibility. We often tend to become part of the problem rather than of the solution.

I was amazed to read in the report of the meeting held by the National Institute of Advances Studies earlier that "Zilla Parishads find it difficult to keep hospitals clean because of above order by the Government on recruitment to group C and D staff". This is precisely the bureaucratic way of thinking and finding

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excuses and scapegoats. If there was true decentralisation and democratisation, the people could have been mobilised to keep the hospitals clean. There has been too much dependency on State Governments.

2.4. Decentralisation and intersectoral collaboration

It is a well-known fact that for promotion of health, there is need for intersectoral collaboration. The National Health Policy states:

> " ..... it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, especially the more closely health related sectors"
>
> The Alma Ata conference declares: "Health for All by the year 2000 cannot be achieved by the health sector alone".

Specific linkages between health and other sectors have to be forged. With decentralisation, greater integration can be expected. The people's representatives at the district and local levels can help in providing a net work between the various sector.

3. Referral system

One of the major objectives and functions of the secondary and tertiary care hospitals is that they should serve as referral centres. The Alma Ata Declaration (1978) says: "86. ..... Primary health care activities in the community are supported by successive levels of referral facilities". Referral system ensures a more fair distribution of health care facilities. It helps to maintain a proper balance between the nature of the health problems and the corresponding provision of care required, with appropriate combination of health personnel and facilities at each level.

The National Health Policy says:

"8. For want of a well established referral system, those seeking curative care have the tendency to visit various specialists centres, thus further contributing to congestions, duplication of efforts and consequential waste of resources.

8.(2) The success of decentralised primary health care system would depend vitally on the organised building up of individual self-reliance and effective community participation; the provision of organised, back-up support of the secondary and tertiary levels of the health care services, providing adequate logistical and technical assistance.

8.(4) The decentralisation of services would require the establishment of a well worked out referral system to provide adequate expertise of the various levels of the organisational set-up nearest to the community".

What is a "well worked out" referral system? Who can refer to what level? When? How?

Can the patient, family, community (leaders) refer straightaway to the secondary or tertiary care service, bypassing the primary care service, to avoid delay, if they considered that tertiary care is necessary? Can the village health worker refer to the secondary and tertiary care facility bypassing the primary health centre? Can a private practitioner (belonging to any system of Medicine) refer a patient to the secondary/ tertiary level?

Will it be a two-way process? Will there be a referral back from the secondary and tertiary level hospitals to the person who referred, once the immediate requirements are met, for follow-up and further management? What all records will be sent to the person referring?

Will priority attention be paid by the specialist at the hospital to the referred patient?

Will there be adequate transport facilities?

Can the referral process be such that specialists will visit the primary health centres and other less specialised areas? There are many advantages:

(1) The specialist gets the opportunity to observe the service conditions and constraints under which the generalist functions.

(2) The specialist can guide and educate (continuing education) the generalist to manage the patient with the available resources and facilities.

(3) There is mutual interaction; rapport can be built up.

The A.P. Jain Committee had recommended

(i) regionalisation of specialist services with adequate laboratory and diagnostic facilities,

(ii) development of district hospitals into full fledged referral hospitals to overcome the deficiency in the number of teaching hospitals.

(iii) flexibility in referring patients to suit the conditions of the patients, and

(iv) mobile teams of specialists to visit subdivisional hospitals and primary health centres at regular intervals.

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The Governments had passed orders asking the specialists in Medical College Hospitals to visit the District Hospitals and the Specialists in District Hospitals to visit and advise the doctors in the taluka hospitals. The experiment was a failure.

The idea of making the district hospital the apex body in general health (medical) care had been advocated earlier. Dr. A. Lakshmanaswamy Mudaliar had suggested that every district hospital be upgraded to make it a teaching hospital for fifty medical students. The Bhore Committee had suggested the three million (district) health plan with the 3-tier referral system.

4. Governmental and non-governmental hospitals

Our health care system is characterized by a mix of public (central, state local) and private (no-profit and for-profit) hospitals. There are significant numbers of hospitals and hospital beds in the private sector. These were mostly voluntary, no-profit hospitals with a sprinkling of private individual entrepreneurs, which were mostly in the nature of nursing homes. While the no-profit hospitals were spread out in urban and rural areas, the for-profit nursing homes were in the urban areas. There are a few co-operatives. Recently, there has been a growth of corporate hospitals; these are mostly in the cities. They probably would play little part in the decentralization under Panchayati Raj.

In a decentralised situation, it is important to take note of the presence of the private hospitals, in the rural areas. This is emphasized in the National Health Policy: " 5.... adequately utilizing the services being rendered by private voluntary organisations active in the Health Sector". The policy further states: "5(1). ..... There are a large number of private, voluntary, organisations active in the health field, all over the country. Their services and support would require to be utilized and

intermeshed with the governmental efforts, in an integrated manner".

Hospitals and hospital beds (1986)

	Hospitals	Beds
Governmental	4,093	3,94,600
Non Governmental	3,381	1,41,100
	7,474	5,35,700

There has to be complimentarity between the public and private hospitals. The activities of the two sectors or groups must fall in line with the general objectives of health care in the country. They need not be, and should not be, the same as regards the detailed and specific objectives. One of the important advantages of the private sector in health care is that these hospitals and health care facilities can experiment. They can afford to take risks in a greater measure than any Governmental institution. They can be innovative. The successful innovative programmes soon influence the remodelling of the health policy.

The presence of governmental and non-governmental hospitals also provide a choice for the consumer. It also helps in reducing the financial strain on the government.

All hospitals, governmental and non-governmental, should avoid any form of rivalry. Each must be supportive of the other, so that together the health needs of the people are met. Networking of the hospitals in a region will be useful for exchanging information and providing cohesion and mutual support for action.

If the voluntary non-governmental hospitals are to playa greater role in health care, they must be encouraged. On the contrary, there is a feeling among the hospialsin the voluntary sector that they are being harassed by certain rigid, and sometime erroneous interpretation of rules and regulations. Application of rules and regulations with understanding can help. Whether Zilla Parishad will be able to do anything susbstantial in this regard has to be seen.

At present, the voluntary hospitals do not get any subsidy. It would be worthwhile to help those hospitals as are non-profit-oriented and willing to provide free and concessional care to the poor and needy. Many of such hospitals are charitable institutions, providing good quality care at low cost.

There are many examples of countries with a mixed system providing subsidies. One such is the New Zealand System with its area (district) boards. The Hospitals and Charitable Institutions Act provides for patient subsidy to private hospitals, equal to the amount spent for patient-day in the public hospitals.

The Zilla Parishads (or Mandal Panchayats) must emphasize the thrust areas in health care. The support to the voluntary hospitals must be such that these hospitals are supportive of primary health care. Emphasis must be placed on such activities as promotion of health, prevention of disease, rehabilitation and, in the curative services, on maternal and child care services, mental health and infectious diseases. The efforts to improve qualityof life must also receive encouragement. The National Health Policy states: "8 (7): With a view to reducing governmental expenditure and fully utilising untapped resources, --------- increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in health field". The support should not be restricted to curative care; it should be more for efforts which promote health and improve quality of life.

CONCLUSION

Gandhiji visualised a Swaraj with generally self-sufficient and self reliant village community. The secondary and tertiary care hospitals in the rural areas can help towards that self-reliance, with respect to health care.

There is bound to be tension between the personnel of the hospitals and the Zilla Parishad and Mandal Panchayats. As long as such tensions are healthy, they can be helpful for better functions and services. The main objectives must be the same.

There is need for flexibility. States differ in their size, population, level of literacy, stage of development, rainfall and opportunities for employment. So also districts vary. Compare the highly developed Bangalore Rural and the backward Raichur. Villages vary. The size, type and services provided by hospitals vary. The health care needs of the people vary. Such flexibility is more easy with decentralisation.

Decentralisation can help in providing better service through the secondary and tertiary care hospitals, if the people and their leaders function in a responsible manner, responsive to

(1). the real needs for health of the people, and
(2) the call for equity in the distribution of the health care services.

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REDEFINING HEALTH

R.L. KAPUR*

World Health Organisation defines health as "a state of complete physical, mental and social well being, not merely the absence of disease or infirmity". I have a great respect for those who have drafted this definiton because in one bold step they extended the concerns of health professions, planners and educators, beyond the confines of physical body and bodily disease. But, there is a lot which is left unsaid. What is this condition which is more than the absence of disease ? What does well-being mean ? Is there a way of identifying it ? Is there a method of inculcating it? The definiton does not cover these aspects. It hides more than it reveals; it promises more than it delivers. However, through its tantalising incompleteness, it introduces a creative doubt, nudging us into introspection. As we continue working in the health centres, delivering health care, preparing health programmes and holding Workshops on health policy, the definiton keeps reminding us that the term health, the way we use it, is but an euphemism for sickness-care; we do not know what it really means.

It is my intention today to share with you a few ideas and bits of concrete information, which may bring about some conceptual clarity to the term health and indicate means to achieve it.

Let me starts with the description of the "systems view" of life.[1] According to this view, life is organised at various ascending levels, each higher level having its own laws of operation, none of which can be reduced to the laws of lower level. At the lower most level, we are all atoms and molecules. When the atoms and molecules combine to form living cells, the laws which govern the living processes are not just the sum total of the laws of chemical and physical interaction. Similarly, while organs are made of cells, the way they function can never be fully understood, however well we understand the cellular processes. Again, while mental

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functions cannot exist without the Brain, these are more than just the brain processes. Proceeding higher up, societies, though constituted of people, have their own laws which go beyond the individuals. Finally, societies of human beings interact with other living beings, in fact, the earth as a whole and these links have their own laws of organisation. These may be respectively referred to as, physico-chemical, Biological, Psychological, Social and Ecological levels of organisation.

Each of these levels is a substratum for constant activity geared towards keeping a dynamic balance, so that the functions pertinent to that level of organisation, continue to be discharged smoothly. The body fluids keep up their pH and ionic concentration within a resonable range, so that the cells keep alive. The heart keeps pumping at a resonable rate so that blood supply reach all the organs. The thought processes and emotions keep interacting to maintain a sense of 'self'. The individuals interact continuously to keep a social cohesion and finally the living and non-living constituents of this Earth keep interacting to maintain the right temperature, the right mixture of gases and so on; so that this world in which we live does not fall apart. All this keeps happening in the face of forces which would trip the balance any moment. The dynamic balance is kept not only at each level but between the different levels and any inbalance at one level can disrupt the balance at the other levels.

Some very interesting research studies have demonstrated how our daily habits, our social interactions and our personalities can influence our bodily health and also giving some startling information about the mechanisms through which influences operate.

In a study carried out in the United States the inhabitants of two States, Nevada and Utah were compared regarding the impact of daily habits.[2] It was found that amongst the population of Utah where majority of population is of Mormons who do not drink or smoke and keep regular daily habits, the dealth rate was 40% less than that in the Nevada population. These two populations have similar medical facilities.

In a study carried out in the Alameda county near San Fancisco[3], 7000 people were followed up after checking up their medical details. After several years, it was found that those who were single, divorced, widowed, with few friends and relatives as well as those who didi not wish to participate in community organisations, died at a rate 2-5 times greater than those with social ties, controlling for all other factors which could produce disease. In another study[4] Japanese who left Japan to settle in U.S. and thus lost the security of the excellent social support system in

Japan had a much higher rate of heart disease than those who did not migrate. Harold Morowitz a Professor of Biophysics reviewed the data[5] of the Hammond report on smoking and found that the effect of divorce on the death rate was as much as of smoking 20 + cigarettes per day. In a Swedish study[6] of old peoples' homes, those who took part in community activities had much better health than those who did not.

How does the social cohesion or its absence influence the death and illness rate ? There is evidence that working through the brain and neural hormons it directly affects the number of those while cells in the blood which are responsible for body's immunity. There is now the whole new discipline of psycho-neuro-immunology which is bringing out very startling findings. Social connectedness increases bodily resistence. Relaxation training increases bodily resistence. Taking part in selfless acts increases bodily resistence - all this through increase in those white cells which raise immunity. Against this stress in life, need for power and feelings of hostility, all decrease the number of these immunity cells and hence bodily reistence.[7]

There is further evidence that not every one falls victim to bodily illness under conditions of social disruption. There are the hardy personalities who actually thrive under these conditions. A study conducted by Suzanne Kobasa[8] shows that those who have a sense of commitment to self, to work and to family, those who maintain a sense of control rather than show helplessness in face of stress and those who see changing life situations as a challenge rather than threat, experience much lower level of illnesses in their lives as compared to those who do not. "Hardies" transform problems into opportunities and thereby do not elicite the stress response in the first place. "Softies" on the other hand distract themselves with drugs, entertainment or inane social interaction. "This kind of avoidance coping can be useful when the problem is insoluble, but when something can be done to alter the stresor and is not, the source of stress remains and is more likely to mobilise a chronic stress reaction with illness as a consequence."

Research is also showing that the thoughts and beliefs of people about their own health do affect their illness rates. People who live in hope suffer less illnesses. People who have a sense of coherence about the world, who feel their lines are meaningful have lower illness rates and finally people who believe they are healthy have an overall lower illness rates.

My teacher N.C. Surya who was the Director of National Institute of Mental Health and Neuro Sciences, when I was a student, describes an instance of a boy whom he saw on the railway platform with one leg amputated, hopping along quite cheerfully testing his ability to go as far as possible with one leg without any crutches.[9] This is health and it can

which coexist with infirmity. There are many examples in literature and amongst the people we know who continued to use whatever resources they had at their disposal to do what they were committed to, to do that had to be done. At this point, one becomes aware of the remark" but what about average people - after all I am an ordinary human being, I cannot be expected to be a saint". It is precisely because you are a human being that you have a range of possible responses to a given situation. An animal has a limited response to its inner needs or outside pressure. When hungry it eats, when threatened it fights or escapes to save his life. Human beings are able to respond to hunger by offering food to someone else who needs it more. In a war situation a soldier is able to keep his mouth shut when hit by a sniper so that his screams do not make his friends vulnerable.

Human beings can choose to be hardy, can choose to be hopeful can choose to be confident, can choose to be healthy. Choosing to be healthy brings health. What is health then? Health amongst human beings is a conscious attempt to keep the dynamic balance at the physical, mental, social and Ecological level. It is not a static entity but an active process. It is not well-being in the sense of alway wearing a beatific smile; it is accuracy and precision. One may not succeed in the enterprise but this conscious effort to mantain the balance is health itself.

You may be lucky enough to be born such a person or having the right kind of training in childhood. If not you need to practice these attitudes till verbal understanding becomes body learning. "Abhayasa" is the key. If what I have said sounds familiar, it is so, because most religions and spiritual philosophies of the world have said the same many times. One would like to believe that these philosophies were concerned not only about the ethical behaviour but in a wider sense, with people's health as a whole.

Can we teach people to be healthy? Coherent societies have ritualised the ways of teaching people about health: through parent-child interaction, through stories, through "Satsangs" and through intellectual discourses.

One person who needs to be taught about health but is never taught is the doctor in our kind of medical education. He is taught about disease but not about health. I shall end my talk with a beautiful anecdote of an unhealthy doctor given by Surya.

"This is a young doctor sitting in his chair in a village dispensary . There is the village woman with her child who has high fever, a running nose and rattling noises in throat and chest. There is no pencillin in the dispensary and no means to get white-blood-counts. The doctor is waving his arms about and giving went to his anger. "What to do! No

pencillin! No microscope! The stupid Government sends me to this place! Take the child to the big hospital. You are asking me how to go. Take a bus, take a bullock cart, do something, I am not here to tell you all that. What ! you are aksing me to give some medicine or other! Do you think I am a quack to give you some coloured water or other? I am not a cheat. Now don't holler ....." and so on.

This doctor has lost all sense of personal responsibility and dignity. Simultaneously he has lost the use of his eyes, ears, head, heart and limbs. His whole brain is paralysed and he can only talk of things that are not there and of the things he cannot do. He talks of the penicillin which is not there, of the microscope which he himseif has systematically ruined by negiect, and of the government about which he can do nothing.

If he had some respect for himself and his body and its capacities, he would have found time, interest and energy to note: The child is having a high temperature, but in a child not necessarily dreadful. A little sponging could be done on the spot. The child is producing fearsome noises in the throat and chest, but is really quite alert. Was she not pulling at his stethoscope and showing interest around the place? A little cleaning up of the nose and throat could at least make the child look less frightful. About pencillin, of whose absence he moans, does he not remember the nuisance of sensitivity tests and the fact that with all precautions some people do die of it and that is not a panacea, and that before penicillin came and before he himself was born children were being taken care of in the circumstances available to them by the best of physicians? Could he not give a few drams of a mixture with quinine ammoniata and syrup of cardomum, which would improve the morale of the mother, the quality of her attention to the baby, and so on. If he was really so worried about the child and if he moan about the things he cannot do, he would have noted that just then a visitor's car was going to town and he could have easily arranged for woman to go wo hospital.

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PEOPLE'S PERCEPTION OF HEALTH CARE: A RURAL EXPERIENCE

MANISHA GUPTE

"People's Perception of Health Care" cannot be compressed into a single, homogenous category. Different sections of society will necessarily have different (sometimes, conflicting) perceptions about their bodies, their concept of illness or well-being and it would be safe to asume that the milieu in which people live (social, economic or cultural) or the collective experiences of any single group (urban, rural, men, women and so forth) would generate differing self perceptions, all of which will lead to varying theories and ideas about illness.

In this paper, I will deal specifically with the perception of rural people, including women. The experience is restricted to a few villages in Pune district in Maharashtra State, yet the observations are not very strictly area specific, because the people represent three religions (Hindu, Muslim, Neo Buddhist) as well as different classes.

Illness that reduces the productive potential of a person is, understandably, seen as important and a situation that merits treatment. A person suffering from tuberculosis may not generally comply with the long, tedious and necessary regimen of treatment, yet if the tuberculosis prevents him or her from reaching the fields or a construction site, a doctor will be sought and temporary relief (through vitamin injections or cough mixtures) obtained. Needless to say, those individuals who are considered more important within the household will receive better treatment, "better" often meaning expensive. Thus, women as a group are disadvantaged, and especially so if they are childless or they happen to be unwanted daughters. Our study of the OPD of the local PHC show that girl children are the single most neglected category where health services are concerned. Also, when a male with TB for example becomes a burden on the family, the entire attitude towards him changes over a period of a few years. Even women members of the family may then grudge him his daily meals. Old, especially senile persons also fall from grace, should they require constant medical care.

One of our studies showed that women suffer more from chronic ailments (backache, white discharge, weakness, prolapses, mental stress) as compared to men. Since these vague, yet persistent problems are more a reflection of drudgery and poverty, poepie learn the hard way that they are incurable. Therefore, in a vicious circle, women will not seek medical attention for their problems and will therefore continue to suffer ill health along with overwork.

Women are seen as a means to producing healthy sons, besides being unpaid manual workers at home and all their health problems are viewed from this narrow angle. Unfortunately, even the modern medical sciences hold this biased perception of woman. Much worse, even a good maternal health programme does not reach out to all Indian women. The rural masses are largely left to fend for themselves, in a situation where safe deliveries are not always possible and where detection of high risks in preganacy is unheard of.

This total lack of control over one's body and the micro-environment in which one lives, leads to the creation of a wide plethora of superstitions and victim blaming myths. For example, in my area, it is widely believed that if a pregnant woman crosses the seeds of the papaya fruit, she and her progeny will become night blind. So rampant is night blindness among pregnant women, that it is considered a natural part of being pregnant. Infact, people will say that the goddess "Paachvi" is worshipped on the fifth day after delivery with the express request of curing the new mother of her night blindness.

Similar are the practices of naming children in a derogatory fashion - such as Dagadu (stone) or Chindhi (rag). This is to fool the evil spirits who may otherwise kill the child. Also, lack of creche facilities leads to doping the child with opium. In lullabies and folklore, opium is mentioned with love and pride.

Helplessness, whether at the whimsical decision of the uds to make or break the farmer, or at the sight of children dying, leads to an atitude of inertia. "God gives, God takes" becomes the maxim (and the escape) to cope with repeated tragedy.

Appeasing of gods, thus becomes a major route to safeguard one's health. Illhealth is seen as an act of punishment. Some gods have been displeased, somewhere. Particularly potent are the local dieties. They can protect, yet they are short tempered and malevolent. When we went to the villages four years ago, the people assured us that they

sought western medical treatment for every conceivable ailment. Today we know differently. There are around 20 exorcists in our village (population 3,000) and as many traditional healers. The formidable consultants however are the exorcists because they exercise great control over the minds of the local people.

Illhealth is also seen as a punishment for "deviance" from social mores. Sexual indulgence leads to leprosy, for example. Stigma towards one's own body is also reflected in the perception of illness. Those illnesses that secrete body wastes (tuberculosis or white discharge for example) or are aesthetically shattering (leprosy) are especially stigmatised and repulsed. This "clean" or "unclean" phenomenon is extended to menstruation and childbirth as well. Some sections, such as women are therefore "Unclean" by nature, and others, the dalit castes are "unclean" by birth. People from the "clean" hemisphere can be defiled by illness and then they are also thrust into the dark world of stigma. Since "scientific" reasons are not available, the degradation of humans to such horrible depths can only be due to immoral or blasphemous acts.

Superstitions and myths, thus serve as coping mechanisms. Though these beliefs affect access to health care, they are, in fact, the product and not the cause of poverty or of ill health. A wide variety of mental illnesses exist, and one of the most common coping mechanisms is through being possessed by a wide range of spirits and demigods. If one observes closely, it becomes evident that women, whether childless, post menopausal or adolescent, form the bulk of the persons afflicted by hysteria. Nervous breakdown is common among the unemployed youth, so is depression. Rural society, fortunately has great tensile strength and will readily accept a person who was "mental" (the expression commonly used to denote madness) earlier.

Modern medicine, unfortunately reinforces all the anti poor, antiwoman biases that already exist in society. The concept of redeeming people through improved hygiene or personal habits is one example. Assuming that people are stupid and that they are incapable of acting towards their own good is another.

The overemphasis of the public health services on family planning is a case reflecting this "do god" bias, where against the will of the people, this coercive programme continues to functions. The already low access to health care is further reduced, because people feel uneasy about public health services. A lack of answerability to the people, both of public and private health care services also

discourages people from seeking medical attention. Information is doled out whimsically, such as needing a hysterecomy because there are "worms" in the uterus. This inscientific and malafide information by an MBBS doctor is in no way better than that of the local healer, who cures a person of rickets and malnutrition by "removing maggots" from the spinal column. Similar is the case of giving unnecessary bottles of saline intravenously to "reduce heat" or to "purify blood". An irrational demand for injections (created by doctors in the first place) is another example of cheating gullible populations.

A curious and sad mixture of underuse and overuse of medical care emerges bcause of this confusing self perception. The urban high tech. modern medicine becomes the unattainable role model. When people do seek medical intervention, the "value" of the illness is directly proportional to the number of injections or saline bottles, or hospital admissions it required. This pride is evident, not only among rich farmers, but also among the poor working class; the latter get into heavy debt for irrational treatments of tuberculosis or of diarrhoea. Since people have a low self perception and have lost faith in some of the sound home or folk remedies for common ailments, they are not totally convinced of simple treatments like ORT.

Cliched as it may sound, the only way to improve people's perception about health care is to improve their access to resources - whether it be food, clean water, employment, education or health facilities. Reducing unnecessary drudgery and overwork would give some breathing space to the poor, especially to women. This would create an incentive for people to question inequality, discrimination and stigma. Abolition of superstitious fears or of their own negative self perception would be a happy product of such progressive questioning.

REGIONAL REVIEW MEETING ON PRIMARY HEALTH CARE SYSTEM DEVELOPMENT HELD AT BANGALORE : PRESENTATION BY DR. S.C. SHARMA, ASSISTANT DIRECTOR GENERAL (HA)

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Following international conference in Alma-Ata 'PHC as a new approach to health care system' came into existence in 1978 — a qualitatively different approach to deal with the health problem of the country.

This approach envisages a system of health care based on the life pattern of the communities, involving local resources and participation, with inter-sectoral coordination, attempts at providing integrated interventions at the periphery. The Govt. of India has adopted target oriented, time-bound approach with main emphasis on the following aspects -

1. Decrease in mortality in children and mothers
2. Vaccination coverage to children and pregnant women
3. Care of mothers during pregnancy and delivery
4. Decrease in the population growth rate by increasing the couple protection rate to 60%

This is being achieved by the following measures:-

1. Strengthening of the existing health infrastructure
2. Training of the traditional birth attendants
3. Providing health worker for 5000 population
4. Involvement of the local communities in the form of the community health guides
5. General development activities

Through the universal provision of comprehensive Primary Health Care (PHC) Services, India is committed to the goal of "Health For All by the year 2000 A.D." (HFA). In HFA concept every

person should be able to achieve a level of health that would enable him or her to lead a socially useful and productive life. Such a level of health would improve the quality of health and bridge the inequalities and is to be achieved through PHC approach.

Health has been declared a fundamental human right which means that the State has a responsibility for the health of its people. Efforts to achieve and maintain health, prevent disease and deal with it when it occurs, require joint efforts by providers as well as acceptors. In other words, the individual, the family and the community is to share the responsibility with the State.

'Health Care' is not same as 'Medical Care'. Health care covers a broad spectrum of present health services, ranging from health education and information, prevention of disease, early diagnosis and treatment and rehabilitation. On the other hand, medical care includes domiciliary and hospital care which is provided directly by the physician or at his behest, and has a limited sphere. Earlier, health care was generally a matter of sanitary requirements and legislation while m-edical care generally concerned itself in prescribing and dispensing medicine during sickness. In a joint report in 1965, WHO/UNICEF gave the term 'basic health services' which envisages a net work of coordinated peripheral and intermediate health units competent to perform a set of functions essential to the health of an area through competent professional and auxillary personnel in an effective manner. These ideas formed the basis of national health planning in our country and led to establishment of Primary Health Centres and Sub-centres.

After India became a signatory to Alma-Ata Declaration of 1978, the Government has started concentrating on the development of

rural health infrastructure so as to provide health care services to about 80% of rural population which had by and large remained neglected. The stress in the National Health Policy is on the provision of preventive, promotive and rehabilitative health services to the people, thus representing a shift from medical care to health care and from the urban to rural population. The main objective is to place the health of the people in hands of the people through the primary health care approach.

PHC is the foundation of rural health care system and forms entry point to the National Health Care System. For developing the country's vast human resources and for the acceleration and speeding of socio-economic development for attaining improved quality of life, PHC is accepted as one of the main instrument of action. In the rural areas health services are provided through a net-work of integrated health and family welfare delivery system. To achieve this objective extension, expansion and consolidation of the PHC infrastructure viz. sub-centres, primary health centres, community health centres has been taken-up extensively with trained village health guides and trained dais at village level.

In order to make health services available, accessible and acceptable, efforts are being made to involve other functionaries i.e. Village Health Guide (VHG), Traditional Birth Attendants (TBAs)/Dais and Multipurpose Workers (MPW) and Social Workers (SW) by imparting them training and support. Medical Officer, alongwith these categories of workers is the leader of the 'Health Team'. In this way the health services are to be made available as near to people's home as possible and at work places with good referral system. Various systems of

medicine including ISM and homoeopathic systems are to be provided depending upon the local acceptability of the people. Besides these, community participation, multi-sectoral coordination and political will, are other basic principles on which PHC approach is based.

To optimise and further improve the efficiency of the available health infrastructure, programmes will have to be identified on the basis of priority and some way require modifications for effective and concerted interventions in the critical areas, especially in health manpower development and other health problems. Quantitatively these achievements are impressive in terms of establishment but it has been observed that they are not operationalised fully and the services provided at these centres need have to be improved to bring in the required credibility for efficient working of the health system. It is also crucial for the PHC System Development that the knowledge and skill of the health functionaries match their job requirements. The basic training, in-service training and continuing education should therefore receive the highest priority and advance planning should be done both at the State and District level to ensure that the required equipment, trained personnel and other physical facilities are available not only for the new infrastructure to be created but also for making up the deficiencies in the existing infrastructure.

PHC infrastructure comprises of health units from the community level service to the Community Health Centre (CHC) level which has been developed and should be strengthened and revamped further by involving VHGs and Dais after giving them training.

In community level services VHGs and Dais form the most important inter-face between the community and health functionaries in the delivery of PHC. There are about 3.9 lakh VHGs trained since inception. Additional VHGs will have to be trained so that there is

one VHG/1000 population/per village. The accountability of the VHG, payment of their honorarium and money for the medicines etc. may be handed over to Panchayati Raj System including their training and re-training. 5.7 lakh training birth attendants (TBAs) have been trained in the country so far. About 80% of deliveries are still conducted by TBAs. Their training and re-training has to be continued. They should be allowed to play greater role in the care of pregnant women by providing them with pre-sterilised disposable delivery kits, weighing scales and educational materials. The present, recoupment amount of Rs. 3/- for soap, cotton etc. has to be performance linked and enhanced to Rs. 10/- per case reported. The training programme of TBAs should be intensified.

SUB-CENTRES :

A target of 1.3 lakh sub-centres was aimed at on a population norm of one Sub-centre for 5000 population in plain areas and one for 3000 in difficult, hilly and tribal areas, with one Female Health Worker, one Health Worker (Male) and one voluntary worker. Out of this, 1,20,767 are in position as on 31.3.1989. This has to be stepped up appropriately by providing buildings for all established centres, in-service training to workers at the sub-centre level, male health worker in each sub-centre areas; and enhancement of budget for drugs and furniture etc.

PRIMARY HEALTH CENTRES :

This provides preventive and promotive health care to a population of 30,000 in plain areas and 20,000 in hilly and tribal areas. Of the 21,666 centres required by the end of the 7th Plan, 18,811 are functioning as on 31.3.1989. This has to be strengthened appropriately by establishment of PHCs in difficult areas, posting of second Medical Officer wherever resources permit preferably a lady doctor, creation of post of Public Health Nurse (PHN), enhancement

of budget for drugs, creation of functional buildings by using locally available material, strengthening of health education component in training programmes etc.

COMMUNITY HEALTH CENTRE :

At present one Community Health Centre is to be established for every one lakh population with the specialities of Medicine, Surgery, Paediatrics and Obstetrics and Gynaecology having 30 beds, X-ray and Laboratory facilities. This unit functions as a referral hospital and coordinates with the Primary Health Centres of its area in preventive and promotive services including family planning. As on 31.3.1989 there are about 1631 CHCs out of a total of 2708 required by 31.3.1990.

Being a referral system from village upwards, proper buildings, appropriate staff, sufficient equipment with vehicles and a sound health management information system should be undertaken to optimise and further improve the PHC System Development.

In addition, health manpower development and training of all categores of staff and functionaries in both basic and in-service training should be given due priority in future.

Community should be involved for the effective health care delivery services and in health education. For this, the Village Panchayats may be utilised for selecting VHGs, formation of village health committes, etc. Voluntary Organisations should be encouraged to establish and run sub-centres, PHCs and Government should provide full support for the referrals done by them.

Monitoring and evaluation system should be geared up and the goals set for various indicators of health and Family Welfare

programme may be evaluated periodically at reasonable intervals by conducting field surveys and feed back given to the appropriate authorities for correcting the deficiencies.

Operational research on PHC System Development should be undertaken to identify cost effective strategies of health services.

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