VOLUNTARY AGENCIES IN HEALTH CARE--NEED FOR A NEW COMMUNITY PARADIGM

- ALOK MUKHOPADHYAY

A Historical Overview

Health care in India has a long tradition of voluntarism. For centuries, traditional healers have taken care of the health needs of their own community as a social responsibility, by using the knowledge, passed on to succeeding generations, of the medicinal values of herbs and plants available around the village. This tradition still continues particularly in the tribal pockets of the country.

This indigenous knowledge went through systematic expression, culminating in the development of more sophisticated but also institutionalised system which led to the evolution of Ayurvedic schools. It also led to monetised heirarchal form of health care where the "Raj Vaidyas" were for the royalty and other Vaidyas for the commoners. But this system became more scientific and holistic. There was also the gradual blooming of a variety of schools: Ayurvedic, Sidha, Unani, and Yoga ~~etc.~~. With the gradual spread of British colonialism, this system was seriously neglected causing incalculable damage.

Unfortunately, the institutionalised voluntarism that evolved during this phase was completely dominated by the thoughts of colonisers, who totally ignored the rich traditional systems of health care in India. This was partly due to the fact that much of this effort grew out of the activities of Christian missionaries. The Indian

...2

elites, who had been partially involved in the voluntary effort during that phase, also firmly believed in the supremacy of everything which came from the West. Consequently, there was little possibility of evolving a health system which assimilated the best of both schools. Perhaps the major exception was Gandhiji's continuous effort to popularise naturopathy, Yoga and vegetarianism through the Ashrams set up in various parts of the country.

Voluntary Health work since Independence

After Independence till the mid-sixties, voluntary effort in health care was again limited to hospital-based health care by rich family charities or religious institutions. In the mid-sixties, the effectiveness of Western curative model of health care in the less developed countries came under serious attack by development planners. The Chinese experience of decentralised health care through effective use of motivated health cadres at the grassroot level also received widespread attention. Out of this rethinking grew various models of community health programmes which emphasised on the decentralised curative service where trained village-level workers would play a key role. Much more importance was given to preventive aspects where the community plays a more effective part in their own health care. ~~There are experiments of this new approach in many parts of the country.~~ Unfortunately, again this refreshing trend also missed the important role of traditional healers and Dais in health care. Very little attention was paid to the Indian systems of medicine.

(There have been described in greater detail in another part of this issue)

Voluntary Health: Types of effort in India today

The voluntary health effort can be broadly classified as follows: into many groups. The key among them are:

i) Specialised community health programmes

Many of them go a little beyond health by running income generation schemes for the poorer communities so that they can meet their basic nutritional needs. Most of them train village level health workers

ii) Integrated development programmes

In these programmes, health is a part of the overall development activity. Consequently their thrust in health care may not be as systematic or as effective as the previous group but the long-term effect of their work on health and development of the community is significant.

iii) Health care for special groups of people

This includes education, rehabilitation, care of handicapped. These specialised agencies are playing an important role keeping in view the fact that hardly any government infrastructure exists in this sector of health care.

iv) Govt.NGOs

These groups play the role of implementing government programmes like family planning, Integrated Child Development Services etc. These services are slightly more efficient than the government system but their overall approach is the same.

v) Rotary Club's Lions Club's, Chamber of Commerce sponsored health work

They usually concentrate on eye camps doing mass-scale cataract operations in the rural areas with the help of various specialists. They also hold specialist camps and often are involved in immunization program

...4

vi) Health researchers and activists

These groups' efforts are usually involved in writing occasional papers, organising meetings on conceptual aspects of health care and critiquing government policy through their journals which have very limited circulation.

vii) Campaign groups

These groups are working on specific health issues e.g., Drug Policy, Amniocentosis etc. ~~Health for All Indian Drug Action Network etc. are examples~~

According to a rough estimate, more than 5000 voluntary organisations are working on above areas/dimensions of health care throughout the country. But the question is, how far are these efforts being able to address themselves to the critical issues of the State of India's Health?

~~Critical Issues in Health: A case of neglect~~

India is bracketed with the poorest and most underdeveloped nations of the world like Mauritania, and Nepal as far as health status is concerned. Also, there is an extraordinary difference between the health status of the people of states of Kerala and Punjab on the one hand and the people of Uttar Pradesh and Bihar on the other. The health status in Kerala and Punjab can be compared with some of the developed countries and UP, Bihar, MP and Rajasthan can be termed as among the worst anywhere in the world. Major causes of the current impoverished State of Health in India can be attributed to the following factors:

1. Inaccessibility of food

In a country which boasts of 26 million tonnes of foodgrain reserve

...5

in a good monsoon year, 40 percent of the people go without minimum nutritional requirement. We still go through the annual cynical debate--whether the people in drought stricken Kalahandi (in Orissa) are dying due to starvation or gastroenteritis. Every year the government increases the salary of its employees to protect them from the impact of inflation, but the effect of price rise of essential commodities on the lowest paid citizens in the country--the wage labourers--hardly receives any attention.

According to the available statistics, the production of coarse grain mainly consumed by the poorest sections has stagnated as the green revolution has shifted to rice and wheat. Pulses are often the only source of protein for the poor, but the percentage of growth to the total output is half of what it was in 1950, and the per capita availability of pulses has halved from 1960. Milk is more easily and cheaply available in Delhi than in the places 400-1000 km away from where it is produced.

Except for isolated efforts of helping a handful of families to increase their income through economic development programmes, the voluntary agencies working in health care have played only a marginal role in the critical issues that will ensure land reform, minimum wage, low cost rationing for the poor or poor people's need oriented agricultural policy. Similarly, occupational hazards which affect the health of millions working in the unorganised sector hardly receives their attention.

Without major effort in these key areas, appreciable change in the health status of the people is not possible.

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2. Lack of safe drinking water

On the eve of the Eighth Five Yar Plan, 227 lakh villages do not have assured potable water supply within 14 km of the village. Again in the critical area of safe drinking water supply, the effort of voluntary organisations has remained limited to a few pockets. Most health organisations do not take this as an important ingredient of their work though the vital link between good health and accessibility to safe drinking water does not need much elaboration.

Sanitation is a problem which we are yet to grapple with effectively even in our big cities, not to mention rural areas. The recent major epidemic of gastroenteritis and cholera in many parts of the country is an indication of current environmental sanitation situation.

3. Inappropriate health systems and services

Currently three-fourth of the health budget is poured into expensive specialist services benefitting less than one-fourth of the population. The existing government primary health services in rural areas, which is barely functional in some places, is totally defunct in most places. This is due to shortage of resources, lopsided priorities, devastating pressure of family planning target-chasing, lack of motivation among the functionaries. There is hardly any participation of the people in health care delivery.

In this broad area, voluntary agencies have played a significant role in developing alternative "models", as well as providing low-cost and effective health services in many parts of the country.

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They have been able to develop village based health cadres, educational material and appropriate technology. They also fill the critical gaps that exist in the government health services.

However
These "models" are far from perfect; they fail to possess the conditions of replicability by the government sector. On the other hand, the vastness and regional diversities that characterise India also make it extremely problematic to think of replication or standardisation of "models". In fact, it is being increasingly acknowledged that the term "model" itself, when applied to people's health care systems, is suspect. There can be no prototype as such. An appropriate system should evolve from the people themselves. Just as health conditions emerge from the community's interaction with its surroundings, it is the people's struggle through time that also determines the nature of the services that they get.

increasingly being
It is also recognised that the task of formulating a "model" or an appropriate, responsive system of health care becomes a highly challenging managerial, sociological, technological, epidemiological and political task which, if simplified down to current level of health planning, will produce imperfect results. ~~After all, the~~ In this regard
~~The addition~~ is not very ~~only a subtle~~ difference from the government in ~~this~~ that
many of them have
~~regard, of~~ having preconceived ideas, ~~a lot of money and~~ little sure knowledge of the dynamics of community health, ~~coming~~ to and a lot of money
Therefore
"mess around" in communities. Genuine "models" of community-based health care are hard to find. Services

The entire concept of "participation" currently in vogue is another problem. In the view of the establishment, for whom anything ultimately referring to empowerment of people is hard to accept, the term has been subverted to mean compliance, contribution or collaboration. In its true sense and implications, participation leading to empowerment stands directly in challege to the interests of the establishment.

The effect of community-health experiments in shaping government policy in health care has been limited although few of the concepts have been incorporated in the government programmes. Also, some voluntary agency representatives have been absorbed in government policy-making bodies. This is an critical area totally neglected by voluntary agencies. Many These voluntary initiatives are not necessarily in the area of extreme needs. One finds very limited voluntary initiatives in the BIMARU states (Bihar, Madhya Pradesh, Rajasthan, UP and Andhra Pradesh) as compared to better off states like Kerala. Even in Kerala, they are not necessarily in the least developed parts of Malabar coast or Highlands.

~~There are hardly any efforts in forming the public opinion or mass organisation like trade unions, people's movement or political bodies in generating a demand for a more appropriate and effective health service.~~ In spite of these limitations, the voluntary health organisations have contributed ~~most~~ a great deal in providing appropriate health services in needy areas.

4. Building up a rational and scientific attitude towards health

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Pharmaceutical industries have successfully promoted "Pills, injections, tonics" as health. In rural India today, patients do not feel satisfied by a treatment which does not include an injection. Similarly in Kerala the consumer demand for specialists and Catscan for any ailment is reaching unbelievable proportions.

Except for Kerala Sastra Sahitya Parishad in Kerala, there are few good large-scale efforts at demystifying medicine among the people. The effort of specialised campaign on drug policy, anti-smoking, amniocentosis has had some limited impact, both at the policy level, and in educating the consumer.

Besides their functional differences, the health groups are divided according to ideological grounds, according to being foreign or locally funded, whether following traditional or modern medicine and along many other groupings and sub-groupings. Most of these groups are dominated by a group of elite which meet, nationally or internationally, express concern and share information but which do not have any mechanism for transferring this information to either the common people or social activists who might be able to use this in their struggle. To this elite, even Paramedics and village health workers are mere functionaries and not agents of change.

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If we in the voluntary sector are seriously concerned about these critical issues in Health than many new challenges and needs have to be met

Conclusions

Given the above situation, besides their current activities the health organisations need to face the challenge of:

* Joining in the broader struggle of social justice with other progressive forces.
* Working on critical issues of socio-economic justice in the areas where they operate.
* Understanding of macro level health plan and working towards a viable alternative health strategy.
* Building up general awareness on rational and holistic health care among the public at large so that an atmosphere can be created for policy shift.
* Helping to broaden the horizon of health functionaries on development issues so that they can fulfill their public responsibilities effectively.

This major shift of focus will put them in a position of conflict with the state, medical establishment and medical industries. Given the background, origin and mandate of most health organisations, how many of them will be able to stand up to it?

28.12.88

Community Health Cell
No 47/1 St Mark's Road
Bangalore 560 001

13 NOVEMBER 1989

Dear

Greetings from CHC!

The last meeting of the Community Health Forum held at Vidyadeep on 5th September 1989 ended inconclusively. It was our impression that every member present did perceive some advantages in being associated in such a Forum and was reluctant to let it fade away. However there were differing perceptions regarding the goals and functioning of the Forum and the individuals' role in it.

We think active pondering is needed by all of us to evolve the characterstics of this Forum that will accommodate our varying needs and experiences.

We are circulating a set of questions that may trigger off such thinking. Will you send back your replies by the last week of November 1989. The replies could become the basis for concrete thinking on the future of the Forum on our next forum meeting, which is most likely to be held on 11th December 1989

Yours sincerely,

Vanaja Ramprasad

Drs Mani Kalliath and
Vanaja Ramprasad

A Report from Kerala
Basic Health Communities

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57

Fr Edwin MJ

CATHOLIC HOSPITAL ASSOCIATION OF INDIA

CONVENTION 1988

COMMUNITY NEEDS - OUR RESPONSES

Fr. Edwin M.J.

I'm asked to speak on community needs and our responses.

I should say the primary need of community health is community itself.

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

It would seem ~~labouring the~~ obvious ~~to say~~ 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.

Let us begin with the question: ~~Do we have communities~~?

~~We need to precede this with yet another question.~~ What is a community? Or: What are the characteristics that make a mass of people into a community?

Community is a much-abused word. While conducting a course on reporting for foreign press, Fr. Michael Traber of World Association of Christian Communicators observed: "People abroad don't get what you mean by 'community' in India". Communities for us mean castes too! Evidently, this is not what we mean!

We need to have consensus of what we mean by community when we speak of community health.

~~A Community, what it could be?~~

Let us list some of the guiding principles.

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".

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".

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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 explicitely 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 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.
   A community with more than thirty families is unwieldy and too big for the small man to handle.

10. A community that intends to have wider macro level in 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? ~~Do our projects, programmes, plans and policies facilitate such community Health~~

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~~- Fr. Edwin MI( )~~

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.

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. What we envisage is a combination of the Basic Christian Communities' concept of Latin America and what we read about Raigarh Ambigapur Health Association (Raha).

Basic Holistic Health Communities — A Report from Kerala

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 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, reach 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 fee to spend on his own discretion upto Rs.50/- for emergency expenses. When the president and the treasurer decide together they can spend upto Rs.100/-. The executive committee of the village can spend upto Rs.500/-. The representative general body of the village, having five representatives each from the communities,

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can spend upto 1,000/-. If it is more than Rs.1,000/- 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.

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 will be 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 includes also an exhibition and also half-a-day or one-day seminars to various categories of people with or without 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.

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,

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showed that the average amount was Rs.4,086/-. We will be able to reduce this to just Rs.500/- 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.

We feel the situation is ripe because (1) the diocese is going all out to build basic communities, (2) we have already a network of primary health care system through the Community Health Development Programme of Kottar Social Service Society and (3) our Sisters running hospitals in the diocese are actively involved in the programme and are ready to make their hospitals available as referral centres.

Unfortunately, even the example given is not yet a realized 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 step in the right direction.

Fr Edwin MSJ ( )

Because, besides the reasons given above, it will (1) initiate an on-going health communication effectively aimed at change, (2) will create an alternate structure for people's participation.

Let me speak a little about its efficacy as a communication process.

Communication researchers tell us that the media by themselves do not bring about major changes. To quote Joseph T. Klapper who summarises the conclusions of the various researches conducted on the efficacy of communications in his book "Effects of Mass Communications". "Minor attitude change appears to be a more likely effect than conversion and a less likely effect than reinforcement". Media help actually more to reinforce than to change!

Various reasons have been adduced to explain this inefficacy of the media.

One thing, people avoid messages that are uncomfortable, and changes are uncomfortable! This makes people go through the various filtering processes like selective exposure, selective perception, selective decision-making, selective implementation etc.. and even if they manage to implement there's the problem of congnitive dissonance, the tension that follows major decisions that makes one revert to the earlier position.

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There are also quite a lot of pressures like those of culture, opinion leadership and primary groups that militate against change.

Culture, to begin with, is the way people behave. Parts of any culture is so interlinked that when you touch any part the whole thing seems to shake, creating insecurities among the people and thus conditioning them against change.

People depend on the above-mentioned opinion-leaders as they don't have either the leisure or the energy to come to conclusions by themselves. The problem is that such opinion leaders as inspiring security among the people are the last to accept a change.

Primary groups too exert pressure because people value the relationships so much that they hesitate to go against the values cherished by the groups.

Fortunately the communication pundits are offering a way out of the problem that would with stand the filters and pressures mentioned above. The solution: group media.

That is, communication aimed at groups. For us, health communication, through groups at discussion.

The interpersonal relationship in groups supplements for the inadequacies of the media.

Well, communities don't go the full length in every aspect with regard to the efficacy of small groups at discussion in effecting changes. For examples, a smaller group can go faster and deeper into a problem while a community of the size we envisage might take a little more time.

But there are aspects where the communities have advantages that outweigh those of the groups.

An advantage that a basic community shares with a group-at-discussion is the strength of interpersonal relationships.

An exclusive advantage of a basic community is that a community creates an environment of new values much more easily than a group. Someone compared a small discussion group to a hot kettle kept in an air conditioned room. The environment cools the enthusiasm. Basic community on the other hand increases the warmth of the entire room.

Another is that, unlike a small group, it has better chances of effecting permanent alternate structures.

Permanent structures are a requirement for sustained action. When the leftist revolution broke out in the sixties in Paris, a politician cooly remarked: "Revolution? We don't bother. But we will be concerned if they create an alternate structure". Revolution will fizzle away, but structures will remain.

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This has also political over tones as health issue is political too. We may be able to transcend the present democratic system where the big throats with big money manage to reach out to the length and breadth of big constituencies and eventually represent the interests of the big.

Religion wise, too, these basic holistic health communities could gradually help to bring about grass-root interreligious dialogue and joint action on the issues of the Kingdom.

Last but not least, a good many of our dedicated personnel who apply for funds to build hospitals to serve the poor and, just forced by the sheer necessity to maintain the hospital and the staff, end up serving the rich, will now be able to serve the poor a little more as people themselves will be maintaining these items.

Well, these are some of the needs of community health.

Our response?

Role of Hospitals in Community Health Care

Dr S Joseph MD
Medical Superintendent
MGDM Hospital, Kangazha
Secretary National Voluntary Health Association of India.

(Presented at the convention, with the help of visuals to substantiate the steady progress of different stages of growth in the quest to attain the goal of need/value based and relevant Health Care — From hospital care to Health Care)

As I am neither an expert in Community Health nor a person dedicating full time to community health work, instead of presenting concepts and logistics relating to community health, I shall share our own experience over the past 22 years of working in a rural community hospital in central Kerala. During this period we have been an integral part of the life, growth and diversification of the programmes of the M.G.D.M. Hospital at Kangazha.

Phase I — High Technology Headstart

The M.G.D.M. Hospital was founded by the Late Shri P. Gee-Varghese whose vision, benevolence and conviction, that man is only a custodian of God's resources, led to the founding of this institution. His goal was to bring the benefit of modern medical care to rural India and thus he chose the remote location of Kangazha, where no health facility existed. The programme started as a wayside dispensary and then moved on to the location where the institution now stands. In late 1967, four postgraduate doctors, two doctor couples, one being us, joind Shri P. Gee-Varghese in this endeavour. The hospital was then being manned by one doctor who continues to be on the team, presently as Chief of Opthalmology.

Between us we had the skills to carry out major cardiothoracic/general surgical work and offer the infrastructural support. In the space of 3 years the hospital grew to be a 150 bedded one, offering by then prevailing standards, high techology services like closed heart surgery, lung and oesophagus surgery, endoscopy etc. At the end of three years when one doctor couple moved on to another mission hospital, the occasion arose for an introspection and the following findings were arrived at:

Status of the Hospital
150 bedded hospital offering high tech curative services attracting patients from surrounding towns.

Problem
The Hospital infact was an island of urban high tech medical care in a thoroughly rural setting without real relevance to the rural population that it really sought to serve; many, if not most patients came from the surrounding towns.

Solution
To innovate medical programmes relevant to the health needs of the rural people.

Phase II — Hospital Based Community Extension work

For the next five years several ideas were considered within the limits of the constraints, aimed at reaching out to the rural marginalised section of the community. Hence hospital based community extension work was started in the form of village level general clinics and mother and child clinics, thus bringing the services of doctors/ specialists to those who could ill afford such services. To this was added community free eye camps with free follow up surgery in the hospital.

Status of the hospital
200 bedded speciality referral hospital.

Problem
Community extension work had limited coverage of the sick, who are poor. No programme for 'Health Promotion' of the masses, for enabling themselves to remain healthy. Causes of illhealth appeared closely linked to poverty and backwardness.

Solution
To initiate a study of the true health problems of the community and to offer comprehensive community based health care.

Phase III — Community based services

With a 6 month pilot study of the community it became clear that poverty was the cause of much illhealth and an integrated development approach was necessary to promote health in the community.

In January 1978 antedating the Alma Ata declaration, a comprehensive integrated community based health programme was launched in six villages covering 500 families in each village, based entirely on socio-economic backwardness and cutting across all barriers of religion, caste and creed. Several economic upliftment programmes were launched in areas of agricultural promotion, availability of credit, veterinary inputs, and seed money scheme etc besides hygiene, environmental sanitation, health education, mother and child care, tuberculosis control programme, basic curative service etc. This was achieved through community participation, utilising a three tier approach. School health programme was launched covering 34 schools. This model of school health programme won wide acceptance as a low cost model, which harnessed the obtaining resources of teachers/ pupils as facilitators.

This integrated health and development approach stood fully endorsed by the Alma Ata declaration which was published by end of 1978.

Status of the hospital
225 bedded speciality hospital with update of technology to cover all basic specialities.

Problem
Though the validity of the community based participatory integrated health and development approach was established, the impact of this was limited to a small population. The dimension of rehabilitation in the primary health care approach of health for all (HFA) remained largely untackled, except for monetory assistance to a few physically handicapped for establishing small trade.

Solution
Instead of a direct exclusively institutional programme (going it alone), to Network with like minded health/developmental agencies in the field, so that benefit reached a far greater population and would avoid duplication while reducing costs

Phase IV — Networking

Thus emerged the concept of networking with other agencies to achieve greater cost effectiveness, cooperation between voluntary agencies and to relate to Govt sponsored National Health Policy Programmes.

The first networking was established with 13 different agencies, both religious and secular in implementing a Preservation of Eye Sight Programme, much in line with the National Programme for prevention of blindness. The strategy was to work through trained village level health workers, supported by field level and institutional backup supervisory/specialists services.

Status of hospital
250 bedded referral hospital offering all speciality services except the superspecialities.

Problems
Though the strategy was cost effective much effort required to be expended on developmental inputs which became increasingly available indigenously over the years. The need to integrate the programmes offering preventive, promotive, educative, curative and rehabilitative (community based) was felt. Much wider programme coverage was required to increase cost efficiency.

Solution
To launch a complete HFA programme including all dimensions, as stated in the Alma Ata declaration.

Phase V — Full 'HFA' coverage

A full HFA programme was launched in 1987 networking with well established lead agencies such as the Malanadu Development Society, Peermade Development Society besides Bethany Perunad, Young Workers Movement at Pulinkunnu etc. This project is entitled PRACHAR (Programme for Rural Awareness in Community Health And Rehabilitation)

It presently covers a population of 1,50,000 and the community based rehabilitation is achieved through five stages of intervention. As most workers in the health field are still none too familiar with the concept of CBR, we shall consider this particular input in greater detail. CBR is carried out in 5 Stages

Stage — I
Prevention of disability through Vitamin A prophylaxis, nutrition education, antenatal care, primary eye/ear care etc and identification of the physical, hearing, visual and mentally handicapped, through the services of trained village level workers, working in their own communities. These workers were appropriately trained by Project 'PRACHAR'

Stage — II
Assessment of the nature, degree of disability through trained CBR supervisors and specialists in the four disciplines related to disability and planning the rehabilitation course, at field level clinics to be organised in nearly seventy locations.

Stage — III
Those requiring institutional curative/corrective services are given free care in MGDM hospital. Besides surgical correction, artificial aid, hearing aids, spectacles, low vision aids, speech therapy, psychotherapy and physiotherapy are offered in the institution. Those requiring permanent institutional services on account of gross multiple handicap are facilitated to achieve this at established centres for the handicapped.

Stage — IV
Reorientation of the disabled in the community enabling the person to achieve daily living skills/vocational rehabilitation, mobility training, mobilising family/community resources. The process is facilitated by village level workers and trained CBR supervisors. For economic rehabilitation locally available monitoring resources are fully mobilised.

Stage — V
The disabled are sought to be fully integrated and made self reliant with the active participation of the family members and local community.

The expertise of hospital specialists is thus utilised to bring relief to the handicapped who cannot normally afford these services. Specially trained supervisory staff carry out the community based rehabilitation of the handicapped aimed at integrating them fully with the community. The programme also envisaged a comprehensive monitoring and evaluation input, thus preparing the ground for future fuller cooperation with the Government sources, hopefully working towards an equal partnership with the government sharing all resources. This would be necessary to achieve self reliance and non-dependance on outside funds as an intermediary goal.

In the past year, 573 handicapped people were identified, who are presently receiving rehabilitative services at different stages of the process.

Over the past two decades, there was a proportionate growth of the vertical dimension curative care programme alongside the horizontal community health programme thus achieving a balanced growth without prejudice to either. While the curative care could be construed to be one where 'Mohammad came to the mountain', in the community level services 'Mountain went to Mohammed'. It was not a question of either curative or community based services, but was both and other ancillary intersectoral services largely mobilising available resources, to achieve the larger goal of 'Health for All'.

These efforts can at best be judged as attempts by a traditional hospital structure to take on its share of responsibility in achieving the National Health Policy goals, in promoting the cause of 'Health for All', and above all in attempting to realise in some measure our preferential option for the marginalized section of the community in our christian stewardship mandate. Undoubtedly, many other possible modes of contributing to these goals remain unexplored, but suffice it to say that if all of us as hospitals do pursue the mandate seriously, even though, HFA may not be attained by 2000 AD. in the rest of the country, there is indeed a bright prospect that the goal could be realised in the State of Kerala, where voluntary hospitals abound.

Should we rise to the occasion, we may well hope to witness the dawn of a new era where 'Health' with Equity and Justice will no more remain an elusive dream.

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 suffering. 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 poor 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 ccoperated 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.

Com H 16.5

(A note to Health Action Team in Secunderabad)

Health Action

July 1989

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

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

a. Health Development in India
b. Taking Stock of this development
c. Health seene in 80s
d. Alternative Community Health Project phenomena
e. Recognising the new paradigm
f. Community Health and Primary Health Care
   i. Vs PHC ii) Role of Hospitals iii) Movement dimension
g. Community Health - Issue Raising
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 six resource people which have been edited for issue.

a. Alok Mukhopadhyay - VHAI
b. Fr Edwin - Kerala
c. Dara Amar - St John's
d. Jacob Cherian - Ambilikkai
e. Anant Phadke - mfc

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f. Abhay Bang - SEARCH

An article by S Joseph in the CHAI Hospital Convention Proceedings on the same theme (refer page 29-31 of proceedings) can also be used, a copy of which is enclosed.

3. The CHC is also putting together the following as a Community Health Resources inventory

a. 50 titles from the Community Health ferment

b. A list of journals and bulletins

c. Some profiles of health projects

d. An address list of all projects/initiatives mentioned in the issue.

e. A reference list for the lead article

(Throughout the lead article the source is shown as the name of the author or group with a number in the bracket which pertains to number in reference list)

4. For visuals to animate the issue we suggest that one could take liberally from the many publications mentioned in the list giving due credit, e.g

i. Cartoons in mfc anthologies (11, 12, 13 of title list)

ii. Photographs and diagrams from Anubhav series (Ford Foundation) (46 of list)

iii. Line drawings from 'Taking Sides' (31 of list)

iv. VHAI- Health Worker Training Kit and Better Care Series (14 and 19 of list)

v. CHAI Publications (30 and 32 of list)

5. For Cover page

We suggest a collage made out of the most striking of the title list - striking in photography or title, e.g Anubhav series interspersed with mfc, VHAI, CHAI, ISI, Lok Paksh, CSA, CSE Report Publications etc.

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6. To symbolise diversity and the Indian experience we suggest maps of India with stars in locations of projects, training centres, research centres, issue raising groups etc. Either one or two large maps in the text or small ones throughout.

7. A set of additional 'Fillers' items have also been included. They could be introduced if space is available somewhere along the line.

8. We have indicated with lines only some ideas for box items or underlining, making bold or italics etc. However the Health Action Team in Secunderabad are more experienced and better qualified to do this effectively. We leave this aspect completely to their own judgement since their skill is well exemplified in previous issues.

for CHC team

VIVEKANANDA GIRIJANA KALYANA KENDRA

B.R. Hills, Mysore Dist. Karnataka

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

By building peoples organisations ~~take~~ – the 'Soliga Abhivruddhi Sanghas', ~~the~~ external distortive influence on Tribal Culture is minimized, and developmental activities include Community Organisation, Education, Adult Education, Cottage Industries, Vocational training, Agriculture, Housing and Cooperatives in liaison with the Government and other agencies.

The health aspect was initially curative and has progressed into community health, with Immunization, Village Health Workers, Traditional Birth Attendants (trained), 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 program, while innovations include the introduction of use of Acupressure as a tool in the hands of Village Health Workers.

ST. XAVIER'S SOCIAL SERVICE ORGANISATION – Ahmedabad (Gujarat)

A voluntary agency working in the slums of Ahmedabad in areas of Community organisation through 'Pragatu Seva Samiti' and 'Jagruthi Mahila Mandal'. Their economy generating activity is by Promoting skills in Garment & Quilt making, Electronics, Masonry, plumbing etc., while strengthening areas like Poultry, Agarbathi making, Kite making and screen printing industry already existing there.

The health component is delivered by

Community Health Workers in areas of Nutrition, Antenatal care, Infections diseases and family Planning methods by a locally evolved training programme. Health Education has been accorded prime importance.

SOCIETY for EDUCATION, WELFARE and ACTION - RURAL

S.E.W.A. - Rural - Jhagadia, Gujarat.

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

The delivery of health services is through a 4-tiered infrastructure, with the CHVs, AWWs, TBAs at community level, MPWs at tertiary level, Mobile Dispensary with M.O. & MPWs at Middle Level and a fully equipped referral hospital with consultants and para medical staff at the Central level.

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

Activities in non health areas include Gramin Tekniki Kendra, Tuteco Tutorial classes for Tribal boys and Girls and Economic Programs for women.

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o COMPREHENSIVE HEALTH & DEVELOPMENT PROJECT - Pachod Aurangabad dt. Maharashtra

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

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

o. CHILD IN NEED INSTITUTE - 24 Paraganas, W. Bengal

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

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

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

- RURAL UNIT FOR HEALTH AND SOCIAL ACTION
  -K. V. Kuppam Block, Tamilnadu.

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

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

Collective leadership models are seen in Village Advisory Committees, Block Development committees, Womens groups, Young Farmers clubs and socio-economic groups with similar occupations.

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

- ACTION for WELFARE and AWAKENING in RURAL ENVIRONMENT (A.W.A.R.E.) - Andhra Pradesh (Telangana)

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

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

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

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

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

- Father Hospital Community Health Project.
  Betul district, Madhya Pradesh
  A comprehensive health care programme as an outreach of a mission hospital with credibility in local area. The components included training of village health workers, training of dais, health education, provision of

immunization, minor medical care and family planning care. Non formal education in literacy, agriculture and hygiene & health were also included. The health workers are supervised by a mobile community health training team.

Mallur Health Cooperative, Sidlaghata Taluk (Karnataka)

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

Rehbar-I-Sehat programme, Kolhahalwal block, (Jammu & Kashmir)

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

Profiles of Initiatives

- **Banwasi Seva Ashram, Mirzapur Dist (Uttar Pradesh)**

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

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

- **Rural Unit for Health and Social Affairs. K.V. Kuppam block (Tamilnadu)**

o STREE HITAKARINI: Bombay's slums.

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

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

o K.E.M. HOSPITAL RURAL HEALTH PROJECT, Pune Dist. (Maharashtra).

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

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

o Bamnasi seva Ashram — as noted by R.N.

• COMPREHENSIVE LABOUR WELFARE SCHEME of V.P.A.S.I. - plantations of Tamilnadu & Kerala.

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

Voluntary 'LINK WORKERS' form the key element in Health education and linking the community to the health services consisting of Maternity & Child Health, Family Planning, Environmental Sanitation, Safe drinking water supply and Health education programme

• MINI HEALTH CENTRES PROGRAM OF VOLUNTARY HEALTH SERVICES : Chinglepet Dt. Tamilnadu.

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

This is now adopted Statewide as a model.

Community Health in Tribal belts

The Nilgiri Adivasi welfare Association
Founded in 1958

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

The Social work and Research Centre (SWRC) Tilonia

The SWRC started community health programmes in Feb 1973, with extensive community contacts, conscientization of people regarding the need for basic health care thereby creating a demand within the community for the services. A dispensary was started and village level health workers were selected by the respective communities and trained at the centre. The villagers meet the salary of the VHWs and a part of medicine expenses. The approach to community health programme included (1) dissemination of

skills to the lowest possible level (2) involve available semi skilled, skilled and unskilled resource personnel in the community (3) awareness building programmes (4) incorporation of health into the farmer's way of life (5) use of the services of professionals in the city whenever and wherever required and (6) participation of the community in all the programmes — supervision of VLWs; meeting certain expenses etc. The local DAIs are involved in the programme selection of items being as in the case of VLWs. The SWRC uses Balwadis, craft classes for women and Non-Formal literacy centres for reaching out to women and teenage girls. The medical team of SWRC visits each village every 15 days. In the school health programme primary school teachers are involved. The SWRC works with the govt supplementing the services wherever necessary. Indegenous medical practitioners in the locality are also involved in the programme.

AROGYA VIKASA, Bangalore (in Shimoga)

In this project, main emphasis is on health promotion and preventive care while the provision of curative services incidental. People's participation occupies a central place in this project. Health promotion through awareness building process — using audio visuals; group discussions, periodic lectures; conducting health exhibitions and family welfare activities. In order to improve community harmony promotion of positive mental health is given importance. In the area

of preventive ~~health~~ care, immunizations programmes early detection of communicable diseases and extending her help in the event of outbreak of epidemics etc are ~~being~~ undertaken. Health promotors – male and female – chosen from the respective villagers are ~~trained~~ given orientation orientation course and field training. Health Education materials in the regional languages are prepared using the already existing manuals prepared by other agencies Arogya vikasa has a ~~Resource Centre~~, Library and a Publication wing

Medicare, Kasturba Medical College, Manipal

Rural Maternity and child welfare Home. Seven Centres, with 6 beds each, with supporting faculty for delivery, at a distance of 3 to 20 miles from the hospital are run. A team from the hospital visits each centre once a week. Intensive health education; Safe water supply and Sewage disposal with the help of Panchayat Immunization Programmes, pest control measures; and family welfare programmes are undertaken apart from a comprehensive medical and dental health care scheme.

Tamulpur Block, Kamrup Dist

Total Health Care Project, Assam

Started in 1976 covers a population of 1,33,000 in 204 villages of the Block consisting of tribal and other backward Castes

Activities of the project include provision of various basic health services, like family planning, Immunization, attending to minor ailments, control of tuberculosis, leprosy and malaria etc.

Com H16.7
57

Community Health

A Resource Centre Directory A to Z

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

1. Asian Community Health Action Network (ACHAN)
   No 61, Dr Radhakrishnan Road, Madras 600 004.
2. All India Drug Action Network (AIDAN)
   C/o Voluntary Health Association of India, 40 Institutional Area, South of I I T, New Delhi 110 016.
3. Action Research in Community Health (ARCH)
   At & P.O Mangrol, Via Rajpipla, Dist Bharuch, Gujarat 393 150
4. Arogya Vikasa
   Keshava Shilpa, Kempegowda Nagar, Behind Uma Theatre, Bangalore 560 019.
5. Action For Welfare & Awakening in Rural Environment (AWARE)
   5-9-24/78, Lake Hill Road Hyderabad 500 463.
6. Banwasi Seva Ashram
   Govindpur, Dist Mirzapur, Uttar Pradesh
7. Bodokhoni
   C/o Fr Chako, Diocese of Behranpur, Ganjam District, Orissa

Please check correctness of the address

8. Catholic Hospital Association of India (CHAI)
   Post Box 2126, 157/6, Staff Road, Secunderabad 500 003.
9. Christian Medical Association of India (CMAI)
   Smruti Theatre Compound, Mount Road Extension, Nagpur 440 001
10. Christian Fellow Community Health Centre (CFCH)
    Santhipuram, Anna District, Ambilikkai 624 612, Tamilnadu.
11. Community Health Cell (CHC)
    No 47/1, St Mark's Road, Bangalore 560 001.
12. Centre for Social Action (CSA)
    Gundappa Block, 64, Pemme Gowda Road, Bangalore 560 006.
13. Comprehensive Labour Welfare Scheme of United Planters' Association of Southern India (CLWS-UPASI)
    Glenview, Coonoor 643 101, Nilgiris, Tamilnadu
14. Child in Need Institute (CINI)
    Vill Baulatpur, P.O. Amgachi, Via Joka, 24 Paraganas South, West Bengal 743 512
15. Centre for Science & Environment (CSE)
    807 Vishal Bhavan, 95 Nehru Place, New Delhi 110 019.

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16. CSI Ministry of Healing
    10 Sambandam Street, T.Nagar, Madras 600 017
17. Deenabandu
    Training and Service in Community Health & Development
    R K Pet 631 303, Tamilnadu.
18. Foundation for Research in Community Health (FRCH)
    84-A, R G Thandani Marg, Sea Face Corner, Worli Bombay 400018
19. Indian Council of Medical Research (ICMR)
    Ansari Nagar, Post Box 4508, New Delhi 110 029
20. Indian Council of Social Sciences Research (ICSSR)
    IIPA Hostel, Indraprastha Estate, New Delhi 110 002
21. Indian Institute of Education
    128/2 Karve Road, Kothrud, Pune 411 029
22. Institute of Health Management (IHMP)
    Pachod, Dist Aurangabad 431 121, Maharashtra
23. International Nursing Services Association, India (INSA)
    No 2 Benson Road, Benson Town, Bangalore 560 046
24. Indian Social Institute, (ISI)
    10 Institutional Area, Lodi Road, New Delhi 110 003
25. Jawaharlal Nehru University (JNU)
    Centre for Social Medicine & Community Health
    New Delhi 110 057
26. St John's Medical College & Hospital (SJMC)
    Sarjapur Road, Bangalore 560 034.
27. K.E.M. Hospital
    Sardar Mudliar Road, Rasta Peth, Pune 411 011
28. Kottar Social Service Society (KSSS)
    Post Box 17, Nagercoil 629 001, Kanyakumari District.
29. Kerala Sashtra Sahitya Parishad(KSSP)
    Parishad Bhavan, Chirakulam Road, Trivandrum 695 001 .
30. Lokvidyan Sanghatana
    759/97 D, Santibhuban, Prabhat Road Lane No 2,
    Deccan Gymkhana, Pune 411 004

30 a (see Page 3)

31. Mallur Health Cooperative
    Siddhalaghatta Taluk, Mallur, Kolar District, Karnataka
32. Medicare
    Kasturba Medical College, Manipal, Karnataka
33. Medico Friend Circle (MFC)
    Village Devgarh (Deolia), Via Partabhgrah, Dist Chittorgarh
    Rajasthan 312 621

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34. MGDM Hospital
    Devagiri PO, Kangazha, Kottayam 686 555, Kerala
35. Ministry of Health and Family Welfare (MHFW)
    Government of India, Nirman Bhavan, New Delhi
36. National Institute of Health and Family Welfare (NIHFW)
    New Mehrauli Road, New Delhi 110 067
37. The Niligiri Adivasi Welfare Association (NAWA)
    Fair Glen Annexe, Kota Hall Road, Kotagiri, Nilgiris 643 217, T.N
38. The National Institute of Mental Health & Neurosciences (NIMHANS)
    Hosur Road, Bangalore 560 029.
39. Padhar Hospital Community Health Project
    Betul Dist. Madhya Pradesh
40. Rural Unit for Health and Social Affairs (RUHSA)
    RUHSA Campus.P.O, Christian Medical College & Hospital,
    North Arcot District 632 209, Tamilnadu
41. Raigarh Ambikapur Health Association (RAHA)
    C/o Bishop's House, P.O Kunkuri, Raigarh Dt. Madhya Pradesh 496225
42. Society for Education Welfare and Action-Rural (SEWA)
    Jhagadia 393 110, Dist Bharuch, Gujarat
43. The Social Work and Research Centre (SWRC)
    Tilonia, Ajmer District, Rajasthan 305 812
44. Socialist Health Collective (SHC)
    Bombay
45. Streehitakarini
    Dadar, Bombay
46. Vivekananda Girijana Kalyana Kendra (VGKK)
    B R Hills 571 313, Via Chamrajanagar, Mysore Dt.
47. Voluntary Health Services (VHS)
    V.H.S Campus, Adyar, Madras 600 020
48. Voluntary Health Association of India (VHAI)
    40, Institutional Area, South of IIT, New Delhi 110 016

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30 a. Lok Paksh
Post Box 10517, New Delhi 110 067

45 a. Society for Education, Awarenes and Research in Community Health (SEARCH)
At P.O Gadchiroli, Maharashtra 442 605

Journals/Bulletins

1. Health for the Millions
   Voluntary Health Association of India,
   40, Institutional Area, South of IIT, New Delhi 110 016

2. medico friend circle bulletin
   MGIMS, Block 'B', Vivekanand Colony, Sevagram, Wardha 442 001,
   Maharashtra

3. Socialist Health Review (Now known as Radical Journal of Health)
   19, June Blossom Society, 60 A, Pali Road, Bandra (West)
   Bombay 400 050

4. Contact
   Christian Medical Commission, World Council of Churches,
   150, route de Ferney, 1211 Geneva 20, Switzerland

5. FUTURE
   UNICEF, 73 Lodi Estate, New Delhi 110 003

6. LINK (ACHAN Newsletter)
   Asian Community Health Action Network, 61 Dr Radhakrishnan Road
   Madras 600 004.

A COMMUNITY HEALTH RESOURCE INVENTORY

(50 titles from the Indian experience)

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

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

Titles and Source

A-Indian Council of Medical Research, New Delhi

1. Alternative Approaches to Health Care, 1976
2. Evaluation of Primary Health Care Programmes, 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 (8 problems)

E- Indian Social Institute, New Delhi

20. Moving Closer to rural poor 1979
21. Health & Culture in a South Indian village 1979
22. People's Participation in Development - Approaches to non formal education 1980
23. Changing health beliefs and practices in rural Tamilnadu 1981
24. Learning from the rural poor - experience of MOTT 1982
25. Development with people - experiments with participation and non formal education 1985
26. Social activists and people's movements 1985

F- Lok Baksh, New Delhi

27. Formulating an alternative rural health care system for India 1982
28. Poverty class and Health culture in India
29. Health and Family Planning services in India - an epidemiological, socio-cultural and political perspective.

G- Catholic Hospital Association of India, Secunderabad

30 Health and Power to people (medical service special issue) 1986
31. Taking sides - the choices before the health worker 1986
32. Trainers manual for training community level workers 1987

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H- Foundation for Research in Community Health, Bombay

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

34. Health Status of the Indian People

I- National Institute of Mental Health and Neurosciences, Bangalore

35. Manual of Mental Health for Medical Officers 1985

36. Manual of Mental Health for Multipurpose workers 1985

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

37. Evaluation of CHW Scheme - a collaborative study

38. Management Training for Primary Health Care.

K- Indian Council of Social Sciences Research, New Delhi

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

L- Centre for Social Action, Bangalore

40. Health Care in India 1983

41. Rakku's Story 1984

M- Institute of Education, Pune

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

N- Centre for Science and Environment, New Delhi

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

O- Kerala Sashtra Sahitya Parishad, Trivandrum

44. Science as Social Action 1984

P- Community Health Cell, Bangalore

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

Q- Ford Foundation, New Delhi

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

R- Some Foreign Publications (with Indian case studies)

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

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

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

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

Participatory Action Research Leads to People's Movement

Drs.Abhay and Rani Bang,
'SEARCH', Gadchiroli.

A malaria supervisor was the first patient of alcohol addiction that we encountered in Gadchiroli when we started working in this remote and tribal district of Maharashtra in 1986. It took 6 months of counselling, 3 hospitalisations and a bout of vomiting of blood to weah him away from liquor addiction. A teacher was our next patient. He could be de-addicted only when he was convinced that he had developed cirrhosis of liver and would die within months if he continued with liquor.

In first 2 years, we could de-addict about twenty patients each year by the typical counselling-hospitalisation approach. And by our rough estimate there were twenty thousand liquor addicts in the district. The situation was hopeless.

But unfortunately the educated people didn't seem to share our concern about this problem. "Men always drink, so what?," was their response. Was it our Gandhian fad which made us look at the liquor as a social problem, we wondered; and mentally shelved the problem for a while.

In the third year of our work, we had organised a series of camps of rural women and youth. One topic they all wanted to discuss was the problem of liquor. Rural women opened up to describe how their own lives were ruined by the liquor addiction of the males - husband, brother, son, son in law ! Every woman had sufferred, they realised. The topic became so popular that when it was not on the time table of a camp, woman complained that they were deprived of this topic while the other women in the earlier camps had opportunity to discuss it ! An extra session in the night from 10 PM to 2 AM had to be arranged. Everybody was not for liquor, we realised. At least half the population (the women) was against it.

Youth from 2 villages said they wanted to do something

about this. As an experiment, they organised a social ban on liquor in their villages. The young boys would patrol the roads in the night. They wouldn't allow a bottle to enter in the village. Those found drunk were fined. We all shared the pleasant surprise that this approach worked !

When this experience was described in a meeting of all tribal activists and voluntary organisations of the district, a collective decision to launch a mass campaign was taken. But did we have a concrete case ?

A small group was entrusted with the responsibility of collecting facts about liquor problem in the district. A survey of 104 villages was organised with the help of village health workers. Information from the excise and prohibition department was collected with the help of a group of teachers. What were the findings of this crude research ?

1) - About 1 lakh males in the district frequently drank, 20,000 were addicted and about 1000 died each year due to alcoholism.

2) - The Government had issued licenses to 57 shops to sell liquor and permits to 2000 persons to buy and possess up to 12 bottles of liquor at a time. In effect these 2000 permit holders were acting as subagents to sell the liquor in the villages.

3) - Total annual sale of liquor in the district was of 70 million rupees, exactly equalling the total annual development plan of the Government for the development of this most backward district in the state.

4) - This was against the guidelines of the central government which clearly stated no sale of liquor should be allowed in the tribal areas.

3 elements had come together

1) Collective realisation of a common problem which caused tremendous suffering to all.
2) Concrete facts to back up this realisation.
3) Common will and organisation to act. // See how the chemical reaction was triggered.

Within months this became a mass movement in the district. Youth and women formed 'mandals' in their villages and passed resolutions to ban liquor. Taluka level confer-

ences against liquor were organised at 4 places. Finally a district level conference against the liquor was planned. 3000 delegates from 150 villages gathered, more than half of them being women, who described their sufferings from liquor and how they tried to counter this by collective action. 2 MLAs from the area, the district collector, Police Chief and the excise officer attended and e listened to people's mood. People even stood up to describe how the police offerred protection to the liquor venders and harrassed them when they opposed illicit liquor. Department had to take punitive action against these police.

A district level Darumukti Sangathana (organisation for Libaration from liquor) was formed and resolutions passed demanding closure of all the licensed liquor shops in the district. People took responsibility to see that the illicit liquor wouldn't be sold in their villages.

And people really did it! A community ban on the sale or consumption of liquor has been effectively put in 200 villages. Women of Chandala Tola, a tribal village, locked the drunk men overnight and took them out in a public procession next day. People from the surrounding villages accompanied us to a village called Ranbhumi which was defying this movement, and warned the village of boycot unless the liquor was banned in Ranbhumi too. Next day the errant village joined the movement. Illicit liquor has been completely weeded out. But what about the sale of licensed liquor ?

A delegation from the district has twice met Chief Minister demanding closure of the licensed liquor shops. The people's pressure on this issue is so strong that all 3 MLAs from the district have represented this demand. The proposal is before the cabinet now ! Gadchiroli is knocking on the door's of the state government in Bombay, 1000 Km away from it.

The expression of people's will and power in Gadchiroli on the issue of liquor has given lead to many organisations

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in Maharashtra. The programme has been taken up at state level by Shetkari Sangathana (Farmers' Organisation)

What does the whole story bring out for us ? The fantastic result is not the main point. The way the problem was identified, researched and emergence of mass action from it - the participatory process of action and research is the key. No amount of hospital based deaddiction or individual counselling would have touched even the fringe of the problem, even though it would have provided us a lifelong work. Exotic medical research would have produced findings locked in the files and journals. But by joining hands with people, we could see the issue develop in to a people's ~~with people, we could see the issue develop in to a people~~' movement against liquor. Experiences like this unfold the deeper meaning of the famous Chinese poem - Go to the People ! Live among them ! Learn from them ! ~~Start~~ Start with what they know ? Build upon what they have !

Thousand fires

The Gadchiroli Darumukti Sangharsha is an excellent example of the paradigm shift from medical model to social model of health action. A deaddiction-counselling programme aimed at the individual addict scratches at the surface of the problem and is a typically medical response. A people's movement gets at the very roots and is the new 'social response' we need to facilitate in the future. Are we ready ?

COMMUNITY CURATIVE CARE TO HEALTH CARE - A JOURNEY

* Dr. Thomas Abraham
** Dr. S. Joseph
M.G.D.M. Hospital, Devagiri,
Kangazha, Kottayam, Kerala.

The M.G.D.M. Hospital was founded in 1964 by Sri. P. Geevarghese, whose benevolence and conviction that man is only a custodian of God's money, made this venture possible. He envisaged the goal of bringing the benefit of modern medicine to the rural population as an expression of God's love and concern specially for the underprivileged who are also created in His image.

In a short space of three years, facilitated by a team of medical specialists, the hospital made a giant strides in developing itself into a 100 beded referral hospital, where closed heart, lung and other major surgical procedures were undertaken with good results. At this point an occasion for introspection arose about the future direction of the hospital programme and the goals and objectives it strove to serve.

Founded for bringing medical relief to the backward rural population, it was realised that the institution on account of its high tech services was attracting mostly patients from the town around where such services were illavailable then. It was reckoned that institution had in fact become a satellite urban medical facility located in a thoroughly rural setting, with little relevance to the people it primarily sought to serve.

Looking outwards

Critical appraisal of the real health needs of the rural population around brought home the message that to serve health needs of the people a significant reorientation and

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reprioritisation of the programme mandate was necessary. Consequently a small beginning was made in the form of community extension medical work through mother and child clinics, immunisation programme and nutrition supplementation. Constraints of material resources was a significant limitation for the programmes until the institution was brought under the aegis of the Malankara Orthodox Syrian Church, to which it now belongs.

In the next phase, free eye camps and follow up work along with other community level medical extension services were offered, which benefited a large number of rural people who could not afford the benefit of medical xxxi speciality services.

However, our grassroot exposure to the rural scenario during these years, made us painfully aware that the real needs especially of the rural poor went much beyond medical care and that an integrated health and development programme was the only answer.

Community based health and development

In 1969 a pilot study was commissioned with the help of social scientists to assess the true health needs of the people, beyond the pale of curative health. Based on the findings of this survey in January 1978 an integrated health and socio-economic development programme was launched in six villages around with established satellite units in these locations, where a nurse practitioner (ANM xxx trained in primary health care by us) and health worker resided and offered primary health care at the peoples' door step with the help of volunteers from the community who came forward to participate in this programme. These volunteers were trained to become health and development promoters and they gave

reward) and organised a participatory forum to channelise and facilitate development inputs. Variety of agricultural, economic and veterinary programme were instituted for the benefit of the poorest section of the population.

Medical services of curative, preventive and educative nature were offered to the ex population.

A school health programme covering 34 schools was also organised at this stage. This programme which harnesses the resources of the teachers and pupils to run a self-reliant, round the year basic curative and educative health programmes was endorsed by the UNESCO (reported vide publication notes/ comments ~~Commenting~~ - N.S. 71 May 1981) as a replicable and appropriate model.

It was very reassuring to us that when the Alma-Atta declaration emerged in late 1978, the declaration virtually endorsed our operational strategy of integrated development. This gave a fresh fillip to the programme and helped overcome some doubts raised about the validity and relevance of a health care programme which appeared to be multidisciplinary.

From islands of change to becoming a 'Movement'

Our experience with the community based health and development services convinced us that the strategy was right, but yet the impact remained only as 'islands of change'. To enable the goal of forming a 'movement' to bring about change in a significant measure it became clear that 'networking' with the like minded agencies and the government infra-structure was inevitable.

The fresh strategy was initiated by collaborating with other church and secular agencies with a track record of

credible field services, through a Preservation of Eye sight programme, launched in 1978. This programme was delivered through village level health workers. Our experience over the next few years validated the feasibility of 'networking' with likeminded agencies.

The experience gleaned through such collaboration taught us practical lessons in ecumenism and secularism, which transcend the usual divisive forces in our community.

Hospital and Community Health services

Our experience over the past 25 years has shown that community health services can develop along with hospital service without prejudice to either. The growth of our institution from a wayside dispensary to a 250 bedded multispeciality referral hospital went hand in hand with the community level services covering a population of over 2 lacs population. Given the 'political will' and unstinted commitment to the mandate of espousing our preferential option for the poor and the marginalised, such a xxxxxxx growth xxx of a multi-dimensional health care programme should be feasible, mobilising the total resources of a hospital.

Full HFA coverage through networking

In 1987 a complete HFA programme 'Prachar' (acronym for Pro Health for rural awareness, community health and rehabilitation) was launched with the partnership of lead agencies in the field such as the Malanadu Development Society, Peermade Development Society besides Bethany Ashram Perumon, Christian Workers Movement etc.

This programme through networking reaches out to areas 150 Kms away, delivered through 220 field level health workers. It includes community based rehabilitation (C B R)

of the handicapped as against the prevalent institutional based rehabilitation with limited coverage. W.H.O. estimates that about 10% of any given population suffers from some degree of 'handicap' and hence can be managed effectively only through a community based strategy. The programme embodies inter agency, intersectoral and inter-church cooperation which are essential to achieve cost effective, relevant and credible ~~xx xxxxxxx~~ services to the rural poor. This programme also mobilises available Government resources; the increasing good will and openness of Government agencies to collaborate with the voluntary sector bodes good for the future development of our rural population.

Concept of networking besides enabling optimal utilisation of scarce resources allows for intersectoral co-operation, for enhancing the credibility of the voluntary sector as a unified force, for transcending the fissiparous tendencies in the society, for demonstrating the feasibility of an ecumenical approach, for demonstrating our concern for and sharing in the National and global goals for health care/development and paving the way for effective programme linkage with the Governmental services.

The constraints of running such a programme are significant. Given the spiritual testament and the refrain of the Panama Canal diggers "The difficult, we will do now; the impossible will take a little longer'
this and more should be possible NOW.

- We wish to acknowledge our gratitude to all our colleagues, partners and well wishers who over the years have contributed to this programme; without them there would be no programme.

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* Dr. Thomas Abraham M.B.B.S. D.C.H.

Community Health : Learning from our failures
A Report from DEENABANDHU, Tamilnadu

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

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

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

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

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

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

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

Village health committees were formed with much fanfare but after some time became inoperative when the committee members found that apart from "prestige", there was no monetary benefit to be had. Some of the committees also used the VHW to run errands, etc., and had to be cautioned. Once the VHWs established their credibility, we found that the committee was not really necessary. We now operate on the basis of trust between us and the VHW, and between her and the community. Of course, two 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 economic deprivation. The emphasis we now lay on herbal remedies is a response to this. We have seen the proven efficacy of several herbs commonly used at the community level.

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

We started this as a total community programme, for the rich and the poor alike, for the upper and the lower caste, for we believed that we had a duty to all. During the initial stages, we found that the services offered by us were being extensively used by those who "have" land, money, education and who are often from the upper castes. This resulted in one of our primary objectives being fulfilled - to double income levels. A mid-programme assessment revealed that though we had largely achieved this objective, it was at the cost of the poor, who showed only marginal growth while the "haves" showed spectacular growth. This was evident in a dairy programme we initiated. This package programme involved bank loans for cows and feeds, fodder development, milk co-operatives and transport of milk to the dairy. Not taken into consideration was 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, choclate and condensed milk was not socially just. This and other lessons made us resolve to work only with the target group i.e., the powerless: the landless and the harijan. All programmes - health, agricultural, animal husbandry, etc - were, offered exclusively to this group. The VHWs too, served only them, Thus our focus became defined and we were able to serve the target group better.

Community Participation

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

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

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

Self-Sufficiency

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

We had this problem until we realised that "self-sufficiency" referred to the project, while what we were aiming to build at the community level was "self-reliance". We were working towards building community capability in health care and, 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)

Guest Editorial

FROM MEDICAL SERVICE TO HEALTH ACTION TO COMMUNITY HEALTH.....

In 1975, a Government Expert Committee (Shrivastava Report) suggested that "we take a conscious and deliberate decision to abandon the present health model and strive to create instead a viable and economic alternative suited to our own conditions, needs and aspirations". To most readers of HEALTH ACTI N, this would seem a rather paradoxical suggestion considering all the rhetoric in the media about family planning programmes, universal immunization programmes, technology missions for immunization and Health for All claims of the government on the one hand and the growth of the high technology diagnostic centres, capitation fee medical colleges, private hos ital chains, highly advertised health/ medical insurance schemes and the increasing flood of drug formulations in the market on the other.

What model should we be abandoning and what are we to build instead?

In this issue we highlight the growing interest in the 'alternative health care approach' seen in the last two decades in the country and explore the issues and perspectives generated and the lessons being learnt from the wealth of the grass roots experience in community health in India.

From a hospital oriented, drugs and high technology Medical Service that was unable to meet the health needs of the people we have moved to a wide range of Health Actions-- preventive, promotive, curative, rehabilitative focussed on the community. This magazine itself reflects this metamorphoses.

However, activists and researchers, issue raisers and trainers, project initiators and development workers

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who are in the midst of all this health action at the community level are beginning to identify critical problems and lacunae in our present thinking about health itself.

If Health for All has to be achieved somewhere in the future, if not by 2000 AD, then Health action must be centred in the developmental process and located in its socio-political-cultural-economic context. COMMUNITY HEALTH ACTION will then mean much more than medical service or health action.

A recent WHO publication highlights the new values of 'Health for All' movement as Equity, Prevention, Sharing, Cooperation, Human Rights, Opportunity, Social Justice, Responsibility, Participation, Self-reliance, Empowerment.

It is these dimensions in their diversity that this special issue seeks to explore and highlight.

The lead article explores the disenchantment with the medical model and describes the 'alternative health care project phenomena and the evolving new paradigm of community health'. It also highlights some issues and initiatives in the community health movement.

Additional articles by participants of this new movement explore various other dimensions building on their own field experiences.

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EXPLORING JARGON

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

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

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

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

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6. Socialised Medicine (State medicine):

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

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

As Parks textbook (standard reference in India) says

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

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

COMPARISON OF HEALTH MANPOWER AND INFRASTRUCTURE IN 1981 WITH BHORE COMMITTEE RECOMMENDATIONS 1971

	Recommended[1]	1981		
POPULATION		685 Million[2]		
		Projection as required by Bhore Committee	Actuals	Shortfalls
PRIMARY HEALTH CENTRES	1:20,000	34,250	5,740[2]	28,510
DOCTORS	1;2,000	3,42,500	2,68,712[3]	73,788
NURSES	1:300	2,283,333	1,50,399[2]	2,132,934
HEALTH VISITORS	1:5,000	137,000	@ 19,033[2]	117,967
MIDWIVES	1/100 births	231,530	@ 23,200[2]	208,330
DENTISTS	1:4,000	170,500	8,648	161,852

@ Trained upto 1981

Source:

1. Bhore Committee Recommendation Report
2. Health Atlas of India, 1986
3. Health Information of India, 1987

Task

The material sent by Community Health Cell, for the July issue on Community Health was estimated to be 80 pages. Health Action can take only 48-50 pages of text apart from Advertisments and other matters. In order to edit the material to the requirement , a reduction of 2/5 of the material is called for.

Suggestions

After reviewing the content list and the details of the cover story (CHC) the reduction could be done as follows.

1. The articles by Fr Edwin, Dr Dara S Amar and Dr Jacob Cherian could be removed and featured in the next issue.

2. All the fillers excepting No 1 i.e, Exploring Jargon and No 4 i.e CHAI Vision can be deleted, from this issue and featured as fillers in subsequent issues.

3. Within CHC cover story item No 4 i.e Health Scene in 80's including the box on National Health scene could be dropped since these statistics have appeared in many other ways in earlier issues.

4. In item No 6 of the same story box 13 Evolving policy alternatives could be dropped ad also Mission Hospitals Edict in item 8.

5. In item 11 the long list of Community Health Training opportunities in India i.e box 18 can be deleted. A one page modification of the training centres is being sent.

6. The profiles of 30 projects can also be dropped.

7. The idea of maps showing projects/training centres/ research centres/coordinating groups could be integrated in one large map and only those mentioned specifically in the text in one way or the other in the articles could be shown as small stars. This map will have to have clarifying note that it does not show all the projects and centres/~~but~~ only a few mentioned in the text. Its basic aim is to show that this phenomena has support from all over India . If in the time available it is complicated it could be dropped.

In India

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Altered Reference list

(The number in the brackets indicates the original number in the first bracket and the changed number in the second bracket)

(1) (1) ICMR-ICSSR, Health for All - An Alternative Strategy, 1981

(2) (2) Central Bureau of Health Intelligence, Health Atlas of of India 1986

(3) (3) Srivastava Report, Health Services & Medical Education, 1975

(4) (4) Ashish Bose, 'For whom the target tolls' Health for the Millions

(6) (5) Community Health Cell, Report on Community Health: The Search for an alternative process, 1987

(7) (6) VHAI, Low cost Health Care, Health for the Millions Aug 1978

(8) (7) Eric Ram, 'Contact' 44 Apr 1978

(9) (8) Antia N H, Medical & Non-Medical Dimensions of Health, National Academy of Medical Sciences Oration, Apr 87

(10) (9) VHAI, Pamphlet 1978

(11) (10) CHAI Policy Statement 1983

(12) (11) CMAI Policy Statement 1986

(13) (12) ACHAN Pamphlet 1982

(14) (13) D Banerji, Health Services in a Country: Postulates of a theory, Lok Paksh (1986)

(16) (14) LINK Newsletter of ACHAN, Vol 7 No 2 Aug-Sept 1988

(17) (15) Medical Service

(18) (16) mfc pamphlet, 1986

(19) (17) AIDAN, Banned & Bannable Drugs, VHAI, 1986

(20) (18) KSSP Pamphlet 1988

(21) (19) FRCH Annual Report 1987

(22) (20) ARCH Pamphlet 1985

8. The table on Bhore Committee Recommendations is being modified since it is too complicated. A simpler version is being sent.

9. In the resource inventory you may keep the 50 titles and delete all the rest. The Bulletin list is unnecessary since I find that the Journal Scan regularly scans most of the journals mentioned.

10. The reference list of the lead article should be retained with the numbers. Some changes will have to be made in light of the deletions. A new reference list is being sent.

11. We would like you to mention CHC Team Bangalore as the AUTHOR OF THE COVER STORY. Somewhere in the magazine at a place which you think suitable you can mention the following.

> The Community Health Cell Team which put together this special issue is an informal resource team based in Bangalore which promotes Enabling dimension in Health Action, Socio-Epidemiological perspective in Health Planning and Participatory management in Health Care.
>
> The Team consists of
>
> 1. Ravi Narayan
> 2. Thelma Narayan
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> 4. Shirdi Prasad Tekur
> 5. Mani Kalliath
> 6. Nagarajan M S
> 7. John S

A Reference List

1. ICMR-ICSSR, Health for All - An alternative strategy, 1981
2. Central Bureau of Health Intelligence, Health Atlas of India 1986
3. Srivastava Report, Health Service & Medical Education, 1975
4. Ashish Bose,'For whom the target tolls' Health for the Millins
5. CSI, Ministry, The National Health Scene; Voluble Indices a handout, 1987
6. Community Health Cell, Report on Community Health: The Search for an alternative process, 1987
7. VHAI, Low cost Health Care, Health for the Millions Aug 1978
8. Eric Ram,'Contact'44 Apr 78
9. Antia N H, Medical & Non-Medical Dimensions of Health, National Academy of Medical Sciences Oration, Apr 1987
10. VHAI, Pamphlet 1978
11. CHAI, Policy Statement 1983
12. CMAI, Policy Statement, 1986
13. ACHAN, Pamphlet 1982
14. D Banerji, Health Services in a Country: Postulates of a theory, Lok Paksh)1986)
15. VHAI, Essentials of National Health Policy, 1987
16. LINK, Newsletter of ACHAN, Vol 7 No 2 Aug-Sept 1988
17. Medical Service,
18. mfc Pamphlet, 1986
19. AIDAN, Banned & Bannable Drugs, VHAI, 1986
20. KSSP Pamphlet 1988
21 FRCH, Annual Report 1987
22. ARCH, Pamphlet 1985
23 Satyamala C et all, Taking sides, Choices before a Health Worker, Anitra Trust 1986

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IN CONCLUSION

An exploration of the diverse initiatives in community health in India have led us to recognising a new paradigm of 'Health Care' evolving in the country.

Key components of this new paradigm in a technological and managerial sense are:

- Community Organisation and participation in Health
- Appropriate Technology for Health
- Community support to Health Care -- financial/resources
- Involvement of Traditional Healers, Dais and indigenous systems
- Education for Health
- Health with Integrated Development

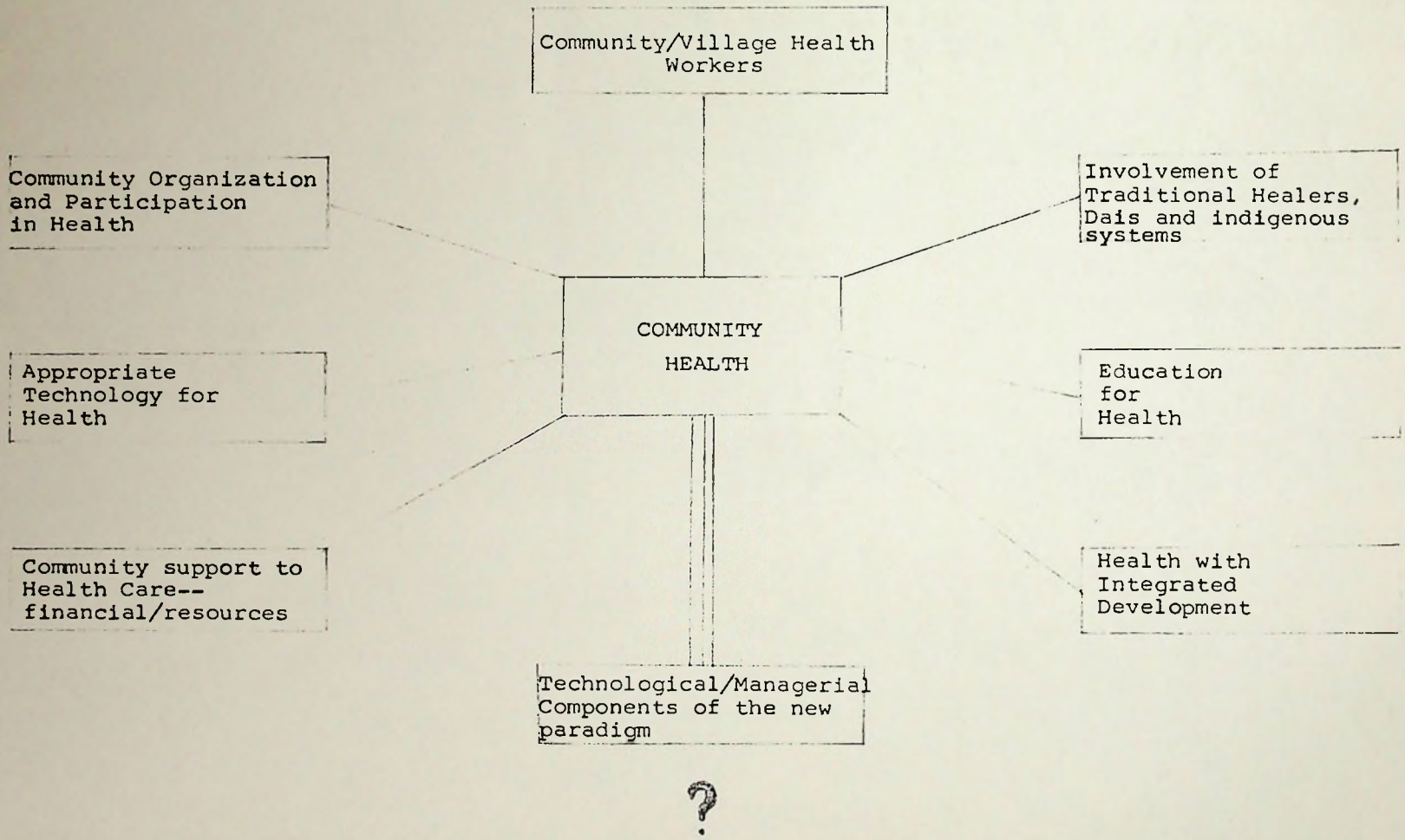
Critical values and issues of the new paradigm are:

- Social Analysis, Conflict Management
- Participatory Team decision making
- Community building efforts
- Demystification and skill transfer
- Individual/Community autonomy
- Medical Pluralism
- Accountability and socio-economic audit of Health Services.

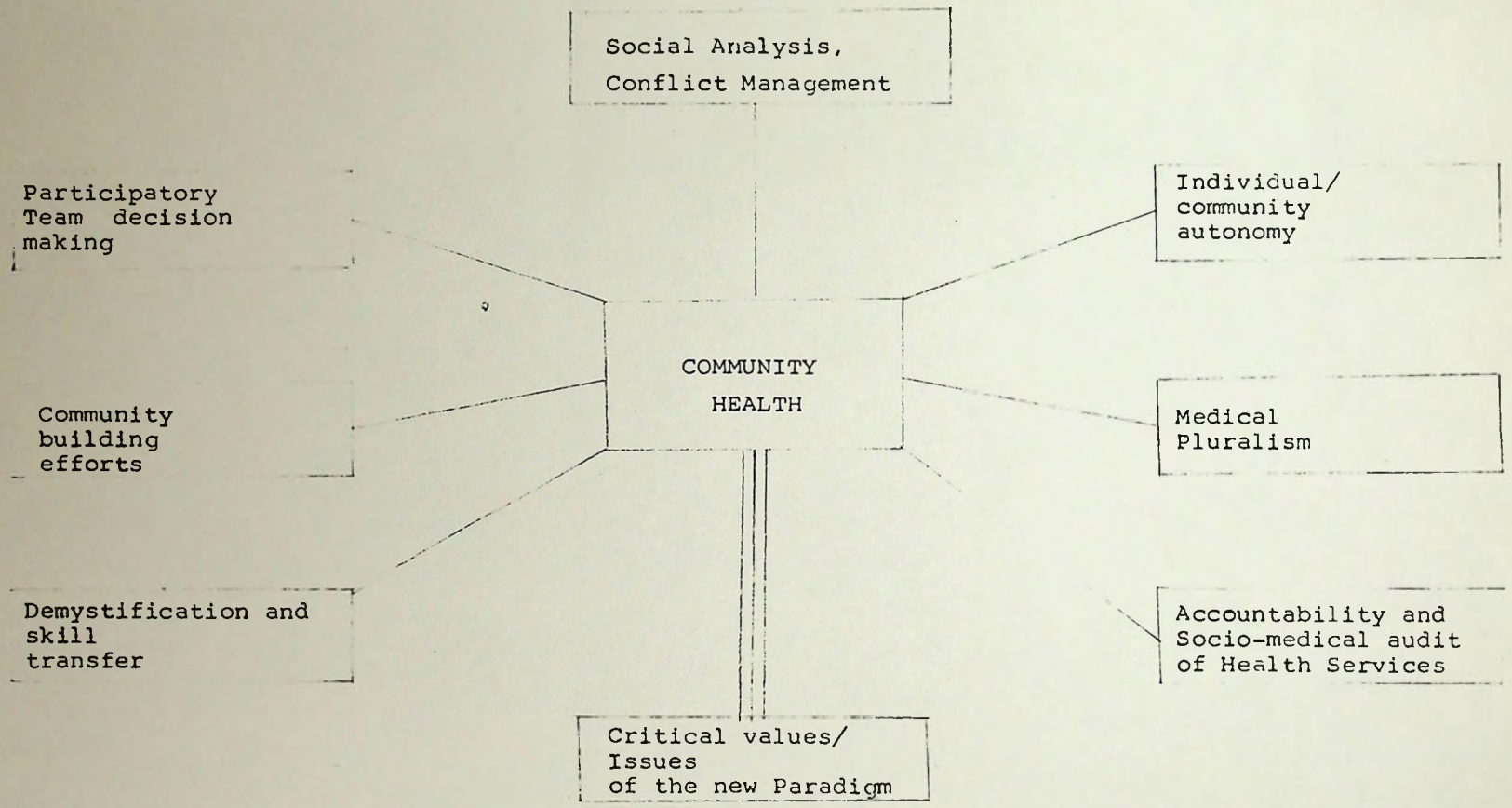
The overall lesson we are learning is that if 'Health for All' by 2000AD has to be a reality for the large majority of our people then there has to be a major shift in our thinking about Health and Health Care <u>from the orthodox Medical model of health we have to move towards understanding, appreciating and practicing a 'Social model of Health' that will tackle health problems at its deeper roots</u>.

This shift of emphasis must take place at all levels and at all dimensions of existing health care planning and management.

The shift would include the following emphasis change (Box 2)



Source: Community Health Cell Reflections



Source: Community Health Cell
Reflections

Box 20

THE PARADIGM SHIFT

Medical Model to Social Model of Health

INDIVIDUAL	------>	COLLECTIVE/COMMUNITY
PATIENT & POPULATION	------>	PERSON & SOCIETY
ANTI DEATH ANTI DISEASE	------>	PRO LIFE PRO LIVING
PHYSICAL/MENTAL PREDOMINANTLY	------>	PHYSICAL/MENTAL/SOCIAL/ CULTURAL/POLITICAL/ECONOLOGICAL
DOCTORS/NURSES MEDICAL AUXILIARIES	------>	TEAM OF HEALTH WORKERS
DISEASE PROCESSES	------>	SOCIAL PROCESSES
HOSPITALS/DISPENSARIES DRUGS/TECHNOLOGY --PROVIDING SERVICES	------>	HEALTH PROMOTING AND COMMUNITY BUILDING CENTRES AND PROCESSES--ENABLING/EMPOWERING THE PEOPLE
INTRACELLULAR RESEARCH	---->	SOCIETAL RESEARCH
PATIENT AS BENEFICIARY, CONSUMER	---->	PEOPLE AS PARTICIPANTS
[redacted]		[redacted]
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

Will the Community Health action initiators work together to out pressure on the 'established medical system' to commit itself to this new vision of Health Care?

Will the Community Health action initiators work together to out pressure on 'Health Policy and decision makers' to move beyond policy statements and get community health oriented programmes and actions off the ground?

Will the Community Health action initiators work with the people and their organisations to enable and empower them to get the means, strucutres, 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.

WILL COMMUNITY HEALTH HAVE A CHANCE?

Box II

(Non-Governmental Organizations)

NGO/Research Centres in Community Health : Some Profiles

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

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

Initiatives and studies include

Evolution and study of low cost community based health systems in Uran and Mandwa,

Socio-economic study of rural transformation,

Women's work fertility and access to health;

PHCs in Maharastra;

Health service projects (NGOs in Maharashtra);

Health financing in India;

Stigma against leprosy;

Alternative school health project;

Facilitation of ICMR-ICSSR joint study group on Health for All an alternative strategy.

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

A group of individuals of diverse background got together to establish this centre in the eastern tribal belt of Gujarat to study the developmental process using the health of children and women of the poorer sections of society as the guiding thread.

The approach was to get involved in the complex process of development (ACTION) and to study critically the health of the community and the processes which results in ill health (RESEARCH) Field based strategies evolved were programmes to attack prevalent diseases, methods and skills of community diagnosis and

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

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

The society has adopted Gadchiroli district, a predominantly tribal district in Maharashtra, for its education, awareness building and research activities. Presently they have 8 long term projects on the study of Active Respiratory Illnesses in children; and a study of women's health focussing on the community. The society also seeks to evolve methods of intervention which will be at the level of the multipurpose workers of the government PHC.

Due to its increasing community involvement the society has also begun to explore the dynamics of women's health and other related issues, the forest issues affecting tribal and the illicit liquor issue and its community context. (refer article by Abhay Bang). It has also tried to modify the health care/medical practices at the District hospital level to make it more responsive to the needs and the people's situation.

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 intracellulay or molecular biological roots of disease and much of the research efforts sponsored by ICMR and other national and regional, government and private research centres has been in this direction. Most of it has been imitative research, 'we too have done it in India' sort of focus and there is the continued myopic view that the future of health in the country will be determined by the discovery of a few more vaccines and maybe the odd drug or contraceptive. This technological focus has blinded us to the fact that the world-over health care action initiators are proving again and again that the clue to health of the people is in locating health problems in the wider social reality and to study them in a socio-epidemiological context. This would help bottlenecks and lead to evolution of 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) Gadchirole (Maharashtra), [redacted] are examples. (Refer boxes)

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

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

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

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

Traditional Medicine

(1)
Amalaki (Emblica officinalis Gaertn.)

Parts used	Fruits (fresh or dry). The seed should be removed before use.
Uses	Anaemia, bleeding, giddiness, pain and burning sensation in the abdomen, greying and falling of hair, eye diseases. This can be used in all age groups as a general tonic.

(2)

Ardraka (Zingiber officinale Rosc.)

Parts used	Underground stem (rhizome) either fresh or dry
Uses	Loss of appetite, indigestion, flatulence, nausea, cough and fever due to upper respiratory tract infection, joint pains.

(3)

Dhanyaka (Coriandrum sativum Linn.)

Parts used	Fruit
Uses	Indigestion, colicky pain, sunstroke, burning during urination and scanty urine, piles, fever.

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(4)

Haridra (Curcuma longa Linn.)

Parts used	Underground stem (rhizome)
Uses	Intolerance to dust inhalation, running of nose, respiratory diseases particularly in cases of difficulty in breathing and cough due to allergy, itching senstation all over the body, jaundice, wounds

(5)

Lashuna (Allium sativum Linn.)

Parts used	Bulb or segments (bulbils)
Uses	Loss of appetite, flatulence, indigestion, cough, piles, skin diseases, chronic fever, obesity, pain and swelling of joints, poor eyesight.

(6)

Maricha (Piper nigrum Linn.)

Parts used	Fruit
Uses	Cold, cough, sore throat, boarse voice, influenza

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Note: For further information such as description, preparation, dose, refer Manual for Community Health Worker of the Ministry of Health and Family Welfare, Government of India, New Delhi October 1978.

(7)

Nimba (Azadirachta indica A. Juss)

Parts used	Whole plant especially leaves, fruit, bark and tender twigs.
Uses	Ulcers, itching, skin disorders, fever, biliousness, wounds, ear discharge.

RECOMMENDATIONS of ICMR-ICSSR on 'Health for All' - An Alternative Strategy

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)

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.

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 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.

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 control of locally endemic 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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[Source CST Handout]

ALMA ATA - - Ten Years After

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

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

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

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

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

A REPORT FROM KERALA

BASIC HEALTH COMMUNITIES

--Fr Edwin MJ

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 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

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.

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 intent to do by way of promoting a holistic health insurance scheme run by the people themselves.

Our health insurance programme is expected to consist of the following components: non formal 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 step in the right direction.

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HEALTH OF PEOPLE IS WEALTH OF NATION

Dr.Jacob Cherian
Director & Chief Surgeon
Christian Fellowship Community Health Centre
AMBILIKKAI 624 612 - T.N.

The present National scheme of Primary Health Centre is not so much a success as it was expected to be (World Health Organization report). Still thousands of people in our country die of infectious conditions, poor nutrition and bad sanitation. Alternative and appropriate systems of delivery of Primary Health Care have been explored, tried and met with success at many places.

Christian Fellowship Community Health Centre at Ambilikkai trained Multipurpose Community Health workers for the first time in our country as early as on 1958. The training was reorganised into a regular course in 1972 with Government recognition. In those days we used to call them Community Health Guides. This training was much appreciated and it was crowned with success. The Government of India accepted it as Multi Purpose Health Workers scheme later on. Community Health Guides (M.P.H.W) working in the field of Health and Medical services especially in rural parts of country under supervision of medical officers, are doing a wonderful job. In our area 43 Community Health Guides, covering 1.5 lakhs of rural population, are doing dedicated work. They have achieved remarkable results during the last 25 years, e.g., Infant mortality rate was brought down from 130 per 1000 to 89 per 1000, birth rate from 31 per 1000 to 19.5 per 1000 and general death rate from 13 per 1000 to 9 per 1000. Almost all infective conditions are wiped out from the area. We work through a network of Mini Health centres. Two Multi Purpose health workers and three village health workers work in each mini health centre covering 5000 population.

Similarly in Voluntary sector, other institutions like the one in Jamkhed are training and placing simple illiterate village women as Voluntary Health Workers in their project. They too have achieved very good results. This was also recognised by World Health Organization. Training and organisation of Mothersangams and Balwadies are other examples of successful-ventures and alternative system piloted by Voluntary sector though it may not give the full coverage. Delivery of health through health insurance by Voluntary Health Service, Madras is yet another example of success story in the field of health- delivery by adopting a different systems using lay-first-aiders.

In our Community Health Field, even leprosy program is integrated with Multi Purpose Health Worker's service. The leprosy /paramedical workers are expected to detect the new cases which have become comparatively much less in our area. Once detected and diagnosed, cases are held (followed up) by Multi Purpose Health Workers (C.H. Guides). Soon we are hpping the National Leprosy Eradication program will be integrated with Community Health net-work, which the Government of India is contemplating to do in 1972. Since our Community Health Guides are well experienced and quick in the delivery of Health Services and also many of the targets to be achieved by the turn of the century (2000 A.D) alloted to them in the limited population (2500 population for each Health Guides) are already achieved, they are turning their attention towards socio-economic development, as health is very much dependent upon socio-economic development.

Limitation of funds is the greatest handicap of any Voluntary Organisation. If dedicated service of Voluntary Organisation could be coupled with adequate and timely supply of material and monetary resources, great things could be achieved in any field especially in the important fields of Health and Development.

In the usual development process in any country, one could see that Voluntary pilot modules or models, research and experiments, lead the nation in the right track. A good community health system, based on mother and child care, sanitation, immunization, nutrition, control of population growth and proper care of minor ailments, should be further boosted by Health Education and adult Education, and economic development. Early five-year-plans in our country were concentrating on building up big hospitals, Medical Colleges and post-graduate

teaching institutes and, also much thrust was given on green revolution. This was a good move in the right direction but side by side industrial revolution should have been given its due importance. Thank God the trend of general policy of our Government in the latter periods of five-year-plans is set in the right direction, towards 'Balanced economy', Community Health and 'Control of population'. Adult education, Industrial Revolution (both small and big) and Green Revolution are pushed to the fore-front. Soon it is hoped that craziness for sick palaces (Big Hospitals) and urban Medical Colleges ~~and big hospitals~~ on the part of the government will be replaced by Community Health Projects, Adult education and Family Welfare programs and socio-economic and agriculture-promotion activities.
It is a pity that still our country is not able to prevent becoming victims of draught and flood by developing ecology (Social forestry) and preservation of rain water and connecting all rivers with canals after building sufficient dams and also building bunds on all the banks of rivers. Vast population already existing is an asset to work up such herculean tasks. Why do we think here of those areas of economic development ? Because unless socio-economic condition is improved, health of the people cannot be promoted beyond a certain limit or level. Unbalanced race for scientific achievements and material targets are also equally dangerous unless it is balanced with selfless service, deep spiritual mottoes and motives and also our hunger and thirst after high moral values.

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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 attemoted 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-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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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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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 comoonents 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,)

COMMUNITY HEALTH : DIFFICULT CHOICES

Each health worker interested in improving the health status of the poor people will need to make a few important decisions:

* Where does she want to spend most of her time - in the dispensary or in the village?
* Which group of people does she want to work with - the better-off or the poor?
* Does she want to continue with her present activities the way they are or does she want to bring about a change in her role?
* Will her present institution support her if she wants to change the direction of her work or does she need to work with another group?
* Can she build up support for her work and herself from any source?
* Is she willing to go through the personal struggle which such work may involve?

Similar decisions taken by other health workers and their experiences can be a source of encouragement and support to all of us struggling to make these decisions.

--Sathyamala et al, Taking Sides

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COMMUNITY HEALTH TRAINING IN INDIA-- [redacted] An overview of courses

Key course

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

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

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

The Course Coordinator
Deenabandu Training Centre
R.K. Pet 631303, Tamilnadu

3

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

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Revised and a separate one has been sent

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

Institute of Health Management
Pachod
Dist Aurangabad
Maharashtra 431121

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

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

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

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

The Principal
St John's Medical College
Bangalore 560034

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

7

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

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

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

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

DCHM Course
RUHSA Post, North Arcot Dist
Tamilnadu 632209.

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

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

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

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

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

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

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

11

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

For details write to:

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

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

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

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Source: prospectus of respective courses

Box 6

THE NATIONAL HEALTHSCENE

VOLUBLE INDICES

Tetanus

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

Diphtheria

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

Pertussis

Around 300,000 cases reported annually.

Poliomyelitis

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

Measles:

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

Tuberculosis

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

Leprosy

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

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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).

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

Blindness attributable to Vitamin A Deficiency

occurs among 20-30,000 children in India.

Water supply and sanitation

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

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

Source: CSI Ministry of Healing (5).

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.

Refer Box 13

13

NATIONAL HEALTH POLICY, 1983

Recommendations

For restructuring Health Services

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

VHAI (15)

7c. Community Health: Is a movement emerging?

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

The positive trends are--

i. Policy reflections of the Government

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

ii. "Village Health Worker Army"

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

iii. Non-medical Health Activists

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

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iv. Health in the education process

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

v. Health on the agenda of science movements

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

vi. Health issues emerging in other movements

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

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

vii. Health orientation of Coordinating groups and issue raising networks

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

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

i. Commercialization of medicine

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

ii. Mushrooming of medicalised health projects

Health projects are mushrooming all over the country 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 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 investigatio in the name of health is another trend.

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

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 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 rational drug policy and rational therapy. AIDAN has not only worked on an alternative drug policy but has also worked at various levels from parliamentarians to the level of the people discussing issues and raising consciousness about the various dimensions of the problem.

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

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

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

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

THE MEDICO-FRIEND-CIRCLE --

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

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

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

Stands for popularisation and demystification of medical sciemee.

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 sodiety, 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

Source. (Ref ND 18)

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 deenly concerned about the drug issue and working towards the adoption and implementation of a people-oriented Rational Drug Policy in India as a part of a people's Health Policy.

AIDAN'S Main Demands

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

Source (Ref NO 19)

Box 17

KERALA SASHTRA SAHITYA PARISHAD (KSSP)

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

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

HEALTH BRIGADE

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

Have completed a very comprehensive health survey covering the whole of Kerala. On the basis of the subey results, the KSSP intends to formulate a people's health programme for Kerala. The KSSP is mounting a vigorous compaign against the recent drug price hike. KSSP publications like 'Hathi Committee - A decade after', 'The Drug Information Packet', 'Banned and Bannable Drugs' have received wide acclaim. (20) Source Ref no

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 as well as orientation courses 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' teaching 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.

COMMUNITY HEALTH AND PRIMARY HEALTH CARE

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

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

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

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

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

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

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

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

What are these differences.

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

   Community Health means a new approach at all three levels

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

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

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

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

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4. Primary Health Care leaves the medicalisation of health and the mystification and heirarchy of medicine unconfronted. Community Health confronts both these issues and tries to evolve an alternative plural, demystified, 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, and community as focus of action and participation, the community health action remains comprehensive.

THE ANTWERP MANIFESTO FOR PRIMARY HEALTH CARE

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

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

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

These principles are:

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

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BUY 14

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

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

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

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

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

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

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

South LINK Newsletter (Ref No 16)

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.

BUY : INSERT
Mission template - 2000 AD
an edict (CBMI)
An evaluative study of BPY 1986
meeting of CBMI
by Jayashree Vaidathi

"RECOGNISING THE NEW PARADIGM"

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

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

Source: Policy Statements of organizations, Ref No 10,11,12,13

HEALTH FOR ALL
ICMR/ICSSR

Prescription ℞

A MASS MOVEMENT

TO

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

Ref no 1

HEALTH SERVICES IN A COUNTRY

Postulates of a theory

Health Service development is

a. a socio-cultural process

b. a political process

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

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

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

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

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

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

- D Banerji (14)

6. RECOGNISING THE NEW PARADIGM

This alternative health care project phenomena has been a spontaneous upsurge in the last two decades and not an organised planned movement. From 1984, a team of us have been studying this process through a series of reflections with individuals and groups and network to build a new understanding of Community Health from field level experience and grass roots action. 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(10, 11, 12, 13 & Ref NO Box NO 10

The ICMR/ICSSR Health for All prescription includes these dimensions as well (Box NO 11 & Ref NO 1

A plea for a New Public Health is the latest in a series of issues and theoretical perspectives emerging from academic centres as well. (Ref NO 14, Box 12

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.

'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 villag to control the mosquito vector. They were remarkably efficient in suspecting tuberculosis in individuals with the classical symptoms especially if they were contacts of known cases. If the diagnosis was established on examination of the sputum or X-ray they gave the 90 streptomycin injections and supervised the regularity of the other antituberculosis treatment by convincing the patient of its importance not only for himself but also for the rest of his family. They also taught other simple measures like disposal of sputum to prevent the spread of the disease.

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

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Box 19 Contd.

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

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

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Box 9 contd

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 (9)

[redacted]

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

f. Increasing community participation in health decision making

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

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

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

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

ii. Secondly the health action 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 [illegible],

youth clubs

mahila mandals

farmers associations

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

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

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

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

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

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

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

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

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

ans so on.

i) Education for Health

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

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

j. Conscientization and political action

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

5. The Alternative Community Health Project Phenomena - Three questions

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

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

WHO were the Community Health Project initiators ?

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.

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 c 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 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 & 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, M.P.
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, Bombay
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.

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 convince us that many ideas, experiences, components of service and the dynamics of action from these projects taken together would help build an Alternative Approach and none are independently the complete alternative. Hence learning from the commonness of approaches and identifying the rich variations that exist would be a more meaningful way of deriving the new approach of community health. The component of the new approach to health action in the Community are:

a. Integrating Health with Development activities

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

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

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

b. Preventive, Promotive and Rehabilitative orientation to health action

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

Immunization programmes
Maternal and child health care

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Family Welfare activities

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

Nutritional supplementation and nutrition education, and school health programmes

were the 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 (TBA) 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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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)

(redacted)

"Technology can only be considered apprppriate 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. (Selfm boa) Box no 8.

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. (After box) (Box 9) 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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THE COVER STORY

Community Health In India

Preamble

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

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

The process also reflects a commitment and a growing diversity of efforts and initiatives all over the country to adapt, innovate, create, alternative approcahes to health care that are more relevant to our [redacted] needs and our social realities. [redacted]

[redacted] 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.

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attempted to explore as much of the diversity as possible of initiatives in community oriented, community based health action as well as quote from the wealth of documentation, reflections and educational materials that this ferment is generating.

(2)

HEALTH DEVELOPMENT IN INDIA

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

These included the

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

Box 1

(2a) CONSTITUTIONAL PLEDGES

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

It shall ensure

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

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

It shall make

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

and

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

-Constitution of India

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 develooment. This was an important milestone and it became a focus 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 develo ment came under scrutiny and health policy was no exception.

3 a. ASSESSING ACHIEVEMENTS/FAILURES

A study group of the Indian Council of Medical Research and the Indian Council of Social Sciences Research in 1984 listedout the achievements and failures of the whole health care strategy as follows:

TAKING STOCK

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

BOX 2

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)

BHORE COMMITTEE RECOMMENDATIONS FOR 1971

	Recommended	Estimated (1971)		Actuals (1971)		1981 (Actuals)	
POPULATION	~~320 million~~	370 million		548 million		685 million(2)	
PRIMARY HEALTH CENTRES	1:20,000	18,500	27,400	5,112	34,250	5,740(2)	28,510
DOCTORS	1:2000	1,85,000	2,74,000	1,61,129	3,42,500	2,68,712(3)	73,788
NURSES	1:300	12,333,333	1,826,666	80,620	2,283,333	150,399(2)	2,132,934
HEALTH VISITORS	1:5000	74,000	109,600	* 8,347	137,000	@ 19,033(2)	117,967
MIDWIVES	1/100 births	100,000	225,776	* 9,253	231,530	@ 23,200(2)	208,330
DENTISTS	1:4000	92,500	137,000	5,512	170,500	8,648(3)	161,852

As required by Bhore Committee to actual population

Projection as required by Bhore Committee

* Trained upto 1971

@ Trained upto 1981

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

3b. QUANTITATIVE EXPANSION

By 1972, when we celebrated the Silver Jubilee of our independence we had made rapid strides and a phenomenal quantitative expansion of health care services. 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 (Central Bureau of Health Intelligence--CBHI). At bottom of charts mention source: Health Atlas of India, 1986, CBHI.

By 1984, we had increased the number of hospitals and dispensaries three fold, doctors five fold, nurses ten fold and dental colleges seven fold--remarkable development indeed it seemed.

However, when we compare this infrastructural development with the Bhore Committee's long term goals enunciated in 1946 itself, we find the situation very 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!

(3c) 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 (Srivastava Report, 1975) had to say: Book (1-4)

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 eudeavour 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 disharmony. 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 obeservations about the inadequacies of the present health care model and exhorted all concerned to search for more relevant alternatives and approaches.

A MULTITUDE OF QUESTIONS

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

Professor Ashish Bose while reviewing the Family Welfare programme has this to say: Box 5

"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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Experts and academics, policy makers and researchers, health personnel and the people all of them have agreed that the quantitative expansion of the health infrastructure and programmes has 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?

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57

Contents

80

Profiles of Training Institutions

(1) International Nursing Services Association (India)
INSA/INDIA

Conducts two training programmes of 10 weeks duration every year on Community Health and Development for health professionals and others involved in Community Health programs. The course is followed by a workshop after one year of every course. The course is divided into 6 weeks class room teaching and 4 weeks field exposure. The topics covered include, health and development, drug issues, nutrition, teaching methodologies, communicable diseases, cost analysis etc. The medium of instruction is English. For details contact—

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

(2) Institute of Health Management, Pachod (IHMP)

Conducts two residential training programmes of 6 weeks duration (Jan and Aug) each on Management of Primary Health care. It is designed to provide a working knowledge of the process of management in the field of health including, management concepts, community organization and development, principles of public health and Health and Management information systems. The course is open to people who are involved in primary health care services. The medium of instruction is English. For further information contact

IHMP
Pachod
Dist Aurangabad
Maharashtra 431121

(3) St John's Medical College and Hospital, Bangalore conduct

(a) Two Community Health Workers Training programmes of 3 months duration each commencing in July and October every year. The training is both institutional and field based. The course is directed at attaining self-sufficiency in knowledge and skill for independant management of a health centre. The trainees are also given basic skills in Herbal medicine, Homeopathy, accupressure and Herbo-mineral medicines, apart from allopathic system of medicine. The course is open to candidates with a basic educational qualification of SSLC or equivalent engaged in health and development work. For details write to

The Principal
St John's Medical College
Bangalore 560034

(b) Post graduate Diploma in Health care Administration

The course is of eleven months duration and it is not a traditional class room lecture oriented one. Emphasis is on job-training, case studies, exercises, seminars etc. It is open to medical doctors, qualified pharmacists, graduates in Commerce, Science and arts with hospital experience. Some of the topics covered in the course are Principles of management, organizational behaviour, materials management, personnel management, finances management and legal aspects of health care. Successful candidates will be

awarded a "Postgraduate Diploma Health Care Administration". The medium instruction is English and organizational Sponsorship is essential. For further details contact

The Coordinator
Healthcare Administration Office
St John's Medical college hospital
Bangalore 560034

(4) RUHSA (Rural Unit for Health & Social Affairs)
Christian Medical college and Hospital, Vellore
conducts
Training programmes on "Community organization and Development" in English Telugu and Tamil for Rural Health and Community Development workers
The Training programme is of twelve duration.
They also conduct workshops on (a) How to start a Community Health Project (b) Communication - its role and relevance to Rural Health and Development. A Fifteen months Diploma Course in Community Health management (in conjunction with VHAI) an Certificate (4 months) Course in Integrated Rural Development are other training programmes of RUHSA.
For details contact: Head of RUHSA Department
RUHSA Kamesh Post
North Arcot Dist
Tamil Nadu 632209

(5) Christian Fellowship community Health Centre and Christian Education, Health and Development Society, Santhipuram, Ambilikkai 624612 Anna Dist, Tamil Nadu.

Also conducts various training courses such as

1. PG Diploma courses in Applied Nutrition and Dietics and catering
2. PG Diploma courses Health and Development
3. Diploma in community Health (CH Guide) - 2 yrs
4. Multipurpose Health Workers (ANM) course
5. Village Health Workers (VLW) course

These courses are either under Madurai Kamaraj University or are recognized by the government. They also conduct special courses on Rural Health orientation and short term courses for voluntary institutions. For details write to the address mentioned above.

(6) Voluntary Health Association of India conducts

(a) Diploma course in community Health Management (DCHM) of 15 months duration in conjunction with RUHSA, Christian Medical college, Vellore. The course is residential and is conducted in RUHSA campus. The course is open to people engaged in health and development field, preferably with a Bachelor's degree/Nursing certificate. On completion of the course, a Diploma will be awarded by the VHAI. For details contact: The Director, DCHM course
RUHSA PO, North Arcot Dist
Tamilnadu 632209

(6) Two year certificate course in Community Health Planning, organization and Management. This is a correspondence course designed for managers, supervisors and others involved in health and development work. The course covers principles of management, personnel management, materials management elementary accounting, basic labour legislation etc. For details write to:

The Coordinator
Community Health Education Training & Personal Development
VHAI
40 Institutional area, South of IIT
New Delhi 110016

(7) Jawaharlal Nehru University, New Delhi

The Centre of Social Medicine and Community Health of this University conducts M.Phil programmes of two years duration in Social Sciences in Health for postgraduates in Sociology, Psychology, Public administration, Political Science, Economics, Anthropology etc. Successful MPhil graduates can pursue their PhD work (3 years) in the same discipline. The Centre also has programmes for MBBS and MSc (Nursing) graduates leading to the award of Masters in Community Health (MCH); the MCH holders are eligible to pursue their PhD Programme in Community Health. For details write to the Centre of Social Medicine and Community Health, School of Social Sciences, JNU, New Delhi 110067.

(8) Deenabandhu Training Centre,
RK Pet 631303, Tamil Nadu

Conducts 6 weeks Leadership Course in Community Health and Development: It is designed to upgrade the skills of middle level community health workers without specific academic qualifications. The participants should, however, be able to read and write English. The training programme covers topics such as concepts and approaches to community health; Human relations, communications; programme management; MCH, communicable diseases, development activities including income generation, survey methods etc. For details write to

The Course Coordinator
Deenabandhu Training Centre
R.K. Pet 631303, Tamil Nadu

CH Training in India - Profiles

- Secondarily Hr Dev (Leadership C. 6 weeks
- CH & Dev Co 10 w
- CH W 12 weeks

Is this social process dimension and value orientation in health action being taken seriously today?
Our study-reflections show that this awareness is gradually evolving as serious groups and committed project initiators subject their action to a critical evaluation in the context of an ongoing social analysis e.g.

- The Deenabandhu Project (Tamilnadu) reports two emerging policy changes in their project which symbolise the recognition of these dimensions
  i) A shift of the programme from its initial focus on total community - rich and poor alike to a focus on the target group of powerless - the landless and the harijan.
  ii) Introduction of a comprehensive account of the nature of poverty and its relationship to ill health, the unjust distribution of land, oppression in the name of religion and other factors in the women village health workers training programme to instill in the women's mind the class nature of ill health

- RCH, Mangrol (Gujarat) records its experience of working among the marginalised poor in the eastern belt of Gujarat and the movements of their efforts from 'health of women and poor children' to organising the poor tribals villagers to challenge the unjust rehabilitation programme for villagers losing their homelands due to the Narmada dam project

- The Badokhan project (Ganjam, Orissa) records the journey of its health workers in helping the people to move from a magical understanding of their problems to a critical one so that they can strike at the root causes. Diarrhoea is not treated only with ORT but the villagers march to the block development office to demand a well as a right of the citizens of India and then when materials and resources were made available dug their own well (collective) as a symbol of their unity and mutual concern ( )

- Community Health Programme (Pachod, Maharashtra) records its efforts in participatory management which implies a redistribution of powers to take decisions and is convinced that this process can increase health awareness effect community reflection and increase demand on health services apart from contributing to social change

- Miraj Project (Maharashtra) records that due to its efforts in training all health workers of various religions and castes together and taking their meals together the age-old caste system is breaking down and the Dais from the harijan (low caste are called upon by upper caste Hindu women to conduct deliveries

- The medico-friend circle a national network of doctors and health activists stands for demystification of medicine,

All these examples taken together show that this social process dimension is beginning to be taken seriously by many groups and there is a move away from developing isolated models to locating the initiative in a local socio-political cultural context.

It must be recognised at this stage that most of the health-action initiatives ~~today~~ are in the NGO/voluntary sector do not set out in their exploration of an alternative health care process after a thorough societal analysis or a critical analysis of the political economy of existing health and health care services. Much of the innovation and creativity is therefore of an adhoc nature action and ideas evolving by trial and error. There is on the other hand a lot of aberrations as well due to this critical lack of understanding of 'health in society'. This aberration manifests in many ways. ~~Most common of which are that the so called people oriented health care programmes' become converted~~

i) A gradual conversion from focus on the poor and indigent to a preferential option for the well to do and paying patient

ii) A promotion of a distribution service and not the evolution of an enabling empowering service

iii) Increase in size, bureaucracy, compartmentalization, over professionalization and hierarchical decision making cut off from the lives of the poor

iv) A preoccupation with ~~need~~ targets and

decentralised
democratic team functioning, active community participation, medical practice built on humane values and equality and firmly opposes the negative unhealthy values of our society which include money and power are glorified, division of money and power, division of labour into manual and intellectual workers, domination of men over women, urban over rural, foreign over Indian

- The Community Health Training Team of the Catholic Hospital Association of India (Secunderabad) defines community health 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 programme' Its training programmes for middle-level workers are therefore based on this perspective

- The Mandwa project (Maharashtra) recounts that its experiment of training semi-literate village women as health workers was opposed by local powerful rich leaders and the government health personnel since they demonstrated results superior to those of the professionals demystified health and reduced peoples dependency. This resulted in loss of practice in the private sector, created surveillance and brought accountability in a normally unaccountable ~~private~~ public sector. The powerful leaders ~~dare~~ were fearful of an alternative power structure developing through the project.

efficiency and cost effectiveness
records, and numbers, rather than a
focus on indices of equity, participation,
quality of services and health abilities of the local
people.
This is inevitable when health action
is not located in a wider socio-political
-economic-cultural analysis of society and
is a great danger faced by all those
who begin this exploration today. Moreover
all those who began this search today

Conclusion

The search for a people oriented health
system explored in this article highlights
that based on the collectivity of Indian
experience
invariably emerge out of the education and
health system which are themselves
not geared to a peoples orientation
Therefore an attitudinal change and
a value reorientation become pre-requisites
though not always ~~possible~~ easy.

In Conclusion: This short exploration
highlights some of the action dimensions
of the search for a people oriented
health system in India. It also highlights
some of the social process dimensions
that need to be recognised by health
action initiators to ensure that the
project/process that evolves ~~emerges~~ through their
effort does not lose its people-orientation
somewhere along the way.
The examples given are a small selection
~~of~~ from the wealth of experience
and reflections emerging in the country

in the last two decades. The main plea of this paper is that the quest for a people oriented health system must not become a quest for a new package of action or a new technology fix. It has to be a new vision, a new attitude of mind and a new value orientation in health action interwoven closely with efforts to build an alternative socio-political-economic cultural system in which health can become a reality for all people'.

'A movement not a project
a means not an end'

Additional Reading

1. Community Health: Search for an alternative process (A CHC reflection)
2. Towards a Paradigm shift', Link Vol 7, No 2 Aug-Sept '88
3. Health and Power to People, Medical Service Vol 43 No 2 Feb-Mar 88
4. Learning from the Rural Poor, ISI, New Delhi
5. Alternative Approaches to Health Care, ICMR, New Delh
6. Evaluation of Primary Health Care Programmes, ICMR New Delhi
7. Health for All - an alternative strategy - ICMR/ICSSR Report
8. CONTACT Nos 82, 44, 32, 10 Christian Medical Commission Geneva
9. The medico friend circle pamphlet and anthologies
10. Development with People, ~~Indian~~ ISI, New Delhi
11. The Mandwa project, Int. Journal of Health Service Vol 18 No1, 1988
12. Anubhav Series: Experiences in Community Health
Ford Foundation, New Delh
13. Formulating an alternative Rural Health care System for India
D Banerji,
14. The medico friend circle anthologies
14. Taking Sides: The choices before a Health worker
C. Satyamala et al, Anitha Trust