TRAINING FOR COMMUNITY HEALTH CARE

- DR DARA S AMAR

[This paper
~~The aim of this presentation is~~ to highlights some of the ~~various~~ attempts made in St. John's Medical College, Bangalore to orient Health Workers, including Medical students, towards Community Health Care. ~~While there are no solutions,~~ The attempts ~~themselves~~ have provided invaluable insights into this important goal.]

Being a Medical College, St. John's aims at providing the training component in the formation of health teams.]

The Salient features of our present programmes are

1. Health Team Training:

St. John's Medical College is in a unique situation to train ~~all the various~~ members of the health team under one roof. We are able to ~~This~~ creates a better understanding among the members of the team of each other's role ~~rather than the isolated form of training available elsewhere for each category of health workers.~~ Medical students, Nursing students, Community Health Workers, Deacons, School teachers, village mothers etc. are the various health team members who get their training at the college ~~St. John's. Since all the training is done by the same faculty, it becomes easier to concentrate on the actual needs of the health team.~~

Concentration on health:

~~St. John's~~ The Medical College has an entire faculty of medical doctors who can devote full time to the health aspect of community development. Therefore, it is only logical that the training at ~~St. John's~~ for the health team should concentrate mainly on health. This training is complemented by the training in developmental work given by other organisations.

Use of local language:

Majority of the training programmes for the health team is conducted, as far as possible, in the local language of Kannada. This is an important aspect since expression of thought is best achieved through the use of local language by the health team trainees. Since the trainees come from

* While the ideal objective is health and development, by virtue of the training and competence of the faculty, the emphasis has been on ~~health~~ training in health. It is complemented by training in development by other organizations.

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different parts of the country, the training programmes here provides facilities for translation of several languages. In fact, the department has already published an entire book on Food Hygiene Practice in Kannada.

Participatory process:

The main objective of the various health programmes of St. John's aims at a participatory process wherein the villagers themselves participate in financing health care, supply of materials and manpower etc. This is particularly exemplified by the Mallur Health Cooperative Centre, which now has its own hospital building etc., through the Health Cooperative Movement which the college initiated in 1973. Village Health Committees have been formed at each of the rural health centres and all decisions are participatory in nature. A large part of the organisation of surgical and other speciality rural camps are also done by the villagers. This is through their village youth groups and Mahila Mandals. Even the training of the various categories of health workers, including medical students, is done through teachers drawn from the village leaders themselves.

Coordination with other agencies:

It is important that St. John's work in coordination with governmental and non-governmental health institutions. Programmes such as the Rural Mobile Clinics, Universal Immunization Programmes, Integrated Child Development Scheme, National Social Service and Rural Internship Training are examples of such coordinated efforts. The teaching faculty are also drawn as guest faculty from various sister institutions.

Integrated Health Care Training:

Villagers in India often resort to indigeneous systems of medicine. The training at St. John's for the various categories of health workers including our medical students, includes training in Herbal Medicine, Herbo Mineral Medicine, Acupressure, Homeopathy and Yoga. Many of our graduate doctors

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working in remote rural areas, have substantiated the fact that there is this need for integration with the other systems of medicines as is being attempted at the college.

Health Education as a priority:

It has been realised at St. John's that over the years of experience in training health team members for the villagers, there is a greater need to pay attention to training in health education methods. In the long run, it is the health education programme that have paid off the maximum dividends. With this in view, health education receives a top priority in the training programmes conducted at the college. Innovative methodologies such as Child to Child health education, rural mothers motivation programmes and rural school teachers health education training programmes are some of the important health education programmes organised by the College. The health education methodologies include the development of local audio-visual aids in the form of simplified demonstration models using locally available materials rather than sophisticated charts, photos, films etc. The materials for most health education sessions are prepared by the village school children and village school teachers. Health education in the field of Nutrition education involves teaching the village mothers to use their own traditional recipes in a nutritionally correct manner. The aim here is to strengthen the existing traditional diets which are often nutritionally far superior to the imported diet from the urban areas. Therefore, Greater stress is laid on the use of local cereals, pulses etc. along with promotion of breast feeding as well as local weaning diets for the village children.

Sensitisation to the rural milieu:

In order that all the trainees at St. John's, including medical students and nursing students, must understand the rural dynamics of life, special training programmes are organised on a residential training basis at our rural health centres. These rural residential training programmes stress

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on understanding the various factors which govern rural life and in turn the health of the people. Areas such as agriculture, animal husbandry, small scale industry, customs and traditions, housing and environment, role of women in society, food practices etc., are all studied through field projects by the various groups of trainees. The training programmes are thus oriented to sensitize the health worker to the various aspects of rural life and how each of these aspects are related to the total health of the villagers. This has already paid off in terms of the practical advise given by our graduate doctors even in the hospital premises.

Reaching out:

Considering the resources and facilities available for health care at St. John's, it is quite natural to try and reach out to the underserved areas using all the available resources for health care. Rural ~~surgical~~ camps in the field of ~~Ophthalmology~~ eye, ~~ENT~~ ear, nose and throat, ~~Dermatology~~ skin, ~~Dentistry~~ teeth, ~~Paediatrics~~ child health and General Surgery ~~etc.~~ are conducted in the villages. Methodologies have been evolved at the village level to ensure asepsis and follow-up for post operative care through the use of trained school teachers, youth volunteers and traditional healers ~~etc.~~ Specialist ~~surgical~~ care, is thus made available at the village itself. In the bargain, the faculty have gained confidence that it is possible to reach out with even ~~sophisticated~~ advanced health care to the villages. These exercises have also proved to be an important force of cohesion, among the various hospital departments and Community Medicine Department. The rural mobile clinics further carry the health care facilities to over 12 health centres, spread through three Community Development Blocks covering over 300 villages. In this process of rendering services to the unreached, our trainees (through the participation in such programmes) gain invaluable experience.

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Understanding health and disease holistically:

In order that our health team trainees do not dichotomise health care into various compartments, the training programmes ~~include giving health care to~~ focus on families rather than individuals. Through programmes such as the Clinico-social case study and field family health care projects, the ~~various categories of~~ trainees are made to understand the cause and consequence of disease in terms of multiple factors rather than only the clinical signs and symptoms of the ~~body. During this training programme,~~ disease affected person. Emphasis is laid on the planning and management of health care at minimal cost. Our graduates ~~in the future,~~ would also be cost conscious and make their programmes financially self perpetuating in the village communities rather than make the people dependent on charities.

Serving the urban under-privileged:

Urban slums in and around Bangalore, are also served by St. ~~John's~~ the Medical College. Health programmes such as immunization coverage against the major killer diseases for children, maternal and child health clinics for expectant mothers and school health programmes, are some of the urban based health activities ~~of St. John's~~. In addition, the Medico-social Unit also aids in counselling for alcoholism, drug addiction, juvenile deliquency etc. The various groups of health team trainees at St. John's thus get an opportunity to learn to serve the under privileged in all aspects of health care.

Continuing education:

Although basic training in health care is imparted to various categories of health workers, it is important that a follow-up is done on the utilisation of the knowledge gained at St. John's. For this purpose, several methods are followed. At the professional level, doctors can seek elective posting in selected specialities for further skill enhancement. Regional Colloquia are organised for sharing professional

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experience among Community Health Workers and Rural doctors. This provides an opportunity for learning from each other. ~~It is more important than lectures etc.~~ Continuing education is also provided by St. John's for health agencies from afar. The United Planters ~~Health~~ Association of Southern India (UPASI) works in collaboration with the Department faculty to train their Medical Officers, Nurses, Compounders and even their Estate Managers in the field of health care and health management. Periodical newsletters also act as a means of net working for graduates and Community Health Workers working in various parts of the country.

Development as part of health:

Extension training in agriculture, water resources and veterinary care for village youth, are part of field training programmes given in rural health centres. The stress is on youth motivation and training in these areas, especially among the rural unemployed youths. Functional literacy programmes and vocational guidance are some of the other services rendered in the villages. Our health trainees, including our medical students, participate in these developmental programmes under their National Social Service activities, which is coordinated by the department faculty.

~~At the~~ Conclusion, ~~it may be stated that~~ all the ~~above~~ programmes are ~~dynamic in nature since they are~~ updated constantly, depending on the feed back received of their effectiveness and efficiency. The emphasis is ~~thus~~ on training and health education rather than merely ~~the~~ provision of multiple services. This ensures that whatever have been the programme inputs, the results will be long lasting, self perpetuating and effective.

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A REPORT FROM KERALA

BASIC HEALTH COMUNITIES

--Fr Edwin MJ*

We read and hear a lot about community health these days. But strangely we find that the proponents often fail to speak about the most important component of a community health programme, ie., communities themselves.

It would seem obvious that we need to have communities to have community health. But unfortunately this is not so.

Building communities is yet to become an integral part of the mental concept of a good many of our community health workers.

What is a community? Or: What are the characteristics that make a mass of people into a community? We need to have consensus of what we mean by community when we speak of community health. Some of the guiding principles of a community are:

1. A community is not a crowd.
   It is not a transient aggregation of passersby.
   Community has certain amount of permanency.
2. A community presupposes commitment to one another.
   And this commitment is actually the most identifying factor.
3. A community has a shared vision.
   Consensus on objectives holds the community together.
   In this sense a community "works together".

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*Director
Xavier Pastoral Centre
PB 17, Nagercoil 629001

4. A community means its members feel with one another. A community, devoid of feelings, is not yet a community. It may be just a task force. Community members "weep with those who weep and laugh with those who laugh".

5. A community celebrates together. It brings imagination, feelings and art to play in the collective affirmation of persons and events and mysteries of life.

6. A healing community heals not only by the explicitly therapeutic programmes but also by its process of affirmation and the strength of the relationships. Community is an antidote against alienation, loneliness, insecurities and the resultant psychosomatic problems.

7. A liberating community, consequently a healing community is a participating community. Participation in decision making is what makes a mass into a people. When people decide together they become conscious of their dignity as partners in progress, as subjects and equals and not just objects and the ruled.

8. A community that is empowering, hence liberating and healing, makes its members not only to decide on the choice of various solutions proposed but also to see the problems together. Knowledge is power. A community that has been enabled

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to identify the problems and constantly to evaluate them is an empowered community. Few will dare to exploit that community.

9. A community that is effective is necessarily small. This follows from our earlier principles. A big community can neither offer powerful relationships nor scope for participation. Only a fellow with a big voice can make himself heard in a big village. Small men feel too small to speak up in bigger structures.

10. A community that intends to have wider macro level im-pact ensures linkage with other similar communities through representative structures at various levels. This ensures both the smallness of the community and the wider level effective action with effective grass-root participation.

11. A healing community takes a holistic view of health that includes the various social, economic, environmental and other factors affecting health.

Do we have such communities? Such structures or infrastructures that would make community health action more sustained and more participatory at grass-roots?

Until we have such communities whatever we call community health programme may at the most be a rural extension programme and not real community health action.

Community health is not just a programme for the people; it is also something of the people and by the people.

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They say examples speak louder. Let me share with you an attempt where we try to integrate the community structure aspect or the infrastructure aspect, into community health action.

We call this project Basic Holistic Health Communities.

BASIC HOLISTIC HEALTH COMMUNITIES

Our first step here is to start organising basic communities of thirty houses each. We have altogether 170 such basic communities now.

These communities are geographical, ensuring that nobody is left out. This geographical aspect ensures also a permanent identity for the communities. As long as the houses are in a given geographical area the communities are also there. Even if for some reason or other some communities or all the communities in a village remain dormant for sometime the day somebody wakes them up they come alive and ready to jump into action.

These communities meet once a week or twice a week or even oftener as the case may be. These meetings are either for prayer, or for celebration, or for nonformal education or for discussions on problems affecting them and so on.

Five representatives from each community make the representative general body of the village. One representative from each community makes the executive body of the village.

Representatives from the villages make the zonal representative bodies, the general body having a representative

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each from the communities and executive committee having village representatives at the ratio of one representative for five communities. What is discussed below that is at grass root communities, each up to the top through their representatives at various levels and what is discussed at the top is reported back to the basic communities.

Our system of handling finance in one of these villages called Kodimunai, will make this accountability to the grass roots clearer. Here the Treasurer is [redacted] free to spend on his own discretion upto Rs.50.00 for emergency expenses. When the President and the Treasurer decide together they can spend upto Rs.100.00. The Executive Committee of the village can spend upto Rs.500.00. The representative general body of the village having five representatives each from the communities can spend upto Rs.1000.00. If it is more than Rs.1000.00 the representative general body of the village makes the decision and sends it for referendum among the basic communities. The decision is not carried if more than half the number of the communities fail to support the decision.

This type of two way communication helps for sustained action. It is enough for anybody in any of these 170 communities to remember the problem and the issue will come alive again.

Once we build these basic communities we use these communities for nonformal education on health concerns. They become grass root forums for health motivation, participation through decision-making evaluation and follow up.

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Here the care is taken not just to propose solutions but more especially to make them see the problems themselves so that through the process of ongoing situational evaluation they are enabled to remain empowered.

This we do through various processes. One such programme is our holistic health orientation camps in basic communities. This willbe a week long programme where trained volunteers help conduct health discussions sessions in the basic communities with the help of a few structured community-discussion exercises. Each community will be encouraged to do also creative assimilation programmes: whatever they learn in the discussions in an evening is translated by the community into cultural programmes to be staged in the community next evening. The village level celebration that will take place the last day will bring to a wider audience the best of the cultural programmes produced by these communities. This health camp normally will include also an exhibition and also half a day or one day seminars to various categories of people with orwithout audio visual programmes. Wherever possible we would include also house visiting programmes and a health survey of the village.

In addition we prepare discussion themes and circulate them among the basic communities. These discussion themes are structured in such a way that they elicit participation of the community. Each theme contains an initial activity related to the theme, questions to elicit participation, a deepening process through the points given, questions leading to community decision, and a concluding activity by way of a song or so.

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Our next process will be to make these communities accept responsibility for their own health care. This we intend to do by way of promoting a holistic health insurance scheme run by the people themselves.

Recently we had a survey to find out the average annual medical expenses incurred by a family. This survey, conducted in four villages, showed that the average amount was Rs.4086.00. We will be able to reduce this to just Rs.500.00 with proper educational preparation and involvement by the people. For this, we would need to transcend the allopathic boundaries and include other therapeutic systems including drugless ones.

Our health insurance programme is expected to consist of the following components: nonformal education through basic communities, collection of funds through basic communities, primary health care through village level representative body and its appointees, secondary and other levels of health care through zonal bodies and the referral centres chosen by them.

Unfortunately, even the example given is not yet a realised dream. Well, this is the vision. We are not yet sure how far we will reach. May be in spite of our optimism we may reach only half way. But we feel even that would be worth the efforts, as it would be a se step in the right direction.

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ORGANIZING PEOPLE FOR HEALTH

- Problems and Contradictions.

Anant R S

(This reflection is based on the experience of work in a health-education-concientization project in a few rather remote, backward villages near Pune, and on the debates, discussions in the Medico-Friend-Circle)

General Perspective on Health-work

Most of the major determinants of the health status of a population - food, water, sanitation, shelter, work-environment, cultural relations..... are far beyond the control of health workers. But Medicos can, with the help of the community, organise preventive and therapeutic (symptomatic or curative) services, can do health-education and advise the planners on health-implications of different socio-economic interventions. These medical interventions are very valuable to prevent certain deaths and diseases, to relieve human su-ffering. But they have only a marginal role in improving the overall health-status of the population. For example, infant and child mortality can be reduced with immunizations and ORT...etc. but no health-programme has abolished malnourishment in children of a nation.

The department of health aiming to improve the health of the people through so many national disease control programs and now through the programme of 'Health for All by 2000 A.D' is therefore a utopian, misleading idea. As a part of a thorough going socio-economic change, medical interventions can be a very good supplementary tool to improve the overall health-status of the people. But the idea that "Health for All by 2000 A.D" would be delivered by the health-ministry/ health projects by the NGOs, though very attractive, is a

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misleading one. All that health-people can hope to achieve is "Health-care for All by 2000 A.D".

This is not sterile semantics. There is a strong reason and a context for making this distinction. There is a widespread technocratic, and managerial illusion that improvement in health of a nation, which is in reality, prrimarily a function of socio-economic development, can be achieved with technological, managerial interventions. Lay people are made to believe that the beneficient state through its Health-Programmes, or the Health-Projects run by NGOs, would improve the health of the people with the help of modern science and technology. These slogans are being promoted in the context of the continuing crisis in the economy leading to increase in poverty, unemployment, inflation, drought and ecological disaster. Other basic element required by for the success of "Health for All" - improvement in socio-economic situation of the people--is in practice, missing due to this economic crisis. What remains is the misleading idea of "Health for All" to be achieved by the efforts of the health-workers.

Those who undertake health-work primarily with an intention of not 'giving a few pills' but of doing some 'basic-work' can, in fact, make very valuable, basic work. Many improvements and some thoroughgoing changes are needed, many new ideas, practices have to be founded and developed, many vested interests to be fought in the field of organising medical care and health-education. This is not a purely technocratic work. There are many sociological, ideological, technical, practical issues to be resolved. Health-work, done with the aim of taking up one of the so many challenging issues, can be very valuable, basic work, a historical need today.

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But in the existing socio-economic frame work and its crisis let there be no illusion of really improving the overall health of the people through health work.

Health-work alone ?

Anybody, who has any idea of the situation at the grass root level, would agree, that in the rural areas, it is not possible to build an organisation of the common people around health issues. The problem of poverty and of paucity of basic amenities is so overwhelming that rural poor are not in a position to rally around exclusively for health. Those, whose basic needs are met, can perhaps form an organisation on issues like occupational health. Recently in Pune, a Citizens' group has been formed to discuss and work even on the issue of mental health. In rural areas, and in the unorganised sections in the cities, however, things are quite different. But at the same time, unless poor people become aware of health issues and actively seek influence medical service, these services would continue to be cut off from the people, and would continue to serve the interests of those who need these services. In other words "health-care for all" can not be realised in its true spirit unless it is'Health by All'--unless the people themselves actively participate in the decision making and implementation. Even if it is not possible to build an organisation of rural poor exclusively on health, health should be one of the activities of a group trying to organise the rural poor for justice and for development.

It is with this perspective, that a health-education-cum conscientization work is being done for the past seven years in a rather remote, backward area near Pune. Neither the

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village Community Development Association, on whose behest this work is being done nor the local organisations are health-organisations as such. Health work is considered as a part of a broader work of education, conscientization, organisation on a range of socio-economic issues. Health is considered neither the main issue nor a mere entry point. Even with a limited aim, and with the support of the broader social work done by the local organisation, the process of increasing the health awareness amongst this marginalised population and of fostering collective self-help has been very gradual one and beset with many problems.

Achievements, Problems, Contradictions

Our health-work consists of training of Village Health Workers (chosen by the marginalised people themselves) in the diagnosis and treatment of routine viral fevers, malaria, diarrhoea, conjunctivitis, scabies, wounds, skin infections etc., and distribution of iron and Vitamin-A supplements to children and pregnant women. These elementary curative services are used to:

a. establish the credibility of the Village Health Workers;

b. as an occasion to interact with the people;

c. an attempt to meet the felt-need of the people.

Rural peor are not much interested in general health-education; given the arduous life they life. But a rural poor is more incluned to listen to why's and how's of diarrhoea-control, when he/she is suffering from diarrhoea and effective treatment is given by the same person who gives health-education about diarrhoea. Hence the strategy of coupling health-education and therapeutics.

The result of this strategy is a mixed one. Let me give some examples of positive experiences and then of some problems and difficulties:

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Our VHWs have a much greater support from the community than that the Government's VHW has. They are trained much better because both the trainee and the trainer are really interested in this work and its philosophy. These VHWs spend a lot of time for this work; attend frequent meetings, participate in other programs of the organisation, travel to and camp at other villages. All this is possible because of a support from the community. The honorarium of a mere Rs.50/- per month does not explain the interest, efforts of these VHWs. (Many of the VHWs even do not get any monthly honorarium). The quack practice of some traditional therapists and that of the compounder-turned-doctor, has been considerably curtailed. Some dent has been made in the 'injection-culture'. People have collectively approached the health authorities to complain about some specific grievances about delivery of health services. (for example, a Morcha about a case of injection-palsy; representations about below par functioning of health-services at the grassroot level..etc) Slide-shows organised by VHWs on prevalent diseases like scabies, diarrhoea are quickly being sought after. More than one hundred women from different villages had walked for a few kilometers and had waited patiently for hours to see a slide show on women's reproductive health. This indicates the interest of rural women in knowing about their own body and health. Discussions in meetings and Shibirs about nutritional requirements of labourers, and of women, about the relation between water supply and health has had an impact. In the consciousness of a section of the people in the organisation, this new health-knowledge has given an additional justification for the demand of higher minimum wages, of leave from hard work during pregnancy, for improvement in water supply,

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These developments are in a way collective attempts towards control over health care activities; are rudementary forms of organised efforts around health issues. However, along with such achievements, there are some knotty problems which show that it is still a long way to go before the awareness of the health problems increases to such an extent that people start influencing the health services and policies in accordance with their own needs.

a. There is a tremendous gap between the consciousness of health-workers and that of the people. People are primarily interested in medicines; rather than knowledge. There is a strong tendency of going to the commercial quack for an injection, pay him five or ten rupees. But when it comes to paying ten paise for the tablet taken from the VHW, there is a tendency of not paying for this self-help, even though over a period of time, people have realised that these tablets are as effective as these injections. There is less of a tendency to see that this process of self-help becomes self-reliant the dominant tendency is either to seek a commercial treatment. It is not easy to go beyond the stereotype responses conditioned by the dominant-culture.

b. Many people as yet to see the work done by VHWs, as a kind of social work done by the representatives of the people. Many feel that these VHWs work 'because they do not need to work at home' or 'because they must be getting something from the agency'. This is in spite of the fact that these VHWs were chosen by the people in a meeting; their help and advice is sought; a call for a meeting, Shibir or even for a Morcha is positively responded to. But still the idea of a movement has not taken real roots.

c. The Government health structure has cooperated by providing medicines, sending their health personnel at request

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A Report from DEENABANDHU(Tamilnadu)

Community Health : Learning from our failures

(Dr Prem John and Dr Hari John, graduates of CMC Vellore recount the lessons they learnt from their failures so that others may benefit from their mistakes and perhaps not repeat them, thus saving time and efforts)

COMMUNITY HEALTH : Community Health, as it is known today, started in the early seventies. International organisations and resource agencies from the West latched on to this new concept and touted it as being a panacea for all ills in the community. In the early stages there was a tendency on the part of practitioners as well as promoters, to give less publicity to problems and failures and to uphold "successes". This resulted in :

1. a number of well motivated people going into community programmes without learning from the failures of others and thus having to reinvent the wheel, thereby wasting a lot of time and money, and
2. community health being practised in a haphazard and "non-scientific" way.

In fairness we should mention here that there were very few models to go by and learn from. But the lack of basic knowledge of social sciences was a great handicap and retarded our progress; often a trial and error method had to be adopted. Apart from the attitudinal problems born out of established values reinforced by sophisticated education, we faced some early prlblems.

We were well received by the better-off, and it was they who offered houses in villages free of cost for establishing clinics. This fulfilled our requirement of "community participation". Only later we realised that all our clinics

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were established in upper caste villages and to large extent the poor were excluded from the services provided by us. It took us two years before we realised the implications and moved away.

At the beginning we spent many months explaining our objectives to "leaders" in the community and asked them to select village health workers. We found that though our stated target group was the landless poor, the majority of those sent to us by the communities were from the land-holding classes. It took time to remedy this situation. Mobile clinics were held on a scheduled basis and it was several years before we learned enough to see only those patients who were referred to us by the VHW. The village clinics, though used as an "entry point", tended to slow the process of acceptance of the VHW by the community and we stopped doing them entirely after four years.

Village health committees were formed with much fanfare but after some time became inoperative when the committee members found that apart from "prestige", there was no monetary benefit to be had. Some of the committees also used the VHW to run errands, etc., and had to be cautioned. Once the VHWs established their credibility, we found that the committee was not really necessary. We now operate on the basis of trust between us and the VHW, and between her and the community. Of course, two independant control mechanisms do exist in the programme, more to see the effectiveness of the VHW than to "supervise".

Use of sophisticated drugs and diagnostic tests were a legacy of our expensive medical education, and we inflicted them on the community for a long time before really understanding

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the people's economic deprivation. The emphasis we now lay on herbal remedies is a response to this. We have seen the proven efficacy of several herbs commonly used at the community level.

We started with a base hospital providing secondary care. The hospital had a very busy and often lucrative practice. We found that we tended to spend more time "curing" people and slowly started de-emphasising this aspect. The effective service carried out by the VHWs also diminished the number of people who needed secondary care. We now believe that if enough preparation of the community is done, it should be possible to start programmes without base clinics, which are often a hindrance. We also believe strongly that existing government facilities should be used, and if they are inadequate, people should be organised to demand better services rather than duplicating services.

We started this as a total community programme, for the rich and the poor alike, for the upper and the lower caste, for we believed that we had a duty to all. During the initial stages, we found that the services offered by us were being extensively used by those who "have" land, money, education and who are often from the upper castes. This resulted in one of our primary objectives being fulfilled - to double income levels . A mid-programme assessment revealed that though we had largely achieved this objective, it was at the cost of the poor, who showed only marginal growth while the "haves" showed spectacular growth. This was evident in a dairy programme we initiated. This package programme involved bank loans for cows and feeds, fodder development, milk co-operatives and transport of milk to the dairy. Not taken into consideration was tha fact that the landless harijans were not used to cows had no place to grow green fodder, and if they had any milk

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sold even the last drop to the dairy, while their children were malnourished. The land-owning classes, on the other hand, increased income levels significantly through the dairy programme. Also, we believed that the transfer of milk from inpoverished areas to the cities to be made into cheese, choclate and condensed milk was not socially just. This and other lessons made us resolve to work only with the target group i.e., the powerless: the landless and the harijan. All programmes - health, agricultural, animal husbandry, etc - were, offered exclusively to this group. The VHWs too, served only them, Thus our focus became defined and we were able to serve the target group better.

Community Participation

Expectations of community participation started coming into vogue in the early 70s. We, too, started with a lot of assumptions: that communities are homogenous and therefore able to take collective decisions based on common good; that communities consider health as a priority and that they will identify and act upon their "felt needs"; that 25% contribution by way of labour was participation; that food-for-work programmes were community participation, etc. Only later did we realise that widespread acceptance of our project did not mean community participation. We had, in fact, imposed a programme on the community and had clearly defined areas in which they should participate, thus acting contrary to our aim of enabling them to make decisions affecting their lives.

We believed that the "leaders" expressed the collective need of the people and many of our earlier schemes were based on this assumption. After several years of our education by the community, we were able to see thefolly of this and involve the entire community and not just "leaders" at all levels of

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programme implementation, right from identification of priorities and planning to evaluation. To claim that we have been entirely successful in this would be untenable, but serious efforts have been made over the years. Since we were unable to make defined parameters, evaluation of this aspect is difficult. It is also hard, because the programme as we said earlier, has evolved through many stages and has undergone changes in its objectives.

Self-Sufficiency

As a corollary of community participation, self-sufficiency has been a goal in itself as well as a process. Several ways of seeking this goal were experimented with, particularly with regard to the support of VHWs. One way was to provide services to the rich to raise resources. There was an inherent danger in this, for we spent far too much of our times serving the rich and this was contrary to our ideology, too. Another alternative was to ask the VHWs to charge for their services, even a very small amount. The question remained, however: why should the already marginalised and oppressed people be made to pay for their health services while a lot of resources all over the country were being allocated to serve the "haves" and the urban elite?

We had this problem until we realised that "self-sufficiency" referred to the project, while what we were aiming to build at the community level was "self-reliance". We were working towards building community capability in health care and, community capability in health care and, hence, self-reliance. Using a community-based approach, (appropriate personnel and technology) we learned that it is possible to make communities self-reliant.

Source:CONTACT, A bimonthly publication of the Christian Medical Commission, Switzerland) (No 82 December, 1984)

A COMMUNITY HEALTH RESOURCE INVENTORY

(50 titles from the Indian experience)

The 70s and 80s have seen an 'explosion' of 'Community Health' materials on the Indian scene, with the increasing wealth of grass-roots field experience. Most of these materials are unfortunately still in English and inspite of the presence of large networks of NGO health initiators these are still not as widely known or as widely read as they should be,

A Community Health Cell, tentative Bibliography has identified over 150 such materials. A shorter version with sources is given here highlighting 50 of them.

Titles and Source

A-Indian Council of Medical Research, New Delhi

1. Alternative Approaches to Health Care, 1976
2. Evaluation of Primary Health Care Programmes, 1990
3. Appropriate Technology for Primary Health Care, 1981

B-Ministry of Health and Family Welfare, New Delhi

4. Health Services and Medical Education (Srivastava Report) 1975
5. Manual for Community Health Worker, 1978
6. Manual for Health Worker - Female Vol I&II, 1979
7. Manual for Health Worker - Male Vol I&II, 1979
8. Manual for Health Assistants (Male & Female) 1980
9. Primary Health Centre Training Guides I-IV 1980
10. Handbook for the delivery care to mothers and children in a community Development Block (Oxford University Press) 1980

C-Medico Friend Circle

11. In Search of Diagnosis - Analysis of Present system of Health Care 1977
12. Health Care - Which way to go? 1982
13. Health and Medicine - Under the Lens 1985

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D- Voluntary Health Association of India, New Delhi

14. Teaching Village Health Workers - a guide to the process 1978

15. Manual for Child Nutrition in Rural India 1978

16. Where there is not Doctor (revised Indian edition) 1979

17. The National Health Policy

18. A Manual of Learning exercises for use in health training programmes in India 1983

19. Better Care Series (8 problems)

E- Indian Social Institute, New Delhi

20. Moving Closer to rural poor 1979

21. Health & Culture in a South Indian village 1979

22. People's Participation in Development - Approaches to non formal education 1980

23. Changing health beliefs and practices in rural Tamilnadu 1981

24. Learning from the rural poor - experience of MOTT 1982

25. Development with people - experiments with participation and non formal education 1985

26. Social activists and people's movements 1985

F- Lok Baksh, New Delhi

27. Formulating an alternative rural health care system for India 1982

28. Poverty class and Health culture in India

29. Health and Family Planning services in India - an epidemiological, socio-cultural and political perspective.

G- Catholic Hospital Association of India, Secunderabad

30 Health and Power to people (medical service special issue) 1986

31. Taking sides - the choices before the health worker 1986

32. Trainers manual for training community level workers 1987

....3

H- Foundation for Research in Community Health, Bombay

33. Community Health Projects in Maharashtra - an evaluation report 1981

34. Health Status of the Indian People

I- National Institute of Mental Health and Neurosciences, Bangalore

35. Manual of Mental Health for Medical Officers 1985

36. Manual of Mental Health for Multipurpose workers 1985

J- National Institute of Health & Family Welfare, New Delhi

37. Evaluation of CHW Scheme - a collaborative study

38. Management Training for Primary Health Care.

K- Indian Council of Social Sciences Research, New Delhi

39. An Alternate system of health care services in India - some proposals 1977

L- Centre for Social Action, Bangalore

40. Health Care in India 1983

41. Rakku's Story 1984

M- Institute of Education, Pune

42. Health for All - an alternative strategy (ICMR/ICSSR Study Group) 1981

N- Centre for Science and Environment, New Delhi

43. The State of India's Environment - the second Citizens' report 1984-85

O- Kerala Sashtra Sahitya Parishad, Trivandrum

44. Science as Social Action 1984

P- Community Health Cell, Bangalore

45. Community Health: The search for an alternative process (Draft report) 1987

Q- Ford Foundation, New Delhi

46. Anubhav Series: Experiences in Community Health (12 project reports available) 1987

R- Some Foreign Publications (with Indian case studies)

47. Health by the People (WHO, Geneva) 1975

48. Practising Health for All (Oxford University Press) 1983

49. Intersectoral linkages and health Development (WHO, Geneva) 1984

50. Disabled Village Children - A guide for community health workers, rehabilitation workers and families (Hesperian Foundation, U.S.A) 1987

TRADITIONAL MEDICINE

Ficus Carica

Fig. Tree (Anjir)

Use

1. Tooth ache	apply few drops of milky juice of the tree by breaking a small branch. This can be repeated if pain persists
2. Ring worm	rub the affected area with the milky juice twice a day until ring worm disappears
3. Warts	wash the feet well and dry. Place few drops on the warts and repeat every night until wart disappears.
4. Diabetes	figs are considered to have antidiabetic properties. Few drops of milky juice of figs in water every morning reduces the sugar in the blood.

Lilliacease - Aloe vera/Indian aloe (H-Ghikavar)

Use

1. Psoriasis	split the leaves of an aloe vera plant, apply the juice directly to psoriasis and let the juice dry. In a week it should be healed.
2. Bald head	fresh juice is to be applied on the scalp.
3. Constipation	juice is a drastic purgative. Use fresh juice 1-2 tsf for adults.

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4. Dandruff — apply fresh juice on the scalp for an hour and then wash it off. Repeat this daily until dandruff disappears.

5. Burns — it has been proven a good remedy for burns, treating effectively even 3rd degree burns.

6. Halwa can be made out of freshy part of the plant which is a remedy for indigestion and peptic ulcers.

Boat lilly, Commelinacea

Rhoeo spalhacea - Boat Lilly

Use

1. Whooping cough — leaves and flowers are boiled to make a hot decoction. An oz. of the liquid is given 3 times a day and whooping cough disappears.

2. Bacillary dysentery : boil the leaves for 10 minutes and use the decoction 3-4 times a day.

Papiliomacea - Fabaceae, Pongam oil tree - Karanj

Use

1. Herpes & scabies — apply the oil extracted from the seed for 3-5 days

2. Rheumatism — The oil massage with Karanj oil is considered beneficial to those suffering from rheumatism

3. Bronchitis — the powdered seed is used as an expectorant in bronchitis

4. Leprosy — oil of the seed is used in leprosy by the tribals.

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Graminae

Lemon Grass

Use

1. cold and cough	widely used in cold an cough. Tea is prepared from leaves
2. Fever	it is given as a diaphoretic in fever also carminative
3. Diuretic	tea made from the leave is diuretic

Euphorbiaceae - Phylanthus Niruri

Seed underleaf - Egg woman

Use

1. Jaundice	whole plant is used as a remedy for jaundice
2. Diabetes	the plant is considered to be useful in [redacted] diabetes
3. Dysentry	infusion of the young [redacted] shoots are often used for dysentry
4. Skin ailments	juice is taken from the plant and rubbed for skin ailments

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Reference: 1988 Table Calendar, Holy Family Hospital, New Delhi

(23)

BASIC PRINCIPLES IN CNAI'S COMMITMENT TO COMMUNITY HEALTH

1. Community Health is an approach to health care services. It takes into consideration a philosophy, attitude and commitment of working with people to help them help themselves. It is not a project, department or funding system.
2. Community Health focusses on the promotion and maintenance of health and gives priority or emphasis to the health team, primary health care and community needs.
3. Community participation is an essential component of Community Health. This recognises the potential role of others to help educate, organise, mobilise and support community development activities where the people have a say in and control over their own future. Community participation thus becomes involved in people's democratic rights and their contributions to the development of their society and nation.
4. In Community Health there is a recognition of a three tier system of primary, secondary and tertiary care approach to the needs of the community and the resources available. Therefore this approach accepts the role and potential of the hospital as integral to the Community Health. A commitment to Community Health is not necessarily anti-hospital. Yet the hospital needs to be supportive of Community Health and recognise and accept this wider concern in health care services.
5. In the provision of services in Community Health there is a bias towards those who are oppressed, exploited, the poor and the marginalised. Thus priority would be given to rural areas and urban slums. Special groups for concern would be women, tribals, dalits, small marginalised farmers and landless labourers.

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6. The organisation of services under Community Health would be appropriate, acceptable, easily available and affordable. It would be cost effective and willing to use unskilled, semi-skilled adequately trained local health personnel.
7. There is a place for voluntary agencies in Community Health.
8. Community Health accepts that health cannot be improved by health services alone; health and development need to be interlinked and interdependent.
9. There is a place for appreciating local customs, traditions, beliefs and health care systems and relating health services to the culture and socio-economic situation of people. Appropriate indigenous medical practices and trained practitioners, or traditional birth attendants are encouraged in Community Health.
10. In the final analysis Community Health is not apolitical. If it concerns the welfare of people and the provision of adequate and appropriate health care then health becomes a social justice issue. It is concerned with structures and systems of society that seem to benefit a few at the expense of many.

ASIAN COMMUNITY HEALTH ACTION NETWORK (ACHAN)

was formed in 1980 by a group of twenty people with substantial experience in working in health care among the poor in Asia and operates through its network of concerned individuals and non-governmental organisations in fifteen Asian countries, most of whom have been engaged in innovative primary care at the community level

ACHAN
seeks to spread a philosophy of community based health care that envisages a process of self reliant human development for the oppressed poor in Asian communities which will result in genuine social change.

ACHAN
views health as the physical, mental, social, spiritual, economic and political oneness of the individual and the community

ACHAN
believes that health problems and priorities should be viewed in terms in which the community sees them and that the community should be actively involved in planning, implementation, monitoring and evaluation of health care programmes.

KERALA SASHTRA SAHITYA PARISHAD (KSSP)

The Kerala Sashtra Sahitya Parishad (KSSP) believes that science which could become a powerful instrument of social change is in the hands of vested interests and has therefore become an instrument against the majority. This state of affairs should, however, change. Scientific temperament should become an integral part of the life process of the people. A powerful process of conscientization and scienticisation should take place to achieve this goal.

KSSP has completed twenty five years of work. A purely voluntary non-governmental organisation, it was initiated by a small group of scientists who took to the task of popularising science through books and periddicals in simple Malayalam, the mother tongue of Keralites. Through the years, this small group has transformed itself into a mass organisation of people from all walks of life.

HEALTH BRIGADE

KSSP is very strongly questioning the relevance of the present day health delivery system which is curative oriented, individualised, institutionalised and highly costly and catering to the needs of a wealthy minority. KSSP feels that a People's Health Movement alone can change the health delivery system in fabour of the rural poor. KSSP is organising health camps, classes and audio-visual campaigns [redacted] on extensive scale. KSSP has recently started [redacted] a big campaign to expose the anti-people and unethical policies of the multinational drug companies.

We have completed a very comprehensive health survey covering the whole of Kerala. On the basis of the survey results, the KSSP intends to formulate a people's health programme for Kerala. The KSSP is mounting a vigorous compaign against the recent drug price hike. KSSP publications like 'Hathi Committee - A decade after', 'The Drug Information Packet', 'Banned and Bannable Drugs' have received wide acclaim. ( )

Profiles of projects from States

STREEHITAKARINI : Bombay's Slums

An organisation of women living in slums, which started with Maternity, Child Health and Family Planning Services by volunteer doctors, and extended into areas of non-formal education, female literacy, income generation programmes for women and running of creches for uncer-fives. Their small savings scheme won the Government campaign award for 1985.

The health component is tackled through Community Health workers and utilizes the nearest government hospitals for referral. The stress is on creating awareness about health and promoting utilization of the facilities available.

K.E.M HOSPITAL, RURAL HEALTH PROJECT, Pune District, Maharashtra

A Co-operative effort of a voluntary organisation with the Government in providing Rural Health Services. Socio-economic development programmes are with the involvement of a separate organisation - UNDARP, with close links to the health project.

Health activities are through Community Health Guides of KEM with Multipurpose workers of the Government cadre at the grass roots. The Secondary and Tertiary links are the upgraded P.H.C at Vadu and KEM Hospital at Pune. All activities are facilitated by awareness programmes at Mahila mandals and youth clubs.

SOCIETY FOR EDUCATION, WELFARE AND ACTION - RURAL

SEWA - Rural - Jhagadia, Gujarat

An experiment in health management, towards creating a participative self-reliant organisational culture in Integrated Health and Rural Development. The government had handed SEWA - Rural principal responsibility for total health care.

The delivery of health services is through a four tier infrastructure, with the CHVs, AWWs, TBAs at Community level, MPWs at tertiary level, Mobile Dispensary with M.O and MPWs at middle level and a fully equipped referral hospital with consultants and paramedical staff at the Central level.

SEWA-Rural has won the WHO's SASAKAWA HEALTH PRIZE for 1985.

Activities in non-health areas include Gramin Takniki Kendra, Tutorial classes for Tribal boys and girls and Economic programmes for women

COMPREHENSIVE LABOUR WELFARE SCHEME OF U.P.&.S.I

- Plantations of Tamilnadu and Kerala

A Labour Welfare Scheme based on the belief that health is indispensable to the productive performance of workers. It has sensitized the management to the validty of the premise that the employee's health and welfare are convergent with the employer's interest.

Voluntary 'LINK WORKERS' form the key element in Health education and linking the Community to the health services consisting of Maternity and Child Health, Family planning, Environmental Sanitation, Safe drinking water supply and Health education programmes.

MINI HEALTH CENTRES PROGRAMME OF VOLUNTARY HEALTH SERVICES

Chenglsput District, Tamilnadu

Aim at enlarging the scope of functions of the Primary Health Centre, emphasising preventive care, treating the family as a unit and ensuring community co-operation. The Mini-Health Centre is the model point of delivery of health care, the components being Maternity services, child welfare and nutrition, family welfare, minor ailment treatment, communicable disease control, referral and most important of all data collection and health record maintenance. The LAY-FIRST-AIDER (L.F.A) is the grass roots contact, with Multipurpose workers and a part-time Doctor at the M.H.C. Ayurvedic and indigenous medicine are utilized, and a form of medical insurance by prepayment helps in community participation.

This is now adopted statewide as a model.

ACTION FOR WELFARE AND AWAKENING IN RURAL ENVIRONMENT :(A.W.A.R.E)

Andhra Pradesh (Telengana)

Seeks to create self-sustaining rural and tribal communities through a process of socio-economic and psychological invigoration. Their activities include Agricultural development, Social action for education, Community programmes, Women's development, Rehabilitation of bonded labourers and landless poor, cottage industry and marketing.

The health philosophy 'JEEVANA SRAVANTHI' which means life's flow started unexpectedly following natural disasters and led to a sustained activity. The services are through village health workers, Paramedical Community Health Workers and Dais, An innovation is a floating health centre on boat catering to 300 villages along the banks of Godavari.

They work along with Governmental and NGOs as a re-inforcing element.

COMPREHENSIVE HEALTH AND DEVELOPMENT PROJECT - Pachod, Aurangabad Dt Maharashtra

A Project to make rural health more effective within the overall policies and framework of the government programme by wider application of innovative modalities and rational and efficient use of limited resources.

The services provide complete maternity care, Health and nutrition education, growth monitoring and nutritional surveillance of children and Environmental programmes, through Community Health Workers. The problem os illiteracy among the CHWs has been overcome using simplified systems and symbolic reporting, while the Health Education messages developed locally are unsophisticated, appropriate and brief.

RURAL UNIT FOR HEALTH AND SOCIAL ACTION

- K V Kuppam Block, Tamilnadu

Reflects a holistic approach to health, in association with the local community, the government and other voluntary agencies. They provide integrated health and development services to the people, including Adult education, Vocational training, Income generation, Agricultural development and agro-support services.

The health component is formed by the Family Care Volunteers (FCVs), Health aides (AAs) and Rural Community Organisers (RCOs) with close health and non-health activity linkages.

Collective leadership models are seen in Village Advisory Committees, Block Development Committees, Women's groups, Young Farmers clubs and socio-economic groupswith similar occupations.

They believe that HEALTH IS BOTH A MEANS AND MEASURE OT DEVELOPMENT.

CHILD-IN-NEED INSTITUTE - 24 Paraganas, West Bengal

Caters Primarily to the health needs of the disadvantaged semi-urban population around the southern outskirts of Calcutta. CINI associates with national and international agencies in research, consultancy and training for Primary Health Care, while it operates mainly in the field of Maternal and Child Health along with Community organisation and community development.

The Health services are village based clinics run by Mahila Mandals which is the focal point of all activities. The Emergency Ward and Nutrition Rehabilitation Centre of the ill and severly malnourished child is a facility used much further than the project area itself.

CINI has had a multiplier effect through persons trained here having weaned off after starting similar new projects.

BANWASI SEVA ASHRAM, Mirzapur District, Uttar Pradesh

An integrated rural development programme based on the Gandhian philosophy of self-sufficiency. The Agro-industrial community development centre (Agrindus) was the nucleas of diverse activities which included agriculture, land reclamation, irrigation, afforrestation, dairy, village industries functional literacy, village fund (gramkosh) people's organisations (gram swarajya sabhas) and legal aid (Lok adalat)

The Health component was a three tier structure of local health volunteers (Swasthya mithras) village health posts (gramin doctors) and Agrindus clinic. The programme included minor ailment care, indigenous medicines, health education nutrition education.

BODOKHONI, Ganjam District, Orissa

An adult education/informal education programme that took up health issues for action. Two village organisations, women's group (Mahila Sangha) and men's organisation (Gramya Sangha) were formed and some health animators were trained to manage common ailments and ptoblems. The organisations initiated a grain bank, a savings scheme, functional lireracy programme, community goat rearing programme subsidesed by IRDP and non-formal school for children. The health animators believed that these programmes were as important as disease treatment since they worked at the root causes of ill health

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MALLUR HEALTH CO-OPERATIVE, Siddlaghata Taluk, Karnataka

A field practice area for St John's Medical College, Bangalore the Mallur Health Co-operative was initiated by a Dairy Co-operative taking on the responsibility of health for its village. Starting with a health cess per litre of milk produced the cooperative organised a health service which included curative, preventive and promotive services with cooperation with the government health centre as well. Years later the health cooperative was changed to a Health endowment fund by the cooperative.

RAHA, Raigarh Ambikapur Health Association, Madhya Pradesh

An informal network of 3 base hospitals and 47 small rural health centres which initiated village health promoters training programme with the help of a mobile team. In addition, school health programmes with volunteer school health guides (from among teachers). TB control programme and an innovative Medical insurance scheme was also organised.

PADHAR HOSPITAL COMMUNITY HEALTH PROJECT, Betul district, Madhya Pradesh

A comprehensive health care programme as an outreach of a mission hospital with credibility in local area. The components included training of village health workers, training of dais, health education, provision of immunization, minor medical care and family planning care. Non-formal education in literacy, agriculture and hygiene and health were also included. The health workers are supervised by a mobile community health training team.

REHBAR-I-SEHAT programme, Kothbhalwal block, Jammu & Kashmir

A project organised by the Government of Jammu & Kashmir to train teachers of village schools as primary health care guides. Their function included minor ailment treatment, health check up, health talks to children and villagers on nutrition, immunization, family welfare environmental sanitation, MCH and personal hygiene, nutrition supplementation programmes for school children and supervision of village functionaries responsible for collecting vital statistics.

COMMUNITY HEALTH PROGRAMMES--PROFILES

The Nilgiri Adivasi Welfare Association (NAWA), Tamilnadu

The NAWA was founded in 1958. Community health programme include, apart from medical care, nutrition; health education; adult education; encouragement of schooling; income generating projects in cooperation with government, bank and voluntary bodies. The tribals are being enabled to develop and adapt to the changing environment. The increasing literacy amongst young people has helped them improve in this direction. The Association is concentrating on the rehabilitation of these people keeping in view their varied stages of development and survival problems. The tribals now value education and seeit as a way to a better future.

Vivekananda Girijana Kalyana Kendra, BR Hills, Mysore

A voluntary organisation working with the Soliga tribals in these areas with the ideal of 'service of God in man'.

By building people's organisations, the Soliga Abhivrudhi Sanghas, external distortive influence on tribal culture is minimized and developmental activities include community organization; education; adult education; cottage industries; vocational training; agriculture; housing and cooperatives in liaison with the government and other agencies.

MEDICARE, Kasturba Medical College, Manipal

Rural Maternity and Child Welfare Home: seven centres with 6 beds each with supporting facilities for delivery, at a distance of 3 to 20 miles from the hospital are run. A team from the hospital visits each centre once a week. Intensive health education, safe water supply and sewage disposal with the help of Panchayat, immunization programmes; pest control measures and family welfare programmes are undertaken apart from a comprehensive medicaland dental health care scheme.

Total Health Care Project, Tamulpur Block, Kamrup Dist. Assam

Started in 1976 covers a population consisting of tribal and other backward castes in 204 villages of the Block. Activities of the project include provision of various basic health services like family planning, immunization, attending to minor ailments, control of tuberculosis, leprosy and malaria etc.

St Xavier's Social Service Organization, Ahmedabad

A voluntary agency working in the slums of Ahmedabad in areas of community organisation through 'Pragathi Seva Samiti' and 'Jagruthi Mahila Mandal'. Their economy generating activity is by promoting skills in garment and quilt making, electronics, masonry, plumbing etc. while strengthening areas like poultry, agarbathi making, Kite-making and screen printing industry already existing there. The health component is delivered by community health workers in areas of nutrition, antental care, infectious diseases and family planning methods by a locally evolved training programme. Health education has been accorded prime importance.

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~~STREEHITAKARINI~~ STREEHITAKARINI

- Started in 1964 - Slums of Bombay City
- Population covered - 100,000.
- Activities :
  - Maternal and Child Health
  - Family Planning services by volunteer doctors

Extended into
- Non formal education
- Female literacy
- Income generation programmes for women
- Creches for under fives
- Small savings scheme. (This won the Government campaign award for 1985

Health activities through
- community Health Workers
- utilization of nearest Government Hospitals

Stress on creating awareness about Health and promoting utilization of facilities available.

K.E.M. ~~Project~~ Hospital Rural Health Project

- Started in 1977, Pune District Maharashtra
- Population covered - 186,442.

Activities
- Maternal and Child Health
- Family Planning
- Control of communicable diseases
- Health Education
- Environmental sanitation
- Mahila Mandal, Youth clubs - awareness programmes

~~Socio-economic programmes~~

Socio-economic development programmes are with a closely linked voluntary organisation - UNITED SOCIO-ECONOMIC DEVELOPMENT AND RESEARCH PROGRAMME ~~(UNDARP)~~.

~~Health~~ through
- Community Health Guides of K.E.M. Project } Grass root level
- Multipurpose workers of Government cadre. }
- Upgraded PHC at Vadu - at Secondary level
- KEM Hospital - at Tertiary level.

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Activities in non-health areas include Gramin Takniki Kendra, Tutorial classes for Tribal boys and girls and Economic programmes for women

SEWA - RURAL

- Started in 1980 Jhagadia, Gujarat.
- Population covered - 35,000.

Activities
- Mainly health, through
  - Community Health Volunteers
  - Anganwadi Workers
  - Trained Birth Attendants
  } at community level.
- Multipurpose workers as intermediaries.
- Mobile Dispensary with Medical Officer and MPWs } at middle level
- fully equipped referral hospital with consultants & paramedical staff } at Central level.

- SEWA-rural has won the W.H.O's SASAKAWA HEALTH PRIZE for 1985.

Activities in non-health areas
- Gramini Takniki Kendra
- Tutorial classes for Tribal boys & girls
- Economic programmes for women.

Affairs

RURAL UNIT FOR HEALTH AND SOCIAL ACTION

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They believe that HEALTH IS BOTH A MEANS AND MEASURE OT DEVELOPMENT.

RUHSA

- Started in 1977 - K.V. Kuppam Block, Tamilnadu.
- Popuby. covered - 100,000

Activities:
- Health and Family Welfare
- Adult Education
- Vocational training
- Community Organisation
- Income generation
- Agricultural development and Agro-support services.

The health component is by
- Family Care Volunteers (FCVs)
- Health Aides (HAs) and
- Rural Community Organisers

with close health and non-health activity linkages.

They believe that HEALTH IS BOTH A MEANS AND MEASURE OF DEVELOPMENT.

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MINI HEALTH CENTRES PROGRAMME OF VOLUNTARY HEALTH SERVICES

Chengleput District, Tamilnadu

Aim at enlarging the scope of functions of the Primary Health Centre, emphasising preventive care, treating the family as a unit and ensuring community co-operation. The Mini-Health Centre is the model point of delivery of health care, the components being Maternity services, child welfare and nutrition, family welfare, minor ailment treatment, communicable disease control, referral and most important of all data collection and health record maintenance. The LAY-FIRST-AIDER (L.F.A) is the grass roots contact, with Multipurpose workers and a part-time Doctor at the M.H.C. Ayurvedic and indigenous medicine are utilized, and a form of medical insurance by prepayment helps in community participation.

This is now adopted statewide as a model.

CLWS of UPASI — Started in 1971 - Plantations in T.N. & Kerala.
Population covered - 250,000 (1984).

Activities
- Maternal and Child Health
- Family Planning
- Environmental Sanitation
- Safe drinking water
- Health Education.

- Voluntary 'LINK-WORKERS' form the key element linking the community to Health Services.
- Has sensitized the management to the idea that employees health and welfare is congruent with employer's interests.

Mini Health Centres program of V.H.S.

- Started in 1977 - Chinglepet Dist. T.N.
- Population covered - 160,000.
- Activities
  - Maternity Services
  - Child Welfare & nutrition
  - Family Welfare
  - Minor ailment treatment
  - Communicable disease control
  - Data collection and Health Record maintenance.
- Lay-First-Aider (LFA) is grass roots contact
- Multipurpose workers and Part-time Doctors at Mini Health Centres.
- Ayurvedic and indigenous medicines utilized.
- A form of medical insurance by prepayment encouraged.
- AIM AT ENLARGING THE SCOPE OF FUNCTIONS OF THE P.H.C.
- ADOPTED AS A MODEL STATEWIDE.

ACTION FOR WELFARE AND AWAKENING IN RURAL ENVIRONMENT :(A.W.A.R.E)

Andhra Pradesh (Telengana)

Seeks to create self-sustaining rural and tribal communities through a process of socio-economic and psychological invigoration. Their activities include Agricultural development, Social action for education, Community programmes, Women's development, Rehabilitation of bonded labourers and landless poor, cottage industry and marketing.

The health philosophy 'JEEVANA SRAVANTHI' which means life's flow started unexpectedly following natural disasters and led to a sustained activity. The services are through village health workers, Paramedical Community Health Workers and Dais, An innovation is a floating health centre on boat catering to 300 villages along the banks of Godavari.

They work along with Governmental and NGOs as a re-inforcing element.

COMPREHENSIVE HEALTH AND DEVELOPMENT PROJECT - Pachod, Aurangabad Dt Maharashtra

A Project to make rural health more effective within the overall policies and framework of the government programme by wider application of innovative modalities and rational and efficient use of limited resources.

The services provide complete maternity care, Health and nutrition education, growth monitoring and nutritional surveillance of children and Environmental programmes, through Community Health Workers. The problem of illiteracy among the CHWs has been overcome using simplified systems and symbolic reporting, while the Health Education messages developed locally are unsophisticated, appropriate and brief.

A.W.A.R.E - Started 1975 - Telangana, Andhra Pradesh

Activities:
- Agricultural development
- Social action for Education
- Community programs
- Women's development
- Rehabilitation of bonded labour and landless poor
- Cottage industries and marketing

Health:
- Health Education
- Environmental Sanitation
- Disease control
- Maternal and Child Health
- Nutrition.

The health philosophy 'JEEVANA SRAVANTHI' which means life's flow started following natural disasters and led to a sustained activity.
Services are through - Village Health Workers and Dais
- Paramedical Community Health Workers
An innovation is a floating health centre on boat, catering to 300 villages along the

Comprehensive Health & Development Projet - Paithad

Started in 1977, Paithad, Aurangabad dt., Maharashtra.

Population covered -

Activities -
- Complete Maternitycare
- Health and Nutrition Education
- Growth monitoring and Nutritional Surveillance of children
- Anganwadis
- Environmental programs

Health activities are through Trained Dais, CHWs, Anganwadis and fortnightly Health Post clinics.

- Simplified systems and symbolic reporting overcomes literacy problems in CHWs.
- Health Education messages are locally developed, unsophisticated and brief.

† INTEGRATED HEALTH SERVICES PROJECT - MIRAJ

~~Started~~ at Miraj Taluk, Sangli Dt. Maharashtra

Population - 2,30,329.

Activities:
- M.CH care
- Family Planning
- School Health.
- Communicable Disease control
- Environmental Sanitation
- Health Education.

-using Basic Health Workers, Dais, ANMs and Village Health Assistants.

† COMPREHENSIVE HEALTH PROJECT, RANGABELIA

Started in 1976 - Rangabelia P.O., 24 Paraganas, W.B.

Popnln:

Activities -
- M.C.H. care
- Communicable disease control
- Minor ailment treatment.
- Family Welfare services
- Housing, safe drinking water, sanitation
- Health Education

in close collaboration with the health services of the Govermt.

† · COMMUNITY HEALTH PROJECT

~~Started in~~ at Lalitpur ~~Dist~~, U.P.

Population - 4,74,519.

Activities :
- Maternal and Child Health.
- Nutrition
- Health Education.
- Communicable disease control.

through Village Health Workers from the community.

† PADHAR HOSPITAL COMMUNITY HEALTH PROJECT

† COMPREHENSIVE RURAL HEALTH PROJECT - JAMKHED

~~Started in~~

Population covered - 40,000.

Activities :
- MCH.
- Nutrition & Immunization.
- Family Welfare services
- Control of communicable diseases.
- Safe water
- Agricultural development
- Health Education.

through Young Farmers Clubs and by Village Health Workers.

† THE RURAL HEALTH RESEARCH PROJECT of F.R.C.H.

- Started in. 1973 North Alibag and Uran Taluk Maharashtra.
- Population 90,000.

Activities :
- Community Organisation
- MCH care
- ~~Preventive~~ Nutrition Education
- Health Education
- Treatment minor ailments.

through Village Health Workers, and with the Primary Health Unit as the apex of preventive, promotive & curative health care

+ PROJECT POSHAK

1971 to 1975 Popnlvn. - 12000 children + 2,700 women.

(10 Tribal + 2 Non-Tribal ~~talug~~ districts of Madhya Pradesh.)

Activities:
- Take home food supplements
- Preventive & Curative Health Services
- Maternal and Child care education

by utilising the existing health and tribal welfare infrastructure of the Government.

+ THE KASA MODEL MOTHER-CHILD-HEALTH-NUTRITION PROJECT

- Started in 1972 at Palghar P.H.C. Kasa, Thana Dist. Maharashtra
- Popnlvn. - 56,364.

Activities: - integrated health & nutrition services to young children and mothers.

by using existing P.H.C. services and personnel along with PTSWs (Part-time Social Workers) serving as link workers and providing special coverage to the needy at clinics or at home.

C/o Grant Medical Coll & J.J. Gp of Hosp Bombay.

+ INDO-DUTCH PROJECT FOR CHILD WELFARE: Hyderabad A.P.

- Started 1969.
- Popnlvn: 33,756

Activities:
- Mother & Child care - health, education and nutrition.
- Mahila Mandals
- Nursery & Primary Schools.
- Youth development / Adult Education
- Nutrition demonstration units
- Poultry & Dairy units.

Utilization of "GRAM SVASTHIKA"s as link between the Community and Health services.

Director Indian Bureau Indo-Dutch project for child welfare 6-3-885 Somajiguda HYD (A.P.)

CHILD-IN-NEED INSTITUTE - 24 Paraganas, West Bengal

Caters Primarily to the health needs of the disadvantaged semi-urban population around the southern outskirts of Calcutta. CINI associates with national and international agencies in research, consultancy and training for Primary Health Care, while it operates mainly in the field of Maternal and Child Health along with Community organisation and community development.

The Health services are village based clinics run by Mahila Mandals which is the focal point of all activities. The Emergency Ward and Nutrition Rehabilitation Centre of the ill and severly malnourished child is a facility used much further than the project area itself.

CINI has had a multiplier effect through persons trained here having weaned off after starting similar new projects.

BANWASI SEVA ASHRAM, Mirzapur District, Uttar Pradesh

An integrated rural development programme based on the Gandhian philosophy of self-sufficiency. The Agro-industrial community development centre (Agrindus) was the nucleus of diverse activities which included agriculture, land reclamation, irrigation, afforrestation, dairy, village industries functional literacy, village fund (gramkosh) people's organisations (gram swarajya sabhas) and legal aid (Lok adalat)

The Health compoonent was a three tier structure of local health volunteers (Swasthya mithras) village health posts (gramin doctors) and Agriodus clinic. The programme included minor ailment care, indigenous medicines, health education nutrition education.

C.I.N.I. · Started in 1974 - 24 Paraganas Dt. West Bengal
Population covered - 70,000.

Activities - Maternal and Child Health Care.
- Community Organisation and Community Development.

Health care is through - Mahila Mandal run clinics
- Balwadis.
- Emergency Ward & Nutritional Rehabilitation centre.

CINI has a multiplier effect with persons trained here starting new, similar projects and weaning off.

BANWASI SEVA ASHRAM

- Started 1954
  Mirzapur Dt U.P.
- Population covered, 3,50,000

Activities
- Agriculture
- Dairy
- Village Industries
- Education
- GRAM KOSH (revolving village fund for cheap credit)
- Social Justice programs

Health and Family Planning activities through
- Swasthya Mitra (local Volunteers)
- Gramin Doctors & 4 Village Health Posts
- AGRINDUS clinics
- ~~Specialised Medical Institution~~

Based on Gandhian Philosophy of Self-Sufficiency with AGRINDUS (Agro-Industrial Community Development centre) as the nucleus of its diverse activities

BODOKHONI, Ganjam District, Orissa

An adult education/informal education programme that took up health issues for action. Two village organisations, women's group (Mahila Sangha) and men's organisation (Gramya Sangha) were formed and some health animators were trained to manage common ailments and ptoblems. The organisations initiated a grain bank, a savings scheme, functional literacy programme, community goat rearing programme subsidesed by IRDP and non-formal school for children. The health animators believed that these programmes were as important as disease treatment since they worked at the root causes of ill health

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MALLUR HEALTH CO-OPERATIVE, Siddlaghata Taluk, Karnataka

A field practice area for St John's Medical College, Bangalore the Mallur Health Co-operative was initiated by a Dairy Co-operative taking on the responsibility of health for its village. Starting with a health cess per litre of milk produced the cooperative organised a health service which included curative, preventive and promotive services with cooperation with the government health centre as well. Years later the health cooperative was changed to a Health endowment fund by the cooperative.

RAHA, Raigarh Ambikapur Health Association, Madhya Pradesh

An informal network of 3 base hospitals and 47 small rural health centres which initiated village health promoters training programme with the help of a mobile team. In addition, school health programmes with volunteer school health guides (from among teachers). TB control programme and an innovative Medical insurance scheme was also organised.

BODOKHONI - Ganjam Dist. Orissa
Started -
Population -
Activities - ◦ Adult Education] taking up health issues for action.
◦ Informal Education]
◦ Grain bank
◦ Savings scheme
◦ Goat rearing ◦ Non formal ~~Educ~~ School for children.

through Health Animators who believe that these are as important as disease treatment — and manage common ailments.
They work ~~through~~ with - Gramya Sangha (Men's org^n)
- Mahila Sangha (Women's org^n)

Mallur Health Co-operative

Sidlaghatta Taluk Karnataka.

Started - 1972

Popnly. -

Activities - ○ Dairy Co-operative
○ Preventive
○ Promotive
○ Curative
} Health service with Govt. health centre.

Dairy Co-operative took up Health responsibility of the village which evolved into a Health Endowment Fund to cater for all health needs

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R.A.H.A. Madhya Pradesh

Started

Popnly.

Activities
- ○ A network of 3 base hospitals and 47 rural health centres
- ○ All aspects of health
- ○ School Health Programs with voluntary School Health Guides from School teachers.
- ○ T.B. control program.
- ○ Innovative medical insurance scheme.

PADHAR HOSPITAL COMMUNITY HEALTH PROJECT, Betul district, Madhya Pradesh

A comprehensive health care programme as an outreach of a mission hospital with credibility in local area. The components included training of village health workers, training of dais, health education, provision of immunization, minor medical care and family planning care. Non-formal education in literacy, agriculture and hygiene and health were also included. The health workers are supervised by a mobile community health training team.

REHBAR-I-SEHAT programme, Kothbhalwal block, Jammu & Kashmir

A project organised by the Government of Jammu & Kashmir to train teachers of village schools as primary health care guides. Their function included minor ailment treatment, health check up, health talks to children and villagers on nutrition, immunization, family welfare environmental sanitation, MCH and personal hygiene, nutrition supplementation programmes for school children and supervision of village functionaries responsible for collecting vital statistics.

Padhar Hosp. CHP - Betul Dist. M.P.
Started -
Popmen -

SOCIETY FOR EDUCATION, WELFARE AND ACTION - RURAL

SEWA - Rural - Jhagadia, Gujarat

An experiment in health management, towards creating a participative self-reliant organisational culture in Integrated Health and Rural Development. The government had handed SEWA - Rural principal responsibility for total health care.

The delivery of health services is through a four tier infrastructure, with the CHVs, AWWs, TBAs at Community level, MPWs at tertiary level, Mobile Dispensary with M.O and MPWs at middle level and a fully equipped referral hospital with consultants and paramedical staff at the Central level.

SEWA-Rural has won the WHO's SASAKAWA HEALTH PRIZE for 1985.

Activities in non-health areas include Gramin Tekniki Kendra, Tutorial classes for Tribal boys and girls and Economic programmes for women

STREEHITAKARINI : Bombay's Slums

An organisation of women living in slums, which started with Maternity, Child Health and Family Planning Services by volunteer doctors, and extended into areas of non-formal education, female literacy, income generation programmes for women and running of creches for uncer-fives. Their small savings scheme won the Government campaign award for 1985.

The health component is tackled through Community Health workers and utilizes the nearest government hospitals for referral. The stress is on creating awareness about health and promoting utilization of the facilities available.

K.E.M HOSPITAL, RURAL HEALTH PROJECT, Pune District, Maharashtra

A Co-operative effort of a voluntary organisation with the Government in providing Rural Health Services. Socio-economic development programmes are with the involvement of a separate organisation - UNDARP, with close links to the health project.

Health activities are through Community Health Guides of KEM with Multipurpose workers of the Government cadre at the grass roots. The Secondary and Tertiary links are the upgraded P.H.C at Vadu and KEM Hospital at Pune. All activities are facilitated by awareness programmes at Mahila mandals and youth clubs.

COMPREHENSIVE LABOUR WELFARE SCHEME OF U.P.S.S.I

- Plantations of Tamilnadu and Kerala

A Labour Welfare Scheme based on the belief that health is indispensable to the productive performance of workers. It has sensitized the management to the validity of the premise that the employee's health and welfare are convergent with the employer's interest.

Voluntary 'LINK WORKERS' form the key element in Health education and linking the Community to the health services consisting of Maternity and Child Health, Family planning, Environmental Sanitation, Safe drinking water supply and Health education programmes.

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Chengleput District, Tamilnadu

Aim at enlarging the scope of functions of the Primary Health Centre, emphasising preventive care, treating the family as a unit and ensuring community co-operation. The Mini-Health Centre is the model point of delivery of health care, the components being Maternity services, child welfare and nutrition, family welfare, minor ailment treatment, communicable disease control, referral and most important of all data collection and health record maintenance. The LAY-FIRST-AIDER (L.F.A) is the grass roots contact, with Multipurpose workers and a part-time Doctor at the M.H.C. Ayurvedic and indigenous medicine are utilized, and a form of medical insurance by prepayment helps in community participation.

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RURAL UNIT FOR HEALTH AND SOCIAL ACTION

- K V Kuppam Block, Tamilnadu

Reflects a holistic approach to health, in association with the local community, the government and other voluntary agencies. They provide integrated health and development services to the people, including Adult education, Vocational training, Income generation, Agricultural development and agro-support services.

The health component is formed by the Family Care Volunteers (FCVs), Health aides (AAs) and Rural Community Organisers (RCOs) with close health and non-health activity linkages.

Collective leadership models are seen in Village Advisory Committees, Block Development Committees, Women's groups, Young Farmers clubs and socio-economic groupswith similar occupations.

They believe that HEALTH IS BOTH A MEANS AND MEASURE OT DEVELOPMENT.

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(27)

THE ANTWERP MANIFESTO FOR PRIMARY HEALTH CARE

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

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

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

These principles are:

* The main roots of poor health lie in living conditions and the environment in general, and more specifically in poverty, inequity and the unfair redistribution of resources in relation to needs, both inside individual countries and internationally.
* Since health is only one of the concerns of people, it is self-defeating not to consider them as partners who are able to play a great part in the protection and the improvement of their own health. They thus have to be fully and really involved in the making of decisions which affect their health, including of course, the provision of health services.

.....2

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

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

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

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

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

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

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

ALMA ATA - - Ten Years After

A decade ago, on September 25, 1978, the Alma Ata conference formulated at Primary Health Care (PHC) strategy to achieve "Health for All" (HFA) by the year 2000. Some argue that there has been virtually no success and that we should abandon the strategy. Others maintain that considerable progress has been made and that we only need to redefine the objectives slightly in planning for the year 2000.

In its first evaluation report, WHO claimed that some progress has been made towards HFA 2000. Paradoxically, it is the developed countries that have benefitted most, Developing countries still have not achieved much success in PHC coverage. The obvious success stories, such as the achievement of 50 percent coverage in child immunization and the final eradication of small pox, cannot conceal the wide gulf which still exists between the urban "haves" and the rural "have-nots". Nearly 65 percent of people in rural India are trapped in the vicious cycle of poverty, malnutrition and infectious disease, which reduces their capacity to work and limits their ability to plan for the future. For example, 100 to 200 out of every 1000 infants born alive still die during their first year of life.

In spite of the dismal statistics, some progress has been made in the decade since Alma Ata, including reductions in the infant mortality rate, the crude birth rate and the death rate, and an increase in life expectancy. The concept of the community health worker, who is selected by the local community to serve the community, has had considerable impact. Medical education has been re-oriented toward social goals, and the teaching of preventive and social medicine has been upgraded. There has been a signifciant progress in re-orienting the PHC to maximize the use of limited resources through better management.

....2

One lesson learned in this decade is that the technocratic approach does not work. Many now believe that short term strategies such as "selective Primary Health Care" should be abandoned because they are in opposition to the fundamental principle of HFA through PHC. Such strategies, which offer quick and relatively cheap remedies for common health problems, will only divert scarce resources from the solution of the underlying and basic problems that generate poor health. What is needed is an integrated socio-economic-health development approach that works from the grass roots up and which gives people control over their own health

(Source: Article Br Dr. Vijay Moses, Head, Department of Community Health, Christian Medical Association of India in FIONA PLUS, Issue 3 December 1988)

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PRIMARY HEALTH CARE

DECLARATION OF ALMA-ATA -- 12.9.1978

RELEVANT EXTRACTS

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care:

1. reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problemsin the community, providing promotive, preventive, curative and rehabilitative services accordinglly;

.....2

3. includes atleast: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; appropriate treatment of common diseases and [redacted] injuries; prevention and control of locally endemic diseases; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

....3

7. relies at local and referral levels, on health workers including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

....

CHAI's Philosophy and Vision of its Community Health P.

The Community Health Department of CHAI also felt the need for a correct understanding of its role in the field of health. All the points mentioned above were the basis for its conclusions. Accordingly we believe that:

1. In a country like India, so vast and varied, where 80% of its population lives in the rural areas and about 90% of the country's health care system caters to the need of the urban minority, a new orientation and rethinking of the whole health care system is the need of the hour.
2. Health is the total well-being of individuals, families and communities as a whole and not merely the absence of sickness. The demands an environment in which the basic needs arefulfilled, social well-being is ensured and psychological as well as spiritual needs are met. Accordingly a new set of parameters will have to be considered for measuring the health of a community such as the people's part in decision making, absence of social evils in the community, organising capacity of the people, the role women and youth play in matters of health and development etc., other than the traditional ones like infant mortality rate, life expectancy etc.
3. The present medical system with undue emphasis on the curative aspect tends mainly to be a profit oriented business, and it concentrates on 'selling health' to the people, and is hardly based on the real needs of vast majority of the people in the country. The root causes of illness lie deep ub in social evils and imbalances, to which the real

...2

answer is a political end, understood as a process through which people are made aware of the real needs, rights and responsibilities, available resources in and around them and get themselves organised for appropriate actions. Only through this process can health become a reality to the vast majority of the Indian Masses.

4. The concept of Community Health here whould be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness and income generating programmes.

EXPLORING JARGON

The World Health Organization has defined Health as a 'state of physical, mental and social well being and not merely an absence of diseases of infirmity

While this definition focusses on the health of individuals it could as well be a description of the ideal state for families and communities. Community Health would therefore mean 'a process of improving the physical, mental and social well being of the community and all its component members.

This interest in health action focussed on the community and not only on the individual is not new. From times immemorial efforts have been made by doctors and communities to evolve health actions that are focussed on the environment - physical, chemical, biological, social, mechanical, psychological, culture, ecological rather than on individual patients. This increasing knowledge has over times evolved into various disciplines and today though we use these names synonymously they do have their own distinctive meanings and focus. In a way they also represent the historical development of skills focussed on community health

1. Medicine: The art of preventing and curing disease
2. Hygiene: The Science of Health
3. Public Health: The branch of medicine that deals with statistics, hygiene and the prevention and overcoming of epidemics.
4. Preventive Medicine: The branch of medical science that deals with prevention of diseases
5. Social Medicine: Systematic study of human diseases with special reference to social factors

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6. Socialised Medicine (State medicine):

The control of medical practice by an organisation of the government, the practitioners being an integral part of the organisation from which they draw their fees and to which the public contribute in some form or other (same as National Health Service)

7. Community Medicine: A unified and balanced integration of curative, preventive and promotional health services focussed on the community

As Parks textbook (standard reference in India) says

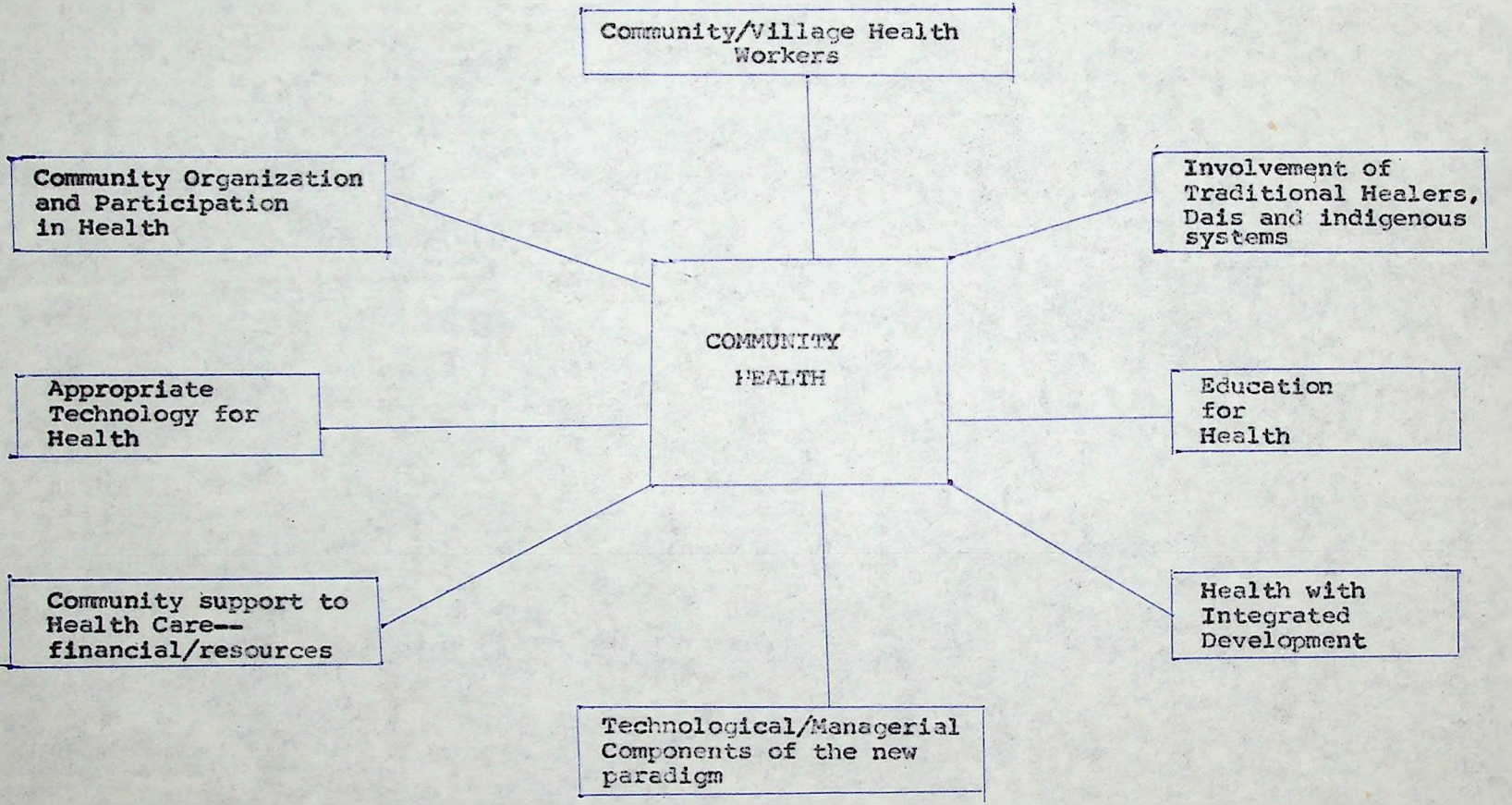
"Once looked upon as a healing art, medicine is looked upon today as the sum total of all activities of a given society that tend to promote, restore and maintain the health of the people. Where such a concept prevails, medicine includes more than a physician's action; it becomes community health"

Community Health as we understand it today includes all the ideas and disciplines mentioned above and more. As new approaches evolve the definition becomes more comprehensive.

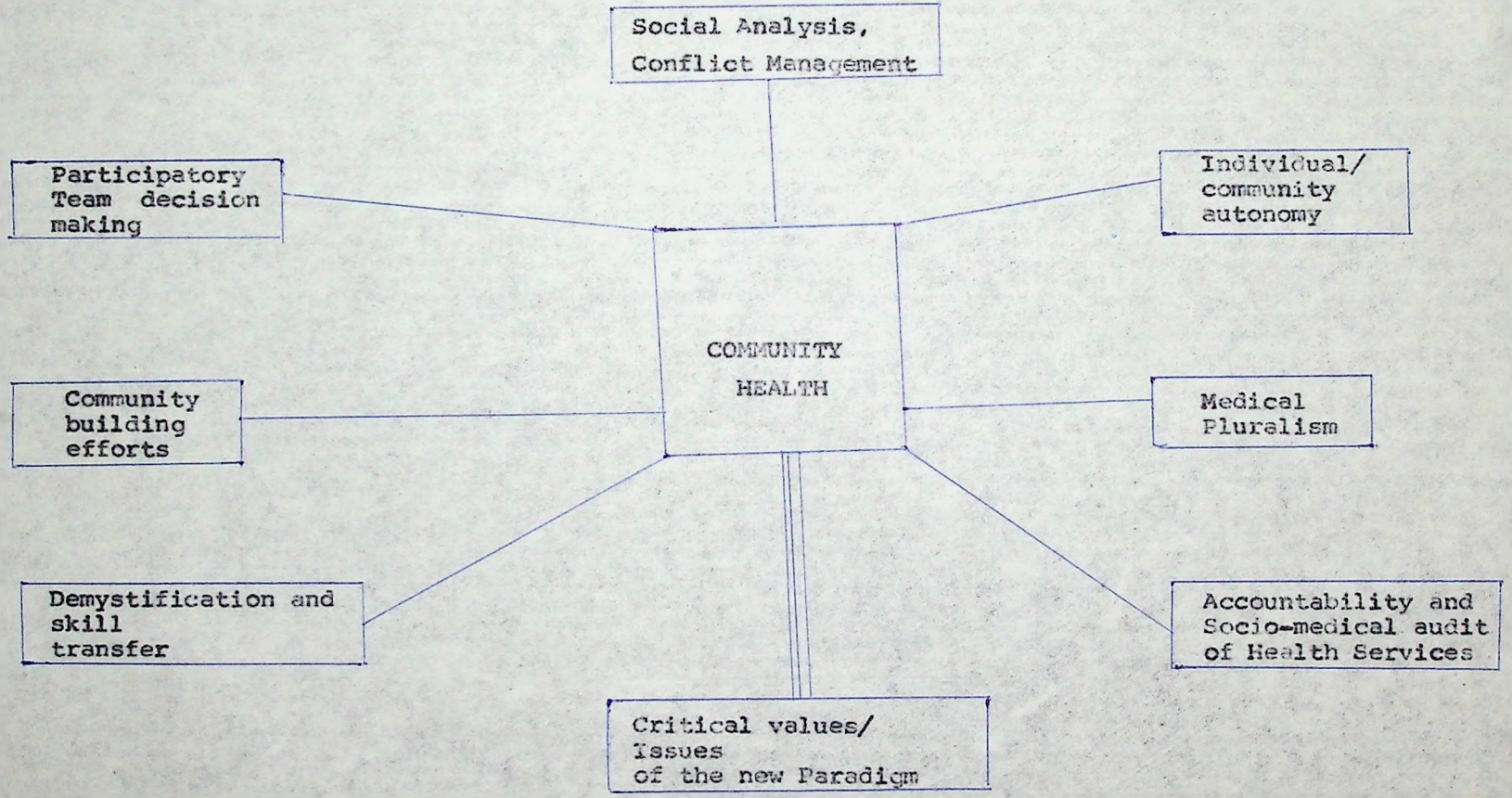
THE PARADIGM SHIFT

Medical Model to Social Model of Health

INDIVIDUAL	------>	COLLECTIVE/COMMUNITY
PATIENT & POPULATION	------>	PERSON & SOCIETY
ANTI DEATH ANTI DISEASE	------>	PRO LIFE PRO LIVING
PHYSICAL/MENTAL PREDOMINANTLY	------>	PHYSICAL/MENTAL/SOCIAL/ CULTURAL/POLITICAL/ECONOLOGICAL
DOCTORS/NURSES MEDICAL AUXILIARIES	------>	TEAM OF HEALTH WORKERS
DISEASE PROCESSES	------>	SOCIAL PROCESSES
HOSPITALS/DISPENSARIES DRUGS/TECHNOLOGY --PROVIDING SERVICES	------>	HEALTH PROMOTING AND COMMUNITY BUILDING CENTRES AND PROCESSES--ENABLING/EMPOWERING THE PEOPLE
INTRACELLULAR RESEARCH	---->	SOCIETAL RESEARCH
PATIENT AS BENEFICIARY, CONSUMER	---->	PEOPLE AS PARTICIPANTS
SINGLE FACTOR	------>	MULTI FACTOR
RISK IDENTIFYING		PROCESS IDENTIFYING
EPIDEMIOLOGY		EPIDEMIOLOGY
PROFESSIONALISED COMPARTMENTALISED MYSTIFIED KNOWLEDGE	------>	DEMYSTIFYING, PERSON CENTRED AUTONOMY CREATING AWARENESS BUILDING
QUEST FOR VACCINE AGAINST DISEASE	------>	QUEST FOR AWARENESS BUILDING PROCESS TO IMMUNIZE AGAINST UNHEALTHY SOCIAL PROCESSES



Source: Community Health Cell
Reflections



Source: Community Health Cell
Reflections

NGO Research Centres in Community Health : Some Profiles

* Foundation For Research in Community Health, Bombay, (Maharashtra), Estb: 1975

Non-government research centre which undertakes conceptual as well as field level research to study, analyse and wherever possible influence the cultural, economic and political factors that affect the health of the people.

Initiatives and studies include evolution and study of low cost community based health systems in Uran and Mandwa. Socio-economic study of rural transformation; Women's work fertility and access to health; PHCs in Maharashtra; Health Service projects (NGOs in Maharashtra) Health Financing in India
Stigma against leprosy
Alternative school health project
Facilitation of ICMR-ICSSR Joint study group on Health for All an alternative strategy.

* Action Research in Community Health - (ARCH) Mangrol, (Gujarat), Estb: 1978

A group of individuals of diverse background got together to establish this centre in the eastern tribal belt of Gujarat to study the developmental process using the health of children and women of the poorer sections of society as the guiding thread.
The approach was to get involved in the complex process of development (ACTION) and to study critically the health of the community and the processes which results in ill health (RESEARCH)

Field based strategies evolved were programmes to attack prevalent diseases, methods and skills of community diagnosis and

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intervention, training of health assistants and part time community health workers, non formal school and finally a just and humane rehabilitation policy for tribals displaced by an ambitious irrigation project in the area.

* Community Health Cell, Bangalore, (Karnataka)
Estb: 1984

A Study-reflection-action experiment started by a small core team who moved beyond the Department of Community Medicine of a medical college in Bangalore to explore issues and build perspectives from community health action projects of voluntary agencies in India. The team promotes socio-epidemiological analysis, participatory management and the shift of health action from provision of services to enabling/ empowerment of the community.
(This issue of Health Action is based mainly on this study-reflection experiment)

* Society for Education, Awareness and Research in Community Health (SEARCH) Gadchiroli (Maharashtra) Estb: 1984

This Society has adopted Gadchiroli district, a predominantly tribal district in Maharashtra, for its education, awareness building and research activities. Presently they have long term projects on the study of Active Respiratory Illnesses in children; and a study of women's health focussing on the community. The Society also seeks to evolve methods of intervention which will be at the level of the multipurpose workers of the government PHC.
Due to its increasing community involvement the Society has also begun to explore the dynamics of women's health and other related issues, the forest issues affecting tribal and the illicit

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liquor issue and its community context. It has also tried to modify the health care/medical practices at the District level to make it more responsive to the needs and the people's situation.

*Health Projects like RUHSA (Tamilnadu), CINI (West Bengal), CHDP Pachod (Maharashtra) and Deenabandhu (Tamilnadu), SEWA-Rural (Gujarat) and others (see profiles of projects page) have also begun to take up research projects on key issues in Community Health apart from putting their own activities on a more sound data base.

COMMUNITY HEALTH TRAINING IN INDIA--PROFILES

1
* Four weeks training programme on COMMUNITY ORGANIZATION AND DEVELOPMENT in English, Telugu and Tamil for Rural Health and Community Development Workers: conducted by Rural Unit for Health and Social Affairs (RUHSA). They also conduct Workshops on HOW TO START A COMMUNITY HEALTH PROJECT. For details write to:
Head of RUHSA Department
RUHSA Campus Post, North Arcot Dist. 632209

2
* Six Weeks Leadership Course in Community Health and Development: conducted by Deenabandu Training Centre. It is designed to upgrade the skills of middle level community health workers without specific academic qualifications. The participants should, however, be able to read and write English. The training programme covers topics such as concepts and approaches to Community Health; Human Relations; communications; programme management; maternal and child health; communicable diseases; development activities including income generation; survey methods etc., For details write to:
The Course Coordinator
Deenabandu Training Centre
R.K. Pet 631303, Tamilnadu

3
* Six weeks residential training programme on MANAGEMENT OF PRIMARY HEALTH CARE: conducted by Institute of Health Management, Pachod. The course is designed to provide a working knowledge of the process of management in the field of health including management concepts; community organization and development; principles of public health

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and health and management information system. The course is open to people who are involved in primary health care services. The medium of instruction is English. for further information contact:

Institute of Health Management
Pachod
Dist Aurangabad
Maharashtra 431121

4
* Eight weeks Certificate Course in INTEGRATED RURAL DEVELOPMENT: conducted by RUHSA. For details write to Head of RUHSA Department (address as in 1).

4
8
* 10 weeks training programme on COMMUNITY HEALTH AND DEVELOPMENT : conducted by International Nursing Services Association (India). The course is for health professionals and others involved in community health programmes. It is divided into 6 weeks class room teaching and 4 weeks field exposure. The topics covered include health and development, drug issues, nutrition, teaching methodologies, communicable diseases, cost analysis etc. The course is followed by a Workshop after one year. The medium of instruction is English. For details write to:

The Programme Director
INSA/INDIA
2 Benson Road, Benson Town, Bangalore 560046

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* Twelve weeks training programme for Community Health Workers: conducted by St John's Medical College and Hospital. The training is both institutional and field based. The course is directed at attaining self-sufficiency in knowledge and skill for independent managment of a health centre. The trainees are also given basic skills in herbal medicine, homoeopathy, accupressure and herbo-mineral medicine. The course is open to candidates with a basic educational qualification of SSLC or equivalent engaged in health and development work. For details contact:
The Principal
St John's Medical College
Bangalore 560034

6

* Four months Certificate course in INTEGRAED RURAL DEVELOPMENT: conducted by RUHSA. For details write to Head of RUHSA Department (address as in 1).

7

* Post-graduate
Eleven months/Diploma course in HEALTH CARE ADMINISTRATION: conducted by St John's Medical College Hospital. The course is not a traditional class room lecture oriented one. Emphasis is on job training, case studies, exercises, seminar etc. It is open to medical doctors, qualified pharmacists, graduates in Commerce, Science and Arts with hospital experience. Some of the topics covered in the course are Principles of Management; organizational behaviour; materials management; personnel management;

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finance management and legal aspects of health care. Successful candidates will be awarded a "Post-graduate Diploma in Health Care Administration". The medium of instruction is English and organizational sponsorship is essential. Fur further details contact:

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

8
* Fifteen months Diploma Course in Community Health Management: conducted by RUHSA in conjunction with VHAI. The course is residential and is conducted in RUHSA campus. The course is open to people engaged in health and development field preferably with a Bachelor's degree/Nursing Certificate. On completion of the course a Diploma will be awarded by the VHAI. For details write to the Director

DCHM Course
RUHSA Post, North Arcot Dist
Tamilnadu 632209.

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9
* Two years Diploma course in COMMUNITY HEALTH (CH Guide): conducted by Christian Fellowship Community Health Centre and Christian Education, Health and Development Society. They also conduct various training course such as:

1. PG Diploma course in Applied Nutrition and Dietics and Catering
2. PG Diploma course in Health and Development
3. Multipurpose Health Workers (ANM) course
4. Village Health Workers (VLW) course

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

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

10

* Two year Certificate Course in COMMUNITY HEALTH PLANNING, ORGANIZATION AND MANAGEMENT. This is a correspondence course designed for managers, supervisors and others involved in health and development work. Thecourse covers principles of management; personnel management; materials management; elementary accouting; basic labour legislation etc. For details, write to:

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

They also conduct Diploma course in COMMUNITY HEALTH MANAGEMENT (15 months) in conjunction with RUHSA. For details write to the addressee in 8 above.

11

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

For details write to:

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

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Successful M.Phil graduates can pursue their PhD work (3 years) in the same discipline.

The Centre also conducts Masters programme in Community Health (MCH) for MBBS and MSc (Nursing) holders. MCH holders are eligible to pursue their PhD programme in Community Health.

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9. Training 'enablers' not 'providers'

The Community Health Action initiators in the country described earlier have also developed many training centres evolving middle level health manpower training programmes in community health for doctors and nurses trained in the orthodox medical system. Many of these training centres have evolved in NGO projects after many years of primary field level experience.

This new crop of training programmes differ from conventional 'public health' and 'preventive and social medicine' in the country in many respects, chief among which are:

1. Most of the training programmes are open to anyone interested in community health not necessarily with a basic medical or nursing degree.

ii. Nearly all of them have additional components in the syllabus like social analysis, community dynamics other systems of medicine, development issues, appropriate technology, training of village based health workers and so on which are not yet components of public health courses in the country.

iii. Nearly all of them are focussed on organisation and practical management of community based health programmes and training of local health workers.

iv. They all promote demystification of medicine, community participation, community organisation and development. There difference lies mainly in their overall socio-political perspective and the role they expect of their trainee.

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In this dimension they range from centres which train for the delivery of an integrated package of services to centres which train for enabling and empowerment of communities.

v. The duration of the course varies from 6 to 12 weeks to 1 year.

vi. Nearly all of them have experimented with more participatory forms of training and generated a number of case studies, role plays, simulation games and learning exercises. This is in fact a major contribution of these programmes though the evolution of a participatory pedagogy is still to be adequately recognised by orthodox medical and health manpower educators in the country.

vii. Apart from health projects which have grown into training centres like RUHSA, CINI, Pachod, Jamkhed, Deenabandhu, Ambilikkai, these training groups include a medical college (St John's, Bangalore), and a Nurses Association (INSA, Bangalore) and two Coordinating Agencies--CHAI & VHAI.

viii. Only one academic department (Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi) offers MCH, MPhil and PhD programmes in Community Health.

Only in 1988, has there been an attempt initiated by VHAI, New Delhi, to organise a network of Community Health Trainers in the country. It is hoped that this step will lead to intensive dialogue and mutual consultation among the trainers so that some sort of common health manpower education policy and new approaches to training can evolve which could have wider relevance for manpower training in the country.

Box

An overview of Courses

COMMUNITY HEALTH TRAINING IN INDIA--PROFILES

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Head of RUHSA Department
RUHSA Campus Post, North Arcot Dist. 632209

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The Course Coordinator
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Source: Prospectus of respective courses.

8.

ISSUE RAISING - A CRITICAL TASK

When we think of 'Community Health' or of health projects of voluntary agencies, it is customary to think of micro level field experiments and initiatives that have been described previously. However individually they can have little impact on health policy or on the overall trends of health care development in the country except at a local level perhaps. No doubt a few individual 'charismatic' NGO health innovators have participated and contributed to 'expert committee reflections' initiated by the government. But on a more long term basis and to counter 'entrenched' medical vested interests and [redacted] attitudes there is a growing need for lobbying and issue raising groups at national and regional levels. This calls for networking and dialogue around values and approaches necessary for the emerging Community Health vision.

Are there such groups in the country. In the 70s the medico friend circle emerged as one such group out of the ferment that marked the Indira/JP era leading to emergency and its aftermath. Over the years this group has brought together people from diverse ideological backgrounds to discuss issues relevant to health care and medical education in the country and through its annual meetings and bulletin voiced these concerns and explored alternatives. [refer box]

The Kerala Sashtra Sahitya Parishad is a different type of issue raising group promoting a scientific attitude but also questioning the role of science in society. Though regional in its focus KSSP has of late become an important and crucial 'health issue' raising group in Kerala. [refer box] The people's science Movement in Maharashtra and more recently the Karnataka Rajya Vignana Parishad have also begun to explore health issue.

Another important network on the national scene is the All India Drug Action Network which has brought together a

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Box

THE MEDICO-FRIEND-CIRCLE --

Works towards a pattern of medical care adequately geared to the predominant rural character of our country.

Works towards a medical curriculum and training tailored to the needs of the vast majority of the people in our country.

Works to develop methods of medical intervention strictly guided by the needs of our people and not by commercial interests.

Stands for popularisation and demystification of medical science.

Believes in a democratically functioning health team and democratic decnetralisation of responsibilities.

Stresses the primary role of preventive and social measures to solve health problems on a social level and the importance of planning these with active participation of the community.

Works towards a kind of medical practice built upon human values, concern for human needs, equality and against negative, unhealthy cultural values and attitudes in society, e.g. glorification of money and power, division of labour into manual and intellectual, domination of men over women, urban over rural, foreign over Indian.....

Believes that non-allopathic therapies be encouraged to take their proper place in the modern system of medical care --

--medico-friend circle -- perspective and activities. 1984 (18)

B-

ALL INDIA DRUG ACTION NETWORK (AIDAN)

AIDAN consists of numerous health, consumer, legal aid and human rights organisations and people's science movements. It is a growing network of academicians, professionals, social activists, individuals and organisations who are deeply concerned about the drug issue and working towards the adoption and implementation of a people-oriented Rational Drug Policy in India as a part of a people's Health Policy.

AIDAN'S Main Demands

* Availability of essential and life saving drugs
* Withdrawal of hazardous and irrational drugs
* Availability of unbiased drug information
* Adequate quality control and drug control
* Drug legislation reform
* Use of generic names
* Technological Self Reliance

Source: AIDAN (19)

wide variety of individuals, groups and associations into a movement for a rational drug policy and rational therapy. AIDAN has not only worked on an alternative drug policy but has also worked at various levels from parliamentarians to the level of the people discussing issues and raising consciousness about the various dimensions of the problem.

The 'Bhopal disaster' was another major event leading to a great deal of involvement and networking of groups in the country supporting the 'plea for relevant research, rehabilitation and legal compensation policies' for the affected victims.

In the eighties an increasing number of smaller groups are emerging at the national, regional and local levels around drug, health and other issues. The 'mfc' type of network is now becoming a generic phenomena. However, all these groups put together are still making little impact on the health situation and are still relatively marginalised.

Lobbying and issue raising is neither a popular task nor an easy one. The 'Drug activists' and the 'Bhopal activists' have experienced the non-responsiveness of the established status quo system to issues of justice on the 'Drugs' and 'Bhopal' matters.

A national Health action network is yet to emerge in the country. Even when it does it will take some time before it can make an impact. This task can however not be ignored any longer.

7c. Community Health: Is a movement emerging?

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

The positive trends are--

i. Policy reflections of the Government

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

ii. "Village Health Worker Army"

A growing army of villagers and lay people have been trained as village health workers by both non-government and government agencies. Whatever the quality of training this process itself is a phenomenal process of demystification of medicine.

iii. Non-medical Health Activists

A growing number of lay people, social workers, developmental activists, journalists, teachers, college students, non-medical scientists, lawyers, consumer groups and so on are recognising the varied dimensions of health and are getting involved in health care issues.

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iv. Health in the education process

Health issues are increasingly becoming part of the syllabi of formal, non-formal and adult education programmes in the country. Schools are also gradually becoming focus of health activity.

v. Health on the agenda of science movements

Movements for the popularisation of scientific attitudes like KSSP (Kerala), Lok Vidnyan Sanghatana (LVS, Maharashtra) and Karnataka Rajya Vigyan Parishad (KRVP, Karnataka) are gradually taking up more health issues.

vi. Health issues emerging in other movements

The environmental movement has grown in recent years with a number of processes around forest issues, environmental issues and social problems. In all of them, the health and nutrition of the affected people is a growing concern. The women's movement is beginning to recognise health issues important to women, eg., family planning, contraceptives, amniocentesis and so on.

The Trade Union movement has got interested in the'drugs issue' but their involvement in health issues is still quite marginal with the exception of independent trade unions like CMSS Dalli Rajhara (Chatisgarh Project).

vii. Health orientation of Coordinating groups and issue raising networks

Groups like VHAI, CHAI, CMAI, mfc, SHC, AIDAN are slowly increasing their commitment to lobbying on various health issues.

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All these trends call for a guarded optimism since a series of negative trends are also becoming increasingly stident. These are--

i. Commercialization of medicine

Medicalisation, over professionalization and a consumerist orientation of medical and health care is increasing in the country. Medicine is becoming big business. The mushrooming of capitation fee medical colleges and high technology investigative centres catering to those who can pay are components of this trend.

ii. Mushrooming of medicalised health projects

Health projects are mushrooming all over the country sup orted by a combination of social, economic and political factors. Foreign funding agencies are vying with each other to fund the alternative. Industrial houses are investing in it for income tax purposes, religious and social organisations are getting involved for prestige, power and increasing their membership; professionals getting involved for status reasons. Most of these projects are 'medical' providing packages of services with little or no understanding of the values/vision of the health movement or a social analysis.

iii. Verticalization of health efforts

Selectivization and vertical top-down health programmes sponsored by government and encouraged by International Funding Agencies like WHO, USAID, UNICEF divert scarce resources and confuse community health action initiators as well as waste time and effort.

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iv. Inadequate Networking

Health action initiators themselves are not adequately networking or lobbying with decision makers or opinion leaders. While there has been a rich experience of micro level experimentation there is inadequate pooling of ideas, training, policy evolving efforts and research; so the entrenched medical establishment goes unconfronted.

v. Status-quo forces

The ability of the existing status quo forces dominated by the haves to internalise and coopt many of the ideas and approaches into the 'health policy rhetoric' butdefeating the spirit of the new vision must not be under-estimated. The increasing number of paradoxical policies and programmes on the national scene are an increasing evidence of this cooption.

vi. Cooption of Health

The misuse and coption of the word--health--itself a new and disturbing trends. The Drug Industry, the medical technology industry, the five star hospitals, the medical professionals are all using the word heath to describe their initiatives most of which is the same old curative high technology, drug oriented package deals under the new label. Alternatively through high pressure advertising insurance programmes, screening programmes and medical check ups to promote 'over investigatio in the name of health is another trend.

Will the negative trends prevail and grow and prevent the evolution of a health movement only time will tell. There is every indication that this may be so.

76 COMMUNITY HEALTH AND HOSPITAL MEDICINE

The community health approach has evolved from the attempts of a large number of people concerned about the present medicalised approach to health care and its inadequacies in responding to the needs of the large majority - the poor and marginalised groups in society. Most of the people involved in developing components of this new approach have themselves had much of their training and experience initially in the hospital-dispensary oriented system. Some of the approaches have emerged from a confrontation of the existing value system and culture of the western-technological model of health care of which the hospital and dispensary are characterstic examples.

Does this mean that the 'community health approach' and the existing medical system of hospitals, dispensaries, health centres, doctors, nurses, drugs, technology, centres of specialisation, education and research are incompatible?

While recognising the need for a 'paradigm' shift in attitude and approaches from the 'provision of medical care' to the 'enabling of community health' we feel that these are neither mutually exclusive nor incompatible.

It is necessary to recognise that many aspects of the value systems of existing highly technological western models of care which we have inherited and continue to transplant in our country are somewhat counter-productive to the goals of community health.

It is necessary to recognise that by their very nature, such highly capital intensive technology systems skew health services in favour of those who can afford to pay for them. Gradually the forces of a market economy of which

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such a model is an integral part, alienates the structure from the poor and underpriviliged and all those who basically cannot afford the luxuries of the type of health such systems symbolise.

However, since community health is basically a new vision, a new value system and a new attitude it can confront and pervade the entire existing superstructure of health care.

Arising from community based experience as a new vision, community health has to challenge the super-structure to become:

a. more 'people' oriented

i.e sensitive to the realities of life of the large majority of people - the poor and underpriviliged,

b. more 'community' oriented

i.e understanding health in its community sense and not just as the problem of individuals.

c. more socio-epidemiologically oriented

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

d. more democratic oriented

i.e more participatory and domocratic in its growth, planning and decision making process,

e. more accountable

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

This confrontation of value systems and re-orientation will help the superstructure and its different elements to emerge from their present ivory-towered isolation and

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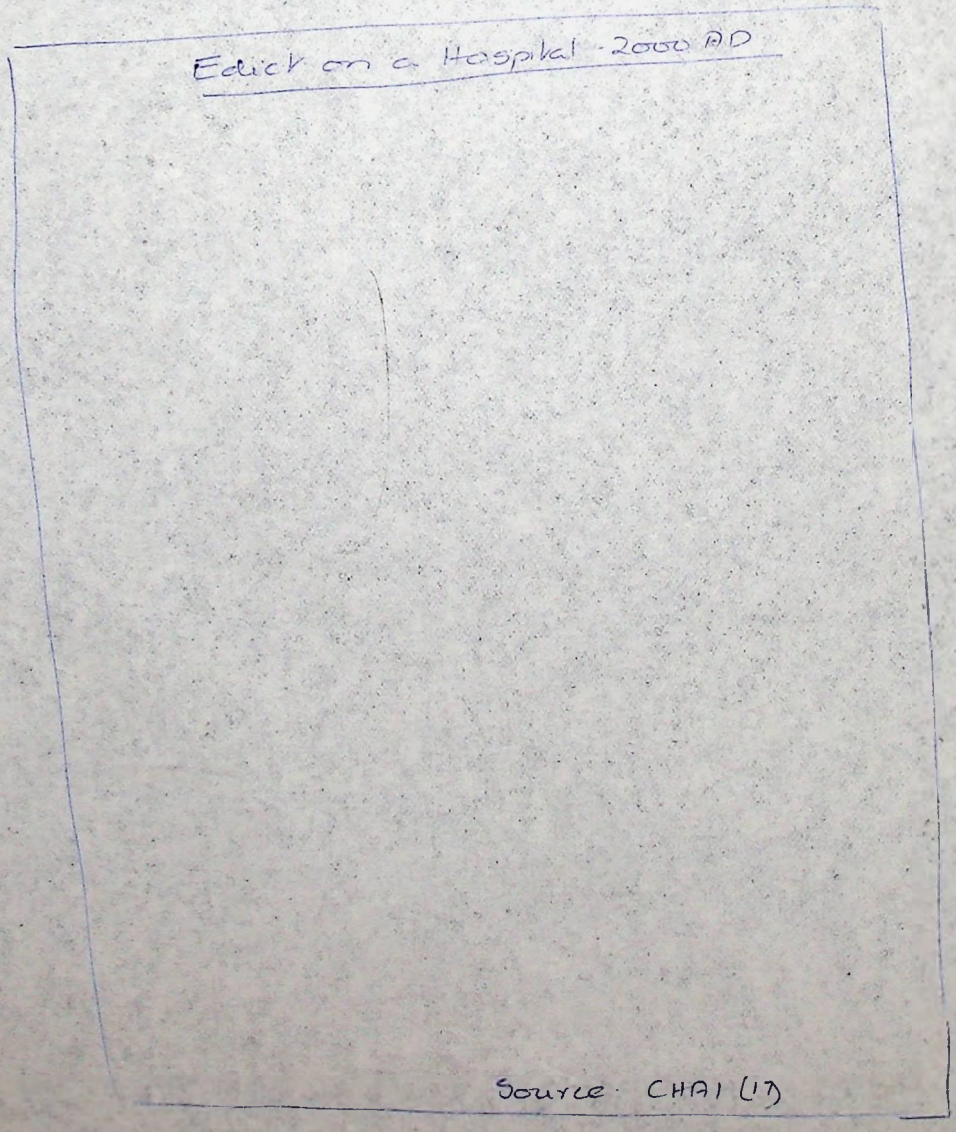
irrelevance and gradually become supportive infrastructure of a more just and healthy society. However this change cannot be miraculous or based on just good intentions or any amount of wishful thinking. It must be a serious commitment to social analysis, participatory evaluation and critical self-searching for greater relevance by all those concerned with planning and decision making in the present superstructure.

Edict on a Hospital - 2000 AD



Source: CHAI (17)

6. RECOGNISING THE NEW PARADIGM

This alternative health care project phenomena has been a spontaneous upsurge in the last two decades and not an organised planned movement. From 1984, a team of us have been studying this process through a series of reflections with individuals and groups and network to build a new understanding of Community Health from field level experience and grass roots action.(6) Our attempt has been to look at successes and failures, strengths and weaknesses, opportunities and threats of all these community health action initiators. Also by taking a 'macro view' and differences, we have been trying to build the components of a new paradigm.

The broad definition that is emerging is:

"Community Health is a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right, and involves the increasing of the individual, family and community atonomy over health and over organisations, means, opportunities, knowledge, skills and supportive structures that make health possible"

The components of Community Health action includes:

Integrate Health with development programs,

Integrate curative with preventive, promotive and rehabilitative activities,

Experiment with low-cost, effective, appropriate technology,

Involve local, indigenous health knowledge, resources and personnel,

Train village-based health workers,

Initiate, support community organisations like youth clubs, farmers clubs and mothers clubs,

Increase community participation in all aspects of health planning and management,

Generate community support by mobilising financial, labour skills and manpower resources.

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While facilitating these managerial/technological innovations the Community Health action initiators have to seriously face up to a wide variety of 'social processes' and 'value issues' that are:

i) Organisation of non-formal, informal, demystifying and consciantising 'education for health' programs;

ii) Initiating a democratic, decentralised, participatory and hon-heirarchical value-system in the interactions within the health team and in the health team-community interactions;

iii) Recognising conflicts of interests and social tensions in the existing inequitous society and initiating action to organise, involve all those who do not/cannot participate at present;

iv) Questioning the over-medicalised value system of health care and training institutios and challenging these within the health team; learning new health oriented values;

v) Recognising that community health needs community-building efforts through group work, promoting co-operative efforts and celebrating collectively;

vi) Confronting the super-structure of medicalised health delivery system to become

- more poor people oriented
- more community oriented
- more socio-epidemiologically oriented
- more democratic,
- more accountable

vii) Recognising the cross-cultural conflicts inherent in transplanting a Western Medical model on a non-western culture and hence exploring integration with other medical cultures and systems in a spirit of dialogue.

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viii) Recognising that community health efforts with the above principles and philosophy cannot be just

- a speciality;
- a professional discipline;
- a technology fix;
- a package of actions;
- a project of measurable activities;

but has to transform itself to

- a new vision of health care;
- a new value-orientation in action and learning;
- a movement, not a project;
- a means, not an end

Are these the axioms of an alternative?

These new 'issues', 'values', approaches to health is now being recognised by a growing number of coordinating groups, academics and policy research groups as well.

Four coordinating groups among the NGOs including the Voluntary Health Association of India, The Catholic Hospital Association of India, The Christian Medical Association of India and the Asian Community Health Action Network have all identified with this new thrust in the policy statements of the 1980s(10 - 13)

The ICMR/ICSSR Health for All prescription includes these dimensions as well (1)

A plea for a New Public Health is the latest in a series of issues and theoretical perspectives emerging from academic centres as well.(14)

However recognising the paradigm is after all only the first step. Taking action to build a new structure is a challenging and daunting task. Converting the old system to a new way of life is not going to be easy.

"RECOGNISING THE NEW PARADIGM"

1978	VOLUNTARY HEALTH ASSOCIATION OF INDIA (3000 Health Institutions and Community Health Programmes)	'making community health a reality for all people, with priority for the less privileged millions, with their involvement and participation through the voluntary health sector...."
1982	ASIAN COMMUNITY HEALTH ACTION NETWORK (Network of concerned individuals and NGOs in fifteen Asian countries)	"to spread a philosophy of community based health care that envisages a process of self-reliant human development for the oppressed poor in Asian communities...."
1983	CATHOLIC HOSPITAL ASSOCIATION OF INDIA (2000 member hospitals and Dispensaries)	"committed to community health ....as a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right...."

Sou[illegible] P.T.O

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1986	CHRISTIAN MEDICAL ASSOCIATION OF INDIA (300 institutions (protestant) plus 5000 individuals associated with these)	"commitment to community health....a process that empowers people to work together to promote their own health and to demand appropriate health services.. relevant, low cost, effective and acceptable...."

Source: Policy Statements of organizations (10-13)

HEALTH FOR ALL
ICMR/ICSSR

Prescription ℞

A MASS MOVEMENT

TO

- REDUCE POVERTY, INEQUALITY AND SPREAD EDUCATION
- ORGANISE POOR AND UNDERPRIVILEGED TO FIGHT FOR THEIR BASIC RIGHTS
- MOVE AWAY FROM COUNTER-PRODUCTIVE, CONSUMERIST WESTERN MODEL OF HEALTH CARE AND REPLACE IT BY AN ALTERNATIVE BASED IN THE COMMUNITY.

Source: ICMR/ICSSR (1)

HEALTH SERVICES IN A COUNTRY

Postulates of a theory

Health Service development is

a. a socio-cultural process

b. a political process

c. a technological and managerial process with an epidemiological and sociological perspective.

There is often a lag between socio-cultural aspirations of the people and their articulation by the political leadership;

The lag is much more between the aspirations of the political leadership and the achievements of community health physicians who have the responsibility for building the needed edifice of the health services.

The task is to narrow, if not totally eliminate, lags that may exist within the three tiers.

Formation of a critical mass of community health physicians and other members of the team, which can take full advantage of the scope offered by the base (i.e., the complex of ecological, epidemiological, cultural, social, political and economic factors at play) requires a new approach to education of community health physicians and other members of the team.

Readymade solutions are not available from affluent countries..... a superstructure of health services is to be built which is firmly rooted in the base.

- D Banerji (14)

EVOLVING POLICY ALTERNATIVES

The National Health Policy statements are beginning to echo these ideas and values.

Whether this is 'populist rhetoric' or a serious 'rethink' only time will tell.

NATIONAL HEALTH POLICY, 1983

Recommendations

For restructuring Health Services

1. Organised support of volunteers, auxillaries, paramedical and multipurpose workers
2. Selection and training of community health volunteers
3. Building of self reliance and effective community participation
4. Establishment of a well worked out referral system
5. Establishment of a nation wide chain of sanitary-cum-epidemiological stations
6. Concept of domiciliary and field camp approach
7. Devising planned programmes to reduce governmental expenditure and fully utilising untapped resources
8. Setting up centres to provide speciality and superspeciality services
9. Mental Health care and care of physically handicapped
10. Priority to unpriviliged and vulnerable section of society
11. Ensuring adequate mobility of personnel of all levels of functioning.

VHAI (15)

The Community Health phenomena - Three questions

WHO were the community health project initiators?

Since the late sixties and particularly in the seventies a large number of initiatives and projects began to get established outside the government system by individuals and groups keen to adapt health care approaches to the needs of our people.

Broadly classified as voluntary agencies in Health Care (now also referred to as non-governmental organisations (NGOs) in policy documents) these initiatives were predominantly rural to begin with but later some of the focus also shifted to the tribal regions and urban slums.

Starting with illness care most of them moved on to whole range of activities and programmes in Health and Development creatively reacting to local needs and realities.

The originators of these projects were doctors, nurses, health and development activists, who had been challenged and stimulated by the social disparities and health needs of the large majority of people in the communities they served.

Each project or initiative evolved in the context of a local social reality and a local health situation. Since these were diverse each of them evolved their own process of action, package of services and local health organisation.

HOW did these initiatives evolve

These initiatives evolved in a variety of ways. Health was sometimes the entry point, sometimes it got into the package at a later date.

a. A rural development programme with a health component.
b. A community based medical/health programme.
c. An integrated development programme in a tribal area.
d. An adult education/non-formal education programme with a health component.
e. A science education programme with a health component.
f. A nutrition supplementation programme with a health component.
g. A conscientization/awareness building programme with a health component.
h. A community extension/outreach programme of a hospital
i. A field practice area of a medical/nursing/paramedical training institution.
j. A school based health programme.
k. A health programme as a component of a trade union movement.
l. A health programme as a component of a project focussed on women's issues
m. Health as a component of a community action in urban slums.
n. A health programme for workers organised by an employers association.

and so on.

As the 'community health' action initiatives grew in experience and numbers a second generation of initiatives evolved:

a. Issue raising group
b. Coordinating/networking groups
c. Community Health education/document/resource centres
d. Community Health training centres
e. Community Health Research centres

But more about it later.

WHAT were the components of Health Action in these initiatives?

There has been a tendency in many circles to see each project as an alternative aproach to health care. Our experiences of studying many of them convince us that many ideas, experiences, components of service and the dynamics of action from these projects taken together would help build an Alternative Approach and none are independently the complete alternative. Hence learning from the commonness of approaches and identifying the rich variations that exist would be a more meaningful way of deriving the new approach of community health. The component of the new approach to health action in the Community are:

a. Integrating Health with Development activities

Recognising ill health as the product of poor nutrition, poor income, poor housing and poor environment many health projects had gradually got involved with

agricultural extension programmes
water supply and irrigation programmes
housing and sanitation schemes
income generation schemes
basic education including literacy, non-formal education and adult education programmes

many projects which had started with a development focus were in turn adding a health care dimension to their activities.

b. Preventive, Promotive and Rehabilitative orientation to health action

Most of these health projects had moved beyond the medicalised concepts of health symbolised by drug distribution to activities - focussed on individuals and groups that present ill health and promote well being.

Immunization programmes
Maternal and child health care

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Family welfare activities

Environmental sanitation Particularly safe drinking water supplies and sanitary disposal of excreta, sullage and refuse

Nutritional supplementation and/nutrition education

and

School health programmes

were the commonest components.

Rehabilitation as a health-oriented action was seen mainly in the context of people suffering from leprosy.

c. Search and experimentation with low cost, effective and appropriate technology

Many projects had tried to evolve or promote more appropriate health care technologies. The emphasis was not only on it being low cost but also on it being more culturally acceptable, demystifying and more within the operational capabilities of local people and health workers. These included

improved dai (TBA) kits

nutrition mixes prepared from locally available foods

indigenous MCH calendar

locally manufactured lower limb prosthesis, bangles and tapes to measure nutritional status of children

low cost sanitation options

home based oral rehydration solutions

herbal and home remedies from the backyard or kitchen

and so on.

Two additional areas of technological appropriatness which had been experimented within many of these projects were:

i. Health communications - Attempts had been made to

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APPROPRIATE TECHNOLOGY

For MCH Work

1. Patient Retained Health Records

Coloured cards in a strong plastic cover retained with patients who bring them during clinic visits. Alloted spaces and information for all aspects of mother and child care - Also a personalised health teaching aid.

2. Arm circumference insertion tape

To measure mid-upper arm circumference a useful indicator of nutritional status of individuals and communities useful for helping workers detect severe undernutrition and for raising level of consciousness among community concerning the problem.

3. Child's bangle

Typically Indian method for diagnosing undernutrition by mothers and health workers. The bangle positive child includes those with marasmic or third degree protein calorie malnutrition.

4. Indigenous Calendar

With festivals, full moons and conversion to English months to help mothers place the birth of the child on the exact date.

5. Amenisia recognition chart

Simple coral used to detect anaemia by comparing the colour of tongue, lower lip and nails with picture on card the colour of tongue.

6. A Sterile delivery pack

Consisting of sterile cotton tie, a new blade and a small bottle of disinfectant, this kit costing a few paises can be used to prevent tetanus in the new born.

7. Better Child Care

A [redacted] informative booklet with colourful pictures and

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basic messages to help health workers and mothers to discuss child care issues

(For further details contact VHAI, Ner Delhi)

"Technology can only be considered appropriate if it helps lead to a change in the distribution of wealth and power....."

use low-cost media alternatives like flash cards and flip charts and also to adapt local folk media and traditional cultural/art forms like

puppetry

kathas (story telling)

street theatre

music and dance forms particularly those which were common features of the festival culture in India.

In tribal regions effective adoptions to 'nachna' (song and dance improvisations) was a common feature

ii. Recording and evaluation techniques - Many projects have evolved simple methods of recording quantifying and keeping track of health activities or material resources utilised by the health workers. These were geared to the capacities of local people (if they were people retained) or to the capacities of the local health workers. Many were geared to get over the constraints of illiteracy.

d. Recognition, promotion and utilization of local health resources

Local health resources include local family based traditions of health and self care as well as traditional systems of medicine and their practitioners. Many health projects had created positive relationships with

local dais (traditional birth attendants)

traditional healers

folk medicine practitioners

and

the practitioners of various non-allopathic systems of medicine practised locally.

This relationship had gone beyond a mere association to an

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LOCAL HEALTH RESOURCES

'The Miraj Experience'

1. Training of Indigenous Dais

173 Dais out of 186 identified by a survey were trained. The emphasis of the training was on scientific techniques in home delivery, elements of good antenatal, intranatal and post-natal care, basic cleanliness and hygiene. They are also taught to recognise danger signals in pregnancy/labour as well as motivate for family planning methods. Dais were provided with autoclaved delivery kits.

2. Village health aides

40 local part time women attendants provided to help the government ANM were retrained as village health guides who could do early reporting of pregnant women and postnatal cases, births and deaths, communicalbe diseases, fevers, neonates and infants unprotected against preventable diseases, collect mothers and children for immunization, distribute iron/and folic acid tablets, follow up TB, Leprosy patients and so on.

3. Indigenous medical practitioners

6 local Ayurvedic doctors were put in charge of Ayurvedic clincs run by the project. Also serving the project area on a private basis were 62 untrained practitioners of Ayurvedic medicine, 33 registered medical practitioners without formal training, 3 bone setters. The doctors of/the project would invite these practitioners during their weekly village visit to join them in examining and treating patients. This training method was beneficial to both parties concerned.

Eric Ram ( )

acceptance of some of the medical and health practices of these systems, by the projects themselves. Promotion of locally available herbal medicines and home remedies was in important component in many.

e. Training of village based health cadres

Training of locally selected individuals in the village in basic health care activities

- minor ailment treatment
- first aid
- recognition of illnesses needing higher levels of referral and care
- nutrition
- maternal and child health care
- family welfare motivation
- environmental sanitation
- identification - reporting - basic measures in communicable disease control especially
  - malaria
  - leprosy
  - tuberculosis
- mental health care

and so on has been probably the most characterstic feature of all these projects. The selection methodology, the training methodology, the range of skills and the scope of training, the plan of activities and the remuneration and community support of these health workers reflects a wide diversity - but the most import nt result of this trend has been the conscious demystification of health issues and the creation of better informed village-based individuals who are available to help

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Box

'The Mandwa Experience'

Several Community Health Projects have demonstrated that most communicable diseases can be controlled even under the existing socio-economic conditions. In the Mandwa Project thirty village women given simple knowledge through weekly discussions under the village tree, and with a simple supportive service were able to achieve this. Let me illustrate with a few examples. They took finger prick blood smears of any patient suffering from fever with rigors and gave them four tablets of chloroquine. If the smear were positive they gave Primoquine treatment. More than that they drew attention of the village to control the mosquito vector. They were remarkably efficient in suspecting tuberculosis in individuals with the classical symptoms especially if they were contacts of known cases. If the diagnosis was established on examination of the sputum or X-ray they gave the 90 streptomycin injections and supervised the regularity of the other antituberculosis treatment by convincing the patient of its importance not only for himself but also for the rest of his family. They also taught other simple measures like disposal of sputum to prevent the spread of the disease.

These women diagnosed twice as many leprosy patients as the full-time leprosy technicians, ensured that regular treatment with Dapsone was taken after confirmation of diagnosis and since these were in the early st ges, there was not a single new case of deformity; the old deformed patients were helped to return home and take regular treatment, for on having seen the germs under a microscope they were able to convince the village of chemical sterilization by regular treatment and induced confidence by visiting the patients in their homes and partaking of their meals.

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Box

There was a marked reduction in deaths from gastro-enteritis not only because of ORT but because of the creation of an epidemiological consciousness in the villages for being prepared for the monsoons.

The immunization rate for triple antigen rose from 15% to 92% when the village health workers started giving them injections on their daily rounds. Since all pregnant women were identified and immunized there was not a single death from tetanus in five years. No mass compaigns were even undertaken in this project, yet the so-called targets set by the PHC were over-reached even in family planning.

This people-based approach even succeeded in the detection of cancer, mental illness and in rehabilitation of the disabled, all without campaigns and camps and at a fraction of the normal cost of our health services.

Let us not minimize the role of the profession and services in such a participatory approach. Their main function should be of teaching and encouraging the people to look after themselves to the extent possible and overcome the fears inculcated through professional mystification. Another important role is to provide the necessary supportive service for those few problems which require skills and facilities of a higher level. Their's is not to appropriate the functions which rightly belong to the people, for experience has shown that they cannot undertake these functions themselves even at a far greater cost. The present approach has only led to exploitation of the people's health by the private sector and lack of accountability of the public sector without much impact on the health status as revealed by our statistics.

The supportive professionalised services have also to be of a graded nature starting with the paramedical worker at the

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subcentre to the surgeon and physician at the Community Health Centre. The primary role of the Community Health Centre should nevertheless be of monitoring the people's health with priority to the promotive and preventive services. The ICSSR/ICMR report has estimated that about 98% of all health and illness care can be undertaken within a 1,00,000 population covered by the Community Health Centre at a cost of about Rs. 30 per capita per annum leaving only a marginal sector for tertiary hospital care. Also that this can be achieved only if the people have the finaicial and administrative control over their health services with guidance and support by the professionals.

I know that this is a radical departure from the existing situation and may not be readily acceptable to those who believe that all decisions on health must be left only to the medical profession. But four decades experience in an independent India has clearly demonstrated that we have not been able to achieve the desired result despite the vast expansion of medical services in both the public as well as the private sector.

Dr N H Antia

Source: Medical & Non-Medical Dimensions of Health, National Academy of Medical Sciences Oration, April 4, 1987 New Delhi

their own people in times of crisis. The pedagogical approach in the training session will determine whether these village workers will become 'Lackeys of the existing system' or the 'liberators of their people' as David Werner had warned from his Mixican experience. In many projects, however we discovered that once health workers had been helped to understand the situation and plan and decide on local health actions, certain leadership qualities did emerge and action on issues wider than health was generated. In a fishing community women health workers had effectively organised people to protest against the local bus system which refused to allow women to carry their baskets of fish on the bus to the local market, In many plantations health workers called link workers had emerged as local union leaders. Such situations were not at all unusual.

f. Increasing community participation in health decision making

In addition to training village health workers many of these projects have attempted to involve the community or their representatives in the planning and decision making process through the organisation of local village informal leaders. Many had involved existing

youth groups
mahila mandals (women's groups)
farmers associations
cooperatives
and
teachers and religious leaders

This is a very important trend and a rather challenging approach. For community participation to be a genuine process of enabling people to take responsibilities for their own health services two pre-requisite conditions are essential:

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i. Firstly the involvement of all sections of the community. In the strafied village set-up with certain caste and class groups dominating decision making and exploiting certain other groups, purposeful involvement of disadvantaged and oppressed sections of the village often mean even exclusive involvement.

ii. Secondly the health action initi tors must be willing to learn from the people and their own experience of local culture and social reality. This means a 'democratic dialogue' on equal terms and involvement in all aspects of decision making not just participation in programmes organised by the health team.

These two pre-requisite conditions have evolved to varying degrees in the different projects and hence the nature of participation is variable.

g. Initiating community organisation

The qualitative difference from the above approach is only of emphasis. Many projects have themselves initiated or catalysed the development of youth clubs, ma

youth clubs

mahila mandals

farmers associations

and various group activities recognising the need for local organisations to participate in planning and sustaining health actions.

This action has also emerged from the observation that even the poor and marginalised are not themselves a cohesive group of a 'community' in the real sense. They have internalised various social, cultural, political, religious divisions that divide society at large. Hence building groups relationships

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and group organisations around issues and common actions are themselves pre-requisites for community health actions.

h. A quest for financial self-sufficiency and generation of local resources

Many projects have concentrated on the dimension of financial participation of the community as a dimension of community participation. These projects have therefore concentrated on generating local finances through

insurance schemes
adding health functions to dairy and other cooperative
graded payment of services according to family income
festival collections

and so on. Experience has, however, cautioned that an exclusive pursuit of this objective can often result in the exclusion of those sections of the community which need the health services most, especially when the purchasing capacity of people is so skewed.

Many projects have however widened this approach of generating local resources to means local resources - material, structural and human - that can be harnessed to support health actions. These have included

grains for nutritional programmes
accommodation for clinics and programmes
basic supportive services by volunteers,
grain banks, voluntary labour, building materials

ans so on.

i) Education for Health

'Health' education has been an important approach in most projects moving beyond the 'conservative' health education approaches which usually includes information transfer on available health services and do's and dont's for individual

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health. The efforts have been demystifying and conscientizing, helping groups to understand the broader issues in health care as part of a wider awareness building process. These have been specific components of health actions or have been introduced as components of existing adult education and non-formal education programmes. As people discover the cause of illnesses that they commonly experience, and identify their roots within their own social situation, they are prepared to do something. This has meant that this approach has often served as a starting point for individual or group education. School health programmes where teachers and high school students are oriented to do something about their own health, that of their own families and their community, share the same vision.

j. Conscientization and political action

There are some projects where the health teams based on their own experience have begun to show a deeper understanding of issues for conscientization and recognise the need to support political action especially those of 'people movements' and mass organisations. This support may be through the organisation of health activities particularly for members of such movements or the addition of health demands on the agenda of people's struggles. In the South, especially the demand for provisions of water supply has often become such a rallying point.

4. The health scene in the 80s

Before we consider the evolution of alternative approaches on the Indian Scene it would be a good idea to recapitulate the salient features of the health situation in India in the 80's. The available indices of ill health are ample evidence of the challenging situation facing health action initiatives.

Vol. 1 Index

Tetanus

In 1981, nearly a quarter million infants died in the first month of life. The estimated mortality rate from tetanus is 13.3 per 1000 live births in the rural areas and 3.2 in the urban areas.

Diphtheria

The reported incidence, which is an under estimate admittedly is around an verage 25000 cases a year, over 1975-81.

Pertussis

Around 300,000 cases reported annually.

Poliomyelitis

Estimated number of cases ranged from 141,000 to 234,000 a year. Annual incidence rate is around 1.5 to 1.8 per 1000 children 0-4 years.

Measles:

Estimated number of cases was 0.96 million in 1977.
The case fatality rate is 1--3 per cent.

Tuberculosis

There are about ten million patients in India, a quarter of them infectious. Some 500,000 deaths occur annually from tuberculosis, most of them in children below 15 years. The incidence rate of infection is 0.8 percent in the 0-4 year age group; 1.1 percent in the 5-9 age group; and two percent in the 10-14 year age group.

Leprosy

It is estimated in 1981 that there are 3.919 million cases with a prevalence rate of 5.72 for 1000 population. 20 to 25 percent of all c cases occur in children nearly one fourth are infectious and another 15 to 20 percent suffer from disabilities. The load of leprosy falls

in the eastern belt of India comprising Andhra Pradesh, Tamil Nadu, Orissa and West Bengal with 53 percent of the case load.

Typhoid

Some 300000 cases are reported annually, the majority among school children. The number of unreported cases would be large.

Diarrhoeal diseases

About 10 percent of total infant deaths are due to diarrhoea. 40% of deaths among children under 5 years are diarrhoea-related. An estimated 1.5 million children under five years die of it.

Acute respiratory infections

Over 17 percent of infant deaths are on this account, the proportion being next only to premature births. Upto 40 percent of out door patients and upto 35 percent of indoor patient are children below five years. The case fatality rate is 10-16 percent.

Malaria

A major problem of resurgence--man-made urban malaria.

Filariasis

Hundren million people in India living in endemic regions facing the threat.

Malnutrition

It is estimated that state of malnutrition ranges from 50% to 65% among the under fives in various places. This is not protein-calorie malnutrition but total calorie malnutrition ie., starvation. Results in lowering of resistance to infection. (poverty line - those who do not have the purchasing power to provide themselves with 2220 K. cals per day).

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	India	LDCs	World
% new born weighing less than 2.5 kg 2.5 kg	27.5	18	9
% of anaemia among pregnant women	70	60	20

Blindness attributable to Vitamin A Deficiency

occurs among 20-30,000 children in India.

Water supply and sanitation

Only 31% of the rural population has access to porta potable water and 0.5% enjoys basic sanitation.

	Rural	Urban
Protected water supply	10%	82.5%
Sound excreta disposal	2%	34%

Source: CSI, Ministry of Healing(5)

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THE NATIONAL HEALTH SCENE

A CHALLENGE FOR COMMUNITY HEALTH

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Diarrhoeal diseases

About 10 percent of total infant deaths are due to diarrhoea. 40% of deaths among children under 5 years are diarrhoea-related. An estimated 1.5 million children under five years die of it.

Acute respiratory infections

Over 17 percent of infant deaths are on this account, the proportion being next only to premature births. Upto 40 percent of out door patients and upto 35 percent of indoor patient are children below five years. The case fatality rate is 10-16 percent.

Malaria

A major problem of resurgence--man-made urban malaria.

Filariasis

Hundren million people in India living in endemic regions facing the threat.

Malnutrition

It is estimated that state of malnutrition ranges from 50% to 65% among the under fives in various places. This is not protein-calorie malnutrition but total calorie malnutrition ie., starvation. Results in lowering of resistance to infection. (poverty line - those who do not have the purchasing power to provide themselves with 2220 K. cals per day).

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	India	LDCs	World
% new born weighing less than 2.5 kg			
2.5 kg	27.5	18	9
% of anaemia among pregnant women	70	60	20

Blindness attributable to Vitamin A Deficiency

occurs among 20-30,000 children in India.

Water supply and sanitation

Only 31% of the rural population has access to porta potable water and 0.5% enjoys basic sanitation.

	Rural	Urban
Protected water supply	10%	82.5%
Sound excreta disposal	2%	34%

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BHORE COMMITTEE RECOMMENDATIONS FOR 1971

	Recommended	Estimated (1971)		Actuals (1971)		1981 (Actuals)
POPULATION		370 million		548 million		685 million
PRIMARY HEALTH CENTRES	1:20,000	18,500	27,400	5,112	34,250	5,740
DOCTORS	1:2000	1,85,000	2,74,000	1,61,129	3,42,500	2,68,712
NURSES	1:300	12,333,333	1,826,666	80,620	2,283,333	150,399
HEALTH VISITORS	1:5000	74,000	109,600	* 8,347	137,000	@ 19,033
MIDWIVES	1/100 births	100,000	225,776	* 9,253	231,530	@ 23,200
DENTISTS	1:4000	92,500	137,000	5,512	170,500	8,648

As required by Bhore Committee to actual population

Projection as required by Bhore Committee

* Trained upto 1971

@ Trained upto 1981

Source: 1. Health Atlas of India, 1986
2. Handbook of Health Information of India, 1986
3. Health Information of India, 1987

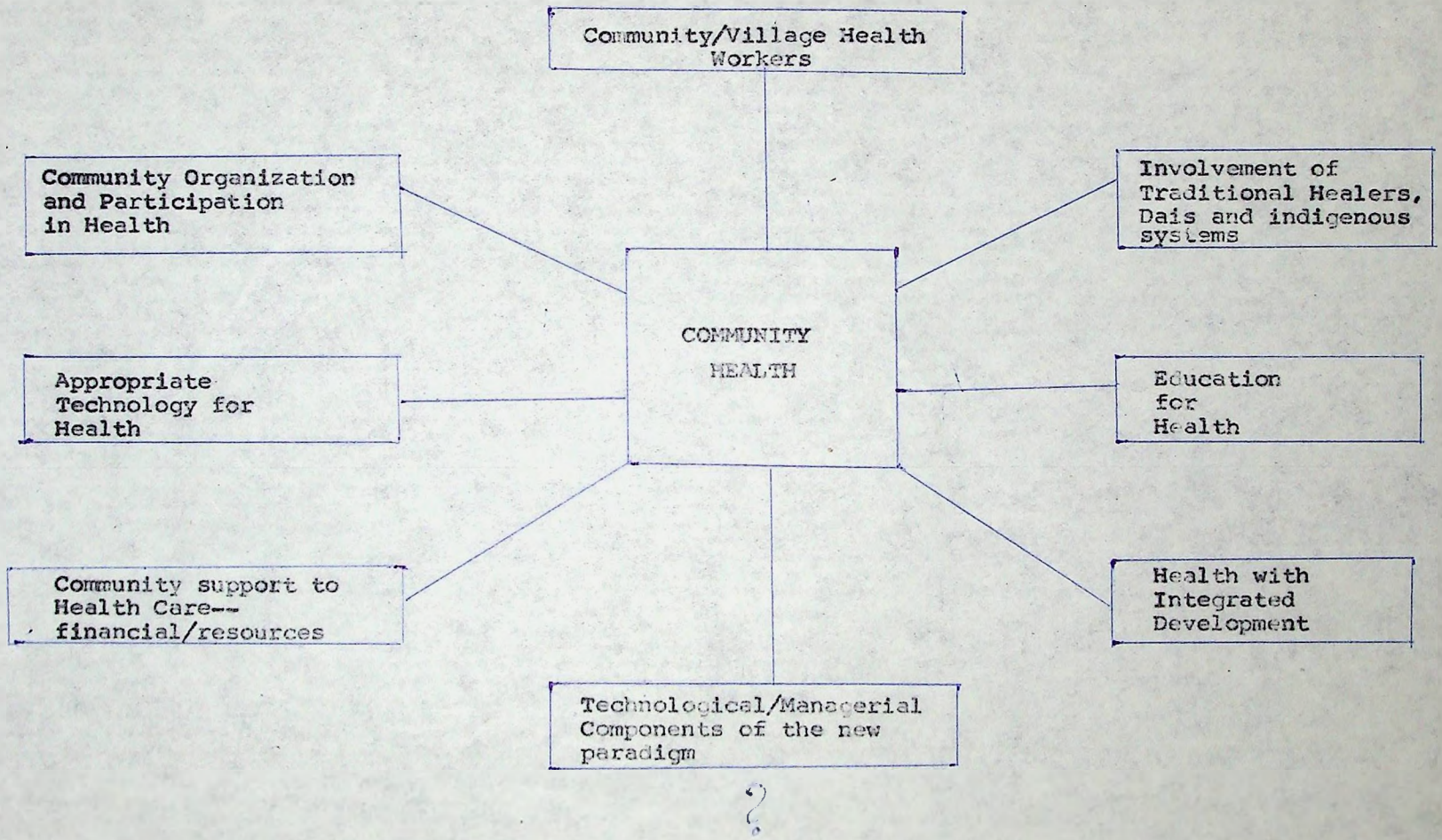
HEALTH FOR ALL
ICMR/ICSSR

Prescription ℞

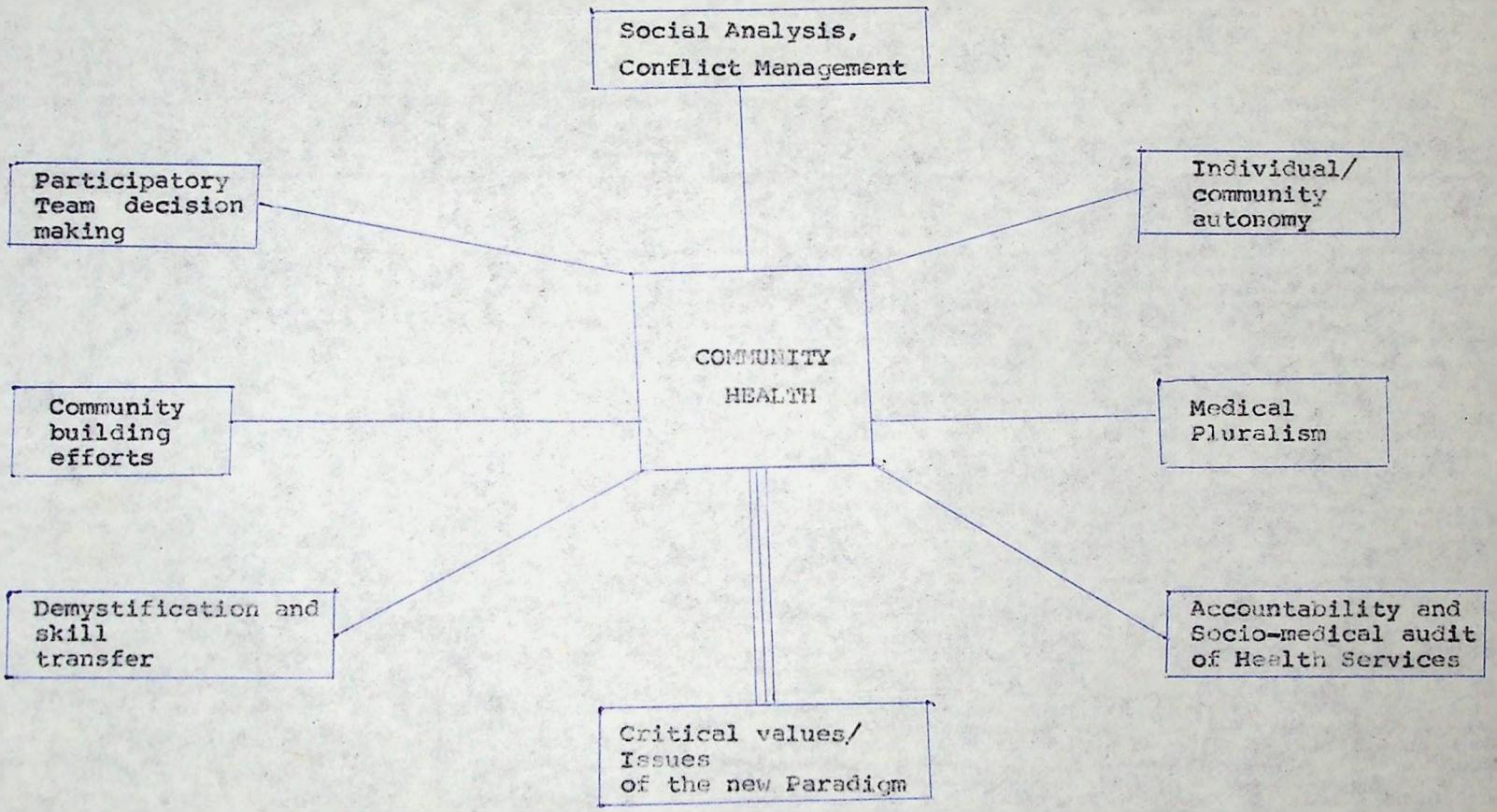
A MASS MOVEMENT

TO

- REDUCE POVERTY, INEQUALITY AND SPREAD EDUCATION
- ORGANISE POOR AND UNDERPRIVILEGED TO FIGHT FOR THEIR BASIC RIGHTS
- MOVE AWAY FROM COUNTER-PRODUCTIVE, CONSUMERIST WESTERN MODEL OF HEALTH CARE AND REPLACE IT BY AN ALTERNATIVE BASED IN THE COMMUNITY.



• Source: Community Health Cell Reflections



Source: Community Health Cell
Reflections

HEALTH DEVELOPMENT IN INDIA

The Constitution of India adopted in 1950 clearly recognises the government's responsibility for the health of all the people and this commitment has ledd to the evolution of a large number of health programmes over the last 40 years

These included the

* Development of the Primary Health Centre concept for every lakh population
* The training of health teams including doctors, health inspectors, lady health visitors, auxiliary nurse midwives, basic health workers, block extension educators for these health centres.
* The National programmes for communicable diseases like Tuberculosis, Leprosy, Malaria, Filaria, Plague, Cholera and so on.
* The Maternal and Child health, Nutrition and Family welfare programmes.
* Efforts at re-orienting medical and nursing education
* Establishment of research and specialist institutions
* The integration of programmes at PHC level, evolving the multi purpose health workers and health supervisor cadres.

	Box items/source
ix. Education for health	Stages in Community Health (FIONA plus)
x. Conscientization and political action	
6. Recognising the new paradigm	
6a. Building a collective understanding (CHC reflections)	
CH definitions	VHAI/CMAI/ACHAN/CHAI goals in 80's
CH Components	
CH Critical issues	A plea for a new public health (D. Banerjee)
6b. Evolving policy alternatives	
7. Community Health issues	
7a. Community health & Primary Health Care	Remembering Alma Ata (CSI) 10 year after (FIONA PLUS)
7b. Community Health & Hospitals	Mission Hospital--2000 AD an edict (CHAI)
7c. Community Health is a movement possible	
8. CH Issue Raising groups - an overview	Profiles--mfc/AIDAN/SHC/KSSP
9. CH training initiatives - an overview	Profiles of 8 institutions
10. CH Research Centres - an overview	Profiles of 4 centres highlighting research issues
11. In conclusions	
From a medical model to a social model The new health paradigm	Table of shifts
12. A Basic Resource Inventory (Readings & Resource Centres)	An Indian map with stars

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HEALTH ACTION

THE LEAD COVER STORY — No.1 in content list

COMMUNITY HEALTH: EXPLORING THE INDIAN EXPERIENCE

	Box items/source
1. Preamble	
2. Health Development in India	Constitutional Pledges
3. Taking Stock	
3a. Assessing achievements/ failures	ICMR/ICSSR list of achievements/ failures
3b. Quantitative expansion	6 charts from Health Atlas of India, 1986
3c. Critical introspection	4 paragraphs from Srivastava Report, 1975
3d. A multitude of questions	A list of questions by masses/ personnel (Ashish Bose)
4. The Health Scene in the 80's :Voluble Indices	Handout of CSI Ministry of Healing
5. The Alternative Health Project Phenomena	
5a. WHO were the initiators	
5b. HOW did these evolve	5c. Indian map and short profiles of projects from States
5d. WHAT were the components of Health action	
i. Health with development	
ii. Preventive/promotive health action	
iii. Appropriate Technology	Some profiles
iv. Promoting local health resources	Some profiles
v. Village based health cadres	Some profiles
vi. Community participation	
vii. Community organization	
viii. Financial resource generation	Some profiles

	Box items/source
ix. Education for health	Stages in Community Health (FIONA plus)
x. Conscientization and political action	
6. Recognising the new emerging paradigm	
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CH definitions	VHAI/CMAI/ACHAN/CHAI goals in 80's
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CH Critical issues	A plea for a new public health (D. Banerjee)
6b. Evolving policy alternatives	National Health policy
7. Community Health issues	
7a. Community health & Primary Health Care	Antwerp Declaration Remembering Alma Ata (CSI) 10 year after (FIONA PLUS)
7b. Community Health & Hospitals	Mission Hospital--2000 AD an edict (CHAI)
7c. Community Health is a movement possible	
8. CH Issue Raising groups - an overview	Profiles--mfc/AIDAN/CEHAT/KSSP
9. CH training initiatives - an overview	Profiles of 8 institutions (Courses)
10. CH Research Centres - an overview	Profiles of 3 centres highlighting research issues FRCH, ARCH, SEARCH
11. In conclusions	
From a medical model to a social model The new health paradigm	Table of shifts
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HEALTH ACTION

July 1989

Theme: Community Health in India

Fillers

1. Exploring jargon
2. Alma ata - ten years after
3. Primary Health Care - Declaration of alma ata
4. CHA's philosophy and vision of its CH programs
5. Basic principles in CHA's commitment to CH
6. Asian Com Health Action Network (ACHAN)
7. Recommendations of ICMR/ICSSR - Health for all - an alternative strategy
8. Traditional Medicine
9. Stages in CH services leading to more complete Primary Health care Development.

A Note to Health Action Team in Secunderabad

Health Action
July 1989

Theme: Community Health in India
: A new vision of Health Care

(1) This issue will consist of a longish lead article put together by the CHC team in Bangalore which explores various aspects of Community Health in India including the following:

i) Health Development in India
ii) Taking Stock of this development
iii) Health scene in 80s
iv) Alternative Health project phenomena
v) Recognising the emerging paradigm
vi) Community Health a) vs PHC b) Role of Hospitals
c) Movement dimension
vii) CH - Issue raising groups
viii) CH - Training initiatives
ix) CH - Research Centres
x) Building the new Health paradigm

The article includes a series of box items or quotations from the diverse materials that have emerged in this process.

(2) In response to the Editors letter we received contributions from seven resource people which have been edited for the issue
a) Alok - VHAI b) Fr Edwin - Kerala c) Dara Amer - St John
d) Jacob Cherian - Ambilikkai e) Anant Phadke - mfc
Two articles are in the post (telegram message)
F) Abhay Bang - SEARCH g) S. Joseph - MGDM Kengazha

For 'g' an alternative exists. An article by S Joseph in the CHAI Hospital Convention Proceedings on the same theme (refer P 29-31 of Proceedings) can be used.

Since the lead article is a longish one, it could be interspersed by shorter contributions mentioned in (2)

FROM INTRACELLULAR TO SOCIETAL RESEARCH

The new approaches to Community Health evolving in the country have shown that a very important but neglected area is research into socio-economic-political-cultural factors that affect health and disease and determine the nature of health care development as well as the response of the people.

Medical research in India has been preoccupied as in other parts of the world with intracellular or molecular biological roots of disease and much of the research efforts sponsored by ICMR and other national and regional, government and private research centres has been in this direction. Most of it has been imitative research, 'we too have done it in India' sort of focus and there is the continued myopic view that the future of health in the country will be determined by the discovery of a few more vaccines and maybe the odd drug or contraceptive. This technological focus has blinded us to the fact that the world-over health care action initiators are proving again and again that the clue to health of the people is in greater societal problems in the wider social reality and to study them in a socio-epidemiological context to determine bottlenecks and to evolve creative innovations is the need of the hour. Some ICMR institutions like the National Institute of Nutrition in Hyderabad, National Tuberculosis Institute in Bangalore and the Vector Control Research Centre in Pondicherry have treaded the path of societal research and made unique contributions to Primary Health Care and Community Health but these are the exceptions to the overriding rule.

Have the NGO Health action initiators fared better? Is anyone interested in health related societal research in the country?

The development of NGO health research units keeping

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in tune with and exploring in depth issues arising out of emerging Community Health movement are few but these are atleast positive signs.

The Foundation for Research in Community Health (Bombay) the Action Research in Community Health, Mangrol (Gujarat), Society for Education Research and Training in Health,(SEARCH) Gadchirole (Maharashtra), Community Health Cell (Bangalore) are examples. [Refer boxes]

A few of the larger NGO Health Projects like CHDP, Pachod, (Maharashtra) SEWA-Rural (Gujarat), CINI (Calcutta), Jamkhed (Maharashtra) and RUHSA (Tamilnadu) have also begun to take up some key research issues but this whole interest is still in a nascent state.

The Social Medicine and Community Health Department at JNU is the only other national centre which is undertaking societal research relevant to Health Care and Health policy issues. The medico friend circle's efforts in providing counter research expertise in the Bhopal disaster and its aftermath was also a beginning of this new trend.

Much needs to be done by both governmental and non-governmental groups, if the emerging 'Community Health' approach and movement has to be put on a sound researched, social and epidemiological basis. But this needs people who see Research as an important need. It also needs innovative 'researchers' who will be willing to learn existing health care research methodologies and then creatively adapt it through interactive, participatory approaches to study the dynamics of Community Health care and the evolving movement.

With the preoccupation with 'microscopic research' are such 'baloonist researchers' available for the task?

NGO Research Centres in Community Health : Some Profiles

* Foundation For Research in Community Health, Bombay, (Maharashtra), Estb: 1975

Non-government research centre which undertakes conceptual as well as field level research to study, analyse and wherever possible influence the cultural, economic and political factors that affect the health of the people.

Initiatives and studies include evolution and study of low cost community based health systems in Uran and Mandwa. Socio-economic study of rural transformation; Women's work fertility and access to health; PHCs in Maharashtra; Health Service projects (NGOs in Maharashtra) Health Financing in India
Stigma against leprosy
Alternative school health project
Facilitation of ICMR-ICSSR Joint study group on Health for All an alternative strategy.

Source : 24

* Action Research in Community Health - (ARCH) Mangrol, (Gujarat), Estb: 1978

A group of individuals of diverse background got together to establish this centre in the eastern tribal belt of Gujarat to study the developmental process using the health of children and women of the poorer sections of society as the guiding thread.
The approach was to get involved in the complex process of development (ACTION) and to study critically the health of the community and the processes which results in ill health (RESEARCH)

Field based strategies evolved were programmes to attack prevalent diseases, methods and skills of community diagnosis and

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intervention, training of health assistants and part time community health workers, non formal school and finally a just and humane rehabilitation policy for tribals displaced by an ambitious irrigation project in the area.

Source: 2h

* Community Health Cell, Bangalore, (Karnataka)
Estb: 1984

A Study-reflection-action experiment started by a small core team who moved beyond the Department of Community Medicine of a medical college in Bangalore to explore issues and build perspectives from community health action projects of voluntary agencies in India. The team promotes socio-epidemiological analysis, participatory management and the shift of health action from provision of services to enabling/ empowerment of the community.
(This issue of Health Action is based mainly on this study-reflection experiment)

* Society for Education, Awareness and Research in Community Health (SEARCH) Gadchiroli (Maharashtra) Estb: 1984

This Society has adopted Gadchiroli district, a predominantly tribal district in Maharashtra, for its education, awareness building and research activities. Presently they have long term projects on the study of Active Respiratory Illnesses in children; and a study of women's health focussing on the community. The Society also seeks to evolve methods of intervention which will be at the level of the multipurpose workers of the government PHC.
Due to its increasing community involvement the Society has also begun to explore the dynamics of women's health and other related issues, the forest issues affecting tribal and the illicit

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(refer article by Dr Abhay Bang)

liquor issue and its community context. It has also tried to modify the health care/medical practices at the District Hospital level to make it more responsive to the needs and the people's situation.

*Health Projects like RUHSA (Tamilnadu), CINI (West Bengal), CHDP Pachod (Maharashtra) and Deenabandhu (Tamilnadu), SEWA-Rural (Gujarat) and others (see profiles of projects page) have also begun to take up research projects on key issues in Community Health apart from putting their own activities on a more sound data base.

7a COMMUNITY HEALTH AND PRIMARY HEALTH CARE

In 1978, Representatives of all the countries of the World met in Alma Ata in USSR and committed themselves to the concepts of 'Primary Health Care'

The Alma Ata declaration which is now a famous Health document defined Primary Health Care

> 'as an essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford'

Primary Health Care (PHC) emerged in Alma Ata Declaration as an alternative view of health and health care, which included, locating health in the wider context of socio-economic development and exploring actions beyond orthodox medical care, that would be pre-requisites and/or supportive of the health of communities. The four principles stressed in the Declaration were:

1. Equitable distribution
2. Community participation
3. Multisectoral approach
4. Appropriate technology

Apart from a series of technological and managerial innovations that were considered, in the view of Health action, that emerged at Alma Ata, probably the most significant development was the recognition of a 'Social-process' dimension in Health care including community organisation, community participation, and a move towards

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equity. Health service providers would be willing now to appreciate social stratification in society, conflicts of interests among different strata and to explore conflict management. These were not explicitly delineated but were inherent to the issues raised in the Declaration. An equally important fact was that these perspectives emerged from the pioneering experience of a large number of voluntary agencies and some health ministries committed to the development of a more just and equitable health care system.

Since India was a signatory and evidently an enthusiastic proponent of this idea it has now become fashionable in India to use 'Primary Health Care' to describe all Alternative Health Action and synonymously with Community Health(CH). While PHC and CH have a lot in common it is important to remember that they are not synonymous, PHC is included in CH but CH is a much more comprehensive term and idea.

What are these differences

1. Primary Health Care concentrates on Primary level (first line contact) and ignores orientation of tertiary and secondary care,

   Community Health means a new approach at all three levels

2. Primary Health Care talks about a community in apolitical terms as if they were some homogenous group. It ignores caste/class and other dimensions in society.

   Community Health recognises stratification and conflict and the role this plays in accessibility and opportunity in health.

3. Primary Health Care leaves the 'development' and modernisation concept unquestioned.

   Community Health locates itself in the centre of the development debate and looks at health culture in a wholistic way.

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4. Primary Health Care leaves the medicalisation of health and the mystification and heirarchy of medicine unconfronted. Community Health confronts both these issues and tries to evolve an alternative, plural, demystification, non-heirarchical value system.

5. Primary Health Care has now become selectivised and all these who would prefer vertical topdown, selective, health solution, funded by government and non-government, International funding agencies have begun to gain control over it.

Community Health by its very terminology does not allow selectivisation, by concentrating on communities as base, community as focus of action and participation, the community health action remains comprehensive. It may be diverse and if at all selective it is the community which makes this choice.

Box

THE ANTWERP MANIFESTO FOR PRIMARY HEALTH CARE

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

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

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

These principles are:

* The main roots of poor health lie in living conditions and the environment in general, and more specifically in poverty, inequity and the unfair redistribution of resources in relation to needs, both inside individual countries and internationally.
* Since health is only one of the concerns of people, it is self-defeating not to consider them as partners who are able to play a great part in the protection and the improvement of their own health. They thus have to be fully and really involved in the making of decisions which affect their health, including of course, the provision of health services.

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

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

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

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

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

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

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

Source: LINK, 1988 (16)

CONSTITUTIONAL PLEDGES

The State shall regard the raising of the level of nutrition and the standard of living of its People and the improvement of Public Health as among its primary duties.

It shall ensure

that the health and strength of workers, men and women, and the tender age of children are not abused.....

that children are given opportunities and facilities to develop in a healthy manner.....

It shall make

provisions for securing just and human conditions of work and for maternity relief.....

and

for public assistance in cases of unemployment, old age, sickness and disablement and in other cases of underserved want.

-Constitution of India

QUANTITATIVE EXPANSION

By 1972 when we celebrated the Silver Jubilee of our Independence we had made rapid strides and a phenomenal quantitative expansion of health care services

(Insert charts 18, 21, 27, 28, 30 and 31 from
HEALTH ATLAS OF INDIA, 1986
Central Bureau of Health Inteligence
Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi)

HEALTH ACTION

July 1989

Theme: Community Health in India

REHBAR-I-SEHAT programme, Kotbhalwal Block, Jammu & Kashmir
C/o Prof of Preventive & Social Medicine, Govt Medical College

A project organized by the Government of Jammu & Kashmir to train teachers of village school's as primary health care guides.

Activities

- minor ailment treatment;
- health check up;
- health education
- nutrition supplementation programme for school children

COMMUNITY HEALTH

A Resource Centre Directory A to Z

(This includes addresses of all Centres, Projects and initiatives mentioned in this special issue)

1. Asian Community Health Action Network (ACHAN)
   No 61, Dr Radhakrishnan Road, Madras 600 004.
2. All India Drug Action Network(AIDAN)
   C/o Voluntary Health Association of India, 40 Institutional Area, South of I I T, New Delhi 110 016.
3. Action Research in Community Health (ARCH)
   At & P.O Mangrol, Via Rajpipla, Dist Bharuch, Gujarat 393 150
4. Arogya Vikasa
   Keshava Shilpa, Kempegowda Nagar, Bangalore 560 019.
5. Action for Welfare & Awakening in Rural Environment (AWARE)
   5-9-24/78, Lake Hill Road, Hyderabad 500 463.
6. Banwasi Seva Ashram,
   Govindpur, Dist Mirzapur, Uttar Pradesh
7. Bodokhoni
8. Catholic Hospital Association of India (CHAI)
   Post Box No 2126, 157/6 Staff Road, Secunderabad 500 003.
9. Christian Medical Association of India (CMAI)
   Smruti Theatre Compound, Mount Road Extension, Nagpur 440 001
10. Christian Fellowship Community Health Centre (CFCH)
    Santhipuram, Anna District, Ambilikkai 624 612, Tamilnadu.
11. Community Health Cell, (CHC)
    47/1 St Mark's Road, Bangalore 560 001, Karnataka
12.
13. Centre for Science & Environment (CSE)
    807 Vishal Bhavan, 95 Nehru Place, New Delhi 110 019.
14. CSI Ministry of Healing
    10, Sambamdam Street, T.Nagar, Madras 600 017
15. Deenabandhu
    Training and Service in Community Health & Development
    R K Pet, 631303, Tamilnadu.

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16. Foundation for Research in Community Health (FRCH)
84-A, R G Thandani Marg, Sea Face Corner, Worli
Bombay 400 018.

17. Indian Council of Medical Research (ICMR)
Ansari Nagar, Post Bos 4508
New Delhi 110 029

18. Indian Council of Social Sciences Research (ICSSR)
IIPA Hostel, Indraprastha Estate, New Delhi 110 002

19. Institute of Education
128/2 Karve Road, Kothrud, Pune 411 029

20. Institute of Health Management (IHMP)
Pachod, Dist Aurangabad 431 121, Maharashtra

21. International Nursing Services Association, India (INSA)
No2 Benson Road
Benson Town, Bangalore 560 046

22. Indian Social Institute; (ISI)
Lodi Road, New Delhi 110 003

23. Jawarharlal Nehru University (JNU)
Centre for Social Medicine & Community Health
New Delhi 110 057

24. St John's Medical College & Hospital (SJMC)
Sarjapur Road, Bangalore 560 034

25. K.E.M. Hospital
Sardar Mudaliar Road, Rasta Peth, Pune 411 011

26. Kottar Social Service Society (KSSS)
Thirumalai Ashram Social Centre, Chunkankadai P.O 629 807
Tamilnadu OR KSSS, Post Box 17, Nagercoil 629 001

27. Kerala Sashtra Sahitya Parishad (KSSP)
Parishad Bhavan, Chirakulam Road, Trivandrum 695 001

28. LokVidyan Sanghatana
759/97 D, Shantibhuvan, Prabhat Road Lane No 2
Deccan Gymkhana, Pune 411 004

29. Mallur Health Co-operative
Siddhalaghata Taluk, Mallur 562 116, Kolar District

30. Medicare
Kasturba Medical College, Manipal

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(2) HEALTH DEVELOPMENT IN INDIA

The Constitution of India adopted in 1950 clearly recognises the government's responsibility for the health of all the people and this commitment has ledd to the evolution of a large number of health programmes over the last 40 years

These included the

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* The Maternal and Child health, Nutrition and Family welfare programmes.
* Efforts at re-orienting medical and nursing education
* Establishment of research and specialist institutions
* The integration of programmes at PHC level, evolving the multi purpose health workers and health supervisor cadres.
* Establishment of pharmacies and training of pharmacists
* Production of medical technology needed for hospitals and dispensaries

Box

(2a) CONSTITUTIONAL PLEDGES

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It shall ensure

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-Constitution of India

THE COVER STORY

Community Health In India

Preamble

This story attempts to bring to the Readers of Health Action a birds eye view of an emerging process in India in which there is a growing shift of emphssis in health work from

Doctors and Nurses
Hospitals and Dispensaries
Drugs and laboratory investigations
surgery and medical technology

to

Village/Community based health workers
Health education/awareness building
Appropriate health technology
Community based health actions
Involvement of traditional healing traditions
Integrated rural development
and so on

The process reflects a growing disenchantment with the hospital/institutional based high technology models of health care which we transplanted and adopted in India to meet the health needs of our people especially since independence.

The process also reflects a commitment and a growing diversity of efforts and initiatives all over the country to adapt, innovate, create, alternative approcahes to health care that are more relevant to our people's needs and our social realities. While it is not possible to introduce readers to all the participating groups and initiatives in the Community Health Movement we have

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Initiatives in Community-Oriented, community-based Health Movements

HEALTH ACTION

July 1989

Theme: Community Health in India

ASIAN COMMUNITY HEALTH ACTION NETWORK (ACHAN)

was formed in 1980 by a group of twenty people with substantial experience in working in health care among the poor in Asia and operates through its network of concerned individuals and non-governmental organisations in fifteen Asian countries, most of whom have been engaged in innovative primary care at the community level

ACHAN

seeks to spread a philosophy of community based health care that envisages a process of self reliant human development for the oppressed poor in Asian communities which will result in genuine social change.

ACHAN

views health as the physical, mental, social, spiritual, economic and political shoneness of the individual and the community

ACHAN

believes that health problems and priorities should be viewed in terms in which the community sees them and that the community should be actively involved in planning, implementation, monitoring and evaluation of health care programmes.

"RECOGNISING THE NEW PARADIGM"

1978	VOLUNTARY HEALTH ASSOCIATION OF INDIA (3000 Health Institutions and Community Health Programmes)	'making community health a reality for all people, with priority for the less privileged millions, with their involvement and participation through the voluntary health sector...."
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Source: Policy Statements of organizations

THE PARADIGM SHIFT

Medical Model to Social Model of Health

INDIVIDUAL	------>	COLLECTIVE/COMMUNITY
PATIENT & POPULATION	------>	PERSON & SOCIETY
ANTI DEATH ANTI DISEASE	------>	PRO LIFE PRO LIVING
PHYSICAL/MENTAL PREDOMINANTLY	------>	PHYSICAL/MENTAL/SOCIAL/ CULTURAL/POLITICAL/ECONOLOGICAL
DOCTORS/NURSES MEDICAL AUXILIARIES	------>	TEAM OF HEALTH WORKERS
DISEASE PROCESSES	------>	SOCIAL PROCESSES
HOSPITALS/DISPENSARIES DRUGS/TECHNOLOGY --PROVIDING SERVICES	------>	HEALTH PROMOTING AND COMMUNITY BUILDING CENTRES AND PROCESSES--ENABLING/EMPOWERING THE PEOPLE
INTRACELLULAR RESEARCH	---->	SOCIETAL RESEARCH
PATIENT AS BENEFICIARY, CONSUMER	---->	PEOPLE AS PARTICIPANTS
SINGLE FACTOR,	------>	MULTI FACTOR
RISK IDENTIFYING,		PROCESS IDENTIFYING,
EPIDEMIOLOGY		EPIDEMIOLOGY
PROFESSIONALISED COMPARTMENTALISED MYSTIFIED KNOWLEDGE	----->	DEMYSTIFYING, PERSON CENTRED AUTONOMY CREATING AWARENESS BUILDING
QUEST FOR VACCINE AGAINST DISEASE	------>	QUEST FOR AWARENESS BUILDING PROCESS TO IMMUNIZE AGAINST UNHEALTHY SOCIAL PROCESSES

TAKING STOCK

A study group of the Indian Council of Medical Research and the Indian Council of Social Sciences Research listed out the achievements and failures of this whole strategy as follows:

Achievements

Life expectancy doubled

Health care services expanded

Manpower training centres increased

Small pox was eradicated

Plague, Cholera and Malaria controlled

Maternal and Child Health and Immunization programmes increased

Largest Family Planning programme in the world

Failures

Health not integrated with Development

Little dent on Malnutrition and Environmental Sanitation

Morbidity Patterns not materially changed

Health Education neglected

TB, Leprosy, Filaria yet to be controlled

Infant Maternal mortality rates still very high

Population stabilization - a long way to go

Overall

1. The model of health care was outdated and counter-productive benefitting the rich and well to do upper and middle classes

2. Health was a low-priority national investment

QUANTITATIVE EXPANSION

By 1972 when we celebrated the Silver Jubilee of our Independence we had made rapid strides and a phenomenal quantitative expansion of health care services

(Insert charts 18, 21, 27, 28, 30 and 31 from
HEALTH ATLAS OF INDIA, 1986
Central Bureau of Health Inteligence
Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi)

HEALTH DEVELOPMENT IN INDIA

The Constitution of India adopted in 1950 clearly recognises the government's responsibility for the health of all the people and this commitment has lead to the evolution of a large number of health programmes over the last 40 years

These included the

* Development of the Primary Health Centre concept for every lakh population
* The training of health teams including doctors, health inspectors, lady health visitors, auxiliary nurse midwives, basic health workers, block extension educators for these health centres.
* The National programmes for communicable diseases like Tuberculosis, Leprosy, Malaria, Filaria, Plague, Cholera and so on.
* The Maternal and Child health, Nutrition and Family welfare programmes.
* Efforts at re-orienting medical and nursing education
* Establishment of research and specialist institutions
* The integration of programmes at PHC level, evolving the multi purpose health workers and health supervisor cadres.

CONSTITUTIONAL PLEDGES

The State shall regard the raising of the level of nutrition and the standard of living of its People and the improvement of Public Health as among its primary duties.

It shall ensure

that the health and strength of workers, men and women, and the tender age of children are not abused.....

that children are given opportunities and facilities to develop in a healthy manner.....

It shall make

provisions for securing just and human conditions of work and for maternity relief.....

and

for public assistance in cases of unemployment, old age, sickness and disablement and in other cases of underserved want.

-Constitution of India

EVOLVING POLICY ALTERNATIVES

The National Health Policy statements are beginning to echo these ideas and values.
Whether this is 'populist rhetoric' or a serious 'rethink' only time will tell.

(T. Jeleve

will win and the Government would lose. The sad fact is that the infrastructure remains unutilised because it is by and large not operational."

"Let us turn to the personnel now.

The Block Medical Officers ask:

* Why is there no set policy for transfers and promotions?
* Why only doctors who can wield political influence manage good postings, while the others 'rot' in villages for years together?

The ANMs ask:

* Why is there no concern for their physical security when they are asked to work and live in remote villages?
* Why did the Government insist on getting free land from the Panchayat which in effect meant the worst possible location for their quarters, mostly on the outskirts of villages?

The Village Health Guides (VHGs) ask:

* Why have they not been paid their paltry honorarium of Rs. 50 per month even after the Government issued orders not to discontinue the scheme under which mostly male VHGs have been recruited?

  (It was decided that in future only female VHGs will be recruited)

Again, if there is a fair debate between the health staff and the high level administrators, the Health Staff will win"

CRITICAL INTROSPECTION

In the seventies, the Government of India set up an expert group on Medical Education and Support Manpower to take stock of the situation and suggest proposals for reforms.

This is what the expert committee had to say:

1. "A universal and egalitarian programme of efficient and effective health services cannot be developed against the background of a socio-economic structure in which the largest masses of people still live below the poverty line. So long as such stark poverty persists, the creative energies of the people will not be fully released; the State will never have adequate resources to finance even minimum national programmes of education or health; and benefits of even the meagre investments made in these services will fail to reach the masses of the people. There is, therefore, no alternative to making a direct, sustained and vigorous attack on the problem of mass poverty and for creation of a more egalitarian society. A nationwide programme of health services should be developed side by side as it will support this major national endeavour and be supported by it in turn."

2. "We have adopted tacitly, and rather uncritically the model of health services from the industrially advanced and consumption-oriented societies of the west. This has its own inherent fallacies; health gets wrongly defined in terms of consumption of specific goods and services; the basic values in life which essentially determine its quality get distorted; over-professionalization increases costs and reduces the autonomy of the individual; and

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Super Cook

ultimately there is an adverse effect even on the health and happiness of the people. These weaknesses of the system are now being increasingly realized in the West and attempts are afoot to remedy them. Even if the system were faultless, the huge cost of the model and its emphasis on over-professionalization is obviously unsuited to the socio-economic conditions of a developing country like ours. It is therefore a tragedy that we continue to persist with this model even when those we borrowed it from have begun to have serious misgivings about its utility and ultimate viability. It is, therefore, desirable that we take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations. The new model will have to place a greater emphasis on human effort (for which we have a large potential) rather than on monetary inputs (for which we have severe constraints).

3. In the existing system, the entire programme of health services has been built up with the metropolitan and capital cities as centres and it tries to spread itself out in the rural areas through intermediate institutions such as Regional, District or Rural Hospitals and Primary Health Centres and its sub-centres. Very naturally, the quantum of quality of the services in this model are at their best in the Centre, gradually diminish in intensity as one moves away from it, and admittedly fail at what is commonly described as the periphery. Unfortunately, the 'periphery' comprises about 80 percent of the people of India who should really be the focus of all the welfare and developmental

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effort of the State. It is, therefore, urgent that this process is reversed and the programme of national health services is built with the community itself as the central focus. This implies the creation of the needed health services within the community by utilising all local resources available, and then to supplement them through a referral service which will gradually rise to the metropolitan or capital cities for dealing with more and more complicated cases."

4. "Throughout the last two hundred years, conflicts have arisen in almost every important aspect of our life, between our traditional patterns and the corresponding systems of the West to which we have been introduced. In many of these aspects, the conflicts are being resolved through the evolution of a new national pattern suited to our own genius and conditions. In medicine and health services unfortunately, these conflicts are yet largely unresolved and the old and new continue to exist side by side, often in functional dishormony. A sustained effort is, therefore needed to resolve these conflicts and to evolve a national system of medicine and health services, in keeping with our life systems, needs and aspirations."

Many other expert committee reports and policy statments of the seventies began to make critical observations about the inadequacies of the present health care model and exhorted all concerned to search for more relevant alternatives and approaches.

A MULTITUDE OF QUESTIONS

What do all these statistics and critical introspection mean to the rural people who have suffered neglect for years? Have the post-independence policies made an impact on their lives?

Professor Ashish Bose while reviewing the Family Welfare programme has this to say:

"There are questions the masses would like to ask.

* Why are doctors not available at the Primary Health Centres and ANMs not available at the sub-centres?
* Why are medicines not available to the poor?
* Why is there no follow-up of acceptors of sterilisation?
* Why are women brought to the PHCs for laparoscopic operation?
* Why are the X-ray machines not working in so many PHCs and hospitals?
* Why is there no facility for oxygen and blood transfusion even in upgraded PHCs?
* Why are Government doctors so indifferent to rural patients?
* Why don't the PHC building have proper water and electricity facilities?
* Why are the new sub-centres and residential houses built for ANMs so sub-standard and located in such forlorn places?
* Why do contractors get away with sub-standard construction under the so called Foreign-Aided Area Projects?

"In this controversy, if there is a fair debate, the masses

....2

Typical

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Will the NGOs work together to pur pressure on the 'established medical system' to commit itself to a new vision of Health Care?

Will the NGOs work together to put pressure on 'Health Policy and decision makers' to move beyond policy statements and get health oriented programmes and actions of the ground?

Will the NGOs work with the people and their organisations to enable and empower them to get the means, structures, opportunities, skills, knowledge and organisations that make health possible?

All these are unanswered questions. Micro level experiments have shown that a lot is possible, but macro level change requires a collective understanding and a collective action that is still to emerge on our individualistic, divided, politically sterile national scene.

WILL COMMUNITY HEALTH HAVE A CHANCE?

HEALTH SERVICES IN A COUNTRY

Postulates of a theory

Health Service development is

a. a socio-cultural process

b. a political process

c. a technological and managerial process with an epidemiological and sociological perspective.

There is often a lag between socio-cultural aspirations of the people and their articulation by the political leadership;

The lag is much more between the aspirations of the political leadership and the achievements of community health physicians who have the responsibility for building the needed edifice of the health services.

The task is to narrow, if not totally eliminate, lags that may exist within the three tiers.

Formation of a critical mass of community health physicians and other members of the team, which can take full advantage of the scope offered by the base (i.e., the complex of ecological, epidemiological, cultural, social, political and economic factors at play) requires a new approach to education of community health physicians and other members of the team.

Readymade solutions are not available from affluent countries..... a superstructure of health services is to be built which is firmly rooted in the base.

- D Banerji ( )

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