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. 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 autonomy 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 conscientising 'education for health' programs;

ii) Initiating a democratic, decentralised, participatory and non-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( )

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

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

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.

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.

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 ( )

THE COVER STORY (Lead) -

Community Health In India

(1) Preamble

This story ~~attempts to~~ brings to the Readers of Health Action a birds eye view of an emerging process in India in which there is a growing shift of emphasis 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 practices
Integrated rural development
and so on

The process reflects a growing disenchantment with the hospital/institutional based high technology medical 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 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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attempted to explore as much of the diversity as possible as well as quote from the wealth of documentation, reflections and educational materials that this ferment is generating,

HEALTH ACTION

July 1989

Theme: Community Health in India

Lead article

1. Community Health : Exploring the Indian Experience	CHC, Bangalore
2. Voluntary Agencies in Community Health : The need for a new paradigm	Alok Mukhopadhyay
3. Community Health : Learning through our failures	Prem and Hari John
4. Building Holistic Health Communities	Edwin S.J
5. Can a Hospital be Community Health oriented?	Samuel Joseph
6. SEARCH: An experience in Community Health Research	Abhay Bang
7. Training for Community Health Care : A medical college experience	Dara Amar
8. Health of People is Wealth of Nation	Jacob Cherian
9. Community Health : Keeping Track (A Basic Resources inventory)	CHC, Bangalore
10. Organizing People for Health - Problems and Contradictions	Anant R S

= bold capital

— bold

~~~ italics
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PRIMARY HEALTH CARE

STAGES IN COMMUNITY HEALTH SERVICES LEADING TO MORE COMPLETE PRIMARY HEALTH CARE DEVELOPMENT ARE:

Stage 0: Community has to come to the hospital resulting in limited access to health care.

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Stage 5: Multi-sectoral, multi.disciplinary integration of many different components in each community, leading to improved health and economic developmemt.

Stage 6: Education, organisation, mobilisation of resources and active implementation of socio-economic development of people for their own total health at the micro-project level.

Stage 7: political activity by communities at the macro level to ensure primary health care with the quality of wholeness in life for all.

(Source: Fiona Plus, A Bi-monthly bulletin on Primary Health Care in Community Health,)

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 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.

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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, conse uently 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 discussion 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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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 accordingly;

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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;

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7. relies at local and referral levels, on health workers including physiciens, 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.

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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 innonative 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.

BASIC PRINCIPLES IN CMAI'S COMMITMENT TO COMMUNITY HEALTH

1. Community Health is am 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.

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(Source: Fiona Plus, A Bi-monthly bulletin on Primary Health Care in Community Health,)

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CHAI's Philosophy and Vision of its Community Health Programme

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 are fulfilled, 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

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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 should 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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Duplicate

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.

RECOMMENDATIONS

We therefore make the following recommendations:

1. The Government of India should, in consultation with all concerned, formulate a comprehensive national policy on health dealing with all its dimensions, viz., philosophical and cultural, socio-economic, nutritional, environmental, educational, preventive and curative. The coordinated and planned implementation of this policy should be the collaborative and cooperative responsibility of individuals, families, local communities, health personnel and State and Central Governments.
2. The basic objectives of this policy should be:
   a. to integrate the development of the health system with the overall plans of socio-economic-political transformation;
   b. to ensure that each individual has access to adequate food and is provided with an environment which is conducive to health and adequate immunization, where necessary;
   c. to devise an educational programme which will ensure that every individual has the essential knowledge, skills and values which would enable him to lead an effectively healthy life and to participate meaningfully in understanding and solving the health problems of the family and the community;
   d. to replace the existing model of health care services by an alternative new model which will be
      - combining the best elements in the tradition and culture of the people with modern science and technology,

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- integrating promotive, preventive and curative functions,
- democratic, decentralised and participatory,
- oriented to the people, i.e., providing adequate health care to every individual and taking special care of the vulnerable groups,
- economical, and
- firmly rooted in the community and aiming at involving the people in the provision of the services they need and increasing their capacity to solve their own problems, and

e. to train the personnel, to produce drugs and materials and to organise research needed for this alternative health care system.

3. A detailed time-bound programme should be prepared, the needed administrative machinery created and finance provided on a priority basis so that this new policy will be fully implemented and the goal of "Health for All" be reached by the end of the century.

(Recommendations of the ICMR/ICSSR on "Health for All" An Alternative Strategy)

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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Duplicate

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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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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etc. In one remote area, a few of our illiterate VHWs were incorporated as Government's "Village Health Guides" (because the PHC doctor was very much impressed by their knowledge), even though the minimum educational qualification required for this post is 8th standard. (This mutual cooperation helps the health authorities to fulfill their targets for remote areas) But the Government authorities (all males) dislike the questioning attitude, " rude manners" of our women VHWs. When our VHWs asked a PHC doctor, in a meeting about the budget of the PHC, and the expenditure under different heads, he got infuriated. Relations were also strained because a Morcha was organised to demand justice in case of an injection-palsy in a boy after an injection in his arm. Any attempt to take democracy seriously, to know and to question some of the practices in the PHC are frowned upon. The 'beneficient authority' obliges by cooperating as long as its hegemony is not threatned. "People's participation" is a nice slogan, but when it is taken seriously in a critical fashion, such attempts are despised. This in turn dempens the already low initiative of the people for asserting their own right.

Such are the problems and contradictions in the process of 'organising people for health care'. Both from a theoretical as well as practical view point, there is no doubt, that without the collective participation, control by the people in fulfilling their health care needs, the health delivery system will not really serve the people, But the process is a very complex, slow and difficult one. It is easier to talk about nice things, but very difficult to achieve them. A lot of practical and analytical work has to be done before we can confidently talk about a strategy of "Health Care by the people" or under the control of the people.

TRAINING FOR COMMUNITY HEALTH CARE

Dara S Amar

(This paper highlights some of the attempts made in St John's Medical College, Bangalore, to orient Health Workers, including Medical students, towards Community Health Care. The attempts 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 various members of the health team under one roof. We are able to create a better understanding among the members of the team of each other's role. 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.

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

Community Participation

One of the main objective of the community health programme of the college is the development of a participatory process wherein the villagers themselves are responsible for the financing of health care, supply of materials and manpower. This is particularly exemplified by the Mallur Health Co-operative Centre, a project initiated jointly by the college and the Mallur Milk Copperative in 1973. Village Health Committees have been formed at each of the rural health centres and decisions are

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participatory in nature. A large part of the organisation of speciality rural camps are also done by the villagers. This is through their village youth groups and Mahila Mandals. Even in the training of the health workers including medical students, the village leaders are drawn in as resource persons.

Coordination with other agencies

We 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. Our teaching faculty also act as guest faculty for various sister institutions and organisations involved in health and development.

Integrated Health Care

Villagers in India often resort to indigenous systems of medicine. The training at the college of the health workers including our medical students, includes training in Herbal Medicine, Herbo Mineral Medicine, Acupressure, Homeopathy and Yoga. Many of our graduate doctors working in remote rural areas, have substantiated the fact that there is need for integration with other systems of medicines as is being attempted at the college.

Health Education - A priority

After years of experience in training health team members for the villagers, we feel there is a greater need to pay attention to training in health education. 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

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senitize the health worker to the various aspects of rural life and how each of these aspects is related to the total health of the villagers.

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 the available resources for health care. Rural camps in the field of eye, ear, nose and throat, skin, teeth, child health and General Surgery 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. Specialist 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 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.

Understanding health and disease holostically

In order that our health team trainees do not dichotomise health care into various compartments, the training programmes focus on families rather than individuals. Through programmes such as the Clinico-social case study and field family health care projects, the 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 disease affected person. Emphasis is laid on

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the planning and management of health care at minimal cost. Our graduates 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-priviliged

Urban slums in and around Bangalore, are also served by the Medical College. Health programmes such as immunization Coverage against the major killer dieseases for children, maternal and child health clinics for expectant mothers and school health programmes, are some of the urban based health activities. In addition, the Medico-Social Unit also aids in counselling for alcoholism, drug addiction, juvenile deliquency etc.

Continuing education

Although basic training in health care is imparted to various categories of health workers, it is important 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 experience among Community Health Workers and Rural doctors. This provides an opportunity for learning from each other. Continuing education is also provided by St John's for health agencies from afar. The United Planters 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

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also act as a means of networking 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 youth. 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.

Conclusion

All the programmes are updated constantly, depending on the feed back received on their effectiveness and efficiency. The emphasis is on training and health education rather than mere 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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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 programmes organised by the college. The health education methodologies include the development of local audio-visuala 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. 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, 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 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 dynamics of rural life, special training programmes are organised on a residential basis at our rural health centres. These rural residential training programmes stress 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

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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 ministers 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 tertairy 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 apportunity 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.

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 hihgly 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.

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.

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. 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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wide variety of individuals, groups and associations into a movement for a tational 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.

Lobhying 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.

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.

Wants 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 sttitudes 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

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

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, [redacted] 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.

CHAI's Philosophy and Vision of its Community Health Programme

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

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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.

BASIC PRINCIPLES IN CHAI'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~~ preference 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 interdependant.
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.

(A Note to Health Action Team in Secudderabad)

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:

a. Health Development In India

b. Taking Stock of this development

c. Health scene in 80s

d. Alternative Health project phenomena

e. Recognising the emerging paradigm

f. Community Health

i. Vs PHC ii) Role of Hospitals iii) Movement dimension

g. Community Health - Issue raising groups

h. Community Health - Training initiatives

i. Community Health - Research Centres

j. 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. Since the Lead article is a longish one it could be interspersed by shorter contributions mentioned in (2)

2. In response to the Editor's letter we received contributions from seven resource people which have been edited for the issue

a. Alok Mukhopadhyay - VHAI

b. Fr Edwin - Kerala

c. Dara Amar - St John's

d. Jacob Cherian - Ambilikkai

e. Anant Phadke - mfc

two articles are in the post (telegram messages)
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5b. 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. Today they represent a wide variety of origins and bases.

a. A rural development programme with a health component eg RUHSA, Tamilnadu, Banwasi Seva Ashram, UP
b. A community based medical/health programme. eg Mini PHC of VHS, Tamilnadu, RAHA Project, MP
c. An integrated development programme in a tribal area. eg. VGKK, Karnataka.
d. An adult education/non-formal education programme with a health component. dg AWARE, AP
e. A science education programme with a health component eg Kishore Bharati, MP
f. A nutrition supplementation programme with a health component. eg Project Poshak, M.P & Project Palghar , Maharashtra
g. A conscientization/awareness building programme with a health component, eg. Bodokhoni, Orissa
h. A community extension/outreach programme of a hospital eg MGDM Hospital Project, Kangazha
i. A field practice area of a medical/nursing/paramedical training institute. eg. Mallur Health Cooperative, Bangalore
j. A school based health programme eg Deena Seva Sangha, B.lore
k. A health programme as a component of a trade union movement eg. CMSS Health Project, Dalli Rajhara
l. A health programme as a component of a project focussed on women's issues eg. Women's voice B.lore, SEWA Ahmedabad
m. Health as a component of a community action in urban slums eg. Streehitakarini, Bambay
n. A health programme for workers organised by an employers association, eg CLWS, of UPASI for tea plantations, Kerala & TN

and so on

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

a. Issue raising groups like mfc, AIDAN, KSSP
b. Coordinating/networking groups like VHAI, CHAI, CMAI and ACHAN
c, Community Health training centres like RUHSA, St John's and others
d. Community Health Research Centres like ARCH, FRCH, SEARCH & others

These will be described later.

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 components

Rehabilitation as a health oriented action was seen mainly in the context of people suffering from leprosy. More recently the concept of community based rehabilitation is also being experimented within a few projects. Basically this new approach believes in the organisation of the disabled in the community into associations and involving them in efforts to improve their own conditions through programmes of education, income generation, skill training and self reliance.

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

Many projects had triedd 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 (RSA) kits
nutrition mixes prepared from locally available foods
indigenous MCH calendar
locally manufactured lower limb prosthesis, b ngles and tapes
to measure nutritional status of children
low cost sanitation options
home based oral rehydration solutions
herbal and home remedies from the badkyard or kitchen.

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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(5) alternative Project'

The Community Health phenomena - Three questions

Duplicate

(5a) 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. (1)

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. (2)

They came from different ideological backgrounds - Gandhian, Christian, Marxist and other convictions. They differed widely in their understanding of the development process; their perceptions of governmental efforts; their conceptions of their own roles in development; the source of their funding and their initial understanding of the health process itself. They all however shared a common conviction that something needed to be done and could be done if one tried to understand the local situation in depth and react creatively to the needs of the community.

5b 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. Today they represent a wide variety of origins and bases.

a. A rural development programme with a health component. e.g RUHSA/Tamilnadu Benwasi Sewa Ashram, Mirzapur UP
b. A community based medical/health programme. e.g Musiri PHC of VHS Adyar, Tamilnadu
c. An integrated development programme in a tribal area. eg RAHA, Project MP VGKK, BR Hills
d. An adult education/non-formal education programme with a health component. eg
e. A science education programme with a health component. eg Kishore Bharati, Madhya Pradesh
f. A nutrition supplementation programme with a health component. eg Project Poshak & Project Palghar
g. A conscientization/awareness building programme with a health component. e.g Bodakhani, Orissa,
h. A community extension/outreach programme of a hospital e.g MGDM Hospital Project, Kangazha
i. A field practice area of a medical/nursing/paramedical training institution. e.g Mallur Health Cooperative, Bangalore
j. A school based health programme. e.g Deena Seva Sangha, Bangalore
k. A health programme as a component of a trade union movement. e.g CMSS Health project, Dalli Rajhara
l. A health programme as a component of a project focussed on women's issues e.g Women's Voice Bangalore, Sewa, Ahmedabad
m. Health as a component of a community action in urban slums. e.g Streechikitsa Karini, Bombay.
n. A health programme for workers organised by an employers association. eg Comprehensive Labour Welfare Scheme of UPASI for tea plantations

and so on. —

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

a. Issue raising groups
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.~~ These will be described later.

(52) 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 approach to health care. Our experiences of studying many of them (6) 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 symb lised 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

— VHAI (7)

(For further details contact VHAI, New 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 (8)

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 important 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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Page 4 Box for Item (e)

'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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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 owmen 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 aporoach. 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 (to 9)

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 Mexican 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 effectivaly 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 stratified 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 initiators 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, 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 or 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.

3. Taking Stock

In 1972, when we celebrated the Silver Jubilee of our independence, there began a critical reflection and introspection on the preceding twenty five years of development. This was an important milestone and it became a forum to take stock of the strengths and weaknesses of our planning and development, particularly in the context of the continuing poor quality of life of a large majority of Indian citizens. All aspects of National development came under scrutiny and Health policy was no exception

(36) Assessing Achievements/Failures

~~TAKING STOCK~~

A study group of the Indian Council of Medical Research and the Indian Council of Social Sciences Research listed out in 1984 the achievements and failures of this Health care 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

Source: ICMR/ICSSR(1)

(3b) <u>QUANTITATIVE EXPANSION</u>

By ~~1955~~ 1972 when we celebrated the Silver Jubilee of our Independence we had made rapid strides and a phenomenal quantitative expansion of health care services. This increase in manpower and infrastructure development continued into the eighties.

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

At bottom of charts mention Source: Health Atlas of India 1986, CBHI

By 1984 we had increased the number of hospitals and dispensaries a three fold, ~~primary health centres a~~ fold, doctors a five fold, nurses a six fold and and dental colleges 7 fold ~~female health workers a~~ fold and male ~~health workers a~~ folds. A remarkable development indeed it seemed.

However when we compare this infra-structural development with the Bhore Committees long term goals enunciated in 1946 itself. we find the situation very ~~disconcerting~~ different and the so called 'rapid growth' becomes questionable.

[Insert table with 1984 totals compared with Bhore Committee recommendations]

Increasing numbers with goals and base lines can be very misleading!.

(30)

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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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 and 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."

Source: Shrivastava Report (3)

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

(5d) 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[4] 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 will win and the government would lose. The sad fact is that the infrastructure remains unutilised because it is by and large not operational".

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3 (contd)

Experts and academics, policy makers and researchers, health personnel and the people all of them agreed that the quantitative expansion of the health infra structure and programmes had been at the cost of the quality of the programme. There was need to evolve a system and approach more relevant to our social reality

Who would begin this task?

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.(6) 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 supported 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 is a new and disturbing trends. The Drug Industry, the medical technology industry, the five star hospitals, the medical professionals are all using the word health 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 investigation' in the name of health is another trend.

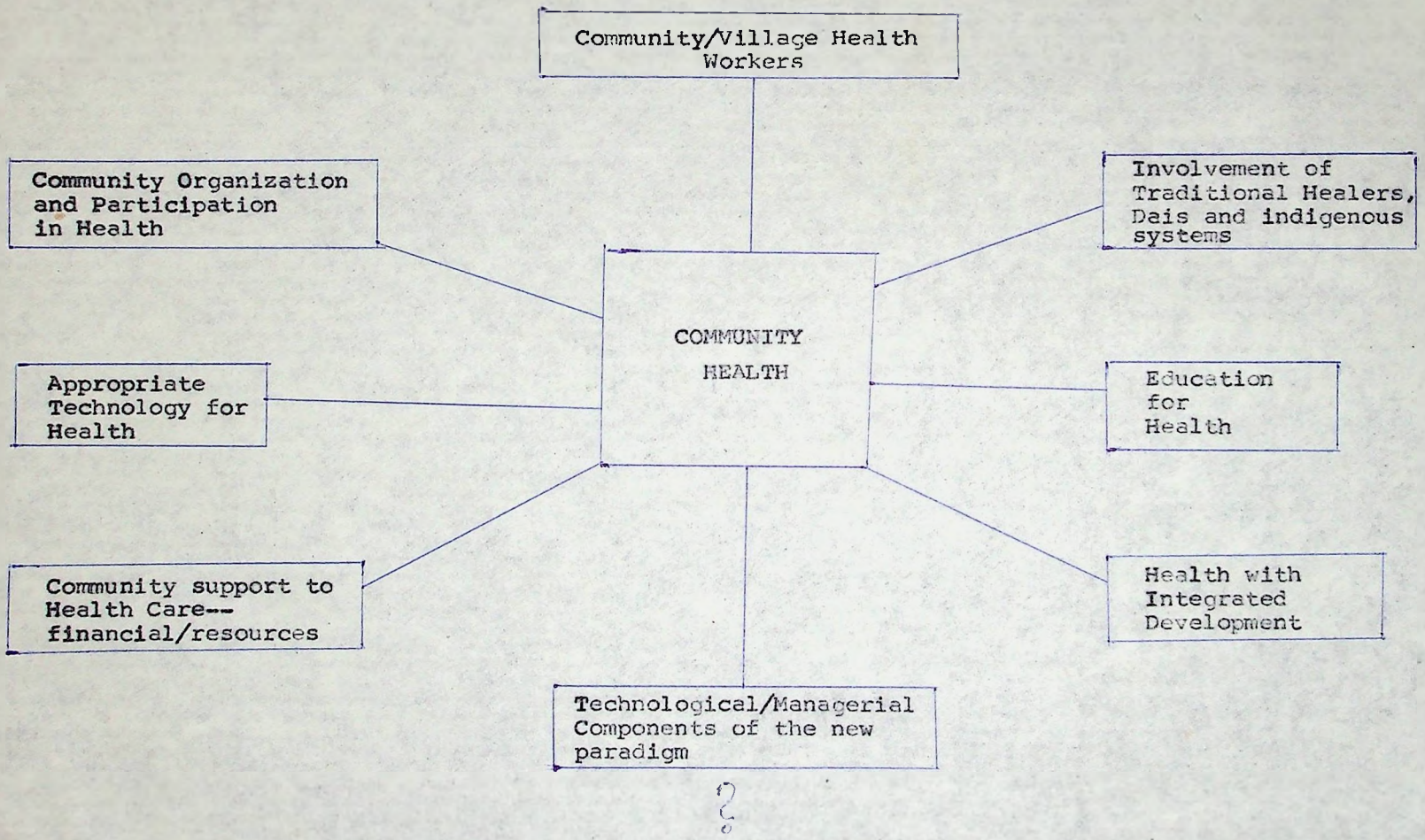
Will the negative trends prevail and grow and prevent the evolution of a health movement only time will tell. There is every indication that this may be so.

THE PARADIGM SHIFT

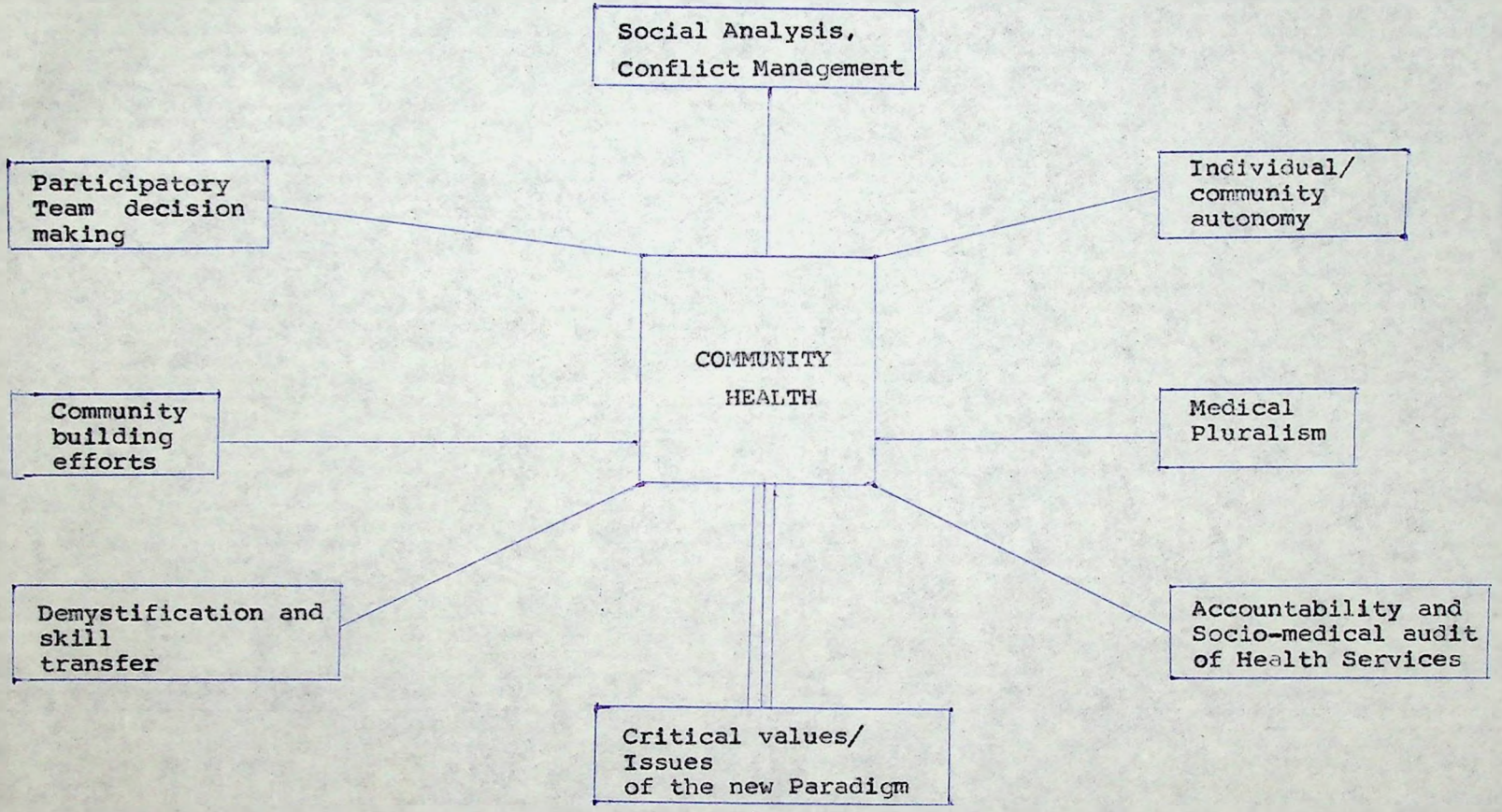
Medical Model to Social Model of Health

INDIVIDUAL	------>	COLLECTIVE/COMMUNITY
PATIENT & POPULATION	------>	PERSON & SOCIETY
ANTI DEATH ANTI DISEASE	------>	PRO LIFE PRO LIVING
PHYSICAL/MENTAL PREDOMINANTLY	------>	PHYSICAL/MENTAL/SOCIAL/ CULTURAL/POLITICAL/ECOLOGICAL
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 KNOWLEDGE
QUEST FOR VACCINE AGAINST DISEASE	------>	QUEST FOR AWARENESS BUILDING PROCESS TO IMMUNIZE AGAINST UNHEALTHY SOCIAL PROCESSES

Duplicate



Source: Community Health Cell Reflections (6)



Source: Community Health Cell
Reflections (6)

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 ~~xikk~~ 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 the 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) Gadchiroie (Maharashtra), Community Health Cell (Bangalore) are examples.

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?

CHaction initiatives

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

CHaction initiate

Will the ~~NGO~~s 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?

CHaction initiate

Will the ~~NGO~~s 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?

Filler 2

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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Duplicate

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.

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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Duplicate

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 and 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

ICMR-ICSSR-Hea M. For All

RECOMMENDATIONS

We therefore make the following recommendations:

1. The Government of India should, in consultation with all concerned, formulate a comprehensive national policy on health dealing with all its dimensions, viz., philosophical and cultural, socio-economic, nutritional, environmental, educational, preventive and curative. The coordinated and planned implementation of this policy should be the collaborative and cooperative responsibility of individuals, families, local communities, health personnel and State and Central Governments.
2. The basic objectives of this policy should be:
   a. to integrate the development of the health system with the overall plans of socio-economic-political transformation;
   b. to ensure that each individual has access to adequate food and is provided with an environment which is conducive to health and adequate immunization, where necessary;
   c. to devise an educational programme which will ensure that every individual has the essential knowledge, skills and values which would enable him to lead an effectively healthy life and to participate meaningfully in understanding and solving the health problems of the family and the community;
   d. to replace the existing model of health care services by an alternative new model which will be
      - combining the best elements in the tradition and culture of the people with modern science and technology,

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- integrating promotive, preventive and curative functions,
- democratic, decentralised and participatory,
- oriented to the people, i.e., providing adequate health care to every individual and taking special care of the vulnerable groups,
- economical, and
- firmly rooted in the community and aiming at involving the people in the provision of the services they need and increasing their capacity to solve their own problems, and

e. to train the personnel, to produce drugs and materials and to organise research needed for this alternative health care system.

3. A detailed time-bound programme should be prepared, the needed administrative machinery created and finance provided on a priority basis so that this new policy will be fully implemented and the goal of "Health for All" be reached by the end of the century.

(Recommendations of the ICMR/ICSSR on "Health for All" An Alternative Strategy)

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 develo ment 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;

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Duplicate

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;

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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.

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STAGES IN COMMUNITY HEALTH SERVICES LEADING TO MORE COMPLETE PRIMARY HEALTH CARE DEVELOPMENT ARE:

Stage 0: Community has to come to the hospital resulting in limited access to health care.

Stage 1: Mobile clinics which give episodic services unable to deal with complications developing between the intervals of care.

Stage 2: Public Health Services which attempt to achieve disease control without necessarily depending on active recepient community involvement.

Stage 3: Hospital-based, community-oriented, Primary Health Care where all resources and health funcationaries are taken regularly and frequently from hospital bases into communities requesting and cooperating actively with this assistance.

Stage 4: Community Based Primary Health Care (CBPHC) with facilities and health personnel firmly established in communities requesting them and actively contributing to their implementation. Tertiary hospitals are then used only for referrals, training and assistance as and when required.

Stage 5: Multi-sectoral, multi.disciplinary integration of many different components in each community, leading to improved health and economic developmemt.

Stage 6: Education, organisation, mobilisation of resources and active implementation of socio-economic development of people for their own total health at the micro-project level.

Stage 7: political activity by communities at the macro level to ensure primary health care with the quality of wholeness in life for all.

(Source: Fiona Plus, A Bi-monthly bulletin on Primary Health Care in Community Health,)

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 Primary 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 [redacted] 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.

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Eyelcare

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 ys 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 feferred 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 independent 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 economic1 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 theyr 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 the 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 impoverished areas to the cities to be made into cheese, chocolate 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 labout 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 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 botn 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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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 what 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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etc. In one remote area, a few of our illiterate VHWs were incorporated as Government's "Village Health Guides" (because the PHC doctor was very much impressed by their knowledge), even though the minimum educational qualification required for this post is 8th standard. (This mutual cooperation helps the health authorities to fulfill their targets for remote areas) But the Government authorities (all males) dislike the questioning attitude, " rude manners" of our women VHWs. When our VHWs asked a PHC doctor, in a meeting about the budget of the PHC, and the expenditure under different heads, he got infuriated. Relations were also strained because a Morcha was organised to demand justice in case of an injection-palsy in a boy after an injection in his arm. Any attempt to take democracy seriously, to know and to question some of the practices in the PHC are frowned upon. The 'beneficient authority' obliges by cooperating as long as its hegemony is not threatned. "People's participation" is a nice slogan, but when it is taken seriously in a critical fashion, such attempts are despised. This in turn dempens the already low initiative of the people for asserting their own right.

Such are the problems and contradictions in the process of 'organising people for health care'. Both from a theoretical as well as practical view point, there is no doubt, that without the collective participation, control by the people in fulfilling their health care needs, the health delivery system will not really serve the people, But the process is a very complex, slow and difficult one. It is easier to talk about nice things, but very difficult to achieve them. A lot of practical and analytical work has to be done before we can confidently talk about a strategy of "Health Care by the people" or under the control of the people.

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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Applicant

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 ad 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

THE NATIONAL HEALTHSCENE

A CHALLENGE FOR COMMUNITY HEALTH

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 23[illegible],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 cases occur in children nearly one fourth are infectious and another 15 to 20 percent suffer from disabilities. The load of lepro-

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 yeas 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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A REPORT FROM KERALA

BASIC HEALTH COMUNITIES

--Fr Edwin MJ*

defining community

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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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 villa e. 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 discussion 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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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

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2. Evaluation of Primary Health Care Programmes, 1980
3. Appropriate Technology for Primary Health Care, 1981

B-Ministry of Health and Family Welfare, New Delhi

4. Health Services and Medical Education (Srivastave 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 (6 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

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H- Foundation for Research in Community Health, Bombay

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I- National Institute of Mental Health and Neurosciences, Bangalore

35. Manual of Mental Health for Medical Officers 1985

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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

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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

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O- Kerala Sashtra Sahitya Parishad, Trivandrum

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TRAINING FOR COMMUNITY HEALTH CARE

Dara S Amar

(This paper highlights some of the attempts made in St John's Medical College, Bangalore, to orient Health Workers, including Medical students, towards Community Health Care. The attempts 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 various members of the health team under one roof. We are able to create a better understanding among the members of the team of each other's role. 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.

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

Community Participation

One of the main objective of the community health programme of the college is the development of a participatory process wherein the villagers themselves are responsible for the financing of health care, supply of materials and manpower. This is particularly exemplified by the Mallur Health Co-operative Centre, a project initiated jointly by the college and the Mallur Milk Copperative in 1973. Village Health Committees have been formed at each of the rural health centres and decisions are

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participatory in nature. A large part of the organisation of speciality rural camps are also done by the villagers. This is through their village youth groups and Mahila Mandals. Even in the training of the health workers including medical students, the village leaders are drawn in as resource persons.

Coordination with other agencies

We 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. Our teaching faculty also act as guest faculty for various sister institutions and organisations involved in health and development.

Integrated Health Care

Villagers in India often resort to indigenous systems of medicine. The training at the college of the health workers including our medical students, includes training in Herbal Medicine, Herbo Mineral Medicine, Acupressure, Homeopathy and Yoga. Many of our graduate doctors working in remote rural areas, have substantiated the fact that there is need for integration with other systems of medicines as is being attempted at the college.

Health Education - A priority

After years of experience in training health team members for the villagers, we feel there is a greater need to pay attention to training in health education. 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

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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 programmes organised by the college. The health education methodologies include the development of local audio-visuals 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. 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. 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 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 dynamics of rural life, special training programmes are organised on a residential basis at our rural health centres. These rural residential training programmes stress 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

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senitize the health worker to the various aspects of rural life and how each of these aspects is related to the total health of the villagers.

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 the available resources for health care. Rural camps in the field of eye, ear, nose and throat, skin, teeth, child health and General Surgery 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. Specialist 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 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.

Understanding health and disease holostically

In order that our health team trainees do not dichotomise health care into various compartments, the training programmes focus on families rather than individuals. Through programmes such as the Clinico-social case study and field family health care projects, the 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 disease affected person. Emphasis is laid on

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the planning and management of health care at minimal cost. Our graduates 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-priviliged

Urban slums in and around Bangalore, are also served by the Medical College. Health programmes such as immunization Coverage against the major killer dieseases for children, maternal and child health clinics for expectant mothers and school health programmes, are some of the urban based health activities. In addition, the Medico-Social Unit also aids in counselling for alcoholism, drug addiction, juvenile deliquency etc.

Continuing education

Although basic training in health care is imparted to various categories of health workers, it is important 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 experience among Community Health Workers and Rural doctors. This provides an opportunity for learning from each other. Continuing education is also provided by St John's for health agencies from afar. The United Planters 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

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also act as a means of networking 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 youth. 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.

Conclusion

All the programmes are updated constantly, depending on the feed back received of their effectiveness and efficiency. The emphasis is on training and health education rather than mere provision of multiple services. This ensures that whatever have been the programme inputs, the results will be long, lasting self perpetuating and effective.

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?

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

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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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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.

file with material
prepared for
HEALTH ACTION
"Community Health"
issue

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I STREEHITAKARINI : Bombay's Slum Women Organise.

- Started 1964 / Bombay City / Covers 100,000 populn.
- M.C.H. Services / F.P. / Nonformal education & Female literacy / Balwadis (creches) / Income generation for women.
- 50 C.H.Ws (400 fam / 2000 populn.) / 5 group leaders 1:5 CHWs / 2 Supervisors.
- CHWs : ₹/Short formal trg. / in-service trg. / regular meets / Rs 75/=
  Gp. leaders : —do— / Rs 150/=
  Activities 1) Health — motivation / educn. / referral. } Volunteer doctors.
  — Suppl. feeding U5s
  — Well baby clinics.
  — F.P. → most significant ē advice to childless couples for credibility.
  2) Educn : - Female education
  - Kreeda Kendras (7-15yrs) for juvenile delinq.
  - Alcoholics Anonymous.
  3) Income generation : Sewing / hosiery / screen-printing / electrical maintenance etc.
  - Small savings Scheme (Govt. small savings campaign award 1985)

Lessons learnt : a) Start ē women / local women for long term.
b) MCH ē F.P.
c) Integrated prog. ē non-formal educn / income generation & savings.
d) Interaction ē other agencies.
e) ~~Local~~ Trg. & dev. of appropriate skills.
f) Services cost money.
g) Start health educn. at early age.

II K.E.M. HOSPITAL RURAL HEALTH PROJECT

- Started 1977 / Pune dist. - Vadu Block - 22 villages, 30,000 populn.
  1980 - extended to adjacent Khendur & Nhavra blocks 60 villages, 1,20,000 populn.
- Cooperative effort of Vol. org. ē Govt. in providing Rural Health Services.
- MCH / FP / Comm. dis. control / Health Edn. / Env. sanitn. / Mahila mandals / youth clubs / socio-eco. programs).
- C.H.G.s selected by community 1M+1F per village (Rs 125/- 50% 75% KEM) } Retrained by KEM Hosp.
- M.P.Ws of govt. organisation
- Vadu ~~hosp~~ PHC upgraded to small hosp. ē good referral links to KEM.
- CHGs popular / elected to Panchayat, upto Sarpanch level.
- UNDARP involved in socio-eco. dev. activities / loans / seed capital / tech. expertise / animal husbandry / smokeless chulhas / Goban gas plants etc.
- Extn. to Khendur & Nhavra blocks ē only CHGs input — problems of lack of admin. control / ineffective links ē IInry IIIry care centres / inadequate interaction ē CHGs

KEY : (1) Recruitment & trg of CHGs & trg. ē PHC staff.
(2) Management & supervision.
(3) MAHILA MANDALS imp. for increasing awareness.

III BANWASI SEVA ASHRAM :

- Started 1954 / Mirzapur dist. U.P. / 3,50,000 populn.
- IRDP - based on Gandhian philosophy of self sufficiency.
- AGRINDUS (The Agro-Industrial Community Dev. Centre) is the nucleus of its diverse activities :
  - ~ Agriculture - Bhoodan/Gramdan/ANTYODAYA/ Land reclamn. & dev. /Afforestn. / Irign. & rain-water conservation.
  - ~ Dairy
  - ~ Village Industries - Local employt/ Approp. vocational trg.
  - ~ Education / Functional literacy.
  - ~ GRAM KOSH - revolving village fund for cheap credit.
  - ~ Peoples organisations: - 3 tier system
    Gram swarajya Sabhas / Kshetriya S.S. / Kendriya S.S.
  - ~ Social justice programs - Lok adalats to settle disputes
    - legal aid for rural entitlements.
  - ~ HEALTH & F.P. : - 4 tier structure - cost paid by patient.
    - a) Swasthya mitra (150) - local volunteers
      ~ prev. & prom. measures/ minor ailts/ household & herbal remedies & F.P.
    - b) Gramin doctors (10) - at village health posts
      ~ paid ashram workers / high school + 2 yrs trg. / as GPs.
    - c) Agrindus clinic (1) - nucleus of health activ / Dr + 2 asstts
    - d) Spec. med. institn. - B.H.U. / Mirzapur dt. hosp.

  80-90% use these health services
  ~ indigenous medicines used.
  ~ health & nutrn. educn. given + Educn. ANC & PNC.

  NO IMMUNIZN. / SUPPL. FEEDING / U-5s programs.

Socio-eco. uplift of 10% families of 100 villages funded by outside agencies.

IV COMPREHENSIVE LABOUR WELF. SCHEME OF U.P.A.S.I.

- Started 1971 / Plantations TN/KER/KAR/ - 2,50,000 populn. (1984).
- MCH/F.P. / Env. Sanitn. / Drinking water/ Health Edn / Trg. medical & managerial manpower Research & evaluation.
- Re-orientation of Medical & Managerial manpower
- Extension of Existing Health Services ~~of~~ to periphery.
- LINK WORKERS - to involve community
  - voluntary / 1 per 20 families / 60% women / trained by UPASI/ Monthly ~~frequent~~ meeting ~ health sector personnel.
  - ~ inform community on services available & benefits
  - ~ gather info. on health & welfare problems in comm. and pass it on to medical/managerial depts for action.
  - ~ imparts health Educn. / Promotes preventive measures/ links community to Health services.

* Plantations - Organised sector / ample budgetary & medical infrastructure.

V MINI HEALTH CENTRES PROGRAM OF VOL. HEALTH SERVICES:

- Started 1977 - St. Thomas Mount Block } Chingleput dt. T.N. / 1,60,000 since 84.
  1984 - Tirupporur Block }

- M.C.H. / Nutr'n. Support / Health records / Comm. dis. control / Health Edn / Fly Welfare / Medical care + referrals / Manpower trg. / Research & evaln / Co-op. health care.

- To enlarge scope of functions of PHCs
  - prevention emphasized as much as cure
  - family as unit of medical care
  - community participation.

M.H.C. → nodal point of delv. of health care. (5000 popln). / Part-time Dr. 2 MPWs (1M+1F)] 2 Supervr. Staff per 4 MHCs.

- data collection & health records
- maternity services.
- child welfare + nutrition
- family welfare
- minor ailments / comm.ble diseases
- referrals to nearest hosp.

- continuity of care
- coopern & community participn

'HEALTH BEGINS AT HOME'
- Extensive preventive care.

LAY FIRST AIDER - 200 families / 1000 popln
- first aid / health educn. / available 24 hrs/day.

- "Medical Insurance" for commty participn by PREPAYMENT Rs 12 to Rs 300 p.a. OR payment for service.
- All staff trained initially & 'in-service' by V.H.S.
- Ayurveda / indigenous medicines utilized.
- Adopted statewide as a model - now - 93 vol. agys. - 300 MHCs.

COHEDEC - 'Community Health Development Combines'
- new evolved concept
- area approach to public health.
- consolidating public & private health streams to serve each area

VI COMMUNITY BASED CONTRACEPTIVE DISTRIBUTION

VI COMPREHENSIVE HEALTH & DEV^{t} PROJECT AT PACHOD.

- Started in 1977 / Aurangabad Dist. Maharashtra / Popln. - 50,000 (21 villages)

Services:
- MCH ē special emphasis on ante, intra and post natal care.
- Health & Nutrn. educn.
- Growth monitoring & nutritional surveillance of children
- Anganwadis
- Environmental programmes including trg. in construction of biogas plants & smokeless chulhas, and social forestry prog.

- Trained Dais - each village ē referral access to hosp.
- CHWs - 1/1000 popnln. - many from Dai cadre. - illiterate ∴ simplified systems of ← trg. testing monitoring ē symbolic reporting.
- Health posts - clinics twice a month each village ē A.N.M.
- Child Health Services thro' all cadres.
- Anganwadis since 1981.
- Communicn. - unsophisticated / appropriate / brief H.E. messages developed locally
- Community Financing of Pry. H. Care - CHWs
  - Govt stipend (50) + basis of service rendered & performance. eg. for ANC / delivery / child survival / Contraception etc.
- Participatory Management, Research & Evaluation
  - concurrent & not terminal activity.

CONCLUSIONS: There are 2 stages in provision of Pry H. Care.
1. Estab. of infrastructure & hardware component to provide services
2. getting people to use them.

Lessons
a) Dais / CHWs from most deprived sections
b) Provision of health services most cost effective when focusing on entire sub-gps. of popnln. at AN.clinic / Anganwadi etc. instead of indiv.
c) Health Educn. thro' peer groups.
d) Community pays its Health Workers.
e) Comm. reps. in participatory planning & decision + evaln.
f) All levels of health workers have detailed advance planning of 1 wk at least

VII PARIVAR SEVA SANSTHA

- Started 1979 / H.O. New Delhi / Clinics & projects 7 in U.P. / 2 in M.P. / 5 in W.B. / 2 in Rajn. / 1 in Bihar / 1 in Guj / 1 in AP / 2 Haryana +8 in U.T. of Delhi.
- Originally 'Marie Stopes Society', now P.S.S. - All are URBAN.

Services:
- Reproductive Health Care incl. safe delv., spacing, terminal F.P. methods / Menstr. Reglns. / MTP / Rx for gynec. disorders.
- MCH
- Diagnostic screening & health care for common diseases.
- Counselling in F.P. & reproductive health.
- Inform^{n}. / Educn. in communicn.
- Training
- Social marketing of contraceptives.

- Self financing - payment for services.
- Sound professional management / services / trg. prog.
- Non-govt. agency ē social objectives thro' above.

VIII CHILD IN NEED INSTITUTE:

- Started 1974 / 24 Paraganas (W.B.) / 70,000 popn/hy.

Services provided - MCH care
- Training
- Community Organisn. & Comm. devt.
- Research & Evaluation
- Consultancy.

- MCH services (a) Weekly clinics - 3 locns.
(b) 10 village based clinics run by Mahila Mandals + CINI staff
(c) Home visits by health workers.

- Village Based Health Care thru' Mahila Mandals who run clinics / Balwadis / Anganwadis etc.
- Emergency Ward & Nutrn. Rehabilitn. centre.
- Environmental sanitn. - Smokeless chulhas.
- Socio-Eco. programmes - Samaki Vlg. Dev. prog. - farm/dairy/poultry/fish/veg.
- Small scale Ind. & income generation by Mahila Mandals.
- Sponsorship of needy students for studies.

Training ē ICDS prog. & NIPCCD - Anganwadi workers
- in prev. & prom. health of i) school teachers, local youth, (comnty leaders) ii) dais iii) indigenous & allop. med. practitioners & iv) Mahila mandal mothers.

Research: ē NFI & ICMR + closely assoc. ē Natl'y. & Internatl. agencies & institutions.

CINI has had a multiplier effects thru' persons trained at CINI who have started new, similar projects & weaned off.

(MAHILA MANDALS KEY TO ACTIVITY)

IX RURAL UNIT FOR HEALTH AND SOCIAL AFFAIRS:

- Started 1977 / K.V. Kuppam Block, T. Nadu / Pop - 100,000.

Areas of work:
- Health & family Welfare
- Adult educn., Vocational trg.
- Community Organisn.
- Income generation
- Agric. dev. & agro-support services
- Research, Trg, Evaluation & Consultancy.

- A holistic approach to health ē local commty, Govt & other Volags.
- For adminstn. KVK Block div. into 18 units < 16 Peripheral service units (PSUs) / 2 Central ser. units (CSUs) (RUHSA HQ & PHC of Govt).

PSU - 5-7,000 popn/hy. CSU - 10,000 pop/hy. + referrals from 8 PSUs.

PSU < 5 FCVs (Family Care Volunteers) - ground level worker 200 fams (1000 pop/hy)
1 H.A. (Health Aide)
1 RCO (Rural Commty Organiser)

CSU - 1 RCO as Multi purpose worker.

Belief - HEALTH & DEVT ARE INTERLINKED & HEALTH IS BOTH A MEANS AND MEASURE OF DEVELOPMENT.

Health & Non health linkages thru' TEAM approach < T - Trg / E - Educn. / A - Agric. & Animal husbandry / M - Medicine.
ē Women & children / eductd unemployed / soc.eco. weaker sections as targets.

eg: 1000/20,000 families 'X'-rated - for priority in all areas.

- The Collective Leadership models
  - Village Advisory Committee ē leaders from var. comm. of villagers.
  - ~~Develo~~ Block Develop^t. Committee
  - Youth Clubs / Women's Gps. / Young farmers clubs / Soc. eco. grps of similar occupns.
- Networking ē Govt. & other agencies.

CERT - trains Ruhsa + other personnel / documents / disseminates RUHSA philosophy

Educ^l. activ. thru' 2 Ed^n. Officers / 2 project officers / 4 continuing education workers & 30 animators (17♀).
- handles 60 centres / each centre caters to 30 learners (non-formal educn.).

Initiative on behalf of women to make them central activators of devpt.

Lessons:
- Project to have sound basic concept.
- Selection of appropriate staff.
- involve community for its own betterment. - even before project starts.
- people led demand generating a service.
- deep understanding of sociology & psychology of people.
- SOCIAL CHANGE MUST BE APPROACHED GRADUALLY - not radically.

X COMMUNITY BASED CONTRACEPTIVE DISTRIBUTION

- Started 1979 - Varanasi Dt. U.P. - Pop 1.2 million.
- A collaborative prog. between FPAI & BHU

Services:
- Education in Family Welfare
- Distrib^n of oral contracepts / condoms & foam tablets.
- Promotion of all methods of F.P.
- Provision of basic primary health care products.
- ~~Ia~~ Income generation activities for women & rural devt. programs.

877 Sanyojaks (Local volunteers) 1 : 1275 pop.
52 Field organisers 6-7 per block 1 : 20,000 "
8 field Supervisors 1 per block 1 : 1,25,000 pop.
} Ref. to Govt. & Volag PHCs, Hosp, B.H.U.

SANYOJAKS - volunteers trained - Home visits NOT done - clients come to them.
(have assured income from independant sources)
Stock pre packed
- sterilized delivery packs for home delys.
- Fe & Fol. acid tabs.
- ORS
- Deworming pills / Fever pills & for pains
- Sulphur / boric powder / anti-lice lotions.

- motivate for F.P.
- refer to health centres
- follow up.
} to suit clients needs.

- Funding FPAI / Staff BHU / Materials thru FPAI from IPPF.
- Sales - proceeds shared betw. sanyojaks & project.

Programmes for Women: - by Khadi Gramodyog Bhandar / IRDP / SBI funding
- Mahila mandals.

Lessons:
- Village based volunteer services.
- Client's needs suited.
- adequate referral back up by local practitioners / Volags / Govt / other agencies.

XI ACTION for WELFARE and AWAKENING in RURAL ENVIRONMENT: A.W.A.R.E.

- Started 1975 / Andhra Pradesh / 1,750 villages, 9,75,000 populn.

Areas of work:

General:
- Agricultural development.
- Social action for education.
- Community programme.
- Womens development
- Prog. for Landless poor
- " " rehabiln. of bonded labour.
- Cottage industry & marketing.

Health:
- Health Educn.
- Env. sanitn.
- Disease control.
- MCH / Nutrn.
- Trg. of Health Workers
- Research
- Monitoring & Evaluation.

Modalities - indirect, aimed at devising systems which can furnish a basis from where target populn. can itself take off.
1) awareness building & organising
2) income & employment generation program.
3) basic needs programme.

- Awareness thru' - informal discussion / non-formal educn
- group meetings < gram Sabhas (village meetings)
  maha Sabhas (mass ")
- community educn. centre - thru' community organisn.

WITHDRAWAL - once 'Cluster Development Officer' of AWARE is replaced by a 'local' C.D.O.

- Economic prodn. - water / soil conservn. / better farming etc. + co-op marketing. / Vocational trg.

- Basic needs:
  - Community Health
  - Women & Child welfare
  - Community development.

+ 2 addl. activities due to circumstances < 1) disaster relief
2) legal assistance to weaker sections

Health - 'Jeevana Sravanthi' came about unexpectedly following a cyclonic disaster & cholera epidemic.
- led to a sustained activity.
Started ē mass immunizn. & curative activity (felt need) & is now into preventive & promotive health care.

Staff: 200 full time field staff - Grads & PGs - various disciplines.
400 Rural organisers
600 Part time village organisers
25,000 volunteer force from project villages

2 Doctors + 3 tiers of H.Ws < Paramedical or CHWs. - 6 mo. trg.
Village Health workers - village nominees
Dais

- Kunavaram floating Community Health Centre - immovn. to reach 300 villages along the banks of Godavari & a boat ē Hosp & health workers)

Organisational Revamping - 2 distinct phases
a Earlier conventional vertical set up ē pyramidal structure.
1984 - sensitised by peoples views & formed clusters of 20 villages by consolidn. of geographic & substantive functions

Funding - a subsidary activity to its programmes.
Acts heavily on peoples human & capital resources.
- Cooperation ē Govt. & NGOs. - as a reinforcing element.

Views: Health is a legal right & a fundamental duty of people.

Lessons:
- AWARE stands BEHIND & WITH people - not ahead of them.
- Peoples ability to make informed choices is real basis for success.
- Upscaling is a constant concern.
- AWARE is not obliged to render help. - willing to work with people.
- Constant introspection & self assessment.
- Did not start ē any plans / blue-prints - evolved as it went along

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SOCIETY for EDUCATION, WELFARE and ACTION - RURAL

- Started 1980 / Jhagadia, Gujarat / Pop - 35,000. - 40 villages.
- Areas of work - Integrated Health & Rural Development.
  - Started ē curative service which ~~[illegible]~~ enjoy high visibility or a Maternity Home converted to a 40 Bed fully equipped hosp.

Community Health Project
- Pilot phase started after 1 yr - getting to know the people.
- Expanded phase - Govt in an unprecedented move, handed over Jhagadia Block in Bharuch dt. to SEWA-rural as the principal executor of the Community Health project.
- responsibility for total health care - May '83.

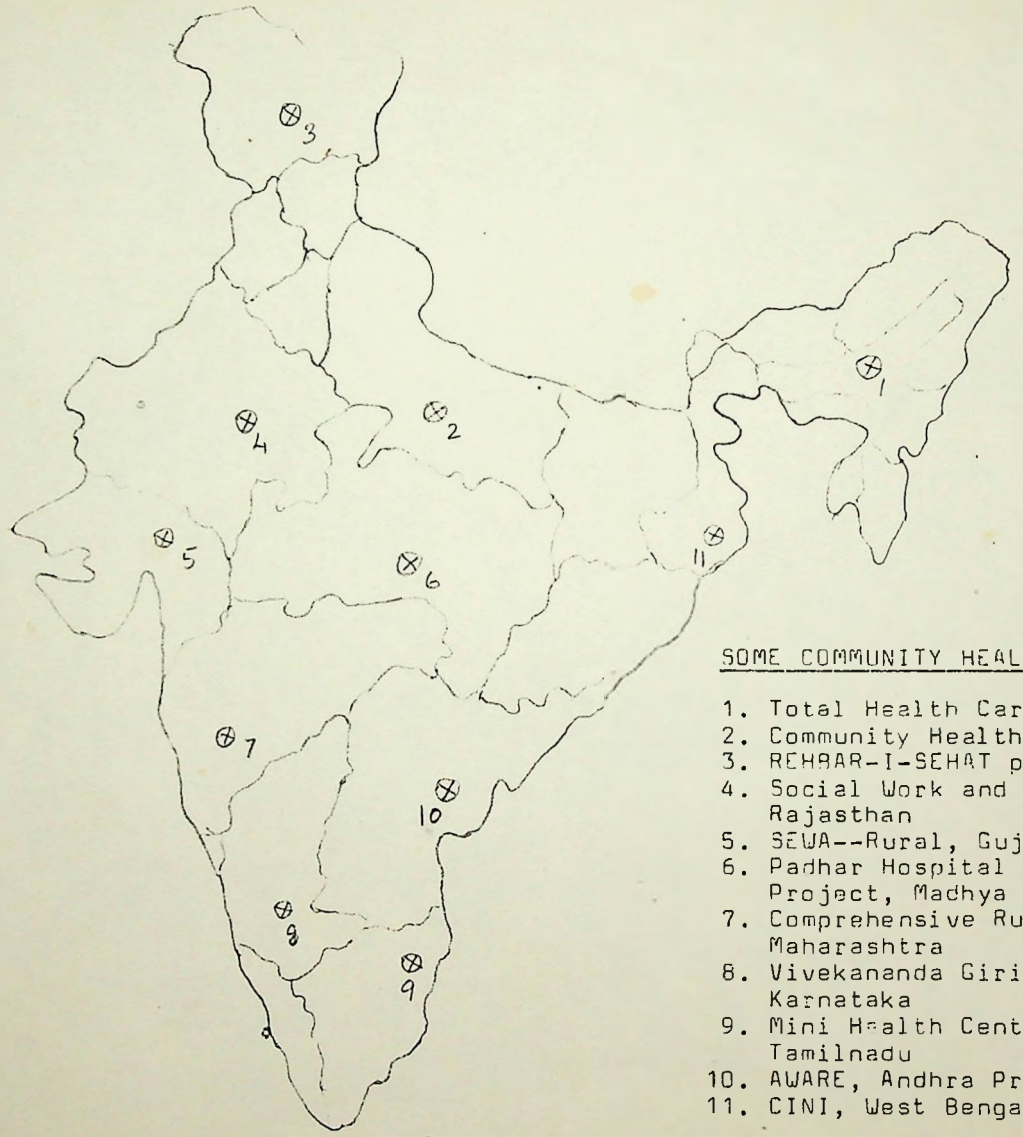
4 tier infrastructure:
- Community level → Peoples health committee & Village level health workers - CHVs, AWWs, TBAs.
- Tertiary level - Village health posts or subcentres ē Male & Fem. MPWs / Health & Anganwadi supervisors
- Middle level - Mobile dispensary / MO., Compdr. MPW (M/F).
- Central level - Fully equipped referral hosp. ē consultants & para medical staff.

Strategy - 5 pronged
i) intensified M.C.H. component in CHP
ii) a greater refinement of CHPs other components.
iii) an improved referral system & comm. outreach
iv) greater mobilizn., motivn. & participn of people & workers
v) strengthening of assocn. ē govt.

Activities in non-health areas:
- Gramin Tekniki Kendras - Eco. prog. for women.
- Tutorial classes for Tribal boys & girls.

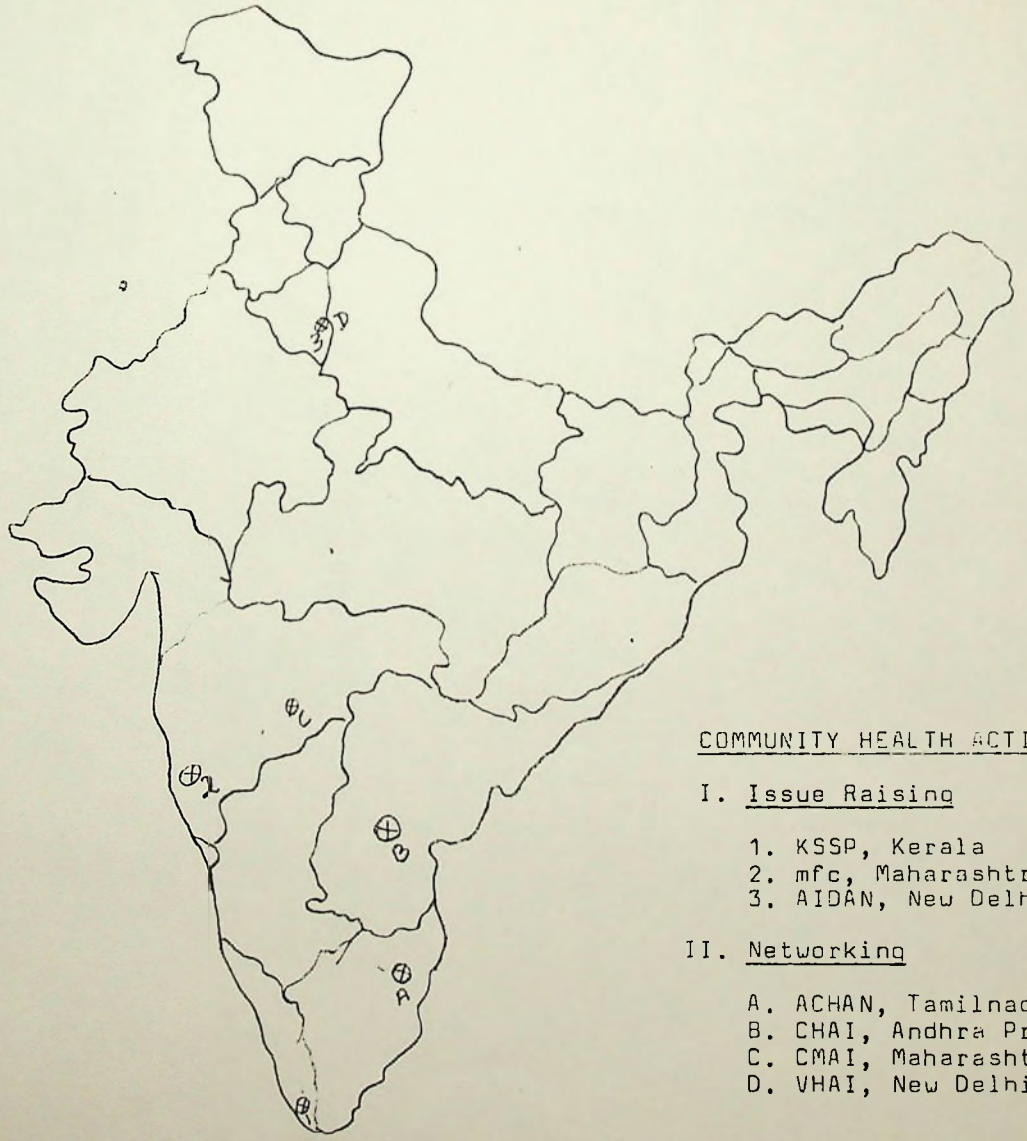
WINNER OF WHO's SASAKAWA HEALTH PRIZE for 1985.

Lessons Learned
(1) Deep commitment to people
(2) Community Health is a way of thinking & behaviour (XII) → Land
(3) Sequence of events for health provision
People → service → staff → Equipt → Building
(4) NOT REVERSE AS IN GOVT. SECTOR
(5) PRIMACY to be given to CHW.
Staff - local preferable.



SOME COMMUNITY HEALTH PROJECTS

1. Total Health Care Project, Assam
2. Community Health Project, UP
3. REHBAR-I-SEHAT programme, Jammu
4. Social Work and Research Centre, Rajasthan
5. SEWA--Rural, Gujarat
6. Padhar Hospital Community Health Project, Madhya Pradesh
7. Comprehensive Rural Health Project, Maharashtra
8. Vivekananda Girijana Kalyana Kendra, Karnataka
9. Mini Health Centres Programmes of VHS, Tamilnadu
10. AWARE, Andhra Pradesh
11. CINI, West Bengal



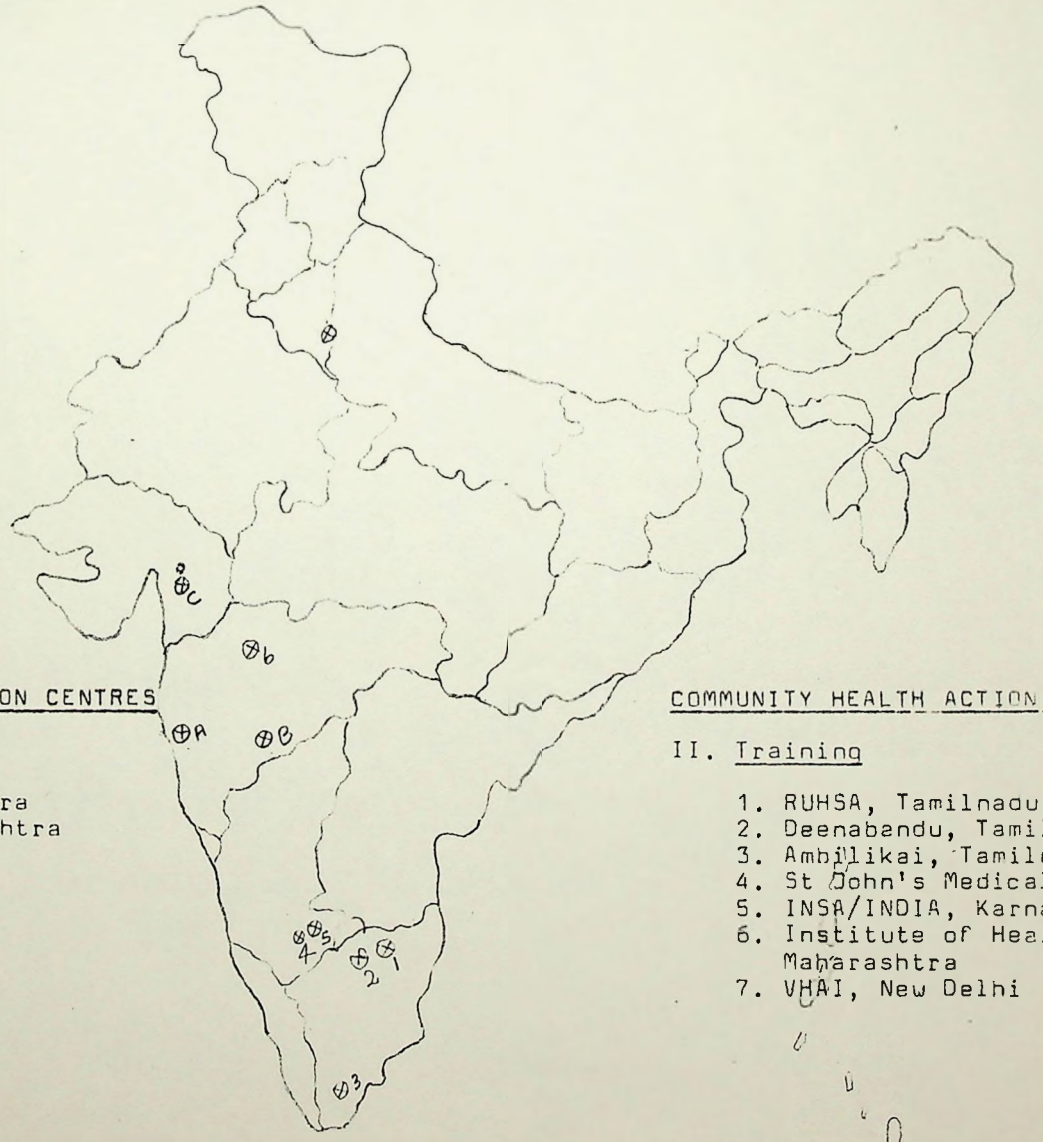
COMMUNITY HEALTH ACTION CENTRES

I. Issue Raising

1. KSSP, Kerala
2. mfc, Maharashtra
3. AIDAN, New Delhi

II. Networking

A. ACHAN, Tamilnadu
B. CHAI, Andhra Pradesh
C. CMAI, Maharashtra
D. VHAI, New Delhi



COMMUNITY HEALTH ACTION CENTRES

I. Research

A. FRCH, Maharashtra
B. SEARCH, Maharashtra
C. ARCH, Gujarat

COMMUNITY HEALTH ACTION CENTRES

II. Training

1. RUHSA, Tamilnadu
2. Deenabandu, Tamilnadu
3. Ambillikai, Tamilnadu
4. St John's Medical College, Karnataka
5. INSA/INDIA, Karnataka
6. Institute of Health Management, Maharashtra
7. VHAI, New Delhi

CHILD-IN-NEED INSTITUTE, Vill. Daulatpur, PO Pailan
Via Joka 743512

Started in 1974--24 Paraganas, West Bengal

Population covered : 70,000

Activities
- maternal and child health
- community organisation and community development

Health care is through
- mahila mandal run clinics
- balwadis
- emergency ward and nutritional rehabilitation centres

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

Action for Welfare & Awakening in Rural Environment (AWARE)
5-9-24/78 Lake Hill Road, Hyderabad 500463, A.P.

Started in 1975--Telegana, Andhra Pradesh

Activities

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 banks of Godavari.

Mini Health Centres Programme of Voluntary Health Services, M.A.C. Institute of Community Health, Voluntary Health Services, Adyar, T.T.T.I. Post, Madras 600113

Started in 1977--Chingleput Dist. Tamilnadu

Population covered : 160,000

Activities
- maternity services;
- child welfare and nutrition;
- family welfare;
- minor ailment treatment
- communicable disease control
- data collection and health record

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 PHC.

Adopted as a model State-wide.

Vivekananda Girijana Kalyana Kendra, B R Hills 571313
Via Chamarajanagar, Mysore District, Karnataka

Working with Soliga tribals.

Activities

- health care;
- community organization;
- education;
- cottage industries including vocational training;
- adult education

Health services are carried out through medical officers, village health workers, traditional birth attendants, health education and use of traditional herbal medicine.

Sickle cell anaemia research and screening programme with hospital care during 'sickle cell crisis' is a feature of their health programme, while innovations include the introduction of use of acupressure by village health workers.

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Comprehensive Rural Health Project, Jamkhed,

Ahmednagar Dist., Maharashtra

Started in 1970

Population covered 40,000

Activities : Maternal and Child Health

: Nutrition and immunization

: Family welfare services

: Control of Communicable diseases

: Safe water

: Agricultural development

: Health education

through young farmers clubs and

by village health workers.

Padhar Hospital Community Health Project, Betul Dist.,
Madhya Pradesh

Activities
- 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

It is an outreach programme of a mission hospital.

SEWA--Rural, Jhagadia, Bharuch, Gujarat 393110

Started in 1980--Jhagadia, Gujrat

Population 35,000

Activities : mainly health through

--community health volunteers

--anganwadi workers

--trained birth attendants at community level;

--multipurpose workers as intermediarie

--mobile dispensary with medical officer and MPWs at middle level;

--fully equipped referral hospital with consultants and paramedical staff at central level

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

Activities in non-health areas--

- gramini takniki kendra;
- tutorial classes for tribal boys & girls;
- economic programmes for women

The Social Work and Research Centre (SWRC), Tilonia,
Ajmer District Rajasthan 305812

Started in 1973

Activities

- building awareness programme
- dispensary
- school health programme
- incorporation of health into the farmer's way of life

The local indigenous medical practitioners and dais are involved in implementing the programmes along with village health workers.

REHBAR-I-SEHAT Programme, Kotbhalwal Block, Jammu & Kashmir

C/o Professor & Head, Department of Preventive and Social Medicine, Government Medical College, Jammu 180001

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

Activities

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

Community Health Project

C/o The Director of Community Health, Harriet Benson Memorial Hospital, Lalitpur, UP

Population	4,74,519
Activities	- Maternal and child health
	- nutrition
	- Health Education
	- Communicable diseases control through village health workers from the community.

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

Started in 1976--in 204 villages of the Block.

Activities - basic health services like:

family planning

immunization;

treatment of minor ailments;

control of tuberculosis, leprosy; malaria

Mallur Health Co-operative, Mallur, Sidlaghatta Taluk, Kolar Dist. Karnataka

Started--1973

Population covered

Activities
- dairy cooperative
- preventive, promotive, curative) health service with government health centre

Dairy cooperative took up health responsibility of the village which evolved into a health endowment fund to cater to all health needs.

Integrated Health Services Project

Wanless Hospital, Miraj Medical Centre, Miraj, Maharashtra

Started in_____	Miraj Taluk
Population	2,30,329
Activities	- Maternal and child health care - family planning - school health - communicable disease control - environmental sanitation - health education using Basic Health Workers, Dais, ANMs and Village Health Assistants.

The Rural Health Research Project of
Foundation for Research in Community Health (FRCH),
48A, Abdul Gaffar Khan Road, Worli, Bombay, Maharashtra

Started in 1973--North Alibag and Uran Taluk, Maharashtra

Population covered : 90,000

Activities
- community organization
- maternal and child health care
- health education
- treatment of minor ailments

through village health workers and with the Primary Health Unit as the apex of preventive, promotive and curative health care.

Comprehensive Health Project, Rangabelia,

Rangabelia High School, Rangabelia PO, 24 Pargana, W. Bengal

Started in 1976--Rangabelia

Activities

- maternal and child health 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 government.

PROJECT POSHAK, Programme Evaluation Organization

27 Alkapuri, Baroda

From 1971 to 1975	10 tibal + 2 non-tribal Districts of Madhya Pradesh
Population covered	12,000 children + 2,700 women
Activities	: Take home food supplements
	: Preventive & curative health services
	: Maternal and Child care educatio
	- by utilising the existing health and tribal welfare infrastructure of the government.

THE KASA MODEL MOTHER-CHILD-HEALTH-NUTRITION PROJECT

C/o Grant Medical College and JJ Group of Hospitals

(Institute of Child Health), Bombay

Started in 1972--Palghar, PHC, Kasa, Thana Dist, Maharashtra

Population 56,364

Activities

- integrated health and nutrition services to young children and mothers by using existing primary health centre services and personnel along with part time social workers (PTSWs) serving as link workers and providing special coverage to the needy at clinics or at home.

INDO-DUTCH Project for Child Welfare

C/o The Director, Indian Bureau, Indo-Dutch Project for Child Welfare, 6-3-885 Somajiguda, Hyderabad

Started in 1969

Population 33,756

Activities
- mother and child care--health education and nutrition
- mahila mandals
- nursery and primary schools
- youth development/adult education
- nutrition demonstration units
- poultry and dairy units

"Gram Svasthikas" are the link between the community and health services.

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- poultry and dairy units

"Gram Svasthikas" are the link between the community and health services.

Comprehensive Health and Development Project, Pachod, Aurangabad Maharashtra

Started in

Activities

- maternity care;
- health and nutrition education;
- growth monitoring and nutritional surveillance of children;
- environmental programmes through community health workers.
- training course in management of small health projects.

The health education materials are locally developed and are unsophisticated, appropriate and brief.

BANWASI SEVA ASHRAM, Govindpur, Dist Mirzapur, UP

Started in 1954--Mirzapur District

Population covered : 3,50,000

Activities : agriculture

: dairy

: village industries;

: education;

: gram kosh (revolving village fund for cheap credit)

: social justice programmes

Health and family planning activities through

- swasthya mitra (local volunteers)
- gramin doctors (at village health posts)
- AGRINDUS clinics

Based on Gandhian philosophy of self-sufficiency with AGRINDUS (Agro Industrial Community Development Centre) as the nucleus of its diverse activities.

BODOKHONI

Please mention exact address
to Charles, Diocese, Berhampur

Activities

- adult education
- informal education

taking up health issues for action

- grain bank
- savings scheme
- goat rearing
- non formal school for children

through health animators who believe that these are as important as disease treatment and manage common ailments.

They work with
- gramya sangha (men's organization)
- mahila sangha (women's organization)

Rural Unit for Health and Social Action (RUHSA)
Christian Medical College & Hospital, RUHSA Campus PO
N.A. Dist, Tamil Nadu 632209

Started in 1977--K.V. Kuppam Block, Tamilnadu

Population covered : 100,000

Activities
- health and family welfare;
- adult education;
- vocational training
- community organisation;
- income generation
- agricultural development and agro-support services
- training programmes in community health

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.

COMPREHENSIVE LABOUR WELFARE SCHEME (CLWS) OF
UNITED PLANTERS ASSOCIATION OF SOUTHERN INDIA (UPASI),
Glenview, Coonoor 643101, Tamil Nadu

Started in 1971--Plantations in Tamilnadu and 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 employee's health and welfare is congruent with employer's interests.

KEM Hospital Vadu Rural Health Project, Sardar Mudliar Road, Rasta Peth, Pune 411011

Started in 1977--Pune District, Maharashtra

Activities : maternal and child health;
family planning;
control of communicable diseases;
health education;
environmental sanitation;
mahila mandal, youth clubs--
awareness programmes.

Health activities through

- community health guides of KEM Rural Health Project;
- multipurpose workers of government cadre;
- upgraded PHC at Vadu--at secondary level;
- KEM Hospital--at tertiary level.

Socio economic development programmes are with a closely linked voluntary organisation--United Socio-economic Development and Research Programme (UNDARP).

STREEHITAKARINI, Dadar, Bombay

Started in 1974--Slums of Bombay City

Population covered : 100,000

Activities : maternal and child health;
family planning services by
volunteer doctors;
non-formal education;
female literacy;
income generation programmes for wome
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.

R.A.H.A. - Raigarh Ambikapur Health Association
C/o Bishop's House, PO Kunkuri, Raigarh Dt Madhya Pradesh 496225

Started in

Population covered

Activities

- a network of 3 base hospitals and 47 rural health centres;
- all aspects of health;
- school health programmes with voluntary school health guides from school teachers
- tuberculosis control programme;
- innovative medical insurance scheme.

The Nilgiri Adivasi Welfare Association, Fair Glen Annexe, Kota Hall Road, Kotagiri, Nilgiris 643217

Started in 1958 - Tribals

Activities
- nutrition;
- health education;
- adult education
- income generating projects in cooperation with government, bank and voluntary bodies;
- rehabilitation of tribals keeping in view their varied stages of development and survival problems

MEDICARE, Kasturba Medical College, Manipal, Karnataka
--a project of the medical college

Activities

- conducting a rural maternity and child welfare home each in seven centres at a distance of 3 to 20 miles from the hospital.
- health education;
- safe water supply and sewage disposal with the help of Panchayat;
- immunization;
- pest control measures
- family welfare programmes

St Xavier's Social Services Organization,

Opp. St Xavier's Loyola Hall, Ahmedabad 380009

Working in the slums of Ahmedabad.

Activities

- community organization;
- income generation programmes;
- health activities in the areas of--

  nutrition;

  antenatal care;

  infectious diseases;

  family planning;methods

  health education.

HEALTH CARE SERVICES IN INDIA
Facts Revealing Gross Maldistribution

The health care service planning in India is characterised by its failure to take into account the holistic picture of the health care services. In the mixed economy model the social sector is planned with a view to provide for the externality and to redistribute the services in favour of the underprivileged masses. This is precisely what has not happened in the planning process simply because the planning commission never has had a holistic picture of the size, distribution and growth trends in the health care service. **The single most important reason for the lack of holistic concept and approach is its failure to take into account the private sector in health care services.**

What follows is a preliminary attempt to estimate the size of and the growth trends in the private health care sector, and the same are compared with the public health care sector. Their distribution between the rural and the urban areas are also examined.

The data are presented in the following three sections :

A. Health Humanpower
B. Health Care Infrastructure
C. Financing of Health Care Services.

THE FOUNDATION FOR RESEARCH
IN COMMUNITY HEALTH
84-A, R, G, Thadani Marg, Sea Face Corner
Worli Bombay-400 018 INDIA

Section A : Health Humanpower

a. **Doctors and Nurses : Number Registered (Table A-1).**

1. In 1986, there were 7,63,437 doctors of all systems of medicine in India. **This comes to one doctor for less than 1000 population.**
2. Of all doctors, the allopathic doctors constituted only 42% in 1986.
3. In 1986, there were 3,92,670 nurses and midwives in India.
4. There was only **ONE nursing person for TWO doctors in India in 1986. The situation demands more than reversal of the ratio** i.e. about 4 nurses per doctor.
5. In addition there were 1,08,511 ANMs, 88,308 MPWs, 18,819 Female Health Assistants in 1987 (Total 2,45,369). Together with nursing personnel, the paramedical human power was 6,38,039. This is grossly inadequate.

b. **Doctors and Nurses : Rural-urban distribution (Table A-2 and A-3)**

1. In 1981 (census data), only 41% of all doctors and 43% of all nurses/midwives were located in rural areas, while 76.3 of the population was rural.
2. Situation is the worst for allopathic doctors and nurses. **In 1981 only 27% of allopathic doctors and only 31% of nurses were located in rural areas.**
3. Over last three decades (1961, 1971, 1981 census data) there is progressive **"deruralisation"** of doctors and nurses.

c. **Doctors : Public-Private Sector distribution (Table A-4)**

1. There is an increasing concentration of **allopathic** doctors in the private sector (Table A-4 covers mainly allopathic doctors).
2. In 1986-87, about 73% of **allopathic** doctors were working in the private sector.
3. When the number of doctors employed in the public sector is taken as proportion of total doctors of all systems of medicine, we find that **only 13 to 18% are employed with the government or local bodies, the rest being in the private sector.**
4. Of all doctors in the private sector 85 to 90% are self-employed or doing private practice.

d. **Medical and Nursing Education Infrastructure (Tables A-5 and A-6)**

1. In 1986, there were 123 **allopathic** medical colleges in India, of which 17% were in the private sector.
2. Between 1974 and 1986, the proportion of private allopathic medical colleges **increased from 8.5% to 17.1%.**
3. In 1986 there were 222 medical colleges for **other systems of medicine** of which 65% were in the private sector. The admission capacity for those colleges was, 10,521 per year, of which 67% admission accounted for by the private colleges.
4. As compared to medical colleges, there were only 8 institutions for B.Sc nursing and 324 for general nursing education.

e. **Out-turn of Medical and Nursing Personnels (Table A-7)**

1. India produces around **15,000 allopathic** and **5,000 to 10,000 non-allopathic** doctors per annum.
2. In comparison, **about 10,000 nursing personnel** (nurses/midwives) are trained per annum.
3. About 15 to 20% of allopathic doctors produced every year, migrate to some other country.

Table A1: MEDICAL AND NURSING HUMANPOWER IN INDIA (1952-87)

REFERENCE YEARS	DOCTORS						DENTISTS	PARAMEDICS		
	ALLOPATHS	HOMOEO-PATHS	AYURVEDS	SIDHA	UNANI	TOTAL		NURSES	MIDWIVES	TOTAL
1952	65370	NA	NA	NA	NA	-	3291	17989	NA	-
1956	76904	NA	NA	NA	NA	-	3003	24724	NA	-
1961	83756	27468	73382	NA	NA	184606	3582	35584	51194$	86778
1966	103184	NA	NA	NA	NA	-	4374	57621	NA	-
1969	128584	110514	155828	NA	24530	419456	5182	69937	NA	-
1971	151129	NA	NA	NA	NA	-	5512	80620	80159	160779
1974	190838	145434	223109	18128	30400	607909	6647	98403	100554	198957
1979	249752	112638	225477	18093	25988	631948	7518	139825	130382	270207
1981	268712	115710	233824	18357	28737	665340	8648	154230	144820	299050
1984	297228	123852	251071	11352	28382	711885	8725	170888	168493	339381
1985	306966	123852	251071	11352	28382	721623	9598	197735	171590	369325
1986	319254	131091	272800	11581	28711	763437	9725	207430	185240	392670
1987	330755	NA	NA	NA	NA	-	9750	NA	NA	-

SOURCE : Health Statistics of India, CBHI, GOI relevant years.

Table A2 : RURAL-URBAN DISTRIBUTION OF MEDICAL HUMANPOWER IN INDIA

REFERENCE YEARS		TOTAL	ALLOPATHS	HOMOEO-PATHS	AYURVEDS	UNANI
1961	R	80484	19187	16185	45112	-
		(48.7)	(29.5)	(52.4)	(61.8)	
	U	84787	45837	11075	27875	-
		(51.3)	(70.5)	(40.6)	(38.2)	
	T	165271	65024	27260	72987	-
		(100.0)	(100.0)	(100.0)	(100.0)	
1971	R	114354	49846	23527	36871	4110
		(49.4)	(39.4)	(61.2)	(62.6)	(52.4)
	U	117154	76507	14917	21994	3736
		(50.6)	(60.6)	(38.8)	(37.4)	(47.6)
	T	231508	126353	38444	58865	7846
		(100.0)	(100.0)	(100.0)	(100.0)	(100.0)
1981	R	124426	53407	31916	36503	2600
		(39.2)	(27.2)	(63.7)	(57.3)	(38.8)
	U	192643	143147	18188	27211	4097
		(60.8)	(72.8)	(36.3)	(42.7)	(61.2)
	T	317069	196554	50104	63714	6697
		(100.0)	(100.0)	(100.0)	(100.0)	(100.0)

Source : Census 1961, 1971, 1981, GOI.

Notes : R = Rural ; U = Urban ; T = Total
Figures in parentheses are percentages.

Unani practitioners were not covered separately by the 1961 Census. Sidha medical practitioners were not covered by the census.

Table A3 : RURAL-URBAN DISTRIBUTION OF NURSES AND OTHER PARAMEDICAL HUMANPOWER IN INDIA :

REFERENCE YEARS		TOTAL	NURSES	MIDWIVES & HEALTH VISITORS
1961	R	63078	29098	33980
		(49.5)	(38.2)	(66.4)
	U	64325	47111	17214
		(50.5)	(61.8)	(33.6)
	T	127403	76209	51194
		(100.0)	(100.0)	(100.0)
1971	R	55425	31711	23714
		(39.6)	(30.6)	(65.3)
	U	84505	71899	12606
		(60.4)	(69.4)	(34.7)
	T	139930	103610	36320
		(100.0)	(100.0)	(100.0)
1981	R	81980	52275	29705
		(37.8)	(31.3)	(59.9)
	U	134787	114913	19874
		(62.2)	(68.7)	(40.1)
	T	216767	167188	49579
		(100.0)	(100.0)	(100.0)

Source : Census 1961, 1971, 1981, GOI.

Notes : R = Rural ; U = Urban ; T = Total.
Figures in parentheses are percentages.

Table A4: SECTORAL EMPLOYMENT OF ALLOPATHIC DOCTORS IN INDIA

Year	Government Service	Private Sector	Total
1942-43	13000 (27.4)	34400 (72.6)	47400[a] (100.0)
1963-64	39687 (39.6)	60502 (60.4)	100189[b] (100.0)
1978-79	69137 (29.3)	166494 (70.6)	235631[c] (100.0)
1984-85	81030 (27.4)	214799 (72.6)	295829[c] (100.0)
1986-87	88105 (26.6)	242650 (73.4)	330755[c] (100.0)

Sources:
a) Report of the Health Survey and Development Committee (Bhore Committee), 1943, Vol.I, pg. 13.
b) IAMR-NIHAE "Stock of Allopathic doctors in India", 1966, pg. 71-72.
c) Health Statistics of India - 1979, CBHI, GOI. Health Information of India - 1985, 1988, CBHI, GOI.

Notes : Figures in parentheses are percentages.

Table A5. : MEDICAL EDUCATION INFRASTRUCTURE IN INDIA (1950-86)
(Allopathic doctors, Dentists and Nurses)

REFERENCE YEARS	MEDICAL COLLEGES NO.	% PRIVATE	DENTAL COLLEGES	NURSING B.Sc.	INSTITUTIONS GENERAL
1950	28	3.57	4	2	227
1951	30	6.66	4	2	246
1952	30	6.66	5	2	235
1956	46	6.52	7	2	239
1961	68	4.41	12	6	202
1966	89	8.98	14	8	246
1969	95	9.47	15	8	251
1974	105	8.57	15	8	262
1979	107	9.34	17	8	275
1983	111	10.81	25	8	324
1984	116	14.65	25	NA	344
1985	121	15.70	29	NA	374
1986	123	17.07	36	NA	386
1987	125	NA	40	NA	NA

SOURCE : Health Statistics of India, CBHI, GOI relevant years.
Medical Education in India, CBHI, GOI, 1987.
Handbook of Medical Education in India, Association of Indian Universities, 1987.

Notes : NA = Not Available

TABLE A6 : MEDICAL EDUCATION INFRASTRUCTURE AS ON APRIL 1, 1986.
(Doctors of Indian Systems of Medicine and Homeopathy)*

	MEDICAL COLLEGES			ADMISSION CAPACITY			OUTTURN (1985)
	GOVERNMENT	PRIVATE	TOTAL	GOVERNMENT	PRIVATE	TOTAL	TOTAL
Ayurveda	44	54	98	1716	2166	3882	1813
	(45.0)	(55.0)	(100.0)	(44.2)	(55.8)	(100.0)	
Unani	6	11	17	256	420	576	539
	(35.3)	(64.7)	(100.0)	(44.4)	(55.6)	(100.0)	
Siddha	2	-	2	150	-	150	49
	(100.0)		(100.0)	(100.0)		(100.0)	
Homeopathy	26	79	105	1318	4595	5913	1769
	(24.8)	(75.2)	(100.0)	(22.3)	(77.7)	(100.0)	
	78	144	222	3440	7181	10521	3970
	(35.1)	(64.9)	(100.0)	(32.7)	(67.3)	(100.0)	

Source : Compiled from "Indian Systems of Medicine and Homeopathy in India : 1986" published by Planning and Evaulation cell of the Ministry of Health and Family Welfare, New Delhi.

* The data are not complete due to non-reporting by many states and institutions.

Table A7 : OUTTURN OF ALLOPATHIC MEDICAL AND NURSING PERSONNEL IN INDIA (1950-1987).

REFERENCE YEARS	ALLOPATHS	DENTISTS	POST GRADUATES (ALLOPATHS & DENTISTS)	NURSES	
				B.Sc.	GENERAL
1950	1557	14	88	14	1282
1955	2743	31	110	21	1962
1960	3387	140	397	25	2562
1965	5387	294	791	67	4255
1970	10407	478	1396	101	6257
1976	11962	499	2265	184	5506
1977	13783	449	3694	190	5892
1978	12190*	466	3699	240	6788
1979	13083	515	3562	219	6503
1980	12170*	501	3759	263	7256
1981	12197*	488	3833	214	8144
1982	11992*	541	3940	240	7351
1983	10511	603	4161	315	7750
1984	10469*	662	4909	NA	8533
1985	9177*	567	5121	NA	8956
1986	NA	677	5427	NA	8208
1987	NA	660	5791	NA	NA

SOURCE : Health Information of India, CBHI, GOI, various years.

Notes :* Data on the outturn of allopaths was not received from 2 medical colleges in 1975-76, 1 in 1976-77, 2 in 1977-78, 6 in 1981-82, 7 in 1982-83, 14 in 1983-84, 15 in 1984-85 and 25 in 1985-86. Thus, the data is grossly underrated.

NA = Not Available.

Section B : Health Care Infrastructure

a. **Number**

1. In 1988 there were 9381 hospitals, 27495 dispensaries, 14,145 PHCs and 5,85,889 hospital beds in the country.

b. **Rural-Urban Distribution (Table B-1)**

1. In 1988, 31.5% of hospitals, 47.3% of dispensaries and 15.8% of hospital beds were located in the rural areas.
2. In 1988 there was **one hospital bed for 363 persons in the urban area and for 1034 persons in the rural area.**

c. **Public-Private Sector Distribution of Hospitals and Hospital Beds (Tables B-2 and B-3)**

1. In 1988, 56% of hospitals and 30% of hospital beds were located in the private sector.
2. However, since 1974, **the growth of the private sector** in hospitals and hospital beds has been phenomenal, **about 8 to 10 times that in the public sector.**

d. **Public-Private Sector Distribution of Dispensaries and Dispensary Beds (Tables B-4 and B-5)**

1. In 1988, 49.4% of dispensaries and 9.2% of dispensary beds were located in the private sector.
2. However, **the growth of private dispensaries** is phenomenal. **The proportion of private dispensaries increased from 13.8% in 1981 to 49.4% in 1988.** The annual growth rate of private dispensaries between 1981-84 was 68% and between 84-88 it was 28%.
3. The absolute number of dispensary **beds** have declined in both the sectors.

Table B1 : HEALTH INFRASTRUCTURE IN INDIA : RURAL-URBAN DISTRIBUTION (1951-88)

Ref. Years	Hospitals	Dispensaries	PHCs (only Rural)	Hospital Beds (Excl. PHC.)	Popn. per bed Urban	Rural
1951	2694 (NK)	6587 (79.4)	0	117000 (NK)	-	-
1956	3307 (39.3)	7194 (84.1)	725	145297 (23.0)	487	2272
1961	3054 (32.8)	9406 (53.1)	2565	229634 (15.8)	343	1589
1966	3971 (32.5)	10231 (78.9)	4631	306518 (18.0)	306	1308
1969	4023 (30.7)	10440 (79.1)	4919	328323 (21.0)	310	1295
1974	4014 (25.2)	10200 (71.6)	5283	341064 (11.2)	358	1424
1979	5766 (25.6)	15968 (69.8)	5423	446605 (13.1)	338	1139
1983	6901 (26.4)	17455 (68.6)	5954	486805 (13.5)	369	1109
1988	9381 (31.5)	27495 (47.3)	14145*	585889 (15.8)	363**	1034**

Source: Health Statistics of India, CBHI, GOI, various years.
Statistical Abstract 1984, CSO, GOI, 1985.
Directory of Hospitals in India, CBHI, GOI, 1981.

Notes : Figures in parentheses are percent rural.
NK = Not Known
* includes Subsidiary Health Centres also.
** Data relates to the year 1986 when total number of hospital beds was 555264.

TABLE B2 : OWNERSHIP STATUS OF HOSPITALS AND HOSPITAL BEDS

Ref. Years	HOSPITALS			HOSPITAL BEDS		
	Government	Private	Total	Government	Private	Total
1974	2832	644	3476	211335	57550	268885
	(81.4)	(18.6)	(100.0)	(78.5)	(21.5)	(100.0)
1979	3735	2031	5766	331233	115372	446605
	(64.7)	(35.3)	(100.0)	(74.2)	(25.8)	(100.0)
1981	3747	2923	6670	334049	132628	466677
	(56.2)	(43.8)	(100.0)	(71.5)	(28.4)	(100.0)
1984	3925	3256	7181	362966	137662	500628
	(54.6)	(45.4)	(100.0)	(72.5)	(27.5)	(100.0)
1986	4093	3381	7474	394553	141182	533735
	(54.7)	(45.3)	(100.0)	(73.9)	(26.1)	(100.0)
1987	4215	3549	7764	411255	144009	555264
	(54.3)	(45.7)	(100.0)	(74.1)	(25.9)	(100.0)
1988	4334	5497	9831	410772	175117	585889
	(44.1)	(55.9)	(100.0)	(70.1)	(29.9)	(100.0)

Source : Health Information of India, CBHI, GOI, various years.
Directory of Hospitals in India, CBHI, DGHS, GOI, 1981.

Notes : Figures in parentheses denote percentages
Government figures include ownership by local bodies.
Data on the number and ownership status of hospitals and beds were not reported by 6 states in 1974, 5 in 1979, 1 in 1981, 1984, 1986, 1987 and 1988.
Madhya Pradesh has not reported its data since 1979.

TABLE B3 : RATE OF GROWTH OF HOSPITALS AND HOSPITAL BEDS (BY OWNERSHIP)

Reference Years	Hospitals		Hospital Beds	
	Government	Private	Government	Private
1974-79	6.37	43.07	11.35	20.09
1979-84	1.02	12.06	1.92	3.86
1984-88	2.61	17.21	3.29	6.81

Source : Same as Table B2.
Notes : Figures are in percentages.

TABLE B4 : OWNERSHIP STATUS OF DISPENSARIES AND DISPENSARY BEDS

Ref. Years	DISPENSARY			DISPENSARY BEDS		
	Govern-ment	Private	Total	Govern-ment	Private	Total
1981	13205	2115	15968 [a]	26231	1314	277306 [b]
	(86.2)	(13.8)	(100.0)	(95.2)	(4.8)	(100.0)
1984	14694	6438	21780 [a]	30251	5306	35742 [b]
	(69.5)	(30.5)	(100.0)	(85.1)	(14.9)	(100.0)
1988	13916	13579	27495	21659	2187	23846
	(50.6)	(49.4)	(100.0)	(90.8)	(9.2)	(100.0)

Source : Same as Table B2.

Notes : Government figures include ownership by local bodies.
a) Ownership details for 648 dispensaries was not available.
b) Ownership details for 185 dispensary beds was not available.

TABLE B5 : RATE OF GROWTH OF DISPENSARIES AND BEDS (BY OWNERSHIP)

Ref. Year	DISPENSARY		DISPENSARY BEDS	
	Government	Private	Government	Private
1981-84	0.26	68.13	5.11	101.26
1984-88	-1.32	27.73	-7.11	-14.69

Source : Same as Table B2.

Notes : Government figures include ownership by local bodies.

Section C : Financing of Health Care Services

Source of Financing

1. State : General health services
2. State : Special health services (eg. Railways, Defense etc).
3. State Insurance : ESIS/CGHS
4. Local Bodies : Municipal Cooperations, Municipalities, Zilla Parishads and Panchayat Samitis
5. Private Insurance : Mediclaim, group insurance, etc, through public insurance companies.
6. Private Prepayment schemes : Select hospitals etc.
7. Private Corporate Sector : Health benefits - contributory/ non-contributory given to employees.
8. Households : Out of pocket expenditure by families mainly financing private practice.

Estimates of Financing by different source

The only definite figure of health care finance is the one for general health services by **the State** (Central, State & Union Territory governments). This includes Medical Services, Medical Education & Research, health services administration, expenditure on non-allopathic systems, communicable disease programs, watersupply, sanitation & sewerage, education & training of paramedics, MCH services and the family planning program. This data is compiled in the **"Combined Finance and Revenue Accounts"** by the Comptroller & Auditor General of India.

Tables C-1 and C-2 give a brief outline of this source of health financing. Table C-1 gives data for select years (every five years since 1951) and Table C-2 gives the complete data from Plan one to Plan six (partly, because of non-availability of source material) as five year data and annual averages for the respective plan period.

These tables reveal that **state expenditure of health care services is a very negligible contribution for people's welfare.** During the **First Plan period** this was only 0.39% of GNP and **at present** it is less than 1.4% of GNP. Even as a proportion of its own total **expenditure** the government has been spending only between 3 and 4% on health services, which as indicated above includes not only medical services but also family planning and water supply. For a country that proclaims socialist or a mixed economy this is a very poor proformance.

The major demand and need of the population is curative services and this is the least provided by the state sector. What little is provided as curative care is mainly in urban areas. Sections A & B have already dealt with this disparity.

This need for curative services is met by a large and expanding private health sector. **There is no definite data of the financing of the private health sector.** What is known is that 73% of allopathic doctors work in the private sector and of this 88% are in private practice.

The private health sector is financed directly by households - in case of about half the organised sector some subsidies in the forms of employer or insurance health benefits exist (which in fact is nothing but social wages). No organised data about the volume of such financing is available.

On the eve of the First Five Year Plan the **National Sample Survey** recorded **private health expenditure (by households)** as Rs. 5.77 per capita per annum in 1951. This was 6 times of what the State sector was spening at that time. Again in 1973-74 the NSS recorded private health expenditure as Rs. 14.05 per capita per annum which was three times greater than the state health expenditure in the same year.

Besides this some scattered data based on small studies exists. Of these the most organised study was in **Narangwal** by R.L. Parker which showed that private health expenditure varied between 3 and 6 times of state health expenditure in the late sixties and early seventies.

A study by **FRCH** in 1987 in **Jalgaon district** in Maharashtra showed that households were spending out of pocket Rs. 174.99 per capita per year obtaining health care services - this was 5.75% of their income. **This expenditure was 6.7 times over and above the state health expenditure of Rs. 26.09 per capita** (0.85% of income) in Jalgaon (see Table C-3). **As a contrast even in capitalist USA the state account for as much as 40% of all health expenditure.** Besides such data no ther data is available for this source of financing of health services which is the most important because of its sheer magnitude. Data on other private sources like corporate financing, private insurance etc. suffers the same fate. Local body financing of health care services constitutes another important public source of funding. This data is not well organised but it is possible to organised it if the state is

willing to compile it, like in the case of State Finances (see Table C-4).

Similarly corporate sector health benefits to employees can be obtained if the state insists that all companies issuing Annual Reports should show this item of expenditure separately.

Table C-1 : State Health Expenditure in India : 1951-1989.

(Rupees Millions)

Financial Year End March	1 Medical	2 Public Health	3 * Family Welfare	4 Health (1+2+3)	5 ** % Plan Health Expenditure Col.4	6 Per capita of Col.4 (Rs.)	7 Col.4 as % of govt. Expenditure	8 Col.4 as % of GNP
1951	149.19	72.22		221.41	No Plan	0.61	2.31	0.22
1956	305.88	219.40	5.08	530.36	43.17	1.32	3.54 (10.65)	0.45 (20.91)
1961	593.13	423.69	16.00	1032.82	52.38	2.35	3.74 (1.13)	0.65 (8.89)
1966	1011.88	731.58	49.80	1793.26	39.76	3.63	2.79 (-5.08)	0.65 (0.0)
1971	1378.00	1612.40	556.00	3546.40	60.48	6.47	3.45 (4.73)	0.82 (5.23)
1976	4445.31	2684.79	822.40	7952.50	58.95	12.88	3.76 (1.80)	0.99 (4.15)
1981	8769.18	7350.95	1464.02	17584.15	41.47	25.66	4.05 (1.54)	10.10 (2.22)
1983 (FW Year book 87-88)	11931.62	10486.59	2946.17	25364.38	57.83	35.46	4.37 (2.63)	1.43 (10.00)
1986 (Estd.)			5365.00	39865.00		51.77		1.37 (-1.40)
1989			7100.00	52000.00		64.45		1.34 (-0.73)

* F.P. figures from 1956-71 are average of Plan Period. Prior to 1974 FP was part of "Medical". Hence for those years we have deducted this average figure from "Medical".

** Based on average of plan period. Figures in brackets are growth rate per year over the previous year.

Sources : 1. Combined Finance and Revenue Accounts, Comptroller & Auditor General of India, GOI, respective years.

2. Report or Currency & Finance; 1988 Vol.II, RBI, 1989.

Table C-2 : State Health Expenditure 1951-52 to 1982-83 : Plan + Non-Plan
(Figures in parentheses are annual averages)

(Rupees Millions)

Plan Period	1 Medical	2 Public Health	3 Family Welfare	4 Health (1+2+3)	5 % Plan of Col. 4 Expd.	6 Total Govt. Expnd.	7 % Col. 4 of Col.6	8 per Capita of col. 4 (Rs)	9 Col.4 as % of GNP
Plan One 1951-52 to 55-56	1246.45 (249.29)	725.10 (145.02)	1.45 (0.29)	1973.00 (394.60)	50.48 outlay	60728.55 (12145.71)	3.25	1.04	0.39
Plan Two 1956-57 to 60-61	2306.30 (461.26)	1609.10 (321.82)	22.00 (4.4)	3937.40 (787.48)	69.59 outlay	115266.75 (23053.35)	3.42	1.88	0.59
Plan Three 1961-62 to 65-66	3889.40 (777.88)	2985.45 (597.09)	249.00 (49.80)	7123.85 (1424.77)	50.05	251871.95 (50374.39)	2.83	3.07	0.71
Plan Holiday 1966-67 to 68-69	3403.35 (1134.45)	3127.50 (1042.50)	705.00 (235.00)	7235.85 (2411.95)	43.30	235365.03 (78455.01)	3.07	4.76	0.78
Plan Four 1969-70 to 73-74	11065.10 (2213.02)	8495.55 (1699.11)	2824.15 (564.83)	22384.80 (4476.96)	47.91	598754.80 (119750.96)	3.74	8.22	0.83
Plan Five 1974-75 to 78-79	25639.70 (5127.94)	16350.95 (3270.19)	5292.55 (1058.51)	47283.20 (9456.64)	49.58	1194988.35 (238997.67)	3.96	15.25	1.18
Part Plan Six 1979-80 to 82-83 (4 yrs.)	38510.80 (9627.70)	32553.72 (8138.43)	7551.24 (1887.81)	78615.76 (19653.94)	52.15 (est)	1862023.72 (465505.93)	4.22	28.60	1.40

Sources : as Table C-1.

Table C-3 : Classwise Distribution of Health Expenditure and Other Selected Variables in Jalgaon District - 1987.

Variable	CLASS Poorest	Lower middle	Middle	Upper middle	Richest	All classes
a) Mean cost per episode (Rupees)	32.01	90.02	130.44	207.01	102.81	102.14
i. Practitioner Fees & Medicine	28.21	63.46	87.04	167.44	90.26	69.97
ii. Diagnostic Tests	0.16	6.43	8.95	5.73	0.00	5.13
iii. Hospitalisation and surgery	0.43	10.14	17.47	19.76	0.00	11.10
iv. Transport	2.14	7.86	10.89	6.86	0.96	7.43
v. Rituals	0.19	0.76	3.00	1.00	8.42	1.48
vi. Others	0.88	1.37	3.08	6.22	3.17	2.23
vii. Non-users of any service (%)	13.77	8.45	6.28	4.05	5.00	7.70
b) Mean cost per contact (Rs.)	13.06	31.92	43.05	62.17	51.15	36.09
c) Mean Health Expenditure per capita per year (Rs.)	50.77	151.07	256.49	417.04	367.48	182.49
d) Mean cost for use of private services (Rs.)						
i. Per episode	43.51	88.03	156.71	235.80	109.92	116.31
ii. Per contact	17.69	32.85	55.77	76.81	61.41	43.24
iii. Per capita per year	69.00	147.73	308.14	475.04	392.91	207.80
iv. Private users (%)	72.19	75.38	80.27	85.13	95.00	77.09
e) Health Expenditure as a percent of Income	6.50	10.50	10.20	10.20	5.60	9.80
f) Disease Prevalence Rate - per 1000 population per month.	132.15	139.85	163.86	167.88	297.87	148.89
g) Total population in survey	681	1566	891	274	47	3459
h) Total no. of patient's (monthly average).	90	219	146	46	14	515

Sources : "Cost of Health Care : A Household Survey in an Indian District" by Ravi Duggal with Suchetha Amin.

Compiled by Ravi Duggal - November 1989

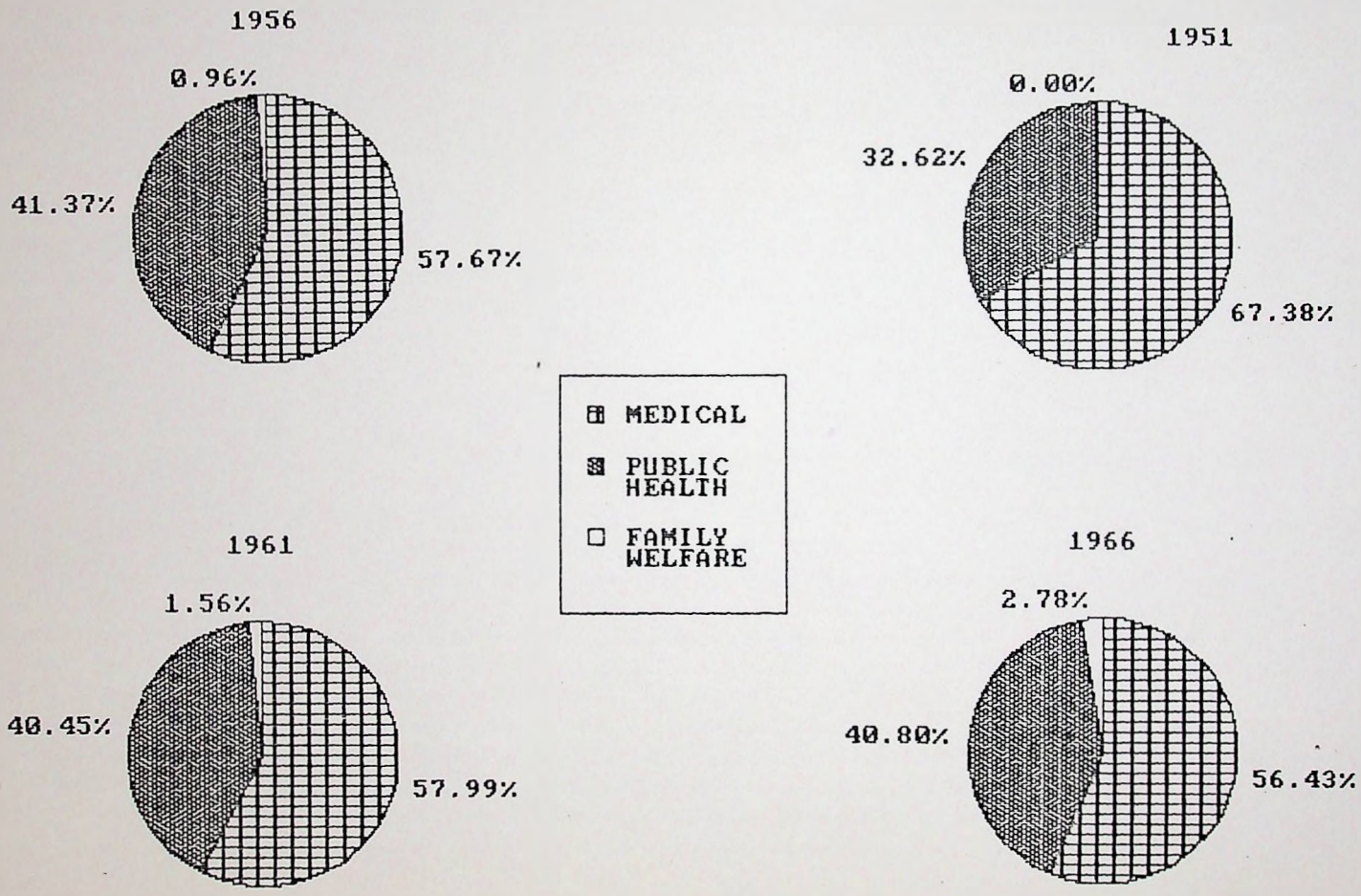
Table C-4 : MUNICIPAL HEALTH FINANCE - (Medical + Public Health + Water Supply & Sanitation)
(All India)

Year	Rs. million Municipal Bodies	Rs. million District Board	Source	Remarks
1951-52	121.52 (30% of Income)	21.45(6.3% of) Income)	GOI, Health Stats of India	Incomplete information population not known
1952-53	161.74 (31.8% ")	13.79 (4.0%)	"	"
1953-54	89.00 (30.5% ")	11.00 (4.9%)	"	"
1954-55	146.71 (32.7% ")	11.31 (2.0%)	"	"
1955-56	156.02 (29.4% ")	4.09 (2.6%)	"	"
1956-57	111.93 (32.0% ")	NA	"	"
1957-58	93.35 (32.7% ")	NA	"	"
1959-60	355.23 (50.9% ")	16.24 (6.63%)	"	"
1960-61	263.71 (53.64% ")	9.20 (6.11%)	"	"
1970-71	530.97 (35.0% of total expnd.)	NA	NCAER	Rs.24.68 per capita (sample 21.5 million population in 12 Municipal Corporation and 27 Municipalities)
1974-75	2155.89 (40.2% " ")	NA	NIUA-1983	Rs.26.71 per capita (sample 1533 municipal bodies covering 80.7 million population)
1976-77	1294.33 (37.8% " ")	NA	NCAER	Rs.48.08 per capita (sample 26.9 million population in 12 Municipal Corporation and 27 Municipalities)
1979-80	3791.84 (37.83% " ")	NA	NIUA-1983	Rs.33.47 per capita (Sample 1533 Municipal bodies with 113.27 million population)
1986-87	2270.00 (38% " ")	NA	NIUA-1989	Rs.55 per capita (sample 41.2 million population of 157 Class I municipal bodies)

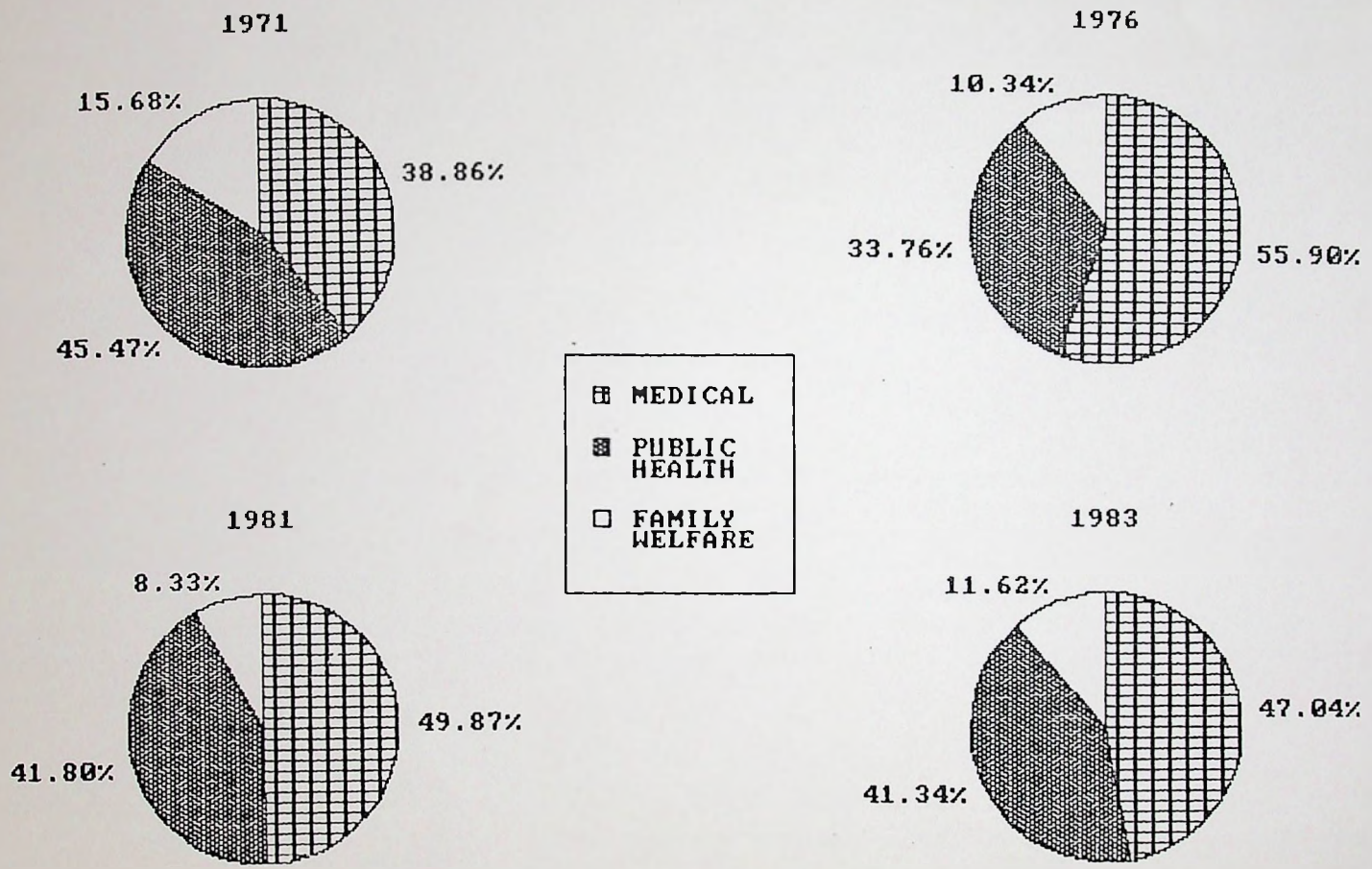
Sources

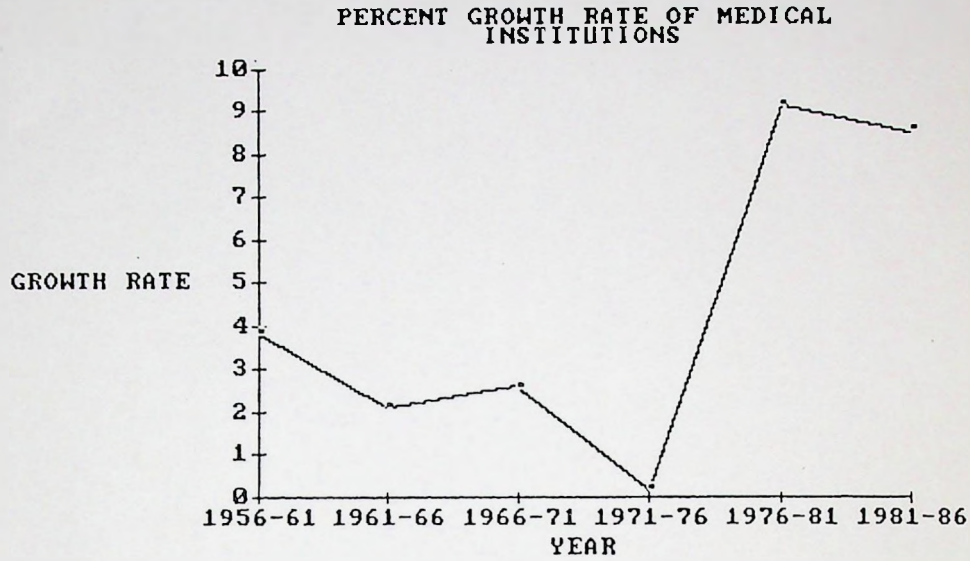
1. GOI - Health Statistics of India, Various years DGHS, MOHFW, Delhi.
2. NCAER - A Study of Resource of Municipal Bodies, 1980, New Delhi.
3. NIUA - 1983 - A Study of Financial Resources of Urban Local Bodies in India and the Level of Services Provided, New Delhi.
4. NIUA - 1989 - Upgrading Municipal Services : Norms and Financial Implications, NIUA Research Studies Series Number 38, New Delhi.

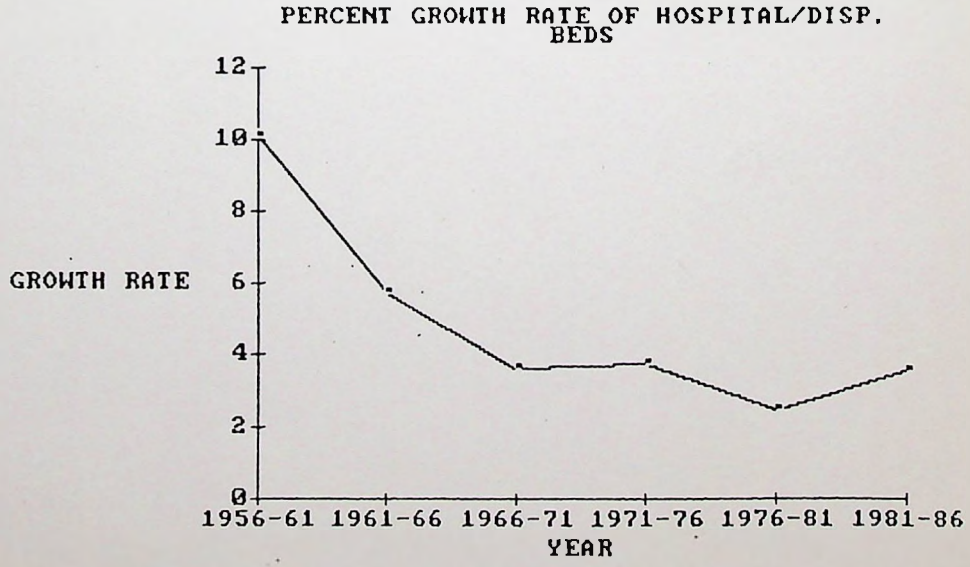
STATE HEALTH EXPENDITURE BY SUBSECTORS



STATE HEALTH EXPENDITURE BY SUBSECTORS




PERCENT GROWTH RATE OF MEDICAL INSTITUTIONS
GROWTH RATE
10
9
8
7
6
5
4
3
2
1
0
1956-61 1961-66 1966-71 1971-76 1976-81 1981-86
YEAR


PERCENT GROWTH RATE OF HOSPITAL/DISP. BEDS
GROWTH RATE
12
10
8
6
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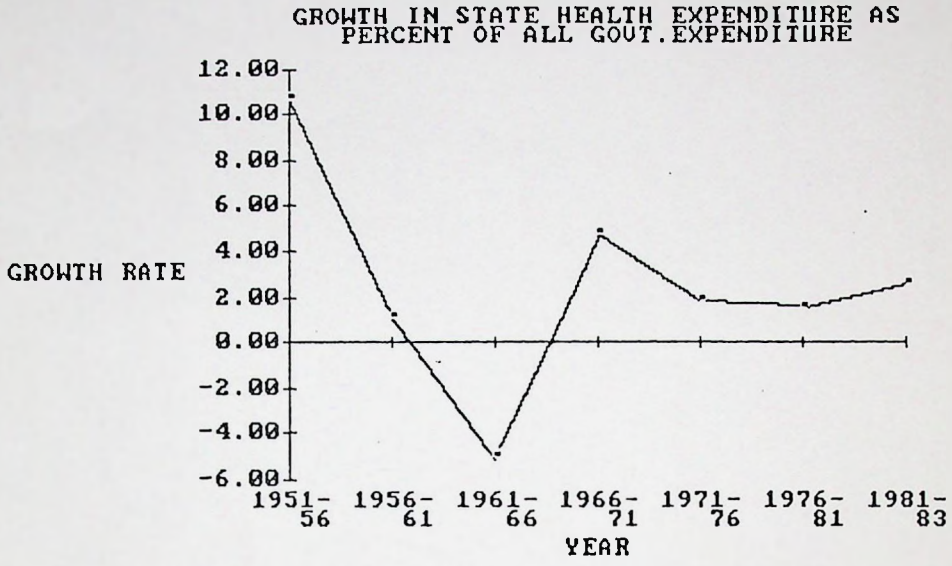
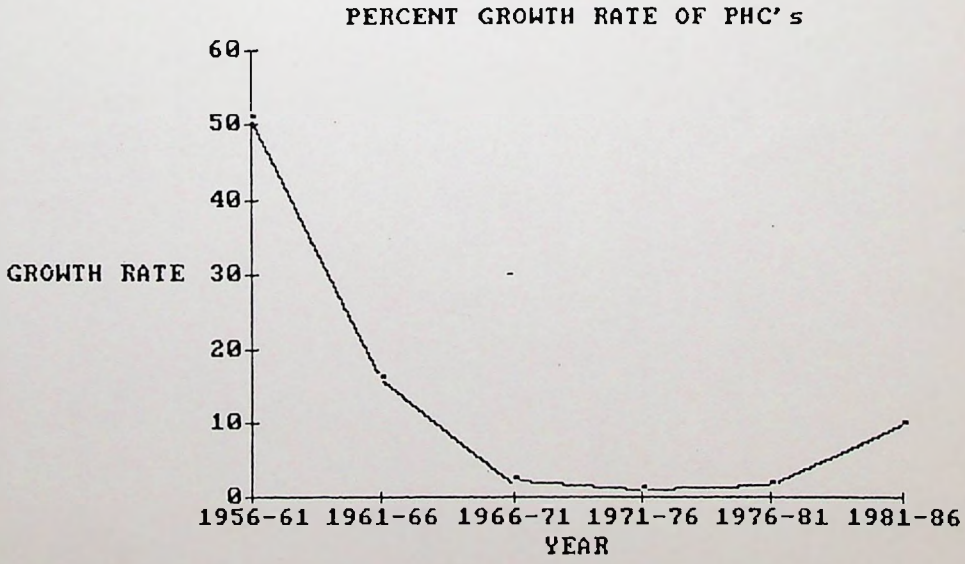
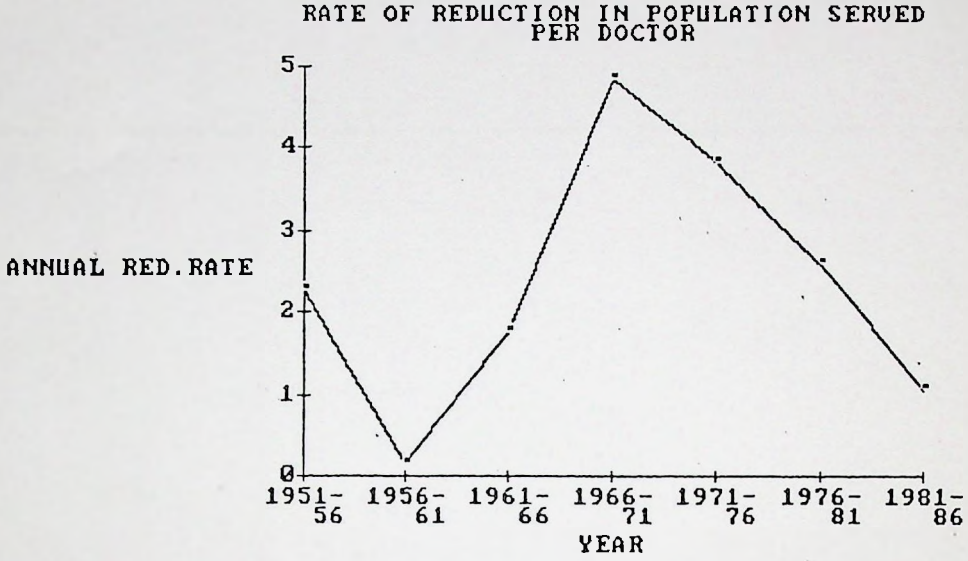
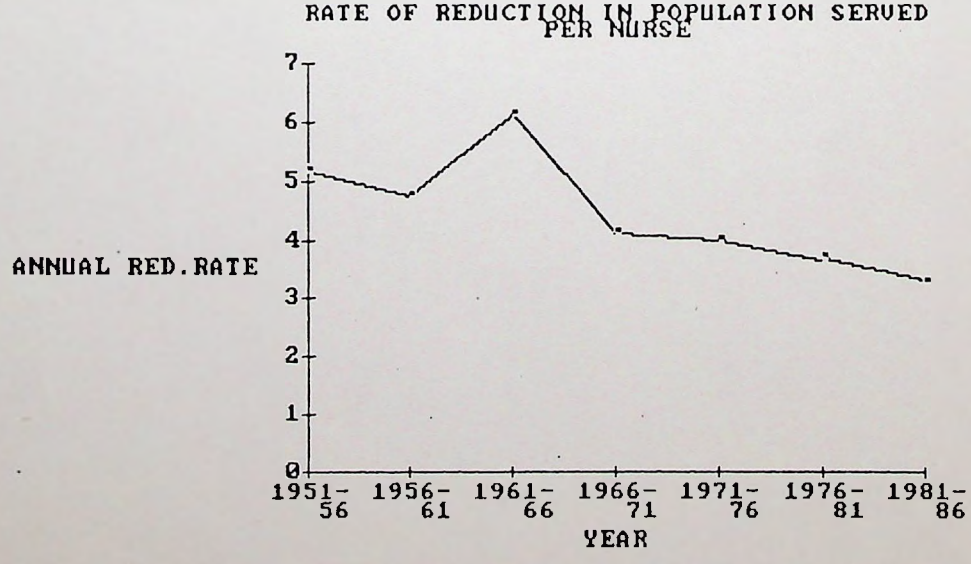
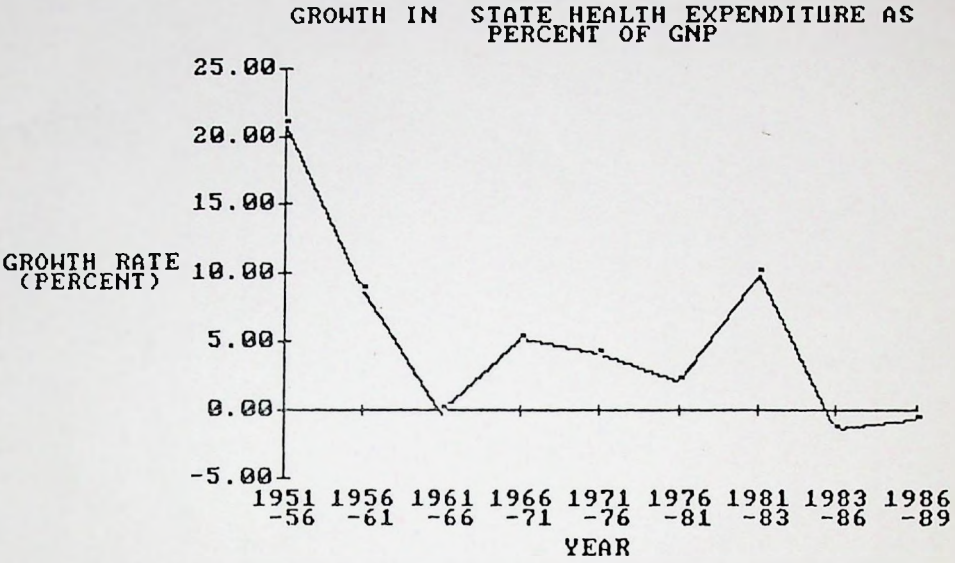
2
0
1956-61 1961-66 1966-71 1971-76 1976-81 1981-86
YEAR

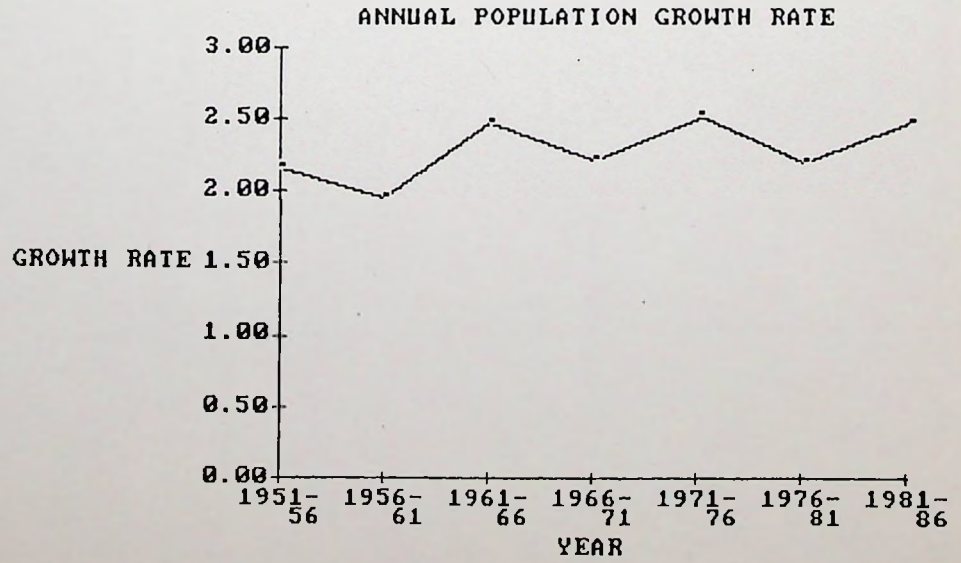

GROWTH IN STATE HEALTH EXPENDITURE AS PERCENT OF ALL GOVT.EXPENDITURE
GROWTH RATE
12.00
10.00
8.00
6.00
4.00
2.00
0.00
-2.00
-4.00
-6.00
1951-56
1956-61
1961-66
1966-71
1971-76
1976-81
1981-83
YEAR


PERCENT GROWTH RATE OF PHC's
GROWTH RATE
60
50
40
30
20
10
0
1956-61
1961-66
1966-71
1971-76
1976-81
1981-86
YEAR


RATE OF REDUCTION IN POPULATION SERVED PER DOCTOR
ANNUAL RED.RATE
5
4
3
2
1
0
1951-56
1956-61
1961-66
1966-71
1971-76
1976-81
1981-86
YEAR


RATE OF REDUCTION IN POPULATION SERVED PER NURSE
ANNUAL RED.RATE
7
6
5
4
3
2
1
0
1951-56
1956-61
1961-66
1966-71
1971-76
1976-81
1981-86
YEAR


GROWTH IN STATE HEALTH EXPENDITURE AS PERCENT OF GNP
GROWTH RATE (PERCENT)
25.00
20.00
15.00
10.00
5.00
0.00
-5.00
1951 -56
1956 -61
1961 -66
1966 -71
1971 -76
1976 -81
1981 -83
1983 -86
1986 -89
YEAR


ANNUAL POPULATION GROWTH RATE
GROWTH RATE
3.00
2.50
2.00
1.50
1.00
0.50
0.00
1951-56
1956-61
1961-66
1966-71
1971-76
1976-81
1981-86
YEAR

PRIVATE HEALTH SECTOR

Regulation and Control

Prevailing situation

The private health sector consisting of general practitioners, nursing home and hospital employ two thirds of the medical manpower and are responsible for two thirds of the total expenditure on health in this country. Despite this there is hardly any regulation of the practice of this sector of health.

This is indeed surprising because such activity cannot be carried out without registration. The medical professional has to be registered with the Medical Council which is a statutory body that last set the standards of medical practice, "discipline" the professionals, monitor their activities and check any malpractices. The doctors who decide to set up their own clinics, as well as hospitals, nursing homes, polyclinics etc. have to register with the respective local body.

The problem with the above is that **the controlling bodies are virtually non-functional.** The reason for this is not only lack of interest but also weak provisions in the various Acts. They are also heavily influenced by the private health sector.

Another agent in the private health sector which needs to be regulated further is the **pharmaceutical industry.** As a chemical industry this agent is regulated to some extent but as a participant in the health sector it operates virtually unregulated.

In view of the existing health situation and health practices regulation of those who provide the nation´s health care is an urgent necessity. Regulation exists in other sectors; so why not in health; especially as consumer resistance is at its lowest in this field and lends easily to malpractice.

How to regulate?

a. **Medical Practitioners** : Each medical practitioner is registered with the respective state Medical Council.

Presently, beyond this registeration the Medical Council does not concern itself with the practitioner, unless some complaint is made and a prima-facie case established. **The Medical Council, and other related bodies in consultation with the health ministry must regulate the following areas of medical practice** : (This is only a selective list)

i. Monitoring that only registered practitioners practice medicine.

ii. Assuring that clinics have **minimum standards of quality** by setting standards for the same (This should include X-ray, CT Scan & pathology laboratories).

iii. Making maintenance of **patient records** compulsory and **accessible** to the patients.

iv. **Auditing of prescriptions** of the doctors in relation to diagnosis.

v. Determining a **fixed tariff of charges** that patients pay to doctors.

vi. Providing **continuing medical education** to all those who practice medicine. For instance a "summer" refresher course every three to five years should be compulsory for all practitioners and their **license renewal** should be dependent on this.

vii. Regulation of geographical distribution of setting up practice to correct the urban-rural disparities (we feel that as of present there is adequate medical humanpower in the country and it only needs redistribution).

viii. Annual return of patients treated - some minimum data to be maintained and filed to an appropriate authority.

b. **Nursing Homes and Hospitals** : Similar to the practitioner, regulations need to be made for setting up and running of hospitals and nursing homes. Minimum quality standards, nurse : doctors ratio, patient : nurse ratio, proper location of premises, geographical distribution, fixed reasonable tarrif charges, proper medical records, maintenance, filing of minimum data returns, properly qualified and adequately trained personnel for jobs assigned, prescription auditing, medical auditing etc.

c. **Pharmaceutical Industry** :

i. The pharmaceutical industry must be allowed to manufacture only **rational drugs** in required amounts with clear priorities in favour of essential drugs. All irrational, non-essential and dangerous drugs must be banned.

ii. Branding of drugs must be prohibited.

iii. There is every reason for a progressive nationalisation of the pharmaceutical industry.

iv. **The regulating body for the pharmaceutical industry must be the Health Ministry and not the Chemicals Ministry.**

v. The practice of canvassing drugs through **pharmaceutical (Medical) representatives** should be **banned.**

vi. A **National Formulary** should be evolved and with generic drug names must become the basis of prescription writing.

vii. **Continuing pharmacological education** of doctors should be through MMC or other such statutory body.

d. **General regulation :**

i. To prevent unnecessary concentration in urban, especially metropolitan areas; **state subsidies, soft loans etc. must not be given to those willing to set up practice or hospitals and nursing homes in these areas. Such loans etc. should be restricted to rural areas and taluka towns.**

ii. **A tax on private medical practice and private hospitals and nursing homes** must be levied. This tax should be the highest in metropolitan areas and lowest in rural areas. Private Hospitals should not be allowed to be operated as Trusts or societies which give them cover for tax relief. They should be treated as corporate bodies. Hospitals operating 'research centres' must be audited and their tax reliefs questioned.

iii. **A social audit of the health sector** must be an ongoing activity of a statutory body which should be created for this purpose.

iv. **A tax on international migration of doctors.**

v. Embargo on private practice of those receiving State Financed Medical Education or high fees/tax for those who want to practice privately.

vi. Decentralising Medical Education by part training at civil/rural hospitals and PHCs. This should be combined with a long term change of relocating medical colleges at the district centres.

Com H-56.

Health Situation

in South-East Asia

BASIC INDICATORS 2002

Includes Progress Towards Achieving Health-Related United Nations Millennium Development Goals

World Health Organization
South-East Asia Region
2003

PREFACE

Collection of data and its analysis to provide necessary evidence for assessing the extent of development of national health systems and their performance at national and/or sub-national levels has been the major role of any health information system. To provide timely feedback and appropriate data to programme managers for action has been a challenging task for the health information team at all levels of the health system. Health intelligence, and not merely health data/information as such, is increasingly being seen as the lifeblood of any health system by health planners and policymakers. There is thus a growing demand for this health information. It is with this in mind that the Regional Office for South-East Asia has taken the initiative to disseminate quantitative evidence through this brochure on basic health indicators. Data on health and health-related indicators of the UN Millennium Development Goals have also been provided.

The data provided in the brochure have been compiled from several sources, including national health information bulletins and other national publications as well as official publications of WHO and other UN agencies. Data provided by technical units in the Regional Office have also been used. These data have been verified and validated by concerned focal points in the health ministries of the Member countries. All efforts have been made to collect and present comparable data from Member countries for each specified time period.

Wherever possible, the latest available information for individual countries (as of 2000 and 2001) has been presented. Since these data are subject to many limitations, including fragmentation, non-comparability due to difference in definitions, concepts and measurement units, as well as inconsistency, caution should be exercised when using the data for trend analysis or intercountry comparisons. Caution in the use of maternal health indicators is especially important since these data often have varying definitions, are based on limited survey findings, or are subject to other limitations.

Footnotes for data in the tables are indicated by a superscript alphabetic character either following the indicator title or following the data value of the indicator for a particular country. The footnotes include explanatory notes regarding major discrepancies with other official sources, where reference years differ from the year or period shown, where definitions differ, how data values were calculated, or where other primary sources of data have been cited. The list of footnotes is provided below the data tables. *Sources* for the data in the tables are indicated by a superscript number either following the indicator title or following the data value of the indicator for a particular country. A reference list of *data sources* and *definitions* for the indicators are also provided below and at the end of the tables. Where data are not available "n/a" has been indicated.

This brochure provides quantitative evidence. For in-depth epidemiological analysis, assessment of time trends and cross-comparison of data, readers may refer to the WHO/SEARO publication — *Health Situation in the South-East Asia Region*.

It is hoped that the brochure would help in sensitizing and prompting health functionaries at all levels to collect, analyze and disseminate timely and consistently reliable health information for all those who need it.

Dr Uton Muchtar Rafei
Regional Director

Demographic Indicators

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Total population (thousands)[1,a]	2002	143,364	805[4,b]	22,586	1,041,144	217,534	309	48,956	24,153	19,287	64,344	850[11,f]
Surface area (thousands of sq km)[2]	2000	144	47	121	3,287	1,905	0.3	677	147	66	513	15
Population density (per sq km)[1,c]	2002	996	17	187	317	114	1,030	72	164	292	125	58[11,f]
Population growth rate (%)[1,d]	2000-2005	2.09	2.55[12,b]	0.68	1.52	1.21	1.96[13,e]	1.16	2.32	0.94	1.14	3.93
Crude birth rate (per 1000 population)[1,d]	2000-2005	29.9	34.09[12,b]	16.7	23.8	20.0	20.0[13,b]	23.2	34.0	17.3	17.8	25.4
Crude death rate (per 1000 population)[1,d]	2000-2005	8.7	8.64[12,b]	9.9	8.4	7.1	4.0[13,b]	11.6	9.9	6.3	6.2	13.2
Urban population (%)[3]	2000	24.5	14.5[12,g]	60.2	28.4	40.9	27.4[13,b]	27.7	11.9	23.6	21.6	15.0[11,f]
Average annual growth rate of the urban population (%)[3,d]	2000-2005	3.98	5.95	1.62	2.81	3.57	3.52	2.86	5.07	2.84	2.67	2.21

Socioeconomic Indicators

Indicator		Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Gross national income (GNI) per capita (US$)[4]		2001	370	640	n/a[n]	460	680	2,040	n/a[n]	250	830	1,970	478[11,f]
Gross domestic product (GDP) per capita growth rate (%)[4]		2000-2001	3.3	4.0	n/a	2.7	1.8	4.5	n/a	3.4	1.0	0.9	n/a
Average annual change in consumer price index (%)[5]		2000-2001	1.1	n/a	n/a	3.7	11.5	0.6	21.1	2.8	14.2	1.7	n/a
Human Development Index (HDI)[5]		2001	0.502	0.511	n/a	0.590	0.682	0.751	0.549	0.499	0.730	0.768	n/a
Dependency ratio[1,j]	Total	2000	72	89	48	62	55	89	61	81	48	47	84
	Old-age(65+)	2000	5	8	9	8	7	7	7	7	9	8	5
	Young (0-14)	2000	67	81	39	54	48	83	53	74	39	39	79
Adult literacy rate (%)[6,j]	Total	2000	40.0	47.3[7]	100[8,k]	57.2	86.8	96.9	84.7	41.7	91.6	95.5	n/a
	Male	2000	49.4	61.1[7]	100[8,k]	68.4	91.8	97.0	88.9	59.4	94.4	97.1	n/a
	Female	2000	30.2	33.6[7]	100[8,k]	45.4	81.9	96.8	80.5	24.0	89.0	93.9	n/a
Gross primary school enrolment ratio (%)[9]	Total	1999/2000	106.11[l]	n/a	n/a	100.93	107.89	133.71	90.95	126.38	105.91[l]	93.50	n/a
	Male	1999/2000	107.57[l]	82.00[10,m]	108.00[10,n]	108.88	109.71	133.22	91.39	140.00	107.39[l]	95.72	n/a
	Female	1999/2000	104.57[l]	62.00[10,m]	101.00[10,n]	92.39	106.00	134.23	90.51	111.74	104.38[l]	91.24	n/a
Gross secondary school enrolment ratio (%)[9]	Total	1999/2000	53.73	n/a	n/a	49.92	54.88	42.75	34.87[l]	53.90	72.12[l]	78.95	n/a
	Male	1999/2000	51.70	7.00[10,n]	n/a	58.91	56.23	41.36	34.92[l]	62.26	69.85[l]	78.06	n/a
	Female	1999/2000	55.90	2.00[10,n]	n/a	40.22	53.50	44.17	34.81[l]	44.86	74.47[l]	79.85	n/a

FOOTNOTES FOR DATA TABLES

a Medium variant projection of the population for mid-year 2001

b Data for 2000

c Calculated from total population for 2001 and surface area for 1999 provided in the source documents

d Medium variant projection of annual average rate during the period

e Data for 1995-2000

f Data for 2002

g Data for 1997

h Estimated to be low income ($745 or less)

i Due to rounding of decimal point, child plus elderly dependency ratios may not add up to Total Dependency Ratio

j Calculated from adult *illiteracy* rates provided in the source document

k Data for 1996

l Data for 1998/1999

m Data for 1995-1999

n Footnote in the source indicates that data refer to years or period other than 1995-1999, differ from the standard definition, or refer to only part of the country

o Data for 1999

p Data for 1995

q Data for 1998

r 91.1% (single dose) 4.6% (two doses) during 1998

s Percentage of total government budget for 2002

t Coverage by NIDS during 2002

u As reported by country for 1999

v Figures not endorsed by country as official statistics

w Data for 1994-1998

x As reported by country for both male and female combined for 1999

y For urban/rural areas for 1998

z Data for 2001

aa Data for 1994-1999

ab Computed from data provided in the source documents for life expectancy by sex

ac Ratio expressed in percentage

ad Data as of 8 March 2002

ae Data based on previous election

af Data refer to latest year available during the period 1991-2000

ag Data for 1991

ah Data for 1998 children less than 7 years of age

ai Data for 1992

aj Data for 1999 for children < 3 years of age

ak Data for 1994

al Data for 1993

am Data for 1989

an For urban/rural areas for 1990

ao For 1999 (MMR = 23 from VRS, MMR = 59.6 from surveillance system)

ap Data for 1987

Health Resources Indicators

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Total expenditure on health (as % of GDP)[14]	2000	3.8	4.1	2.1	4.9	2.7	7.6	2.2	5.4	3.6	3.7	9.4[11,a]
Public share to health expenditure (%)[14]	2000	36.4	90.6	77.3	17.8	23.7	83.4	17.1	29.3	49.0	57.4	n/a
Per capita total health expenditure (international dollars)[14]	2000	47	64	33	71	84	254	24	66	120	237	n/a
Physicians per 10,000 population[16]	2001	2.51	1.6[o]	29.7[c]	5.2[s]	1.1[q]	8.4[b]	3.0[b]	0.54	4.1[b]	3.0[o]	n/a
Hospital beds per 10,000 population[15]	2001	3.36	16.0[o]	136.1[p]	6.9[s]	6.03[s]	17.4[o]	6.3[b]	1.5	29[b]	22.3[o]	n/a

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Primary Health Care Coverage Indicators

Indicator		Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Infants immunized (%)[15]	DPT3	2001	70.2[o]	88.0[o]	37.4[q]	52.1[q]	95.0[q]	98.0[c]	89.0[o]	80.0	88.0[b]	94.6[o]	58.0[11]
	OPV3	2001	69.1[o]	89.0[o]	76.5[q]	59.2[q]	88.4[q]	98.0[b]	93.0[b]	80.0	88.0[o]	94.8[o]	84.0[11,b]
	BCG	2001	90.0[o]	93.0[o]	63.9[q]	69.1[q]	93.1[q]	99.5[o]	95.0[b]	95.0	100.0[o]	100.0[o]	n/a
	Measles	2001	62.1[o]	79.0[o]	34.4[q]	41.7[q]	86.8[q]	99.0[b]	90.0[b]	75.0	81.0[c]	88.1[b]	n/a
Pregnant women immunized with tetanus toxoid (%)[15]		2001	63.7[o]	73.0[o]	4.6[r]	66.8[o]	73.4[q]	94.0[o]	77.0[b]	24.2	90.0[o]	76.3[b]	n/a
Attended by trained personnel: (% of live births)	Pregnant women[15]	2001	33.7[o]	72.0[b]	100.0[o]	65.1[o]	71.9[q]	93.0	60.1[q]	35.0[o]	98.0[c]	83.4[k]	n/a
	Deliveries[15]	2001	21.8[o]	23.7[o]	98.6[o]	42.3[o]	62.3[q]	97.0	77.5[o]	13.5[o]	97.0[c]	94.5[o]	n/a
Women of child bearing age using contraceptives (%)[15]		2001	53.8[o]	30.7[o]	67.0[o]	48.2[q]	66.4[q]	42.0[c]	55.1[37]	38.9[35]	71.0[o]	72.2	n/a
Population with access to safe water (%)[15]	Total	2001	97.3[o]	77.8[b]	99.9[q]	77.9[q]	n/a	76.5	71.5[b]	59.0[k]	75.4[b]	92.7[b]	n/a
	Urban	2001	99.2[o]	97.5[b]	n/a	92.6[q]	88.2[q]	n/a	89.2[b]	61.0[k]	96.0[o]	n/a	n/a
	Rural	2001	96.7[o]	73.2[b]	n/a	72.3[q]	71.9[q]	n/a	65.8[b]	59.0[k]	74.6[b]	n/a	n/a
Population with access to adequate sanitation (%)[15]	Total	2001	54.1[o]	88.0[o]	99.2[q]	36.0[s]	n/a	85	63.1[b]	23.0[k]	72.6[b]	97.7[o]	n/a
	Urban	2001	74.6[o]	n/a	n/a	80.7[q]	86.9[s]	n/a	83.6[b]	74.0[k]	87.0[b]	n/a	n/a
	Rural	2001	49.3[o]	n/a	n/a	18.9[s]	54.2[q]	n/a	56.5[b]	18.0[k]	68.3[b]	n/a	n/a

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Health Status Indicators

Indicator		Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Life expectancy at birth (years)[34]:	Total	2002	62.6	61.3	65.8	61.0	66.4	64.6	62.3[15,u]	60.1	70.3	69.3	57.5
	Male	2002	62.6	60.2	64.4	60.1	64.9	64.5	60.7[15,u]	59.9	67.2	66.0	54.8
	Female	2002	62.6	62.4	67.1	62.0	67.9	65.0	63.9[15,u]	60.2	74.3	72.7	60.5
Healthy life expectancy (HALE) at birth (years)[34]:	Total	2002	54.3	52.9	58.9	53.4	58.2	55.8	51.6[v]	51.8	61.3	60.0	49.7
	Male	2002	55.3	52.9	58.0	53.3	57.4	57.4	49.9[v]	52.5	59.2	57.7	47.9
	Female	2002	53.3	52.9	59.7	53.6	58.9	56.3	53.5[v]	51.1	64.0	62.5	51.8
Infant mortality rate (per 1000 live births)[15]		2001	51.0[b]	60.5[b]	21.8[b]	68.0[n]	41.4[g]	21.0[c]	59.8[c]	64.2	15.4[q]	21.5	70-95[11,f]
Under-five mortality rate (per 1000 live births)[34]:	Male	2002	71	93	56	87	45	38	78[15,x]	81	20	32	142
	Female	2002	73	92	54	95	36	43	78[15,x]	87	16	26	108
Total fertility rate (per woman)[14]		2001	3.6	5.2	2.1	3.1	2.4	5.5	3.0	4.6	2.1	2.0	n/a
Maternal mortality ratio (per 100,000 live births)[15]		2000	230	258	105[k]	407[c]	373[g]	100	100/180[r]	415[z]	59.6[o]	13.2	800[11,f]
Low birth weight newborns (%)[15]		2000	19.5	15.1[o]	9.0[q]	23.0[p]	7.7[s]	17.6[z]	15.0	23.2[s]	16.7	8.1[o]	n/a
Children with low weight-for-age (%)[15]		2000	47.7[aa]	18.7[o]	60.6[q]	47.0[q]	20.3[q]	30.0[g]	35.5	47.1[q]	29.4	11.3[q]	45.0[11,b]

Gender Equity Indicators

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Life expectancy at birth ratio (females as a % of males)[14,ab]	2001	99.7	103.6	106.7	102.8	104.7	100.8	105.3	98.8	111.3	109.9	n/a
Gender-related development index (GDI)[5]	2001	0.495	n/a	n/a	0.574	0.677	n/a	n/a	0.479	0.726	0.766	n/a
Gender empowerment measure (GEM)[5]	2001	0.218	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0.272	0.457	n/a
Ratio of earned income (females as % of males)[5,ac]	2001	56	n/a	n/a	n/a	n/a	n/a	n/a	n/a	50	61	n/a
Seats held in parliament (% women)[5,ad]	2001	2.0	9.3	n/a	9.3	8.0	6.0	n/a	7.9[ae]	4.4	9.6	n/a
Professional and technical workers (% women)[5,af]	2001	25	n/a	n/a	n/a	n/a	40	n/a	n/a	49	55	n/a
Adult literacy ratio (females as a % of males)[6,ab]	2000	61.1	55.0	100.0	66.4	89.2	99.8	90.6	40.4	94.3	96.7	n/a
Primary school enrolment ratio (females as a % of males)[9,ab]	1999/2000	97.2	75.6	93.5	84.9	96.6	100.8	99.0	79.8	97.2	95.3	n/a
Secondary school enrolment ratio (females as a % of males)[9,ab]	1999/2000	108.1	28.6	n/a	68.3	95.1	106.8	99.7	72.1	106.6	102.3	n/a

FOOTNOTES FOR DATA TABLES

a Medium variant projection of the population for mid-year 2001

b Data for 2000

c Calculated from total population for 2001 and surface area for 1999 provided in the source documents

d Medium variant projection of annual average rate during the period

e Data for 1995-2000

f Data for 2002

g Data for 1997

h Estimated to be low income ($745 or less)

i Due to rounding of decimal point, child plus elderly dependency ratios may not add up to Total Dependency Ratio

j Calculated from adult *illiteracy* rates provided in the source document

k Data for 1996

l Data for 1998/1999

m Data for 1995-1999

n Footnote in the source indicates that data refer to years or period other than 1995-1999, differ from the standard definition, or refer to only part of the country

o Data for 1999

p Data for 1995

q Data for 1998

r 91.1% (single dose) 4.6% (two doses) during 1998

s Percentage of total government budget for 2002

t Coverage by NIDS during 2002

u As reported by country for 1999

v Figures not endorsed by country as official statistics

w Data for 1994-1998

x As reported by country for both male and female combined for 1999

y For urban/rural areas for 1998

z Data for 2001

aa Data for 1994-1999

ab Computed from data provided in the source documents for life expectancy by sex

ac Ratio expressed in percentage

ad Data as of 8 March 2002

ae Data based on previous election

af Data refer to latest year available during the period 1991-2000

ag Data for 1991

ah Data for 1998 children less than 7 years of age

ai Data for 1992

aj Data for 1999 for children < 3 years of age

ak Data for 1994

al Data for 1993

am Data for 1989

an For urban/rural areas for 1990

ao For 1999 (MMR = 23 from VRS, MMR = 59.6 from surveillance system)

ap Data for 1987

Health-Related Millennium Development Goals

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Goal (G) Target (T) Indicator (I)												
Goal 1 : ERADICATE EXTREME POVERTY AND HUNGER												
Target 2 : Halve, between 1990 and 2015, the proportion of people who suffer from hunger												
G1.T2.I4 — Prevalence of underweight children (under-five years of age)	1990[16]	54.0[3g]	39.7[k]	5.0[p]	53.4[3i]	41.7[3i]	n/a	32.4	46.9[p]	37.6[3l]	20.8[3g]	n/a
	2001[15]	47.7[c]	18.7[o]	27.9[34]	47.0[34]	24.6[34,b]	30.0	35.5[b]	48.3[36]	29.4[b]	11.3[q]	45.0[11,b]
G1.T2.I5 — Proportion (%) of population below minimum level of dietary energy consumption (proxy-5)	1991[17]	35	n/a	18	25	9	n/a	10	19	29	28	n/a
	1999[17]	35	n/a	34	24	6	n/a	6	19	23	18	n/a
Goal 4 : REDUCE CHILD MORTALITY												
Target 5 : Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate												
G4.T5.I13 — Under-five mortality rate (probability of dying between birth and age 5)	1990[16]	136.0[18]	96.9[3k]	23.0[k]	112.0[18]	64.0[3i]	48.0	130.0[18]	165.0	22.6[3g]	42.0[3g]	n/a
	2002[34]	72.3	84.0[15 b]	90.0[18]	90.9	51.4[37,b]	30.0	78.0[o]	91.0[z]	18.3	31.4[o]	125.0[11 o]
G4.T5.I14 — Infant mortality rate	1990[16]	92.0[3g]	70.7[ak]	14.1[k]	80.0[15]	60.0[3i]	34.0	100.0[18]	102.0	19.3	32.8[3g]	n/a
	2000[15]	51.0	60.5	21.8	68.0[15 w]	40.9[37,b]	21.0	59.8[o]	64.2[z]	15.4[q]	21.5[z]	70-95[11,l]
G4.T5.I15 — Proportion (%) of 1 year-old children immunized for measles	1990[16]	53.0[3g]	69.0[3g]	99.7[p]	32.7[3i]	90.3[3i]	85.0	71.0[3i]	65.0[3g]	86.0[3l]	58.1[am]	n/a
	2001[34]	76.0	78.0	34.0	56.0	93.9[37,b]	99.0	73.0	71.0	99.0	94.0	n/a
Goal 5 : IMPROVE MATERNAL HEALTH												
Target 6 : Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio												
G5.T6.I16 — Maternal mortality ratio	1990[16]	470[3g]	380[3k]	n/a	420[3i]	425[3i]	500	100/190[3an]	850[3g]	42[3g]	36.0	n/a
	2001[15]	230[b]	255[37,b]	105[x]	407[q]	373[p]	100[b]	255 [35 o]	415	59.6[ao]	13.2[b]	800[11,l]
G5.T6.I17 — Proportion (%) of births attended by skilled health personnel	1990[16]	14.0[k]	15.1[ak]	n/a	89/36[an]	31.7[ai]	95.0[p]	n/a	9.0[x]	85.2[am]	84.8	n/a
	2001[15]	21.8[o]	23.7[b]	98.6[p]	42.3[x]	64.8[37,b]	97.0	77.5[b]	10.9[36]	97.0[b]	94.5[o]	n/a

SOURCES OF DATA

1 UN, *World Population Prospects, The 2000 Revision, Volume I: Comprehensive Tables*, New York, 2001

2 UN, *2000 Demographic Yearbook*, New York, 2002

3 UN, *World Urbanization Prospects, The 1999 Revision*, New York, 2001

4 World Bank, *World Development Report 2003*, Oxford University Press, New York, 2003

5 UNDP, *Human Development Report 2003*, Oxford University Press, New York, 2003

Health-Related Millennium Development Goals

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Goal 6 : COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES												
Target 7 : Have halted by 2015, and begun to reverse, the spread of HIV/AIDS												
G6.T7.I18 —HIV prevalence among young people												
15-24 years age group (proxy-18)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2001[31] (M)	0.01	n/a	n/a	0.22	0.05	n/a	n/a	0.17	0.02	0.88	n/a
	2001[31] (F)	0.01	n/a	n/a	0.46	0.05	n/a	n/a	0.18	0.03	1.32	
15-49 years age group	2001[38]	<0.1	<0.1	0.3[34,f]	0.8	0.1	0.1	1.3[34,f]	0.5	<0.1	1.7[34,f]	n/a
G6.T7.I19 — Condom use in high risk population (proxy-19)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2001[32] (M)	n/a	n/a	n/a	51.2	n/a	n/a	n/a	n/a	44.4[g]	n/a	n/a
	2001[32] (F)	n/a	n/a	n/a	39.8	n/a	n/a	n/a	n/a	n/a	n/a	n/a
G6.T7.I20 — Ratio of children orphaned/non-orphaned in schools (proxy 20)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2001[33]	2,100	n/a	n/a	n/a	18,000	n/a	n/a	13,000	2,000	290,000	n/a
Target 8 : Have halted by 2015, and begun to reverse the incidence of malaria and other major diseases												
G6.T8.I21$_a$ – Malaria death rate per 100,000 in children (0-4 years of age)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2000[20]	1	8	0	6	0	n/a	3	11	4	9	n/a
G6.T8.I21$_b$ – Malaria death rate per 100,000 (all ages)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2002[34]	7.5	11.4	0.0	2.9	3.2	n/a	14.6	17.7	5.5	6.4	
G6.T8.I21$_c$ – Malaria prevalence rate per 100,000 (proxy-21c)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2002[34]	34	44	19	14	15	n/a	22	78	57	49	22

6 UNESCO, http://www.unesco.org, July 2002 assessment

7 UNESCO, *Statistical Yearbook 1999*

8 WHO, Regional Office for South-East Asia, Routine and ad hoc reports from countries to the EHP Unit, New Delhi, 2000

9 UNESCO, http:// www.unesco.org, October 2002

10 UNICEF, *The State of the World's Children 2003*, Oxford University Press, New York, 2003

11 Timor-Leste, *Health Profile*, Dili, 26 August 2002

12 Bhutan, Ministry of Health and Education, *Report on National Health Survey 2000*

13 Maldives, *Statistical Yearbook of Maldives 2001*

14 WHO Geneva, *The World Health Report 2002*, Geneva, 2002

15 WHO, Regional Office for South-East Asia, *Health Situation in the South-East Asia Region 1998-2000*, New Delhi, 2002

16 WHO [illegible] HFA data set 199.

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Target 8 (continued)												
G6.T8.I22$_a$ — Proportion (%) of population under age 5 in malaria risk areas using insecticide-treated bed nets	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2000[21]	n/a	n/a	n/a	n/a	0.1	n/a	n/a	n/a	n/a	n/a	n/a
G6.T8.I22$_b$ — Proportion (%) of population under age 5 with fever being treated with antimalarial drugs	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2000[22]	n/a	n/a	n/a	n/a	4	n/a	n/a	n/a	n/a	n/a	n/a
G6.T8.I23$_a$ — Tuberculosis death rate per 100,000	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2002[34]	54.4	23.0	31.8	40.4	66.1	3.5	33.2	26.4	11.4	18.5	54.6
G6.T8.I23$_b$ – Tuberculosis prevalence rate per 100,000	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2002[34]	471	215	343	426	739	48	268	300	116	241	779
G6.T8.I24$_a$ – Proportion (%) of Smear Positive Pulmonary Tuberculosis cases detected and put under directly observed treatment short course (DOTS) (proxy-24a)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2001[29,39]	26.3	25.8	56.3	22.7	20.7	88.1	58.6	59.7	74.3	75.1	n/a
G6.T8.I24$_b$ – Proportion (%) of Smear-Positive Pulmonary Tuberculosis cases detected cured under directly observed treatment short course (DOTS) (proxy-24b)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2000[25,39]	83	90	91	84	87	95	82	86	77	69	n/a

17 http://millenniumindicators.un.org/unsd, FAO estimates (3690), July 2003
18 World Bank, http://www.developmentgoals.com, World Development Indicators Database, April 2002
19 http://millenniumindicators.un.org/unsd, WHO [29996], July 2003
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28 http://millenniumindicators.un.org/unsd, WHO estimates [29986], July 2003
29 http://millenniumindicators.un.org/unsd, WHO [30026], July 2003
30 http://millenniumindicators.un.org/unsd, WHO [30020], April 2003

Health-Related Millennium Development Goals

Indicator	Year	Bangla-desh	Bhutan	DPR Korea	India	Indo-nesia	Mal-dives	Myan-mar	Nepal	Sri Lanka	Thailand	Timor-Leste
Goal 7 : ENSURE ENVIRONMENTAL SUSTAINABILITY												
Target 9 : Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources												
G7.T9.I29 — Proportion (%) of population using biomass fuels (proxy-29)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	2000[34]	96[g]	n/a	n/a	81[ag]	63[p]	n/a	100[q]	97[p]	89	72[q]	n/a
Target 10 : Halve, by 2015, the proportion of people without sustainable access to safe drinking water												
G7.T10.I30$_a$ – Proportion (%) of population with sustainable access to an improved water source, rural (proxy-30a)	1990[28,34]	93	n/a	n/a	61	62	n/a	n/a	64	62	78	n/a
	2000[26,34]	97	60	100	79	69	100	66	87	70	81	n/a
G7.T10.I30$_b$ – Proportion (%) of population with sustainable access to an improved water source, urban (proxy-30b)	1990[26,34]	99	n/a	n/a	88	92	n/a	n/a	93	91	87	n/a
	2000[26,34]	99	86	100	95	90	100	89	94	98	95	n/a
Target 11 : By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers												
G7.T11.I31 — Proportion (%) of urban population with access to improved sanitation	1990[27,34]	81	n/a	n/a	44	66	n/a	n/a	69	94	95	n/a
	2000[27,34]	71	65	99	61	69	100	84	73	97	96	n/a
Goal 8 : DEVELOP GLOBAL PARTNERSHIP FOR DEVELOPMENT												
Target 17 : In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries												
G8.T17.I46 — Proportion (%) of population with access to affordable essential drugs on a sustainable basis (proxy-46)	1990	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	1997[28]	80	80	50	80	80	80	50	50	95	80	n/a

31 http://millenniumindicators.un.org/unsd, UNAIDS [30008], April 2003
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33 http://millenniumindicators.un.org/unsd, UNAIDS [29987], April 2003
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35 Myanmar, *Health in Myanmar 2002*
36 Nepal, *Demographic and Health Survey 2001*
37 Country Presentations at the Consultative Meeting on MDG Dataset, June 2003, WHO/SEARO, New Delhi
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Definitions for Indicators

Adult literacy rate (%): is the percentage of persons aged 15 years and above who can read and write. The application of this definition is subject to qualifiers in each country and at each census. (UN, *2000 Demographic Yearbook*). **Adult literacy ratio (females as a % of males):** is the ratio of adult literacy of females to that of males, expressed as a percentage. **Average annual change in consumer price index (%):** it reflects changes in the cost to the average consumer of acquiring a basket of goods and services that may be fixed or changed at specified intervals. (UNDP, *Human Development Report 2002*). **Average annual growth rate of the urban population (%):** is the average annual rate of change in the percentage of the urban population computed from the total increase in the urban population over five year periods, based on the methodology of the Population Division of the United Nations. (UN, *World Urbanization Prospects*, the 1999 Revision). **Children with low weight-for-age (%):** is the number of children with low weight-for-age as a percentage of the children weighed. Children whose nutritional status (weight-for-age) is low are those whose status falls below 80% of the median weight of reference value or below 2 standard deviations of the national or international reference populations, such as growth charts of the US National Center for Health Statistics. (UNICEF, *The State of World's Children, 2000*). **Crude birth rate (per 1000 population):** is the annual number of live births occurring per thousand mid-year population. (UN, *1993 Demographic Yearbook*). **Crude death rate (per 1000 population):** is the annual number of deaths occurring per thousand mid-year population. (UN, *2000 Demographic Yearbook*). **Deliveries attended by trained personnel (% of live births):** is the number of deliveries attended by trained personnel per 100 live births. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Gender Empowerment Measure (GEM):** is an index which focuses on three variables that reflect women's participation in political decision making, their access to professional opportunities, and their earning power. (UNDP, *Human Development Report 2003*). **Gender-related Development Index (GDI):** is an adjustment of the Human Development Index (HDI) for gender equity in life expectancy, educational attainment and income. (UNDP, *Human Development Report 2003*). **Gross Domestic Product (GDP) per capita growth rate (%):** is based on GDP measured in constant prices. Growth in GDP is considered a broad measure of the growth of an economy. GDP in constant prices can be estimated by measuring the total quantity of goods and services produced in a period, valuing prices, and subtracting the cost of intermediate inputs, also in constant prices. (World Bank, *World Development Report 2002*). **Gross National Income (GNI) per capita (US$):** Formerly Gross National Product or GNP, the broadest measure of national income, measures total value added from domestic and foreign sources claimed by residents. GNI comprises Gross Domestic Product (GDP) plus net receipts of primary income from foreign sources. Data are converted from national currency to current US Dollars using the World Bank Atlas Method. This involves using a 3-year average of exchange rates. (World Bank, *World Development Report 2002*). **Gross primary school enrolment ratio (%):** is the total enrolment in first-level education, regardless of age, divided by the population of the age-group which officially corresponds to primary schooling. (UNESCO, *World Education Report 1995*). **Gross secondary school enrolment ratio (%):** is the total enrolment in second-level education, regardless of age, divided by the population of the age-group which officially corresponds to secondary schooling. (UNESCO, *World Education Report 1995*). **Healthy Life Expectancy (HALE) at birth (years):** is the full health life expectancy at birth. It is the number of years a newborn child is expected to live in full health during his/her life time subject to health risks prevailing for a cross section of the population at the time of his/her birth. In other words, it is the life expectancy at birth minus the total time expected to be lost being in ill health. (WHO, *The World Health Report 2002*). **Hospital beds per 10,000 population:** is the ratio of total number of hospital beds available in the country to the total population, expressed per 10,000 population. **Human Development Index (HDI):** is a composite of three indicators which reflect important dimensions of human development: longevity as measured by life expectancy at birth; educational attainment as measured by a combination of adult literacy (two-thirds weight) and combined primary, secondary and tertiary enrolment ratios (one-third weight); and standard of living as measured by real GDP per capita (in purchasing power parity dollars). (UNDP, *Human Development Report 2003*). **Infant mortality rate (per 1000 live births):** is the number of deaths under one year of age per 1000 live births. (WHO, *International Statistical Classification of Diseases and Related Health Problems*). **Infants immunized with BCG (%):** is the percentage of infants reaching their first birthday that have been fully immunized (one dose) against tuberculosis. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*) **Infants immunized with DPT3 (%):** is the percentage of infants reaching their first birthday that have been fully immunized (three doses according to the immunization scheme adopted in the country) against diphtheria, tetanus, and whooping cough. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Infants immunized with measles vaccine (%):** is the percentage of infants reaching their first birthday fully immunized against measles (one dose). (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Infants immunized with OPV3 (%):** is the percentage of infants reaching their first birthday that have been fully immunized against poliomyelitis (three doses). (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Life expectancy at birth (years):** is the number of years newborn children would live if subject to the mortality risks prevailing for a cross-section of the population at the time of their birth. (UNICEF, *The State of the World's Children 2003*). **Life expectancy at birth ratio (females as a % of males):** is the ratio of the life expectancy at birth of females to that of males, expressed as a percentage. **Low birth weight newborns (%):** is the number of liveborn babies with birth weight less than 2500 grams as a percentage of the total number of liveborn babies weighed, with the measurement being taken preferably within the first hours of life, before significant postnatal weight loss has occurred. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Maternal mortality ratio (per 100,000 live births):** is the number of maternal deaths per 100,000 live births; may also be expressed per 1000 or 10,000 live births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. (WHO, *International Statistical Classification of Diseases and Related Health Problems*). **Old-age dependency ratio:** is the ratio of persons 65 years and above to those in the "economically productive" age group (15-64 years), i.e. the number of persons 65 years and above per 100 persons between 15 and 64 years. **Per capita total health expenditure (international dollars):** is the average amount in international dollars spent per person on health in the country. **Physicians per 10,000 population:** is the ratio of total number of physicians working in the country to the total population, expressed per 10,000 population. **Population density (per sq km):** is the number of persons in the total population for a given year per square kilometer of total surface area. (UN, *2000 Demographic Yearbook*). **Population growth rate (%):** is computed by taking into account the crude birth rate, the crude death rate, and the net international migration rate of a country for a given year. (Rates have been computed as average annual rates of population growth over periods of five years). It is an algebraic sum of the natural growth rate (crude birth rate minus crude death rate) and the net international migration rate, expressed as a percentage. (UN, *World Population Prospects, The 2000 Revision*). **Population with access to adequate sanitation (%):** is the percentage of the population with adequate excreta-disposal facilities that can effectively prevent human, animal and insect contact with excreta. (WHO, *The World Health Report 1996*). **Population with access to safe water (%):** is the percentage of the population with safe drinking-water available in the home or with reasonable access to treated surface waters and untreated but uncontaminated water such as that from protected boreholes, springs and sanitary wells. (WHO, *The World Health Report 1996*). **Pregnant women attended by trained personnel (% of live births):** is the number of pregnant women cared for during pregnancy by personnel trained for pregnancy and childbirth per 100 live births. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Pregnant women immunized with tetanus toxoid (%):** is the number of pregnant women immunized with two or more doses of tetanus toxoid per 100 live births. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Primary school enrolment ratio (females as a % of males):** is the ratio of the primary school enrolment ratio of females to the primary school enrolment ratio of males, expressed as a percentage. **Professional and technical workers (% women):** women's share of positions defined according to the International Standard Classification of Occupations (ISCO-88) to include physical, mathematical and engineering science professionals (and associate professionals), life science and health professionals (and associate professionals), teaching professionals (and associate professionals) and other professionals and associate professionals. (UNDP, *Human Development Report 2002*). **Public share to total health expenditure (%):** is the proportion of government expenditure on health to the total health expenditure. **Ratio of earned income (females as % of males):** is the ratio of estimated female earned income to estimated male earned income, expressed as a percentage. (UNDP, *Human Development Report 2002*). **Seats held in parliament (% women):** is the proportion of parliament seats held by women to those held by men. **Secondary school enrolment ratio (females as a % of males):** is the ratio of the secondary school enrolment ratio of females to the secondary school enrolment ratio of males, expressed as a percentage. **Surface area (thousands of sq km):** refers to the total surface area, comprising land area and inland waters (assumed to consist of major rivers and lakes) and excluding only polar regions and uninhabited islands. (UN, *2000 Demographic Yearbook*). **Total dependency ratio:** is the ratio of persons in the "dependent" ages (under 15 years *plus* 65 years and above) to those in the "economically productive" age group (15-64 years), i.e. the number of persons under 15 years *plus* those 65 years and above per 100 persons between 15 and 64 years. **Total expenditure on health (as % of GDP):** is the ratio of total expenditure on health from all sources to the gross domestic product of the country, expressed in percentage. **Total fertility rate (per woman):** represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children at each age in accordance with prevailing age-specific fertility rates. (UNICEF, *The State of the World's Children 1996*). **Total population (thousands):** is the mid-year estimate of the total population of a country or area as prepared by the Population Division of the United Nations based on their methodology for estimations and projections to provide a consistent series of demographic parameters for every country of the world. (UN, *World Population Prospects, The 1994 Revision*). **Under-five mortality rate (per 1000 live births):** is the number of deaths of children under five years of age per 1000 live births. (WHO, *The World Health Report 1996*). **Urban population (%):** is the percentage of persons living in urban areas. Urban is defined according to national census definitions. The definitions for countries of the South-East Asia Region are presented below. *Bangladesh*: Places having a municipality (pourashava), a town committee (shahar committee) or a cantonment board. *India*: Towns (places with municipal corporation, municipal area committee, town committee, notified area committee or cantonment board); also, all places having 5000 or more inhabitants, a density of not less than 1000 persons per square mile or 390 per square kilometer, pronounced urban characteristics and at least three-fourths of the adult male population employed in pursuits other than agriculture. *Indonesia*: Municipalities, regency capitals and other places with urban characteristics. *Maldives*: Malé, the capital. *Nepal*: Localities of 9000 or more inhabitants. *Sri Lanka*: Municipalities, urban councils and towns. *Thailand*: Municipal areas. For *Bhutan*, *DPR Korea*, and *Myanmar*, no definition of "urban" is available. (UN, *Demographic Yearbook, 1988 and 1993*). **Women of childbearing age using contraceptives (%):** is the number of women of childbearing age (defined as ages 15-49 years) using contraceptives per 100 women of this age group. (WHO, *Implementation of Strategies for Health for All by the Year 2000, Third Monitoring of Progress, Common Framework*). **Young dependency ratio:** is the ratio of children under 15 years to those in the "economically productive" age group (15-64 years), i.e. the number of persons under 15 years per 100 persons between 15 and 64 years.

MDG Indicators: Concepts and Definitions[1]

Prevalence of Underweight Children (under-five years of age) (G1.T2.I4): Proportion of Children of under-five years with low weight-for-age as measured by percentage of children in moderate and severe malnutrition – those falling below 80% of the median weight for reference value or below 2 standard deviations of national or international reference populations, such as growth charts of the US National Center for Health Statistics. (UNICEF). ***Proportion (%) of population below minimum level of dietary energy consumption (G1.T2.I5):*** Since there is no specific data available, proxy indicator "***Proportion of population undernourished***" is used. It is the proportion in percentage of persons whose food intake falls below the minimum requirement or food intake that is insufficient to meet dietary energy requirements continuously. (FAO). ***Under-five mortality rate (G4.T5.I13):*** Probability of dying between birth and exactly five years of age, expressed per 1,000 live births (WHO). ***Infant mortality rate (G4.T5.I14):*** Probability of dying between birth and exactly one year of age expressed per 1,000 live births. (WHO, ICD-10). ***Proportion (%) of 1 year old children immunized for measles (G4.T5.I15):*** The percentage of infants reaching their first birthday fully immunized against measles (1 dose). (WHO). ***Maternal mortality ratio (G5.T6.I16):*** Annual number of maternal deaths per 100,000 live-births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. (WHO, ICD-10). ***Proportion (%) of births attended by skilled health persons: (G5.T6.I17):*** The proportion in percentage of births attended by skilled personnel per 100 live-births. Skilled health personnel refer exclusively to those health personnel (for example, doctors, nurses, midwives) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications. Traditional birth attendants trained or untrained are not included in this category. (WHO). ***HIV prevalence among young people (G6.T7.I18):*** Since the relevant data is not available, the proxy indicator as proposed by UNAIDS/WHO is used. The proxy indicator is "***HIV prevalence among 15-24 years old by sex***" which is the estimated number of young people (15-24 years old) living with HIV/AIDS as per proportion of the same population and sex. These country-specific estimates are expressed as a range generated by regional modeling (UNAIDS). The other proxy indicator is "***HIV prevalence rate among population 15-49 years of age***". ***Condom use in high-risk population (G6.T7.I19):*** Since the data is not available, it has been proposed to use "***condom-use among 15-24 years old by sex***". This is the percentage of young men and women of age 15-24 years, who said that they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months (UNICEF/UNAIDS). ***Ratio of children orphaned/non-orphaned in schools (G6.T7.I20):*** *Since the data is not available, proxy indicator is used as* "***AIDS orphans currently living***" which is the estimated number of children (0-14) in a given year, having lost their mother or both parents to AIDS. (UNAIDS). ***Malaria death rate per 100,000 in children (0-4 years of age)*** **(G6.T8.I21$_a$):** Proportion of children (0-4 years of age) died due to malaria in a given year. (WHO). ***Malaria death rate per 100,000 in all age groups (G6.T8.I21$_b$):*** Proportion of people of all age groups died due to malaria in a given year (WHO). It is malaria crude death rate. ***Malaria prevalence rate per 100,000 population (G6.T8.I21$_c$):*** Proportion of notified or reported cases of malaria per 100,000 population in a given year (WHO). It is malaria crude prevalence rate. ***Proportion (%) of population under age 5 in malaria risk areas using insecticide treated bed nets (G6.T8.I22$_a$):*** The percentage of children under-five years of age who are using insecticide-treated bed nets among the same population living in malaria risk area, in a given year. (UNICEF/WHO). ***Proportion (%) of population under age 5 with fever being treated with anti-malarial drugs (G6.T8.I22$_b$):*** The percentage of children under-five years of age who are with fever being treated with anti-malarial drugs among the same population living in malaria risk area, in a given year. (UNICEF/WHO). ***Tuberculosis death rate per 100,000 (G6.T8.I23$_a$):*** Proportion of people of all age- groups died due to tuberculosis in a given year. (WHO). ***Tuberculosis prevalence rate per 100,000 (G6.T8.I23$_b$):*** Proportion of tuberculosis cases of all age-groups per 100,000 population in a given year (WHO). ***Proportion (%) of smear-positive pulmonary tuberculosis cases detected and put under directly observed treatment short-course (DOTS) (G6.T8.I24$_a$):*** Since the baseline data is not available WHO proposed to use "DOTS detection rate" (WHO). ***Proportion (%) of smear-positive pulmonary tuberculosis cases detected cured under directly observed treatment short-course (DOTS) (G6.T8.I24$_b$):*** Since the baseline data is not available WHO proposed to use "*DOTS cure rate*" which implies treatment success rate that is treatment completion rate and cure rate (WHO). ***Proportion (%) of population using bio-mass fuel (G7.T9.I29):*** Bio-mass fuel is any material, derived from plants or animals, deliberately burnt by human, for example, wood, animal dung, crop residues, and coal. Since the baseline data is not available the proxy indicator is proposed as "***percentage of populations using solid fuels***". (WHO/UNICEF). ***Proportion (%) of population with sustainable access to an improved water source, rural (G7.T10.I30$_a$):*** Since the baseline data are not available, the proxy indicator "***percentage of population with access to improved drinking water sources, rural***" is used. "Improved" water sources mean household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection. "Access" means the availability of at least 20 litres per person per day from a source within one kilometre of the user's dwelling. (WHO). ***Proportion (%) of population with sustainable access to an improved water source, urban (G7.T10.I30$_b$):*** Since the baseline data are not available, the proxy indicator "***percentage of population with access to improved drinking water sources, urban***" is used. "Improved" water sources mean household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection. "Access" means the availability of at least 20 litres per person per day from a source within one kilometre of the user's dwelling. (WHO). ***Proportion (%) of urban population with access to improved sanitation (G7.T11.I31):*** "Improved" sanitation means: connection to a public sewer, connection to septic system, pour-flush latrine, simple pit latrine, or ventilated improved pit latrine. The excreta disposal system is considered adequate if it is private or shared (but not public) and if hygienically separates human excreta from human contact. (WHO). ***Proportion (%) of population with access to affordable essential drugs on a sustainable basis (G8.T17.I46):*** Since the baseline data is not available, the proxy indicator "***percentage of population with access to essential drugs***", which WHO routinely reports for international comparison, is used. Every year, in order to estimate the level of access to essential drugs, WHO Global Action Programme on Essential Drugs interviews relevant experts in each country about the pharmaceutical situation. The interviewees could choose from four levels of access by the population to essential drugs: less than 50%; between 50-80%; 80-95%; and above 95%. They indicate which category is most appropriate for their country. Essential drugs are those drugs that satisfy the health care needs of the majority of the population. (WHO).

[1] The concepts and definitions reproduced from the original sources (in bracket at end of each definition).

Health Situation

in South-East Asia

BASIC INDICATORS 2002

Includes Progress Towards Achieving Health-Related United Nations Millennium Development Goals

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