SARAI PLAN

Half the population in Sarai Village is tribal while the other half is low caste people. The land around the village was owned by the tribals earlier but now it belonged to the 'Malik' in the nearby village and the Sarai villagers were working for the Malik for the wage of Rs.3/- per day. The nearest medical facility was in the town about 27 km away. There was no motorable road for 10km to the town. Diarrhoea deaths during monsoon and famine deaths during lean season was a common occurance. The children and mothers were highly anaemic.

It was at the state Fr.Amal came to this village. He spent sometime with the villagers and came to the conclusion that something had to be done. He contacted the Sisters of Charity and explained the condition of the village. Sr.Karuna in that community was occassionally visiting some villages near their station. She talked to Sr.Sneha and both of them decided to work in the village of Sarai and obtained necessary permission from their superiors.

Question: What will be your plan of action if you were in the position of Sr.Karuna and Sr.Sneha?

Mi:19.09.1986:200.

CASE STUDY : CHAKRAPUR

Chakrapur is about 20 km from the project base. It is in a hilly area and is quite cut off from other villages. The people depend on each other for survival. Very few of them are literate. Caste feeling is not very strong in the village.

45% of the villagers are Yadavs
25% " " Brahmins
20% " " Harijans
5% " " Kumbhars
5% " " Muslims

The people requested the Community Health Project (CHP) to open a health clinic 2 years ago and gave full cooperation. They provided a place for the clinic and repaired the road partly through shramdan, Panchayat's cash donation and food for work programme started by the CHP.

Then the project director decided to train a Village Health Worker (VHW). He chose Lakshmi, an intelligent though poor Kumbhar woman. After the training Lakshmi was very efficient and responsible in her work. The villagers were quite satisfied with her. She was therefore also made responsible for distributing bulgar and milk in a feeding programme for the village children.

Some months later a Farmers' Club was formed for the benefit of all in the village. The club committee had a representative from all caste groups. The project's social worker, was also a member of this committee. He was supposed to coordinate the different activities of the programme in the village, though the project director had the ultimate authority.

Recently, the Farmers' Club criticised the VHW's work. They felt she was distributing only half the bulgar and suspected she was cheating. They complained to the social worker and also told him that the VHW was of "low moral character". The social worker, who respected both the club members and the VHW, went to investigate. He found the VHW was actually distributing less bulgar and told the project director about this.

After some days the Farmers' Club demanded that the 2 village volunteers that helped the VHW be replaced by people chosen by the club. The VHW knew the project director had faith in her. She argued with the club members that her helpers were already trained in their work and the children listened to them. She saw no reason to waste time and effort in training new people.

The matter was left as it was. Two months later the VHW asked all the parents of children in the feeding programme to pay Rs. 0.25 per month for the food. She also ordered them to bring some salt to be mixed with the bulgar. The Brahmins and Yadavs of the village were adamant that their children should not consume Harijan's salt as that amounted to breaking the 'sacred' caste code. They threatened the VHW with dire consequences if she went ahead with her proposal. The VHW, secure in her position, ridiculed them as 'High Caste Fools'. She threatened the Brahmins and Yadavs by saying "I'll see to it that you get no work in the food for work programme". Of course she had no authority to say this. A heated discussion followed. One of the members of the Farmers' Club slapped the VHW.

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CASE STUDY : VISHALNAGAR

A group of Health Workers were living in a Health Centre one mile away from Vishalnagar. A landlord of this village requested the Health Workers to open a dispensary and agreed to donate land for the building. The Health Workers opened the dispensary and had been working there for about six months when one day some people from the village threw stones at them. The Health Workers were at first shocked by this violence. After some days they decided to ask an outside agency to help them find out what had gone wrong. The group did a survey of the village and we are giving below some of the information they found out :

Vishalnagar has a population of 525 and there are 90 households in the village. The average number of people per house is 5.8 and the average number of children per house is 2.7.

Economic structure :

Most of the village people depend on agriculture for their livelihood. The total acreage under cultivation is about 400 acres.

Land holding pattern :

1 farmer	-	250 acres
1 farmer	-	100 "
1 farmer	-	30 "
17 families	-	some land (less than 2 acreas each)
66 families	-	landless labourers

The land of the landlords is cultivated by tenants but there is no document to prove the tenancy. These tenants are small farmers and landless labourers. At harvest time 50% of the produce goes to the landlord and the remaining 50% (after subtracting the price of seeds, fertilizers, electricity bill) is distributed among the tenants.

Wages : Women are paid Rs.2/- per day
Men are paid Rs.4/- per day

Other sources of income :

There are 36 cows, 16 bullocks and 19 buffaloes in the village. Except for 10 animals the rest of the livestock belongs to the three landlords. The animals are cared for by the Harijans for which the Harijans received Rs.3 to Rs.5 per month as wages.

Credit :

The landlords are the main money lenders. There are no co-operatives or banks in the village. The village people take loans mostly to buy grains when they have no work, for marraiges and for funerals. They have to repay the loan during the harvest season and the amount is cut off from their wages. The interest rate is between Rs. 10 - Rs.12 per Rs.100 per month. Normally after the loan has been cut off a labourer gets no more than Rs.15 - 20.

Housing :

The landlords live in good houses. Most of the Harijans live in little huts. A few years ago the Government donated some land to 30 Harijans to build their houses. As some of the land was outside the Panchayat's limit the Harijans were not

able to get finances to build all the houses. Only 15 houses could be completed. At the time of the survey seven of the 15 houses were in the hands of the landlords(mortgaged). The houses in the possession of the landlords were rented out to the Harijans for Rs.10 per month.

Political Structure :

The Panchayat office is situated in the neighbouring village. There are two panchayat members in Vishalnagar. These two members are the Puppets of the landlords. After their election to the Panchayat, they have got the Government grant to dig two drinking water wells, electricity the village and build the 15 Harijan houses.

Religious groups :

Hindus	- 66.2%
Christians	- 33.5%
Muslims	- 0.3%

The whole village celebrates the festivals of different religions together.

Caste structure : There are 3 main casts in the village:

Reddys	- 25.7%
Harijans	- 37.2%
Vaddas	- 17.4%
Others	- 19.7%

Of these the Reddy are the dominant caste. Untouchability against the Harijans is still practices. The Harijans are not allowed to take water from the same well.

Health Status :

The staple diet is ragi, dhal and green vegetables. The rich landlords have two meals in a day whereas the poor people have only one. There are no serious illnesses in the last year except for two cases of Asthma. The motality rate in children is low. 10% of the Harijans families had limited their family size by the birth control operation.

Health Services :

There is no private practitioners in the village. The Government hospital is about 2 miles away. The dispensary run by the Health Workers does not get more than one or two patients per day. The Health Workers were giving medicines, grains, mild powder and clothes to the landlord for distribution among the poor but these things never reached the poor.

Needs :

When asked what the people needed most, the majority expressed their wish to have a house of their own. Some of them are living in rented houses belonging to the landlords. (If the labourers fail or refuse to work in the fields of the landlord, the landlord would simply lock the houses. The other people are staying in huts). Another need the village people expressed was a school. The poor people also asked to be provided with cattle as there was no possibility of them acquiring any land. In spite of the poverty and misery many expressed the desire to build a place of worship.

Needs in order of people's priority:

1. Houses
2. School
3. Cattle
4. Temple
5. Better wages

****

CASE STUDY : GUMRI (T.W.)

Gumri Health Centre had a staff of three trained ANMs, Sindhu, Kamala and Balama. Balama was the most experienced of the three having worked in a good Community Health Programme for three years. She had also attended a course inCommunity Health and Development. Sindhu and Kamala had joined Gumri immediately after their training 5 years ago. These ANMs decided to start a Community Health Programme in the nearby villages. As Balama was more experienced, she was naturally chosen as their leader.

The ANMs visited several villages. They selected three of the villages where they had been particularly well received. Together they discussed the objectives of their programme and how they would go about implementing it. They decided to take as target group the under-five children and the women of child bearing age. Balama who was aware of the necessity to have the people involved in the programme, insisted that they should first spend time visiting the villages, befriending the people and learning about the problems of the communities before starting any specific activity.

Sindhu and Kamala did not contradict her, but Sindhu felt strongly that immunization and Family Planning programmes should be started immediately. Sindhu thought, "After all, don't we all know that these programmes are a priority? Then why waste time visiting the villages, and chatting with the people when we could already start good programmes?" Kamala was a happy, go lucky person and could not care less what she started with. She was therefore ready to follow Balama all the way.

Still, after their discussion, the following plan of action was decided:

1. Joint weekly visits to the three villages
2. Primary level curative service to be started immediately
3. Intensive visits of the families to be done
4. Leaders to be identified, good rapport with the people to be established, before starting specific programme
5. Health programme to be planned jointly with the people.

Sindhu was amused. "Whoever would think of planning with the people?" she thought. So they started their work. After six months a visitor helped the health workers to review their activities in order to find out how things were progressing.

The following observations were made:

1. The three villages were regularly visited by the three workers once a week. During these visits the patients were first seen. Then the workers visited the families separately. Besides this, Balama and Kamala very often went together for an extra weekly visit to all the villages. During that time Sindhu went to the PHC and obtained from the doctor there, DPT and DT vaccines.

2. Balama and Kamala took time to visit the families, discussed with the people and became quite friendly with all. They met the Sarpanch and several of the important people in the village and discussed with them the community's needs. They learnt that, in two villages, there was no drinking water facility and this was a real problem. The drinking water had to be taken from a pool where buffaloes took their bath.

.....2/

3. Sindhu visited the schools and Balwadi, gathered the children present there and gave the first dose of DPT and DT to 450 children. When the time came for the second dose, only 200 children received the dose (it was the marriage season and many children did not come to the school).

4. During another visit, Sindhu had also gathered the women to give health education. She expected, through this programme, to be able to motivate the women for family planning. The first day all the women came as they did not know what to expect. But soon most of the women dropped out of the class.

After two months of the work Sindhu decided that it was a waste of time to visit the villages so often and so decided to visit once a month only. Balama and Kamala continued their weekly visit with the same enthusiasm.

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chtt:pt: 19.5.'81

Prepared by
Community Health Team
Voluntary Health Association of India
C-14, Community Centre, S.D.A.
New Delhi-110 016.

FIGHTING BACK

It started two months back when five Harijans of Karamchedu village of Prakasam District in Andhra Pradesh were killed by the Kamma landlords of the area. The government refused to arrest the culprits. The Harijan MLA's were reluctant to raise the problem in the Legislative Assembly. Upon this, more than 500 Harijans of Madiga sect moved from Karamchedu even though the Mala Harijans refused to join them for fear of unemployment.

The Madiga settled down in Chirala 8 K.M. from Karamchedu. Under the leadership of Kathi Padma Rao, a Harijan college lecturer, Karamchedu Victims Relief Committee has been formed. From Rs.1.20 lakhs they raised as donations from various sources, they bought 8 acres of land and have started building new homes. Though they left Karamchedu without money or posessions, their unity and defiance have helped them to build four thatched huts and an open community kitchen to serve them rice or gruel twice a day. They have definitely clarified that they would not accept any official help. They have named the village Vijayanagar.

The Harijan representatives of Andhra Pradesh are using this personal trajedy of the death of five Harijans as a stepping stone to a social movement which will fight against the opression of downtrodden in the state. They met at Chirala and called for a'rail aur rastha roko' agitation on September 8th. This agitation disrupted the traffic upto Hyderabad. The demands were that the real culprits who are related to political leaders be punished and that the migrated Harijans be permanently rehabilitated in Vijayanagar.

The Kammas of Karamchedu accuse Padma Rao of trying to gain political leadership and money from the trajedy. They claim that before the incident took place, there was close inter-caste relationship between Kammas and the Harijans to the extend that both of them were drawing water from the same pond and that the Killing occured when Kamma youths were assaulted by Harijans.

(India Today Sept. 30th '85)

Why did the Madiga

Why did the Madiga Harijans of Karamchedu take to this course of action?

What are the features of this people's action?

What relation do you see between the responses of the Government and the Kammas?

Why Harijans and Tribal murders are frequent occurences in India?

What all factors contributed to spreading this micro (village) level incident to a macro (state/national) movement?.

Community Health Department
C.H.A.
C.B.C.I. Centre
Goledakkhana
New Delhi-110 001

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

SHORPAKKAM . CASE STUDY (DUPLICATION OF SERVICES)

A team of health workers, attached to the private health centre of Shorpakkam, decided to start a community health programme in an area near their health centre. They knew that they would not be duplicating services because the Government Primary Health Centre was situated more than 20 km. from Shorpakkam, and people visited, attending Shorpakkam health centre had told them that nobody ever visited their village.

The health workers of Shorpakkam had good rapport with the villagers through the dispensary attached to the health centre. The workers studied their OPD records and found that their patients were mainly coming from three fairly big villages situated between two to three km. from Shorpakkam.

The health workers discussed with the patients of the three villages the possibility of developing community health programmes in their respective villages. All of them were very keen on this and repeated that nobody ever came to visit them and help them with their health problems.

And so the health workers started their programmes in the three selected villages. They had a weekly dispensary, mother and child health programme with CRS food supply and house to house visiting.

During their house to house visit of one of the villages, the health workers came across a Government ANM who was residing in that particular village for the past one year. It seems that the PHC had opened three new sub centres in the past year, and one of these sub centre was in this particular village. The ANM was a very nice person and seemed to be well accepted by the women of the village.

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Prepared by
Voluntary Health Association
of India, C-14 Community
Centre, S.D.A. Delhi - 16.

Questions :

1. The people of one village misled to the health workers of Shorpakkam. Why, do you think did the people hid the fact that there was a govt. sub centre in their village ?

2. On the base of the peole's word the health workers started a Community Health Programme. Are there any other steps the health workers should have taken before choosing the villages? What steps ?

3. If you were in the same position than the health workers of Shorpakkam, what you do now ? Explain your answer.

QUESTIONNAIRE

a. Read the list of adjectives given below. Which six adjectives seem to you to be the most accurate when describing villagers.

1.
2.
3.
4.
5.
6.

Shrewd	Analytical	Powerful	Sensitive
Competent	Generous	Over-bearing	Weak
Lazy	Shallow	Exploited	Backward
Reliable	Insecure	Risk-taking	Hard-working
Mature	Conservative	Impulsive	Immature
Unco-operative	Emotional	Naive	Idealistic
Irresponsible	Restless	Progressive	Apathetic
Enthusiastic	Frustrated	Uncommunicative	Responsible
Money-minded	Confused	Helpful	Appreciative
Unreliable	Dogmatic	Concerned	Incompetent
Ignorant	Efficient	Childish	Cautious
Stupid	Paternalistic	Unkind	Independent
Kind	Dependent	Supportive	Skillful

b. From the same list, which six adjectives seem to you to be the most accurate when describing yourself?

1.
2.
3.
4.
5.
6.

c. From the same list, which six adjectives do you think would describe qualities most desirable in a development worker?

1.
2.
3.
4.
5.
6.

THIRUNELLY - CASE STUDY

Thirunelly is situated in Wynad District of Kerala State, adjacent to Karnataka boundry, with thick reserve forests around and it has a population of 2000 people. 90% of the inhabitants are Adivasis who once enjoyed the ownership of the entire land. But later, with the invasion of migrants from other places, the illiterate and simple Tribals lost all their land and today they own only 10 to 15 cents of land and a few people have 2 to 3 acres. About 95% of the people are agricultural labours. The nearest public health centre is 4 km. away from this village, and the lower primary school in the area has 86 students but only 8 are Adivasis. There is a temple in Thirunelly, which attracts pilgrims from all over the country.

Thirunelly comes to limelight and public attention every year because of mass deaths in the beginning of monsoon, when there is no work, People are affected by Diarrhoea vomiting and fever and quite a number of them succumb to it. Government named this phenomenon gastro-enterits. In 1977, 13 people died and many groups like Lions Club, Jeycees and other agencies including the Diocese brought in aid from outside. Later in 1978 Diocesan Social Service launched a conscientization programme in their village on a massive scale.In 1978, 8 people and in 1979, 7 died again.

Questions.

- Why do mass-death occur in Thirunelly?
- If you are in this situation what programmes would you undertake?

COMMUNITY HEALTH DEPARTMENT
C H A I.

Tribals
Landlessness
Labourer
PHC - Faraway
Schools - Few Tribals
Migration
Network

Diarrhoea.
Water ↓
Food ↓
Income ↓
Inadequate or Irrelevant Aid

ST JOHN'S MEDICAL COLLEGE
BANGALORE

PARTICIPATION ASSESSMENT (First Step)

1. Check off the things that you did during today's session.

_____ I listened
_____ I read
_____ I copied down notes
_____ I wrote down my own ideas
_____ I mentally evaluated ideas presented by others
_____ I offered ideas of my own verbally
_____ I took part in small group discussion
_____ I took part in whole group discussion
_____ Any other ? Specify : _____

_____ I engaged in problem solving individually ----- in a team
_____ I related theoretical concepts to my own field experience
_____ I role-played
_____ I participated in practical activity
_____ I created or helped create a (communication) message
_____ I got bored
_____ I fell asleep

2. Which statement best describes the way you feel in a new group ? I generally:

_____ prefer to sit quietly and listen to others
_____ feel quite at ease taking part in discussion
_____ find myself ready for some form of leadership role
_____ sometimes wish I could take over and structure the discussion
_____ feel ill at ease
_____ prefer to listen for a while and then participate after I have a feel for the group
_____ other _____

3. Imagine that you have been approached by a social reformer who wants you to change some aspect of your lifestyle in the interest of the nation or of the world, or perhaps just "for your own good". You appreciate the new point of view, but are also aware that any change on your part would involve certain personal risk and criticism from some of your peers. What would you do? You may check off more than one box, but if so, rank them by number.

_____ Take the social reformer's advice and adopt the change right away.
_____ Wait to see what other people will do.
_____ Actively look for other community members who are interested, and form _____ a study group _____ an action group
_____ Try to learn more about the subject without letting anyone know of your interest
_____ Other response (specify) _____

.... 2

4. Facing problems
1. List 5 specific problems that you and people in your peer group often face.
2. Number them in order of difficulty of solution.
3. Put an asterisk in front of those that can be solved only through influential connections.
4. Put a circle around the ones that require a lot of money to resolve.
5. Underline the ones that affect you in particular.
6. Re-underline the one that would make you most happy if solved.
7. Against each of the problems that affect you, write the date when you last did something towards solving them.
8. Check off the ones that you have been able to solve
9. Consider: what does this exercise tell you about your ability to confront problems ?

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HANDLING CONFLICT

1. The ELEMENTS of conflict, as examplified from "The Prisoners' Dilemma":

A: ASSUMPTIONS:

They may be accurate or inaccurate.

1. Accurate: "The object of this game is to make as much money as possible, without hurting or helping the other".

2. Inaccurate: "The object of this game is to beat the others".

I: INTENTIONS:

They may be genuine or exploitive.

1. Genuine: "We must earn money"

2. Exploitive: "We must win".

C. COMMUNICATION:

It may be evaluative (judgemental, accusatory) or merely descriptive (direct, non-accusatory); and it may include positive or negative feelings.

1. Evaluative and judgemental: "You crooks can't be trusted!"

2. Descriptive and Direct: " I am not sure I can trust you"

3. With negative Feelings: "You're cheating!" (Anger)

4. With positive feelings: "Let's both play the blue card"(Trust)

D. BEHAVIOUR:

It may be reactive (against) or proactive (for); rejecting or accepting; defensive or open.

1. Reactive : "We'll play the red card!"

2. Proactive: "Let's play the blue card."

3. Rejecting: "No negotiations with them!"

4. Accepting: "Let's give them a chance to prove themselves."

5. Defensive: "Be careful! They are out to trick us!"

6. Open: "Whatever happens, we'll stand by our word."

TWO POSSIBLE APPROACHES to resolve a conflict;

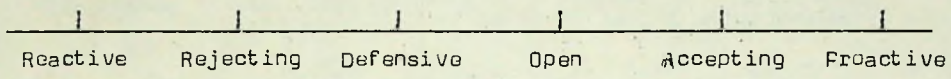
A. From the level of Assumptions and Intentions:

ASSUMPTIONS

Accurate | Inaccurate

--- To move from Conflict situation to a Problem-Solving one, correct the assumptions and intentions of both sides. (see Page 3)

B. From the level of Communications and Behaviour:



(Negative Feelings: "Against") (Positive Feelings: "For")

___To move from Conflict situation, a move to the right in this case would be the right one.

PARENT-ADOLESCENT CONFLICT

Situation:

An over-protective mother and a rebellious teenager.

Mother: "All I want is that my son should be happy and secure."

Son: "I wish she'd stop talking about my happiness. It's she who makes my life miserable. Her whining and worrying and ragging are driving me crazy!"

Assumption:

1. Inaccurate:

Mother: "He needs me to look after him."

Son: "She's out to embarrass me and make my life miserable."

2. Accurate:

Mother: "He doesn't like my babying him."

Son: "She's concerned about me."

Intentions:

1. Exploitive:

Mother: "He'll do as I think best and like it!"

Son: "I'm going to see that she keeps out of my hair!"

2. Genuine:

Mother: "I really want my son to grow up happy."

Son: "I want to prove to her that she need not worry about me".

ASSUMPTIONS

	Accurate	Inaccurate
	Mother: "He doesn't like my babying him, so I have to find out how I can best help him to be happy and mature".	Mother: "He's not old enough to look after himself, so I've got to do what is best to help him grow up happy".
positive	Son: "She's worried about me, so I have to show her, that she need not be; that I can stand on my own feet".	Son: "Until I can prove to her that I don't need her to wipe my nose; she's going to drive me crazy. So I'd better show her that I am old enough to take care of myself."
	PROBLEM-SOLVING	HELPING APPROACH
INTENTIONS		
	Mother: "He may not like it, but he'll do as I say as long as he's my son."	Mother: "He is not old enough to look after himself, so I intend to tell him how to behave, whether he likes it or not! After all, Mother knows best!"
exploitive	Son: "Let her worry! I'll pay her off against my father. What she doesn't know won't hurt her!"	Son: "As long as she keeps nagging me and embarrassing me in front of my friends, I'm going to stay as far away from her as possible, and do whatever I please!"
	MANIPULATION	CONFLICT

III HOUSE RENT

Find out through inquiries what is the minimum rent for a quarter in a bustee or village per month = Rs._____(III)

IV MISCELLANEOUS

Expenditure for fuel, light, etc. is calculated as 20% of the total monthly income.

- Food	(I)	Rs. _____
- Cloth	(II)	Rs. _____
- Rent	(III)	Rs. _____
TOTAL		Rs. _____ X 1/4
= Miscellaneous		Rs. _____(IV)

Therefore, the minimum amount of money needed today to support a family of four in your area = I + II + III + IV = Rs._____.

A

1. Extent of inequality in the world today:

a. In 1850, 3/4 of the world's population possessed 5/8 of the world's wealth.

In 1975, 2/3 of the world's population possessed 1/8 of the world's wealth

b. Whence came this uneven distribution of the world's resources?

"The tilting of the balance in favour of the West has come about in the last 130 years.....through the gun, through colonial plunder, slave trade, slave labour, child labour, racial discrimination, the creation of a dispossessed proletariate, and the destruction of the soul and life-style of many peoples."

(S.Rayan)

c. The growing gap between the rich nations and the poor had already been pointed out by Barbara Ward in the 1950's but the gap continues to widen:

"Today 85% and tomorrow 90% rot in misery to make possible the economic comfort of 15% today and 10% tomorrow"

(Heder Camara)

d. The result of this inequality is the ABSOLUTE POVERTY of millions in the "fourth" world:

- 1/3 to 1/2 of the two billion human beings in Asia, Africa and Latin America suffer from hunger and malnutrition.

- 1/5 to 1/4 of their children die before their fifth birthday, and millions of those who do survive lead impoded lives, due to brain damage, stunted physical growth and sapped vitality due to undernourishment.

- The life expectancy of the average person is twenty years less than his counterpart in the affluent world; that is, he is denied 30% of the life-span of one born in the developed nations: he is condemned at birth to an early death.

- 800 million of these people are illiterate and, despite continued expansion of educational opportunities, even more of their children are likely to be so.

e. Julius Nyerere, President of Tanzania, has warned the rich nations: "Poverty is not the real problem of the modern world, for we have the knowledge and the resources which will enable us to overcome poverty. The real problem of the modern world, the thing which creates misery, wars and hatred among men, is the division of mankind into rich and poor".

f. It is not so much the question of some having more to eat or better clothes to wear, while others cannot provide even the basic requirements; it is rather the power that this wealth gives to some to dominate, to oppress and to exploit the others. In so doing, the rich and powerful justify themselves: "We deserve this wealth and power: we have put our God-given talents to use and have worked

2. Extent of inequality in India today:

a. While we often and with some justification, blame all our problems on the greediness of the affluent, developed nations, the same ever-widening gap between the "haves" and the "have-nots" appears here even.

b. Within our population of upwards 600 millions of people, roughly 250 million live below the "poverty line", that dividing line that demarcates bare minimum of survival for an individual. This is the bottom 40 per cent. Another 250 million live just above the "poverty line" of human survival. The remaining 15-20 per cent, in an ascending pyramid represent the wealthy, dominant classes with power, position and quality education: the raw material for further exploitation of the others.

c. In rural India, the top ten per cent own 50% of the land, while the bottom 50 per cent own 4%; top ten per cent get 1/3 of annual income of the nation, while the bottom 50% get less than this amount for all of their numbers. 0.1% of the population owns more than half the wealth of the area.

d. The poor are organised, without political power, and are taken advantage of. A slum dweller admits: "Even to get a sweeper's job, we have to pay a bribe of Rs.200/-"

e. The very poor (bottom 40 percent) have less than Rs.40/- per month to spend. Most cannot read or write.

IMAGES

Lazy	Insecure	Impersonal
Dependable	Conservative	Progressive
Mature	Emotional	Uncommunicative
Uncooperative	Restless	Helpful
Professional	Frustrated	Concerned
Irresponsible	Confused	Backward
Enthusiastic	Dogmatic	Hard-working
Money-minded	Efficient	Immature
Loyal	Insincere	Idealistic
Undependable	Over-productive	Apathetic
Encouraging	Risk-taking	Responsible
Supportive	Self-controlled	Unprofessional
Over-sensitive	Impulsive	Appreciative
Superficial	Naive	Exploited

1. From the list of adjectives given above, which seem to you best to describe the urban worker? Select as many words as you wish. If you wish to add one of your own, feel free to do so.

2. From the same list, which adjectives seem best to you to describe the unemployed?

3. From the same list, which adjectives seem best to you to describe the villager?

4. From the same list, which adjectives seem best to you to describe the average student?

5. From the same list, which adjectives seem best to you to describe your parents?

6. From the same list, which adjectives seem best to you to describe yourselves?

C

HOUSE VISIT SURVEY

1. What community do you belong to?
2. How many members are there in your family?
3. Are all the children going to school?
4. How many members of the family earn living?
5. What are the market prices? rice? wheat? dal? oil? etc.?
6. Can you manage to buy what you need for the family?
7. What are you most worried about now? low employment? rising prices? children's education? health? debts? etc.
8. What kind of injustice are you facing in your daily life? unfair practices? discriminations?
9. Do you get any help from any source in solving your problems?
10. What kind of support would you like to get from us? How could we help you?
11. What makes you feel happy about your life?
12. What are your hopes and ambitions for the future?
13. Family make-up: ages (children, teenagers, adults, old) and sex.
14. Type of house: mud or cement; number of rooms electrified or not; owned or rented.
15. Occupation of wage-earners; self-employed or not: farmer, factory worker, government worker, contract labourer, teacher, etc.
16. Education: how many literate; how many with basic schooling; high schooling, higher studies; language(s) spoken.
17. Income: sources and how it is spent on food, clothing, fuel and lighting, entertainment, rent and other things.
18. Savings; in what form
19. Religion and caste
20. Medical facilities at family's disposal.

At the end of each interview, you should record your findings to these questions once you have returned home.

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D

1. Do our findings differ according to the section of town we come from? Why might this be so?

2. How does this "minimum monthly income" compare with the incomes of the families we met during our house survey last time?

3. Do the families we met then exceed the number of members of the "model" family of four we have used on this survey? What would this mean with regard to their minimum monthly needs?

4. What may be the consequences when minimum monthly requirements and income do not meet? Cutting corners? family insecurity? undernourished and underclothed children? etc.

5. What are some of the possible consequences of family insecurity? quarrels? drunkenness? indebtedness that becomes chronic? etc.

6. Who is to blame for so many people in our community living under or just on "the poverty line"?

7. Where does your family shop? What type of rice does your family buy? What type of cloth? How much rent? How much entertainment goes into your miscellaneous expenses?

8. Was this a new experience for you, or have you often done the shopping in the past?

9. How did you go about choosing the market and the different shops?

10. What did you learn from this experience?

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COMH

AN OVERVIEW OF DIFFERENT COMMUNITY HEALTH PROGRAMMES IN INDIA

(MODELS AND APPROACHES)

I. INTRODUCTION

Community health approach to health care has been widely recognized as the right alternative for ensuring health to the poor millions in developing natives. In India too, governmental as well as voluntary efforts are made for the promotion of community health. In the evolution of health care system, this approach has emerged through a process of dialogue between the medical and the social sciences in an effort to make the health care system relevant and responsive to the socio-politico- economic realities in the society. Again, in the process ofevolution and formulation of community health in terms of its principles, philosophies and methodologies, various models have been proposed and practised. In this paper an attempt is made to categorize these models into four, each with its own characteristic features.

Further, each model with its characteristics could be explained as following a certain approach in community health. These approaches are broadly divided into three. An understanding of these three approaches could give us a frame work to assess as to which approach each models follows. Another interesting correlation is that each of these three approaches reflects a certain philosphy of development work.

In the following paragraphs an introduction is made into such an analytical overview. In the latter part of this paper the four models with their characteristics are listed out. Under each model, the particular approach into which it fits into is also given with certain indicators or assessment.

II. DIFFERENT MODELS IN COMMUNITY HEALTH

A study of the ongoing projects and the literature available on them reveals that in India there exists different models/ types of community health products. They fall under four major categories. Each one is run by different types of institutional set ups as big hospitals, small hospitals, rural dispensaries, or run by non structured voluntary health/ action groups. Again, each model is unique in terms of infrastructure, services rendered, needs met,and the results achieved. It would be clear from the forthcoming table.

III. DIFFERENT APPROACHESIN COMMUNITY HEALTH.

Three approaches have been identifyed in community health. They are : Medical approach, health extension approach, Comprehensive approach.

(a). Medical approach: Considers health as the absence of diseases brought about by medical interventions based on modern sciences and technology and sees the role of the community(the people) as responding to the directions given by the medical professionals. It has its roots in the medical model of health care.which believes that the eradication ofill-health depends on doctors and medicines.

(b) Health extension approach: Based on a critique of medical approach. It accepts WHO defenition ofhealth as the total physical, mental and social well being of the individual. Mere advancement of medical

technology and the sophistication of services would not bring health to the majority of the people - especially the poor - and that the approach should be a planned redistribution of health care facilities to reach the vastness of the society. The approach also advocates other socio- economic uplift programmes to enable people to benefit from health care facilities. Preventive care is also emphasized.

(c) Comprehensive approach: Views health, the concept of total well being in the context of the situational realities of the individual. This concept is elaborated by stating that health, the state of total well being, is also a human condition which does not improve either by providing more services or mobilizing the community for providing more health services. It improves only by having the community take control and responsibility for decisions about how to mobolize , utilize and distribute services and resources. Here community is the subject, decision maker, It is a process of conscientization* organization and capacitation of the community for action. It has bearing on the social, economic, political and cultural dimensions of human life, in the sence that the approach strives to bring about changes in them so that there would emerge a society where human life would be more healthy in the complete sense of the word.

IV. COMMUNITY HEALTH AND THE DIFFERENT APPROACHES IN DEVELOPMENT:

Development work is based on certain analysis of the backwardness of the people. According to the analysis , different philosophy of development work are arrived at. They are mainly three approaches: Modernization approach, welfare approach, and social justice approach. In the context of speaking about different approaches in community health work, it would be worth mentioning these approaches. It is interesting to note that reflections of these approaches are found in the three community health approaches.

(a) The modernization approach analyses poverty as the lack of enough production and it makes efforts to gear up production through advanced technology in the field of agriculture and industry. It believes that the result of modernization would trickle down to the lower strata of society.

(b) The welfare approach recognizes different classes and castes existing in the society. It is due to the co-existence of development and under development in the society. This state is accepted as a normal reality. Efforts are made to alleviate the sufferings of the poor through organizing relief and charity work. People are passive receipients here. Recently there has been some changes in this approach and it recognizes the participation of the people and the mobilization of their resource. Programmes also have improved remarkably from relief work to development programmes aimed at the uplift of the poor. through income generating programme, literacy programmes, vocational training etc. The poor continues to exist and the disparity between the rich and the poor also continues as a reality. Statusquo is not disturbed.

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*Conscientization is "an awakening of consciousness, the development of a critical awareness of a person's on identity and situation, a reawakening of the capacity to analyse the causes and consequences of one's own situation and to act l logically and reflectively to transform that reality"
(David Millwood)

c. In social justice approach a critical analysis of the society is employed and poverty and backwardness are understood as man made historical reality. The reasons are attributed to the various forces and the dynamic at work in the society. Poverty is presipitated as a result of injustice. Justice could be brought in only through a restructuring of the society. It could be achieved through empowering the people through awareness building and organization. Ultimate development of the poor would mean fair distribution of the means of production, living wages, consumption of good food, availability of public amenities, practice of human values as love, cooperation and unity.

It becames clear that the analysis and approaches of development work has correlation with that of community health work, Characteristics of modernization approach are reflected in medical approach and features of welfare approach find expression in health planning approach. Social justice approch goes well with, comprehensive approach in terms of its analysis and approach.

V. THE FOUR MODELS AND THREE APPROACHES IN COMMUNITY HEALTH

As mentioned already, the community health programme existing in the country could be classified into four based on the characteristic. The following table would give that. Under each programme a note is made as to which approach of community health it belongs to. To make it clear six indicators are given based on which thise assesment is made. These indicators are: role of health services, role of professional, role of community worker, Community participation, evaluation and financial support. For each approach these indicators show different explanations.

MODEL I.

A. CHARACTERISTICS

Type of institution/ infrastructure	Nature of Services Rendered	Needs met	Result- Qualitative changes.
Capital intensive, highly sophisticated and institutionalized big hospitals. Mobile medical team with doctor a medicines.	- Extension service from hospital. - Curative care. - Running village clinics. - Referral service, free medicines. - weekly or fortnightly visits.	- Treatment of minor physical ailments. - Referral and free transportaion to the hospital.	- People become more conscious abo sickness and medicines. - more patients in the hospital - feeling of dependence in the people, demanding free services. - shift from home remedies and indigenous medicines.

B. THE APPROACH FOLLOWED.

The approach followed is medical approach. The following are six indicators which would help us to make an assesment on that.

Indicators.	Explanation.
a. Role of health service	- means to improve the health status of the people
b. Role of Medical Professional	- Key to the programme- manager, planner, problem solver, coach, consultant, clinician, leader, teacher, evaluator.
c. Role of community health worker	- a means by which medical advances could be applied more rapidly and effectively.
d. Community participation	- a means to ensure more acceptibility and utilization of services.
e. Evaluation	- Based on analysis and interpretation of statistics which reflect the scope and results of applied medical science and technology.
f. Financial support.	- needed to create, expand and maintain the service.

MODEL . II

A. CHARACTERISTICS

Type of institution/ infrastructure.	Nature of services rendered.	Needs met	Results- Qualitative changes.
Capital intensive, sophisticated and institutionalised small hospitals. Medical team with or without doctor.	- Extension services. - curative and preventive care. - Village clinics - Referral services. - Medicines at reduced rates. - weekly or fortnightly visits. - Health Education - MCH programmes/ immunization. - Village Health Workers with medical kit.	- Treatment of minor ailments. - Referral and free transporation to the hospital. - personal and environmental hygeine.	- people meeting in groups. - Learn some preventive methods. - More patients in the hospital - Learn that they can do something about health.

B. APPROACH FOLLOWED

The approach followed is Medical approach. But there are certain changes, in the sense that it is not strictly Medical approach. There is an inclination towards Health Extention approach.

Indicators.	Explanation.
a. Role of health services.	- Means to improve the health status of the people.
b. Role of medical professional	- Medical professional continues to be the key personnel. But, para medicals gain a role here.
c. Role of Community Health Worker (CHW)	- along with being a person to ensure more community acceptability for medicines, CHW also imparts preventive health education.
d. Community participation	- a means to ensure more acceptability to medicines as well as a means to disseminate ideas of preventive health education.
e. Evaluation	- based on analysis and interpretation of health statistics that shows the scope and result of applied medical science as well as the effectiveness of preventive health education.
f. Financial support	- needed to create, expand and maintain the service.

(3) b

MODEL .III.

A. CHARACTERISTICS

Type of institution/ infrastructure.	Nature of services rendered.	Needs met.	Results - Qualitative changes.
Rural health centres manned by nurses, not institionalized, still very much structured. A team composed of a nurse and social workers.	-Preventive, promotive and curative. - Community health workers with simple medicines. - Health education, Adult Education - Smallincome generating projects - kitchen garden - M C H - Collaboration with govt and other agencies. - village meetings and discussions on different village problems. - promotion of collective action.	- Better environmental sanitation. - M.C.H. Services. - Supplimentary income for a section of the population.	- people become aware of the importa of preventive medical care. - Less patients to go. to the hospit - Better child care. - people try to see health in relati to economic backwardness. - Develop more interaction among the villages, formation of small infor groups, mahilamandals. - people became aware of their collecti strength.

B. APPROACH FOLLOWED.

The approach followed is Health Extension approach. The following indicators would make it clear.

Indicators.	Explanations.
a. Role of health services.	- as it vews that good health is the result of planned health services, experts from other fields as economists, social workers, etc- are also involved to make services effective.
b. Role of medical professional	- The medical professional is viewed as a component rather than key. Furth , experts from other disciplines are also involved - economists, soci l workers, etc. Attempts are also made to include community leaders.
c. Role of Community Health Worker	- CHW is considered as an agent of change - and works as a multi purpose v worker which include medical services, prevention, public health wo k, h education, nutrition education, food production and housing improvements.

d. Community participation. - Participation of the community is considered important because it provid a resourcebase, a means to mobilize more resource - personnel, money and material. Mainly it involves the community leaders.

e. Evaluation. - Concerned with assesing whether a programme with a variety of activities (raging from health to economic development programmes) provides the most benefits in terms of health improvements for the least amount of resour

f. Financial support. - Used to build small health centres and to generate community resources - man power, money and material. The programme has to be made self-supporting.

MODEL . IV

A. CHARACTERISTICS.

Type of institution/ infrastructure	Nature of service Rendered.	Needs met	Results - Qualitative changes.
Rural health centres/ actiongroups. Flexible and non structured. One team composed of a nurse and activist.	- Services aimed at building healthy communities. - Community diagnosis. - Critical understanding of health and its relation to unjust social order. - Awareness building through non-formal education programmes. -Organizing the people for collective action. -Exposing social illness. - Formation of Action groups, Mahila mandals, youth clubs, village committees, Farmer's club, Trade unions.	- Basic needs met by the people through their organized efforts. - Better services from the government.	- Participation and collective acti of the people to build up a healt community/ society. - Increased self confidence and independency. - faith in their own power to fight for a healty society. - Health is considered as a right and duty andat the same timeseen a s a politicial issue. - people struggling against social injustices. - Cooperation among the people based on crticial understanding of soci realities. - New forms of politics and new for peoples' movement. - Alternative indigenous medical sy developed.

- Demanding services from the Govt. from health as well as other departments.
- Identifying and training village animators.
- Promotion of low cost and simple home remedies.

B. APPROACHES FOLLOWED

In this model the comprehensive approach is followed. The following explanation would make it clear.

Indicators.	Explanations.
a. Role of health services.	- the concept of health is totally integrated into the socio-political febric of the community. Hence health services are a part of a strategy(or an entry point) for development and a tool in process of community growth.
b. Role of medical professional	- Since the role of health service is to enable change in the existing social structures(to bring about equity of opportunities andservices), the professio is viewed as a resource- an enabler , educator and a stimulus. The communit is the decision maker which defines the role of the professionals and the professional is accountable to the people.
c. Role of communityhealth worker.	- Community Health Worker(CHW) is an agent of change, an educator, a volunteer selected by the community. Uses health work primarly as a means of bringin about change in the attitudes and behaviours, and in the long run, social structures through health and development activities. Thus, CHW works towrds social justice and social, and political and economic equality as well as carrying out the health and traditional community development tasks. CHW could be better called, community level worker(CLW) since the wrk is total development work.

d. Community participation. - Community participation in health is a step which will help people gain control over their own lives by collectively working towards making the socio economic and political structures compatible with and conducive to health and development of the poor. It starts with awareness building and organization. Community is the decision maker in the community programme, and through such involvement they go through a process of learning to live together, think together and work together and take control of policies which affect their lives.

e. Evaluation. - The communityis the evaluator,- it is participatory evaluation methods- community decides on the objectives,priorities and methodologies of the process. The development worker, as an enabler helpes the community and works with them. The evaluation itself is a tool and a method for community awareness, self determination and growth. In the entire process, stress is laid on the qualitative aspects of the people and the efforts at bringingabout changesin the existing health delivery system and theestablishment of alternative models of the people

f. Financial support. -To spark off a programme finance is needed. But the goal is to start a programme which is able to be sustained through community contribution and commitment not through outside finances. The investment is in education, rather than technology and expanded services. It also means money to identify and develop indigenous resources in terms of man power, materials and support. In terms of health aid, it looks for seed money. Maximum efforts are made to make use of government funds but not at the cost of allowing them to dictate terms. It should never hamper the community in its process of growth towards awareness and organization.

CONCLUSION:

Community health is a term understood and interpreted in different ways by different people. This is due to the differences in the analysis of the ill health. Based on one's analysis the programme that is initiated would conform to a particular approach and philosophy.

This paper, we think, would help the implementors of community health programmes as well as those who intend to start one to develop a still more reflective understanding. This understanding blended with our commitment to the poor would help us all. to make our involvement more meaningful.

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EXTRACTED FROM THE REPORT OF A SYMPOSIUM ORGANISED JOINTLY BY INDIAN COUNCIL OF MEDICAL RESEARCH AND INDIAN COUNCIL OF SOCIAL SCIENCE RESEARCH ON "ALTERNATIVE APPROACHES TO HEALTH CARE" AT THE NATIONAL INSTITUTE OF NUTRITION, HYDERABAD FROM 27TH TO 30TH OCTOBER 1976.

SERVICE RESPONSIBILITY OF A DEPARTMENT OF COMMUNITY MEDICINE THROUGH A HEALTH CO-OPERATIVE

B. MAHADEVAN*

Background

Health facilities in rural areas in the country were provided through Primary Health Centres 9(PHCs) started as part of an national rural development scheme called "Community Programmes" in 1952, with a very modest staff in each centre to form the nucleus of integrated health services and cater to the need of about 60,000 population in a Block. There are now over 5,200 PHCs, each Centre caters to a population ranging from 80,000 to 1,20,000. Each PHC therefore has to take care of a very large number of persons. The scheme was extended to involve Medical Colleges in rural health work and through deliberations of many committees, the status of PHCs was improved both qualitatively and quantitatively. An integrated approach of providing health services to the rural people, with the provision of two doctors to every PHC and a Basic Health Worker (BHW) with an Auxiliary Nurse Midwife (ANM) to every 10,000 population, was attempted.

A pilot Mobile-cum-Training-cum-Services Hospital Scheme was introduced in some Medical Colleges with a view to involve medical and nursing students in rural community medicine. The intention was to establish ultimately one mobile hospital per medical college. More medical Colleges were established with the sole purpose of providing rural health services. Specialist camps were organised for cataract operations, vasectomy and tubectomy. Although the government's idea is to train doctors for rural areas, these doctors are not attracted to such places. The migration of Indian doctors to the more developed countries continues. Even passing a Parliament Act which empowers government to oblige doctors and engineers below the age of 30 years to work for a period of four years in rural areas, the problem remains unsolved due to the inability of providing reasonable living conditions for them in villages.

Some medical colleges like Vellore Christian Medical College incorporated in their teaching programme, the rural dimension in significant way. The organisers of the community Health Centre, have found that it costs about Rs. 8.50 per person per year, which includes preventive, promotive and curative services. The administration is not very happy about this project due to the high recurring costs.

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*Maj. Gen. B. Mahadevan PVSM, AVSM Professor and Head of the Department of Community Medicine, St. John's Medical College Bangalore (Karnataka).

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The Kerala Government with Government of India's initial one time grants, have established Health Co-operatives in 11 districts. Doctors are encouraged to seek self-employment in these co-operatives. Doctors and paramedical staff take shares in these co-operatives. A certain fee is levied on services, and medicines are also paid for. One is looking forward anxiously to the success of the scheme. The initial reaction of the people has been good.

Voluntary agencies have established a large number of hospitals in urban areas. However, funds are not available to these hospitals for any significant rural health work, although an increasing number of dispensaries are being opened in the rural sections of the country.

From the facts and figures just given, it is clear that the government in spite of its herculean efforts has not been able to seriously tackle the problem and with the scarce allotments made for the health services, no tangible improvements is possible in the near future. No voluntary agency can hope to embark on a scheme where even the government has failed but is in a better position to try out new methods through pilot projects.

When planning rural health services, one has to consider two components, namely the delivery of package of rural health services in villages and recruitment of personnel who will deliver the same. At the same time, there is an inescapable need for complementary services which will develop the villages economy and education of the rural people. Many rural health schemes taken up enthusiastically at the beginning flounder for lack of popular support that has to be expressed by financial contributions. This is the crux of the matter. Any health delivery scheme should be a self-sufficient fiscal entity. This may be a limiting factor but the only sound way of attempting to solve rural health problems, is to start it in places where conditions are favourable for the introduction of self-supporting scheme.

Funds for rural health schemes may be raised through many ways

1. Tagging health services to co-operatives.

To start health co-operatives by themselves is difficult as health holds a low priority in the felt needs of the people and may not get the required support in the initial stages. The procedure of tagging on health services to existing co-operatives has many advantages - good leadership, a readymade frame work of Community administration for introduction of effective health services and community envolvement, as channels of communication with the people have already been established. Co-operative Dairying and Marketing Co-operative of different commodities like grains, cereals, cottage industrial products etc., lend themselves admirably to this type of health services.

2. Running health services with assistance from factory administration where labourers are from villages nearby.

A minimal deduction at the source of salary and a contribution from the factory management will help to build-up the required funds and formation of a health co-operative. Geographical location of industries and rural labour in close proximity are limiting factors but the scheme is worthy of trial, in special areas.

3. Assistance from Panchayats.

Please where Panchayats and the people are interested in health services and are willing to contribute to the same, may venture on this method, but unless sufficient funds are forthcoming regularly and persistently the scheme will collapse.

A devoted team of health workers can establish themselves in a village and build-up the required clientele and popular opinion. The people can then be induced to form a co-operative and directly employ the doctor and essential paramedical staff. Until such time, a central agency or other funding agency may have to meet the expenses; This can be attempted even without forming a co-operative in areas of affluence, where people are willing to pay for the health services and employ the doctor and other staff through collection of revenue for the purpose.

The Nellur Milk Co-operative (MC)

Nallur is a village in Kolar district of Karnataka, situated about 60 km. from the city of Bangalore. The Nallur Milk Cooperative (MC) was an established concern with a sound and progressive leadership and has been functioning for many years. In addition to production and sale of milk, it provides other benefits like provision of fodder and cattle foods, tractor facilities and loans at low rates of interest.

Besides the people of Nallur, two other villages, Muthur and Kachahalli are members of the Co-operative and the total population covered is about 3,000. These villages have a silk farm cooperative besides cooperative dairying. The economic position was satisfactory, and therefore all conditions were favourable for the introduction of other self-supporting schemes.

The inspiration for establishment of a Comprehensive Health Care Programme for the cooperative members and their families of these villages, came from Sr. Anne Cummins of Coordinating Agency for Health Planning and Fr. Jones of the Catholic Bishop Conference of India. With these pioneers, the Dean and the Department of Community Medicine of St. John's Medical College, representatives of the Karnataka Government and Bangalore Government Dairy with leaders of the MC worked out a scheme for tagging on a health services to it.

The main objectives of the Nallur Health Project are:

1. To study and devise methods by which the financial base needed for effective health services could emerge from the people themselves in a self-sustaining manner;

2. To help in the establishment of rural health centres with the staff and rendering of effective health services to a wide circle of needy people without distinction of race, caste or creed;

3. To study the required strategy and methodology for the effective rendering of primary health care in rural areas by trying to determine the priority areas in health care and devising the structure found suitable to village conditions;

4. To help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas; and

5. To train intern doctors, nurses and other medical and paramedical staff for the purpose of rendering assistance in rural areas.

...4/-

The St. John's Medical College and its Department of Community Medicine were to be mainly concerned in acting as a catalytic agency, in the formation of self-sustaining rural community health scheme, fulfilling the above objectives.

Sponsorship was by the following agencies organisations

1. MMC.
2. Coordinating Agency for Health Planning
3. Catholic Bishops Conference of India
4. St. John's Medical College (Dept. of Community Medicine).

Source of funds

It was estimated that a monthly budget of Rs. 2,500-3,000 would be required for running the Health Co-operative and financial support was forthcoming by a joint contribution of three paise per litre of milk from the MMC and Bangalore Dairy, in a phased formula as shown in Table 1 below. Ultimately the MMC was to completely finance the scheme.

Table 1 - Contribution to the Health Co-operative.

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
First	1p*	2p
Second	2p	1p
Third	3p	nil

* Paise

This budget was adequate to support a health programme, organised by a Medical Officer, Nurse Compounder and an Ayah. The staff were appointed by the Health Co-operative Committee.

The Health Co-operative Committee included the following members:

Chairman, MMC
Secretary, MMC.
Dean, St. John's Medical College Bangalore.
Head of the Department. of Community.-
Medicine, St. John's Medical College.
Director/General Manager, Bangalore Dairy.
Representative of State Health Service.
Medical Officer Mallur Health Co-operative (Secretary)

The composition ensured integrated planning between the MMC and Health Co-operative.

The Health Co-operative got off to a good start by being inaugurated on 19 March 1973 by the Minister of Animal Husbandary. Dr. V.K. Rajkumar, a Senior House Officer in St. Martha's Hospital, joined as Resident Medical Officer in-charge of the Co-operative. This Medical Officer by dedicated work and self-sacrifice, made the Mallur Health Co-operative a successful enterprise.

Coverage, services and benefits provided

...5/-

The St. John's Medical College adopted this Health Co-operative as a rural training centre for interns. Visits by specialists of other departments including specialists camps were organised. At present, four interns are attached at any one time for whom residential accommodation has been provided by the MC on a rental basis. The interns conduct baseline demographic surveys, immunization and school health programmes, special health projects and mass health education programmes.

The Health Co-operative Committee meets by turns, at Mallur and at St. John's Medical College, to discuss progress and plan for the future.

The Health team comprising Dr. Rajkumar, Miss Maria and interns under the technical supervision of department of Community Medicine has made good contact with the villagers and a comprehensive health care programme has been introduced. The community of Mallur and other member villages with a population of 3,000, actively participate in all programmes. They have no unreasonable expectations or demands, as the health project is their own contribution. This is a basic difference between Health Centres organised through cooperatives and governmental agencies. The leaders are actively involved in the planning and organisation as the Chairman, MC is the Chairman of the Health Co-operative Committee and the Secretary MC is its member. Paramedical workers are drawn from the village community and trained for community health work. [illegible] The young Farmers Association actively assists in many of the health programmes. They help interns in their surveys, programmes of immunization and environmental sanitation, including chlorination of wells and construction of sanitary latrines. They also organise the physical arrangements for the mass health education programmes. The Mahila Mandal under the dynamic guidance of Mrs. Rajkumar, runs a nursery school and acts as a forum where health education, applied nutrition programmes and mothercraft are taught to the womenfolk of the village.

The health team and interns organise the following services with community participation:

Personal services

1. Curative Clinic (daily outpatients):
2. Maternity and child health services:

   (i) antenatal care,
   (ii) midwifery (domiciliary),
   (iii) postnatal care, and
   (iv) under five clinics (domiciliary).

3. School health services for village schools.
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and cholera.
5. Tuberculosis (TB) and Leprosy-case detection, treatment and follow-up.
6. Motivation for family planning.
7. Specialist camps at Mallur (periodical visits by St. Martha's Hospital specialists).
8. Hospital referrals.
9. Family record maintenance.

Community Services

1. Protection of well water supplies by chlorination.
2. Popularisation and construction of sanitary latrines,

3. Collection of health data through periodical surveys.
4. Coordination and cooperation with government health personnel in national health programme activities.
5. Health education at personal, group and village levels.
6. Nutrition education and nutrition supplementation Programmes.

Members of the Milk Co-operative and their families are entitled to all the above mentioned services free of cost. Non-members coming from other surrounding villages pay for drugs/ dressings and minor surgery. All preventive and promotive work are given free to all categories. Table II shows the number of member and non-member families in each village.

Table II - Number of member and non-member families in each village.

Village	Families		
	Member	Non-member	Total
Hallur	188	202	390
Hathur	63	124	187
Kachahalli	30	21	51
Bhatarenhalli	17	14	31
Harrulunagenahalli	6.	18	24
	304	379	683
	45 percent	55.5 percent	

Personnel, facilities, resources and mode of payment for personnal

The Health Co-operative in November 1973 was joined by another dedicated worker, Maria, an Italian Public Health Nurse, She with her companion Cathy, a volunteer from Canada, looked after the maternal and child health work.

Within five months of starting the project (August 1973), the cost of fodder went up and milk production of the milk Co-operative fell as some members began to sell out on higher rates. The MMC took a decision, much to the discomfiture of the Government Dairy Authorities, to sell directly to private parties in Bangalore, who offered better prices. The Govt. Dairy, therefore, stopped its contribution of two paise per litre of milk as health subsidy, and the Health Co-operative was in a critical situation. It is at this stage a momentous decision was taken by the responsible village leaders who were more than convinced of the positive role of the Health Centre and its staff in improving the health status of the people in Hallur and other villages. The Milk Co-operative was doing well and decided to contribute five paise per litre of milk for health and took over financial responsibility for running the Health Centre. This financial strategy on the part of village leaders resulted in the project becoming a viable unit. The Milk Co-operative has borne the entire recurring costs of the health project ever since, and Table III gives the Income/Expenditure position for the period July 1974 to June 1975.

Table III - Recurring Costs - Year - July = 1974 to June 1975.

Total milk production	6,27,898 litres
Income estimated at five paise/litre	Rs.31,394.90
Actual income received from MMC	Rs.33,100.00
Total expenditure for the year	Rs.33,790.74

Present position: Salaries:

At present the Milk Co-operative is supplying about 2,000 litres of milk per day to Bangalore. Each member is now contributing six paise per litre of milk a day. The contribution towards the Health Centre is Rs.3,600.00 per month.

The actual expenditure per month is indicated below:

Salaries (Medical Officer, Clerk, Compounder, A.N.M. and Ayah)	Rs. 1,600.00
Drugs	Rs. 1,500.00
Rent and electricity	Rs. 200.00
Miscellaneous	Rs. 250.00
T O T A L :	Rs. 3,500.00

In case the actual expenditure exceeds this amount, the extra expenditure is met by the Milk Co-operative. The Staff of the Health Centre consist of a Medical Officer, an ANM, a compounder, an Ayah and a clerk.

In addition, members of the Youth Association, women's Association and Village Panchayat participate in the activities of the Health Centre.

Although the Hallur Health project is mainly financed by the Hallur Milk Co-operative, it also receives help and technical direction from St. John's Medical College and the Government Health Services. These inputs are shown in Table IV.

Table IV - Inputs from other agencies/organisations.

Source	Capital	Recurring
1. Hallur Milk Cooperative	Buildings, furniture, refrigerator health education material	Salaries, rent/ electricity, drugs, general stores and petrol.
2. St. John's Medical College	Physicians and mid-wifery kit, minor surgical equipment, motor cycle (on loan through UNICEF)	Interns services, specialist services and rent for interns quarters.
3. Government Health Services	Nil	Vaccines, vitamin A, Iron and folic acid supplement, family planning devices, surveillance of communicable diseases (through PHC, Sidlaghatta), health education films (through Health Education Department of Director of Health Services).

Factors affecting quality of services, difficulties faced, methods of enforcement of control and evaluation

The experience over the last two and a half years has shown that:

(i) A health function can be grafted on to an economic co-operative;

(ii) A sound cooperative such as IMC can support substantially the recurring costs of a health programme;

(iii) Tagging on of a health function to a cooperative benefits not only the members and their families but also the nonmembers who get indirect benefits of professional services, preventive and promotive programmes.

The Department of Community Medicine and its staff were mainly concerned in acting as a catalytic agent, in the formation of a self-sustaining rural community health scheme. An experiement was embarked upon and the Mallur Project is this experiment. A total health care programme can be effectively delivered through a cooperative in rural areas. The IMC is even contemplating construction of a 15 bedded hospital at Mallur, with the help of government and its own funds.

Further, the Health Centre with its working philosophy, has indirectly helped the Department of Community Medicine to conceptualise a primary health care system for training of future physicians, so that they play their rightful role in a contemporary society.

The health team and interns have played an important role in the development of the village in general and health aspects in particular. Attempts are being made to increase the membership of the milk cooperative by purchase of more cows and increasing enrolment. Other economic activities such as development of village/cottage industries and handicrafts and ensuring sale of products, are contemplated. It is fully realised that in the planning of such self-supporting programmes, the health team has to be actively supported by other members who will attend to the social and economic development problems of the community. Success or failure would depend on tackling the financial side efficiently.

The quality of promotive and curative services would have to be improved. Simpler skills, cheaper drugs and intermediate technology have to be introduced to suit rural conditions. A drive to improve the education of the people, including health education, is to be attempted through the use of Village Level Workers. Their training Programme is being organised. Whether there has been an improvement in the morbidity and mortality statistics at Mallur, subsequent to the introduction of these cooperatives in comparison with other areas in the vicinity, needs study and this has been taken up as a health project.

The question of introducting such self-sustaining Co-operative Schemes to other areas around Bangalore is under active consideration. These are challenges that have to be met in rural India and it is hoped that with the cooperation and participation that are readily forthcoming from the simple rural folk, the economic and health projects will meet with success.

Conclusion

A good and well informed faculty with modern concepts of medical education, has a capacity for extensive research in the organisation and delivery of health services through experiment, models and pilot projects. Medical educators in general, and faculty staff of departments of Community Medicine in particular, must assure their share of responsibility for meeting the quantitative as well as qualitative needs of the people and must be concerned not only with the basic mission of the university or government which is learning, but also actively help the people of a locality or region in organising and running their own primary health care services.

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For establishing an effective and viable primary health care system, the cooperation of the local community must be ensured. In fact, the people should be adequately motivated, involved in decision making and actively participate in health programmes, so that ultimately it becomes their own "peoples programme". Local resources such as cooperatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local programmes. It is desirable that the primary health care system should be a self-sufficient fiscal entity. Community priorities are more likely to be met if the people themselves raise and spend the resources required. A "total health" approach is essential, promotional, preventive and curative care need to be completely integrated.

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Voluntary Health Association of India

C-14, Community Centre
Safdarjung Development Area
New Delhi-110016

Telegrams : VOLHEALTH
New Delhi-110016
Phone : 652007, 652008

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MAINTAINING ONGOING RECORDS

Now that we have decided with the community the work that we will do, it is important to keep a record of this work.

Why are records important?

1. Pregnancy, birth, illness and death are facts of life. To give the required attention to pregnant women, we need to know when they are pregnant. To give care to under fives we need to know when a child is born and watch its growth. To make a community realise that a lot of diseases are preventable, we need to record the illnesses they suffer from and show how many of the people suffer from a preventable illness. Therefore a good record system helps us in our work i.e. in setting objectives, evaluating our work and in re-setting objectives.

2. We may be taking the help of the PHC for vaccines. In such a case we are required to submit records of the children we vaccinated. So records help us while dealing with the Government.

3. Most of us have to prepare yearly reports for our institution. If we have taken funds from an agency we need to give this agency a report of our work. Records help us to prepare reports.

The most important reason for keeping records is to have useful information which can be used by us and the community in taking decisions about our work. A lot of us spend upto 60% of our time trying to maintain records and getting information from them. This is not necessary if we use a simple and effective record system.

Below, we suggest a simple and useful way of recording information about:

1. Children's Services
2. Maternal Services
3. OPD Services

We will look at each of these one by one.

CHILDREN'S SERVICES

In any village, children under five years of age are most likely to fall sick and even die. A child's growth has to be followed carefully till the age of five.

Necessary information about children in this age group should be recorded in

A. a separate section of the same register in which we recorded the baseline survey;

B. the road to health card.

It is necessary to do this because the road to health card should be kept with the mother. Since you also need a record of children's services for your reference, you should maintain these records in your register.

A. What to record in your children's services register?

A sample table giving the information to be recorded is attached at the end of this paper (Table I).

How to maintain the children's services records?

1. Enter the names of all the under fives in your village in this register and fill in the information for each child. If you have done the baseline survey you can take this information from there.

2. Each newborn child should be entered immediately in the children's service register.

3. Very often we have more than one child with the same name, or a similar name. This makes it difficult to record details of the child in the correct place, specially in a busy clinic. We therefore suggest that you write the child's number from the road to health card in column 2 as shown in Table I). This way when a mother brings her child to the clinic you can see the child's number from the road to health card and locate the number in your register. This is easier than trying to find the child's name.

4. In column 7, 8 and 9 enter the date on which each dose of immunization is given.

5. In column 10, record the weight of the child each month. If you weigh the child for the first time in April, draw a line across January to March to show that you first weighed the child in April. If a child leaves the village for a few months, write the reason for the absence in these months.

6. In column 11, you should record in RED INK such information about the child:

   - chronic illness eg. TB, Night blindness
   - reason for special care eg. Premature baby

Changes in children's services should also be recorded in column 11. Given below are some examples:

a) If a child becomes more than five years old, draw a line across all the columns next to the child's name and write in Remarks (column 11) 'Over Five'.

b) If a child leaves the village permanently, draw a line across all the columns next to the child's name and write in Remarks (column 11) 'Left village'.

c) If a new family comes to live permanently in the village and has a child under five years of age, enter its name in the register and write in Remarks (column 11) 'New in village'.

d) If a child dies draw a red line across all the columns next to the child's name and write in remarks (column 11) 'Dead'. Also enter date and reason of death.

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HOW TO PREPARE A SUMMARY OF CHILDREN'S SERVICES FOR ONE YEAR ?

Useful Information	How to find this from your records?
1. Total Number of children attended by you last year	Count all the entries in column 2 (Child's Number)
2. Total Number of new births in last year	Count all children born in last year by seeing column 6 (Date of birth)
3. Total Number of children that died in last year	Count all deaths recorded in column 11 (Remarks).
4. Total Number of children that left the village permanently	Count all children that left village in column 11(Remarks).
5. Total Number of children over five	Count all children over five in column 11 (Remarks).
6. Cases of significant illness in under fives	Write name of illness. Count cases of illnesses recorded in column 11 (Remarks)
7. Immunization coverage	Count Number of children immunized from column 7,8,9.
8. Number of malnourished children	See from road to health charts of all under fives (explained in next section)
9. Number of under fives on your records at the end of year	To calculate this, write down:

Total Number of children attended last year = (a)

Number of deaths in last year = (b)

Number of children left village permanently during last year = (c)

Number of children Over Five = (d)

Add b + c + d = (E)

Number of under fives on your records at the end of the year = a-E

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B. How to maintain the Road to Health Cards ?

The Road to Health Card is a very good way of checking the growth of a child from birth to the age of 5 years. The chart from birth to 3 years is given on one side of the card and the 4th and 5th years are on the reverse side.

How to use the Road to Health Card ?

1. When a child under five years first comes to the clinic, MAKE A CALENDAR FOR THE CHILD ON THE ROAD TO HEALTH CARD. The way to make the calendar is given below:

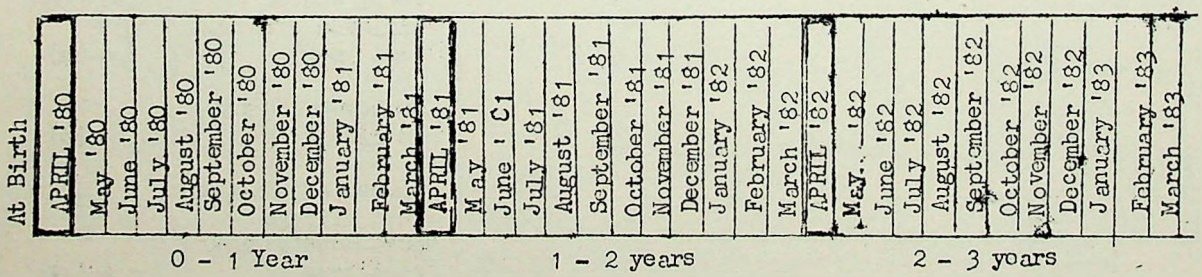
   a) Find out the month and year in which the child was born. If the mother does not know the exact month of birth, estimate the month of birth as correctly as you can. It may be easier for the mother to remember that her child was born

      - before or after a particular festival
      - before or after the harvest
      - before or after any major event

   b) Once you know or have estimated the birth month and year, write this month and year in the box on the extreme left of the card. This box has dark lines and 'At birth' is written next to the box.

   c) You will also find a box with dark lines at the beginning of each of the five years. Write the birth month in each of these boxes.

   d) Now, write the names of the following months and year in between the dark boxes. Remember to change the year each time January is reached. You will now have a calendar of the child for 5 years.



In the above example, the child was born in APRIL 1980.

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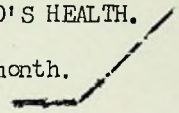
How to record weights?

a) If the child is weighed At Birth or a few days later, enter the weight in the 1st column.

b) If the child is weighed for the first time, when it is already some months old, enter the weight in the appropriate column.
eg: If the child is born in April 1980 and is weighed for the first time, in June '81, find June '81 in the child's calendar you have just made and enter the weight in this column.

How to assess the growth of the child?

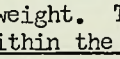
THE DIRECTION OF THE CHILD'S GROWTH CURVE SHOWS THE CHILD'S HEALTH.

1. The weight of a healthy child should increase every month. The curve for a healthy child should look like this: 

2. If the child's curve is straight, eg:. _____ . _____ this means the child is not gaining weight. This is a dnager sign. You should find out from the mother if the child is:

   a) eating well
   b) active or not
   c) has any symptoms of illness eg: cold, cough, fever, diarrhoea.

   Tell the mother to feed the child at least 5 times each day and to watch the child carefully.

3. If the child's curve goes down eg:  this means the child is losing weight. This is very dangerous, even if the child's curve is within the Road to Health Curve. The child may be ill. Find out from the mother the reason for the loss of weight. Ask specially for symptoms of any illness. Tell the mother to give the child special care and to feed the child well. You should also make it a point to give this child special attention.

MAKE SURE THAT YOU WEIGH THE CHILD EVERY MONTH.
This card should be kept with the mother. Explain the card to her. Each time the child is weighed, tell her about the state of her child's health. Also tell her if her child needs special care. The mother needs to keep the card with her because she is the person most responsible for her child's well being.

You only need to collect the card from the mothers once in a year in order to analyse the number of malnourished children in your programme.

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MATERNAL SERVICES

All pregnant mothers need good Antenatal coverage (ANC). The objective of giving Antenatal Coverage is to ensure that the mother

has a normal pregnancy
has a normal delivery and
gives birth to a normal baby

In order to do this we must have on our records the names and details of all pregnant mothers in our villages.

What to record:

A sample of the records to be maintained is attached at the end of this paper (Table II).

How to maintain these records:

1. It is easier for us to give antenatal coverage if we know which pregnant women are going to deliver in a particular month. We therefore enter names of pregnant women under the month they are due for delivery.

   eg: If you see a pregnant woman for the first time, in May and she is due to deliver in October, enter her name under the month of October. In order to maintain your record like this you need to draw the columns for each month on a separate page (see sample attached at the end of paper, Table II)

2. Parity: This means the number of times a mother has conceived before this present pregnancy. This includes all previous term deliveries and abortions.

   eg: Kamala was pregnant three times before this pregnancy. She had two normal deliveries and one abortion. Her parity will be written like this: P2 + 1

   P stands for parity
   2 stands for previous full term deliveries
   1 stands for previous abortion

   Enter this in column (6)

3. Expected date of delivery (EDD):

   Enter the EDD in column 7. EDD is calculated like this:

   Find out from the mother the date and month of her last menstrual period. Add 7 days to this and substract 3 months from this.

   For example: Radha had her last menstrual period on 10th of May 1980. Her EDD will be calculated like this:

   To the date of her last menstrual period
   add 7 days : May 10 + 7 days = May 17, 1980
   Substract 3 months : May - 3 months = February 17
   EDD : February 17, 1981.

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4. Date of first antenatal check up:

Enter the date on which you examine a pregnant mother for the first time. If the mother is seen and examined by you for the first time during her second trimester, then enter the date of examination under Trimester II. Leave the columns Trimester I & III blank. The information from this column will tell you how early you are able to contact pregnant women.

5. Tetanus Toxoid:

Enter the dates when Tetanus Toxoid was GIVEN to the mother in column 9. (For the dosage schedule see paper of MCH)
This would help you in finding out the date when the mother is due for her next dose and you will be able to adivse her accordingly. It will also help you in finding out how effective your tetanus toxoid coverage is.

6. Delivery:

When you come to know that a pregnant mother has delivered you must visit the mother to find out the details of the delivery.
Enter these details in column 10.

All full term deliveries with vertex presentation are normal. The other deliveries are all abnormal. See paper on MCH to find out the various abnormal deliveries that could coccur.

7. Still birth/Live birth:

If a child is born dead (does not breathe at all) it is a still birth. If the child cries after birth but dies after 2 hours it should be recorded as a live birth in column 11. Also enter "died after 2 hours" and the reason for the death in column 14.

8. Remarks (Column 14)

In column 14, note down the date of post natal visit, condition of the mother and the condition of the baby.

Note: If the pregnancy results in an abortion, draw a line across all the columns after the mother's name and write in Remarks (column 14) "Abortion" and the date of abortion.

How to prepare a summary of maternal services for 1 year:

1. Total number of pregnant mothers entered in the register from January to December = A

2. Total number of mothers delivered from January to December = B

3. Number of abortions from January to December = C

4. Number of mothers not yet delivered this year = A- (B+C) = D

(A few mothers entered in the previous months may not have delivered by December. These mothers, who have still to deliver, should be entered again under January for the next year.)

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5. Percentage of mothers covered by Tetanus Toxoid:

   - total number of mothers delivered from January to December = a
   - number of mothers who received complete dose of tetanus toxoid = b
   - percentage of mothers covered by tetanus toxoid = $\frac{b}{a} \times 100 = C\%$

6.a. Number of women contacted in 1st trimester
   b. Number of women contacted in 2nd trimester
   c. Number of women contacted in 3rd trimester

7. Some of the other useful information you can get grom the records:

   a. Percentage of normal deliveries
   b. Percentage of deliveries conducted at home
   c. Percentage of deliveries conducted by Dais

How to use this information:

This information would help you in evaluating your work and in resetting objectives.

For example:

1. If you find that the percentage of women covered by tetanus toxoid is very low then one of your objectives for the next year would be to find out the reason why women are not prepared to take tetanus toxoid. If tetanus is really a problem in the area your objective would be to give appropriate health education to the mothers.

2. If you find that the majority ofthe deliveries are conducted by Dais then one of the objectives for the next year could be to train Dais in conducting aseptic deliveries

3. If you find that many more pregnant mothers come to you in the 3rd trimester than in the 1st and 2nd trimester, one of your objectives for the next year could be to make greater efforts to contact all pregnant women in the 1st or 2nd trimester.

OUT PATIENT SERVICES

OUT PATIENT RECORDS (OPD)

Those of us who run a dispensary or village clinic already keep a record of the patients we treat. Some of us keep more detailed OPD records than others. Also, some of us use information from OPD records to make decisions about our work. In the assignment of 'Analysing OPD Records' we have already mentioned the various kinds of information that we can get from such records. To remind you, from OPD records, we should be able to find out:

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a) the diseases we have been treating
b) in which months we get most cases of a particular disease
c) how many patients come back to us with the same disease
d) which medicines to stock
e) how many patients do we get per day
f) distance and villages from which patients come
g) economic status of patients, are they males or females, from which caste etc.

How to keep OPD Records

In table III attached at the end of this paper, we have given a suggested sample of OPD records.

NOTE:

1. In column 15, make a note of
   a) patient referred
   b) patient needing admission
   c) any other important information

2. If you are using OPD cards you could add a column to record the OPD number of each patient.

How to use information from OPD Records:

1. From Column 1, we can find out the number of people we treated, each month, and in the full year.

   Find out:

   a) In which months do we get most patients? Why?
   b) On an average how many patients do we treat per day?

   Question: On an average how much time does our team spend in the dispensary per day?

2. From column 4, we can find out the number of male and female patients we have seen in one year.

   Find out:

   a) Do we see more males or females?
   b) Is this difference a big one? Why?

3. From column 5, we can find out the number of patients that come to us from different caste groups (or Tribal/non-tribal).

   Find out:

   a) Do we get most of our patients from any particular caste group? If yes, why?
   b) Do we get patients from the lower castes? If not, why?

4. From column 6, we can find out the number of patients that come to us from different villages.

   Find out:

   a) From which villages do we get most of our patients?
   b) Are these villages in our target area? If not, why is it that patients from the target area do not come to us?
   c) How far are the villages from which patients come?

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5. From column 7, we can find out the diseases we have been treating.

   Find out:

   a) How many cases of each disease have we seen in a year?
   b) How many of these diseases are preventable?

6. From column 8, we can find out which medicines we use.

   Find out:

   a) Which medicines do you need to stock and in which quantity?

7. From columns 9-14, we can find out the income and expenditure of the dispensary. We can also decide how much to charge a patient.

   Find out:

   a) What is the average cost of treatment per patient ?
   b) What is the average income to the dispensary per patient?

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*chtt:pt:26.8.'81

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

COMH

UNDERSTANDING COMMUNITY HEALTH

Everybody talks about community health programme and many are carring out. Still many want to start it. It is good to analise and see "why we do community health programme and what we do in community health programme?" It is a well accepted fact that 80% of the Indian masses live in rural areas and 20% in the urban area. WHO has proclaimed health for all by 2000 AD. According to our present situation this slogan is really a questionmark to us, on mainly how this can be achieved? The existing health care system is not catering to the needs of the rural masses.

Everyone know the defenition of WHO "that health is not meare absence of desease but health is a state of total physical, mental, and social well being". Jesus said, "I came to the world to give life and life in its fullness". Reflecting on this, we realise that our health care system is desease oriented and not person oriented. Attaining this total well being demands an enviornment in which the basic needs are fulfilled, social well-being is ensured and psychological as well as spiritual needs are met. For example: Government of India made a survey in which they found out most of the mothers and children die - due to malnutrition, infection and uncontroled fertility.

The methods that Government used for this did not bring much change, because it was a target oriented programme. We as Christians who work according to the carism of Christ, specially in his healing mission, let us go deep in this findings. How we have to tackle such problems. In the community or in a society the root causes of illness lie deep in social evils and inbalances. For this the remedy is not a curative approach, but people should be made aware of the real needs, rights and responsibilities and also the available resources in and around them and get themselves organised for appropriate actions. Through this process health become a reality to the vast majority of the Indian masses.

The world counsil of churches had interviewed 6000 out patients in India and found out that only 5% needed doctors care, 15% by paramedicals care and another 15% had self curing deseases; which means 80% could have been treated in the community. This analysis make us to reflect that the total

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health cannot be achieved by medical solution only, but deseases has got a chain of causes which has to be tackled for the total wellbeing, eg. diarrhoea.

Because of the many different factors that influences man's health and life in an interdependent and integrated way, both as an individual and in community, community health programme should also be an integrated efforts directed towards this whole life situation. Factors related to food, housing, work, education and general living conditions are therefore important as well as everything that helps man with regard to his identity and dignity, and give room for initiatives related to human development.

The new set of parameters

Today the health status of the country is measured by infant and maternal mortality rate. If we are working out for the total wellbeing of the people, this way of messuring the health has to be changed and a new set has to be used, such as the people's part in decision making, absence of social evils in the community, organising capacity of the people, role women and youth play in matters of health and development etc.

So the concept of community health should be understood as a process of enabling people to exercise collectively their responsibilities to maintain their health as their right and responsibility. Thus it is beyond mere distribution of medicines, prevention of sickness and income generating programmes.

Health for all by 2000 AD is a realistic and feasible goal. Some conditions are however essential for success. The attainment of this goal depends above all on three things.

1. The extent to which it is possible/to reduce poverty and unequality and to spread education.
2. The extent to which it will be possible to organise the poor and under privileged groups. So that they are able to fight for their right, and,
3. The extent to which we are able to move away from the counter productive consumerist western model of health care and to replace it by the alternative model based in the community.

These are our tasks and it needs millions of young men and women both within and without the health sector to work for them. If a mass movement for this purpose can be organised and the people rededicate themselves to the realisation of their national goal. The country will be able to keep its tryst with destiny at least by 2000 AD.

COMMUNITY HEALTH DEPARTMENT
C H A I

COMH

APPENDIX

DECLARATION OF ALMA-ATA

On 12 September 1978, at Alma-Ata in Soviet Kazakhstan, representatives of 134 nations agreed the terms of a solemn Declaration Pledging urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. The Climax of a major International Conference on Primary Health Care, jointly sponsored by WHO and UNICEF this Declaration stated:

1. The conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.

2. The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

3. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

4. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

5. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations

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and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

6. 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 contract 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.

7. 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 problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; 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,

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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;

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.

8. All governments should formulate national policies, strategies nd plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilise the country's resources and to use available external resources rationally.

9. All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

10. An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace detente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic

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development of which primary health care, as an essential part, should be allotted its proper share.

* * * *

The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

PZ/

The Catholic Hospital Association of India
C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

O R G A N I Z I N G T H E C O M M U N I T Y

All of us are familiar with the saying, "Strength lies in numbers". We have heard it often and most of us have seen or experienced the truth of this saying in our own lives. We may have seen a group of city dwellers protesting against corruption in the municipal corporation. We may have seen or read about a group of tribals demanding a just redistribution of govt. lands. Whatever be the case, a well organized group of people can achieve more longstanding results than single individuals. This is because of the power they have as a group.

In this paper we shall discuss in more detail why we must help the community to organise and some guidelines about how to do this. We will also discuss some of the problems in organizing the community.

WHY MUST WE HELP THE COMMUNITY TO ORGANIZE ?

1. In unity there is strength.

An organised group increases the solidarity, spirit of cooperation and self confidence amongst the members. A group also provides courage and support to its members to face situations that arise while solving the community's problems. It encourages sharing in the community by distributing work, responsibilites and benefits among the members of the group.

2. Moblilizing resources

An organized group can more successfully get together the resources available in the community for a specific activity. For example, getting the village together for a sanitation drive will be more successful if the members of a Mahila Mandal or Youth Club take the responsiblity for it. Raising the resources in cash or kind from the community for an activity can also be done more effectively by the members of such groups.

3. Systematic planning

Organization enables people to plan systematically for collective action in meeting their basic needs such as food, housing, health etc. In order to become strong and tackle the community's problems, the community must be organized. Regular meetings, an enthusiastic leadership, meaningful short term activities - all these help the group to realise its potential and to undertake more difficult long-term activites to solve their basic needs.

Thus building up groups in the community is an effective way of strengthening people's participation in development programmes.

HOW TO ORGANIZE THE COMMUNITY

The effectiveness of a group depends on a number of things such as the satisfaction it provides to its members, the type of leadership within the group etc. Therefore it is important for us to keep certain points in mind when organizing groups in community, namely :

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1. Interest

We can organize a community on the basis of different factors; for example we can form a Mahila Samiti or Women's group. A young farmer's club would bring together farmers with land. Low income landless labourers can be brought together as a group. Whatever the group, we must remember that people will make the effort to ~~xhx~~ form a group, if they think they will benefit from it. Individuals come together to satisfy a personal interest (monetary, emotional, mental, social etc.) This principle can help us intwo ways.

(a) We must be clear about our goals - why and shom we want to organize in the community. If only 25% of the people in the village have land we cannot expect everyone to be interested in a farmer's club. Only few people with land will be interested in forming such a group. This can lead to a more unhealthy situation in the village. On the other hand a farmer's association can do a lot of good in a village in which more than 90% of the families have at least 2-3 acres each.

(b) A group becomes attractive to its members, only if it satisfies their needs. For example, a farmer's association might show a lot of enthusiasm in attending classes on dry farming methods. The same group of farmers may show no interest in learning to read and write, as they may not see this as a need.

2. Knowing the Community

Before organizing groups in the community, we must get to know the people well, understand their problems, customs and traditions. We must give the community time to understand our motives. We must also find out whether there are already some groups functioning in the village before starting new ones. For example, there may be a youth group already in the village which will now has only been undertaking cultural functions on festival days. In this case there may be no need to organize another youth club. Instead we could get to know better, the functioning of the existing Youth Club and slowly try and build up this group by introducing fresh ideas into the group eg. literacy classes, village sanitation etc.

3. Slow process

The process of organizing and building up groups in the village is a slow one. We cannot expect the people to be enthusiastic about our ideas on organization since they may not be sure of what they are going to get involved in. It is always better to go slow. For example, if we feel that a Mahila Mandal could be very useful in our village then we may have to meet the women in a series of informal ~~th~~erings, individually and in small groups. During these meetings, we could introduce the ideas of a regular Mahila Mandal and the different types of activiites that a Mahila Mandal could undertake. The women will accept the ideas only if they feel that this will be of some value to them. This may take more or less time according to the confidence the women place is us, our rapport with them, their own needs etc.

4. Administration

Organization means that things are done in an ordered way. Meetings should take place at regular intervals to take decisions and to see that these are carried out. Records should be kept of the decisions taken. These records should be read out at the next ~~t~~ing.

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- to bring all the members up to date on all that has happend so far .
- to see if those responsible have done their tasks.

Tasks should be divided between different people. The tendency of giving responsibility to the same people every time, should be avoided.

Care should be taken to handle all financial resources of the group carefully. Everybody should know how much money has been collected, on what it has spent, how much remains and what is done with it. Simple but careful accounting is necessary for this. If there is no control over the collection and use of money then things may go wrong. This may also happen if the matter is left entirely to one or two individuals. Accounts should be checked on a regular basis, however small the total amount is.

REMEMBER : The group will be highly motivated to continue as a group if

- they feel the group is their own
- if everyone participates in decision making.

PROBLEMS IN ORGANIZING GROUPS

Organizing groups inthe community may create certain problems depending on the type of group, our rapport with the people, the type of leadership provided by us etc. Some of these problems which we must be aware of are discussed below.

1. Handling conflict situations within a group and between groups

In Chakrapur village, the project staff had organized a Young Farmers Club which got into a series of quarrels with the VHW of the village. The staff of the project were aware of the situation but did not take any action until things reached a very serious point. Our role in handling such conflict situations is very important. We must

(a) be alert to pick up and the help resolve such conflicts before matters become very unpleasant.

(b) be impartial in our judgements and behaviour towards individuals and groups in the community, It is also important to note that all major quarrels (regarding development programmes) in a village are best resolved along with the community and project staff.

(c) be constantly aware of and emphasize the common interest with which the group has become together. The groups should take up activities which will strengthen common bonds rather than high light their differences.

2. Short - sightedness

In a particular village in Gujarat, a group of development workers organized a buffalo cooperative for small farmers. These farmers had a little land to their own. However they depended heavily on the landlords for work specially during the harvest season. Each of these farmers had one or two buffaloes but were forced to sell their milk at very low rates to the landlord who would sell all the milk in the nearest big town at a high rate. By organizing a buffalo cooperative the development workers were

able to help in the marketing of the milk and in getting higher prices. The landlord was thus eliminated as the middleman. This was obviously unacceptable to the landlord, who eventually threatened to get labour from the next village during the coming harvest !

It is important for us to beaware that such serious problems in the community can be created by our short sighted attempts to organize groups. This is especially true when we organize groups around economic issues like wages etc. where the interests of another group in the community are threatened. Therefore, unless we are prepared to handle such conflict situations and are aware of the repercussion on the community of such an action we shoud be cautious in our approach.

3. Outside aid

Resisting pressures from within the community and from within ourselves to get aid from outside for the group activities is a major problem. The ease with which financial assistance is available from funding agencies often prevents us from allowing the members to persevere in their efforts to collect money for small activities. Barely is a Mahila Mandal formed and a decision to start a savings scheme or small goat scheme taken when the pressure to get immediate funds from an agency throws us into a dilemma. Should we or shouldn't we use outside resources for say a Youth Club activities ? This is a difficult question for which no definite answers are possible. It is important to remember however, that it is easy to destroy the group's intiative in undertaking their activities if easy money is available from outside.

4. Keeping up the group interest

One of the major problems often encountered by organizers is that they find it difficult to keep the interest of the members of a group alive after a period of time. One of the questions often asked is "how do we sustain the interest of the members of (say) our Mahila Mandal ?" It is natural that people will not be able to participate fully in the groups activities during busy agricultural seasons such as sowing and harvesting. This is not a cause of worry. On the other hand when there us a serious lack of interest and continued low atteneance at meetings we must take a second look at the Mandal's activities. We have often seen Mandla's formed by enthusaistic women coming together for sewing classes ,soon becoming smaller and smaller because further classes on bead-bag making etc., do not seem to interest the women despite repeated requests to come. In these cases it is obvious that the women were enthusiastic upto the point that they learned to stich their own clothes and a few clothes for their own children. They were uninterested in bead bags because

(a) they could not afford the raw materials.

(b) they found it difficult to sell these in the local market.

Most of these women were quite poor and were keen to increase their income by producing some saleable stuff eg. pickles, papads etc. These income generating programmes can be started in a small way, producing goods for the local market. Other small activities like savings schemes, goat schemes etc. can also be taken up.

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Whatever the activities, the basic principle to remember is the one first mentioned in the previous section i.e. individuals will come together to satisfy a personal interest. When people feel that they are wasting their time in the group then they lose interest ans soon drop out.

To Summarize :

We have seen that building up groups in the community is one of the effective ways of mobilizing people's participation in the development process. We must get to know the community and be clear about our goals before organizing groups. We have also discussed some of the problems that could arise when we undertake this activity. It is important here to remember that organizing against vested interest in the community can lead to a serious situation and both the community and we need to be specially prepared to handle such situations.

Prepared by

Voluntary Health Association of India
C - 14, Community Centre,
S.D.A., New Delhi - 110016.

chtt/la/29-2-1984

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001

Tel. 310694, 322064

INVOLVING LOCAL LEADERS

In the workshop, we have often discussed the importance of involving local leaders in our Community Health Programme. Let us briefly review who these leaders are, why it is important to involve them in our programme and how to recognize them in the community.

WHO ARE LEADERS?

There are two kinds of leaders: formal and informal leaders.

Formal Leaders are persons who have been appointed or elected to fulfil certain administrative responsibilities for the whole village. They hold a recognised post and may or may not be paid for it.

Examples: (i) Sarpanch, Panchayat Members, Tehsildars or Revenue Collector etc. These leaders are part of the government's administrative structure.

(ii) In certain tribal areas each village may elect its own headman and committee members to help the headman. These may or may not be a part of the government structure.

Informal Leaders are people whom the community respects and trusts. People go to such leaders when they have a problem or need advice.

Examples:
- The people may go to the pujari for all religious matters
- The people may take the opinion of certain village leaders when there is a family dispute
- The people may goto the faith healer (Bhuva, Badwa) when there is some illness in the family
- The people would take the advice of the dai in matters related to pregnancy and child birth

It is thus clear from the above that informal leaders have a lot of influence in all important matters in the community. The people look upon them as knowledgeable and having a sound judgement.

WHY SHOULD WE INVOLVE ALL THESE LEADERS IN OUR PROGRAMMES?

Both formal and informal leaders have a lot of power in the community and are able to influence the decisions of the people. In some cases people simply follow a trusted leader, in others, leaders can get people to participate in an activity by creating awareness.

Leaders arealso capable of forcibly getting the participation of the people by threats and in extreme cases by actual violence.

It is important for us to work with both kinds of leaders. Formal leaders may or may not have (Eg: Vishalnagar Case) the trust of the community. But it is important that they be informed of, and if possible involved in all our activities because these leaders are usually the most powerful in that they could have a strong economic hold on the people.

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Informal leaders, on the other hand, may be more trusted by the community and can be of great help to us if their cooperation is sought. They can also influence the community against our work if their involvement is not sought.

Let us now look at some of the ways in which local leaders can help or hinder our work.

1. Gaining the trust of the people

When we enter the community as outsiders it is natural that the people may question and be suspicious of our motives. Here, if the local leaders, especially the informal leaders, understand our reasons for wanting to work with the community they can help us to gain acceptance with the people. This way, they will also help us get more information about the people, finding out the needs of the community etc.

- A Team of Health Workers wanted to start a Leprosy Control Programme and cover a whole block. All the team members were new in the area. At first, the people of the nearby villages looked at them with distrust. The team, realising that they needed the trust of the people to achieve the aim of their programme, made an effort to contact all the village Sarpanches of the block before starting their work. They also tried to find out who were the influential people in the most important villages, started to befriend them and, in the process explained their reasons to be there and what they expected to achieve. In no time the team felt that people started to look at them in a different way and came forward to help the programme. One of the most important local informal leaders became a strong supporter of the programme, considering himself as part of the team and helping them in their numerous difficulties.

2. Help in specific activities

There are many ways by which local leaders can help us in our activities. They can be very helpful in planning and implementing all our programmes. For example, they can be most useful in involving the community in collecting information for the baseline survey, getting the community to decide on a particular plan of action and in helping to evaluate the success of our programmes. Leaders can help to raise resources from the community for programmes and can take on a great deal of responsibility to see that programmes are run smoothly.

- A group of health workers in a tribal area had been doing health and development work for 3 years. They had built up a good relationship with the people during this time. In the third year, a severe drought occured in the area and a funding agency gave them funds for a drought relief programme. The money was used to buy seeds which did not require much water to grow.

  A committee of 4 persons chosen by each village took the responsibility for the proper implementation of the scheme in each of their villages. Within two days the committees had drawn up an impartial and

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accurate list of beneficiaries with their land holdings and the quantity of seeds required by each. The committee members along with the health workers purchased the seeds. The distribution was done in a systematic manner and proper records were maintained by each committee. Twenty five villages (with 900 families) benefitted from this programme.

Just as local leaders can be a great help, not involving them can also hurt our programme. We have seen that their support can help us gain community acceptance and participation. Several case studies which we have discussed in the workshop have shown the harmful effects of non acceptance by the community. However, it is important for us to take into account the various factors in a village situation and not be completely taken in by whatever a leader says (remember the case study - Hidden Motives).

HOW TO RECOGNIZE INFLUENTIAL LEADERS?

In your visits to the village, you will probably find that certain people's names are often mentioned in answer to questions like:

1. Who are the important people in the village?
2. Whose opinion do you respect?
3. Whose advice do you follow?
4. Who settles arguments within or in between families?
5. When there is an illness in the family, whom do you go to?
6. Who are the first persons to do something when there is serious trouble in the village?

These people whose names you hear often are probably those with leadership qualities and respected by the community. You must remember that you must ask the above and related questions in different sections of the village otherwise you may not get a complete picture. Thus, in a village with different caste groups it is most likely that each caste group has its own elders and leaders who influence that caste group more than the leaders belonging to the other groups. This is an important point for you to remember.

Keeping ones ears and eyes open i.e. by listening and observing people, events, situations, during village visits, you can identify informal leaders and also check the information you have on individual leaders.

- In a village of south India, a team of health workers identified very quickly the formal leaders. It was also easy for them to find out the informal Caste Leaders. But it took them several years to realise that the Harijans of the village had great trust in one of their young men and that, in fact this young man was one of the most powerful leaders of the Harijans. This fact came to light when the Harijan colony was burnt down and help had to be organised to rebuilt it. He was the only one who could control the grief of the people and encourage them to rebuild the colony altogether, those who had not suffered from the fire helping those who had lost everything.

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TO SUMMARIZE :

We have seen that it is important to involve local leaders in our Community Health Programme because they are powerful and can make decisions that result in the success or failure of a programme. Community participation, so essential for the success of our programmes, is usually decided by the community leaders.

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Prepared by:

Community Health Team
Voluntary Health Association of India
C-14, Community Centre, S D A
New Delhi-110 016

chtt:rr: 29.3.84

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

WHAT DO YOU NEED TO THINK OF BEFORE PLANNING A COMMUNITY HEALTH PROGRAMME

I. INTRODUCTION

Resources available for Health Programmes are generally limited. It is, therefore, important to make the best use of these limited resources. It is now accepted by all that one of the best ways to improve the health status of the people, within the limited resources available, is by good Community Health Programmes.

The principles on which Community Health Programmes a re based have already been discussed and all of us now accept that such programmes

- require an integrated approach to the solution of the community's numerous problems
- need the full participation of the Community in solving these problems
- and that people's participation should mean full involvement in the different phases of the programmes.

Health has a different meaning for different people. For the majority of professional health personnel (Doctors-Nurses-Paramedical Workers etc.) the meaning of health is generally restricted to absence of diseases. Still, in our country the majority of people have more urgent problems to face in their daily life and all these problems have a strong influence on their health. They are food - drinking water - sickness - education - unemployment - shelter and clothing - social and cultural acceptance. If such is the case, before starting to develop a Community Health Programme, we will have to be well informed on the people's problems in the area where the programme is to be implemented, the already existing facilities for meeting these problems and the available resources which can be used for community development programmes.

When planning, a few points must be kept in mind: The projected programme should

- be planned in full collaboration with the community
- be based on actual and felt need of the community
- be realistically planned
- as far as possible make use of locally available resources.

II. CHOICE OF AN AREA (TARGET AREA)

As a rule you are already attached to a base institution, either a dispensary, health centre or hospital. This institution's broad objective is to improve, in one way or another, the health status of the population living around it. Thus the target area where you would normally start a Community Health Programme is already fairly well defined.

But even then, you will have to select more specifically whether you have to start in villages situated north, south, east or west of the base institution, which villages to select how many villages to start with etc.

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Probably you know the villages around your base institution very well. You know how they live, how poor they are. You also know that there are no medical facilities available, except your institution, nor is there any help of any type nearby.

Well, try to put on paper all the general information we are suggesting you get and realise how much you really know.

To help you in your selection we suggest the following steps:

1. Study the location of your institution and of the area arount it:

   a. Make a good map of area covering about 15 to 20 Km around your institution. On the map, locate state-districts-block divisions boundaries, all villages, roads, rivers existing health facilities and any other informations you would find useful.

   b. Make a list of all the villages situated on the map with their population as per the latest census.

      Census are made every ten years. The latest one is just being completed(1981). In case the census has been done several years ago and you want to have an approximate correct figure of the population, you can calculate it as follows:

      $$\text{Population as per last census} + \left(\text{Population as per last census} \times \frac{2.5 \times \text{Number of years}}{100}\right) = \text{approximate correct population}$$

      The increase of the population is calculated on the average increase of the population in India: 2.5% per year. So, if a village is said to have a population of 2,500 in the last survey and you want to know its correct approximate population 6 years after completion of the survey you can easily find it this way:

      $$2{,}500 + \frac{(2{,}500 \times 2.5 \times 6)}{100} = 2{,}875$$

   c. Find out under which block development the village situated on the map belong.

      If you do not have a good map you can easily under or over estimate distances, you may think a village is only 2 Km from your institution and it appears so on a ma p where roads and path have not been situated. But when you decide to visit that "nearby" village, you realise that you have to walk around a big water reservoir and it takes you more than one hour to do so.

      - A para medical worker had to visit a village, which, on the map appeared to be 3 miles from the base centre and he decided to go there cycling. To his dismay, the road which he thought was good all the way, turned out to be a foot path after only one mile from the base centre. This foot path was following the boundaries of flooded paddy fields and twisted in all directions. Because of this he had to carry his cycle for most of the remaining journey and the distance was much more than the three miles he had expected it to be. In fact, it took him two hours to reach the village and how tired he was after reaching it!

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A visited village can appear to us very small and so we would decide that it is not worth concentrating our efforts on it. But the population of this village, is, according the latest census, above 1,000. How can that be?

The reason is very simple: We probably saw only one of the several hamlets of the village! This is a very common happening mainly in a tribal areas where hamlets of a same village are sometimes far away from each other.

- In Bihar, during the drought relief work, a team of health workers used to visit weekly a small village. According to their estimate this village had only about 30 houses and all of them were inhabitated by non tribal Hindus.

  After three months, the workers missed the small path they usually took and, after asking the direction of the village from Tribals working in the nearby fields, they were shown another path which would take them to the same village.

  When reaching the place indicated to them as the village, the workers could not recognise it. More over, they were in a Tribal village, so it had to be a different one from the one they used to visit!

  But when talking with the village people they were told "no, you are in the right village". How can this be? This village had, in fact, four hamlets separated from each other by about 3 to 4 furlongs. Communities of these hamlets were all different: Tribals - Muslims - Hindus - Christians.

  Up to then, the workers had only visited the Hindu hamlet of the village and the people of this hamlet carefully avoided talking about the other hamlets of the village: For all that the health workers knew this hamlet was the village!

If a target area chosen by a Health Centre is situated in a different block than the one in which the health centre is situated this has to be known. Why?

- A group of workers have a community development programme in an area covering 20 small villages. Their Block Development Office is only 6 miles from their own centre and they have good rapport with the Block Development Officer. Still they cannot obtain help from the BDO for the villages of their target area. All of them are situated in a block different from the one where the Health Centre is.

2. <u>Study the Communication system in the area</u>:

   a. Is there a railway communication system in the area? If yes, how is it? How frequent are the trains, where do they go, what villages and towns do they link together?

   b. How is the bus system in the area? Where do they go? How often? Which villages can you reach by bus?

   c. What is the condition of the roads leading to the different villages of the area? Are some of them blocked by water during the rainy season? Which ones? How long would the villages be isolated from the base centre?

   d. Are there short-cuts allowing communication between villages through the fields? Are these short-cuts easy

to walk? What would be the distance between two villages linked by short-cuts?

To know the conditions of roads in all seasons is important. A village with a Community Health Programme needs constant and regular contact with the base centre.

- One centre planned a Medical Extension Programme and applied to a donor agency for funds. In the application they requested a vehicle to visit three centres bi-weekly, recurring cost of the vehicle and salaries for two full time workers. The proposal seemed interesting and thus the donor agency sent a person to study the proposal with the centre. Surprisingly, the three villages were found to have roads which would be cut during the rainy season, and there, the rainy season lasts for 5 months! This fact had been over looked by the planners!

To know the timing of the buses when we go to villages can become very important.

- People of a village situated about 10 miles from a dispensary were very keen to have a nurse of the dispensary visit their village regularly. They insisted so much that the nurse, though very busy, decided to go. But she would have to go by bus as the dispensary had no vehicle. No problem, said the people, we have many buses between here and the village. There is a very good one leaving this dispensary at 8 a.m., so why don't you take it?" She did take it and spent a fruitful busy day in the village. But when she wanted to come back, she discovered that the bus which took her in the morning was the only one going back in the direction of the dispensary, and of course it had left hours ago. She then had to walk for more than one hour before she could reach another village where a bus going to her dispensary would pass through sometime in the evening... She waited in that village for more than 2 hours before seeing the famous bus come.

3. <u>Get information on the Socio-Cultural-Economic condition</u> OF the area (from Govt. sources)

   a. What is the density of the population?
   b. What is the general pattern of agriculture in the area? Is land irrigated? by what means is it irrigated? What type of crops is grown on the land? How many crops per year?
   c. How big is land holding per family? (average) How many families have small land holding (percentage) How many families are landless? (percentage)
   d. Is there industry in the area? If yes, how many workers are employed in them?
   e. What is the average daily wage of unqualified labourer?
   f. What are the main communities in the area (percentage)?

Our effort should reach the greatest number of people. It is therefore important for us to know the density of the population in our area as well as the approximate population of the villages, before we finalise our plans.

- One group of workers decided that the area most in need of their help was situated in the north of their base centre and thus they were ready to select it as the target area of their Community Health Programme. The reason for this choice was that very few patients were coming from there, but thos who come were all very ill. There was, therefore, a need for better contact between the base centre and the population of the villages situated in that area. But when studying the density

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of the population and the socio-economic situation of that area, it came out that there were in fact few villages there as it was a jungle area. The villages were small, far away from each other, isolated. A programme there would have benefitted very few people and would have been difficult to implement.

But in the east of the base centre, there was an area with several fairly big villages, so would it not be better to select the east are first as a target area?

- The workers of the centre who had almost decided to select the villages situated in the east of their base centre, considered the other villages located in south and west of their base centre. They then realised that the villages located in the east of the centre had their field well irrigated by a big water tank. They had an average of two to three crops per year. On the contrary, villages situated in the south and the west had no irrigation facilities of any type. The villages of these areas were considerably smaller than in the villages located in the east, but the need of the people was much greater.

Our effort should benefit the people really in need of help. It is therefore important for us to know about economic conditions of the area where our centre is situated and of the villages situated in it. Economic situation will differ from village to village, but as a rule some areas can be demarcated as poor, fairly poor or well off.

4. Study all the existing facilities in the area

a. Has each village of the area an elementary school? Where are the middle and high schools? Are there any colleges in the area? Are ther any technical schools?
b. Which villages have people's associations? (Mahila Mandal, Youth Clubs etc.)
c. Where is the Primary Health Centre? Where are the sub centres? Are there any government dispensary in the area? Where? Are there any specialised health programmes, such as Leprosy Control Units, in the area? What are do they cover? Are there any private dispensaries and doctors in the area? Where are they?
d. Where is the nearest hospital? How far is it from your base centre? How do the people go there? What facilities are available there (Number of beds, O.T. etc.)

These facilities have to be studied village wise. This is important for you to know because people in villages with more facilities may have a better awareness of the need for change.

One important study to be made by you is the already existing health facilities in the area. If you plan a small programme, covering 2 or 4 villages only, you can easily obtain information on government activities in the area from the Primary Health Centre. You should establish good rapport with the Primary Health Centre's staff and inquire where are their sub centres, where the other government dispensaries, how are they staffed, what area do they cover, what work do they do. If you plan a bigger programme or a specialised programme you should contact the district health authorities or even the

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state health authorities before you start and find out from them if and how your services are welcome. This is mainly important in the case of a specialised programme such as a leprosy control programme. Be careful whom you contact in government circle: Contact the right person at the right level.

- A team of voluntary health workers specialised in leprosy started a Leprosy Control Programme in a defined area. It developed well and became a very good Leprosy Control Programme. Three years later, to the surprise of the health workers who started the programme, the government opened another Leprosy Control Programme in the area already covered by the voluntary health workers's programme.

  What a waste! Why did the government duplicate the work of these voluntary workers? The answer is simple: The voluntary workers omitted to contact the government authorities, in this case, the District Leprosy Officer.

It is also important for you to be well aware of other private health institutions in the area and of the different types of programme done by them, so as not to duplicate services.

III. WHERE TO FIND INFORMATION

In the previous chapter we have suggested that you collect general information on the area where you eventually would start a community health programme. Most of the information we asked you to gather can easily be obtained from:

1. The District Level:

   The district map, the list of primary health centres and their sub-centres, as well as the description of the different programmes attached to them, can be obtained from the District Health Officer. He can also let you know what type of help his department can eventually give to your programme and what future plans the government has for your area.

   This list of the hospitals in the district, with their facilities and staffing pattern, can be obtained from the District Medical Officer.

   In some states, the DHO and the DMO's functions are held by one person only. You will have to find out how it is in your own district.

   Specialised programmes, such as Leprosy Control Programme - TB Control Programme - Family Planning Programme have sometimes a separate person in charge at the district level. If you want to know more about these programmes you will have to contact the person in charge at the district level, for example, The District TB Officer.

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2. The Block Level:

The map of the block, the list of the villages with their population as per the last census book, the land holding pattern - village wise, the government scheme for agricultural - animal husbandry - cottage industry development can be obtained from the Block Development Officer. He can also tell you what kind of help is available for the villages through his department.

Information on the health scheme in the block must be obtained from the Primary Health Centre, of the block. The doctor in charge can give you information on the sub centres attached to his PHC and on all the Programmes going on from the PHC.

3. The District Census Book:

Every ten years, the government has a complete census of the population done all over the country. A book, giving the result of the census, is published for each district. Much information is available in this book such as: villages and their population, percentage of literacy, landholding per village, development of local industry, landless workers, unemployed workers etc. Generally the district census book gives small maps of each block of the district.

IV. STAFF REQUIRED FOR A COMMUNITY HEALTH PROGRAMME

The professional staff required for a Community Health Programme will naturally differ according to the size of the programme and the type of area the programme has to cover. For example, if the programme is to be in a forest area, there will be need for more staff for the same population than if it were to be in a plain. In the forest area the villages are generally much smaller and more scattered than in the plain, and the communication system would be poor.

For an approximate population of 5,000 the following professional staffing pattern can be considered as adequate:

2 full-time health workers and a doctor who is willing to assume the medical responsibility of the programme.

The two full time workers have to be well chosen, and the qualifications will have to be according to the activities of the programme. In a Community Health Programme, where an integrated approach of community problem is accepted, we would advise the following:

1. To meet the health needs of the women of child bearing age and of the under five children:
   1 ANM or Nurse.

   She would be in charge of the mother and child programme: pre-natal care - home deliveries - post natal care - follow up of under five children including immunization programme - nutrition - health check up. She would deal with other priorities of the programme for that group, such as family welfare programme.

2. To animate the community, organise people's committees and associations: one male Social Worker (Community Organizer).

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It will be easier for a man to relate to the men of community and to attend village meetings which generally are held at night. The social worker does not have to be a graduate. He must be someone who can listen, understand and work with village people. It is preferable to have, for this work, someone who belongs to the area.

The professional staff will try to motivate the community so that people participate in the different activities of the programme. One example of such participation is the VILLAGE HEALTH WORKERS. In many programmes, the person considered as the Basic Health Worker is a person from the community, trained by the professional staff, to meet the basic health needs of the community. The VHWs are very useful, if well trained and well supported by the professional health workers. Generally the ANM or Nurse would be in charge of the VHWs' training and supervision. For some of you, this staffing pattern will seem impossible to have. Do not get discouraged. Start with a smaller area. Generally a small dispensary would have two persons working there. If you organise the timing of your dispensary it would then be possible for you to have a community health programme in 2 or 3 villages to start with. Once the programme gets well under way, it will probably be possible for you to expand your programme to cover 5 or 6 villages.

V. EXPENDITURES TO BE FORESEEN AND HOW TO MEET THEM

Community Health Programmes, unless attached to a hospital with a fairly good income, are generally deficit programmes. People of the villages will certainly be ready to meet most of the expenses, if we work out the programme with them. But some expenses would just be too much for them. So when planning a programme we must be very much aware of one important fact.

RESOURCES BEING VERY LIMITED, WE MUST MAKE THE BEST OF THEM.

Yes, resources are limited, and the expenses of the programme should be, as far as possible met by the beneficiaries. Therefore, we must carefully work out our budget so that most of it can be met by the people.

What will we have to think of as expenditure? At the planning time they can be of two types, namely:

1. Non-recurring expenses
2. Recurring expenses

1. Non-recuring expenses:

These are expenses which will occur once only. For example, you think that to reach the villages of your programme you should need three cycles. The cycles will have to be bought at the beginning of the programme only. So in non-recurring expenses could be: buildings if any
equipment and furniture
vehicle if required: car -motor cycle - cycle
educational material

When planning a Community Health Programme, to be attached to an already existing centre, the non-recurring expenses will be very limited.

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2. Recurring expenses:

These are expenses which will have to be met every year. For example, the salary of the workers. The expenses you will have to think of will be:

- salaries of the workers
- drugs for primary level of health care in villages and immunizations
- vehicle expenses.

Salaries of the workers is generally the main item. In a case where there are two full time progessional workers for 5,000 people, the salaries will come easily up to Rs.1,000 per month.

N.B.: When planning a Community Health Programme and preparing its budget you must remember that resources are very limited and, because of this examine carefully whether the community and you will be able to meet the amount of expenditures you are budgeting.

We would like you to pay particular attention to two instances:

a. Recurring cost of a vehicle:

Many small health centres feel the need for a vehicle and this is understandable because of poor communication system in the area where they are situated. Donor agencies would generally be ready to donate a vehicle to deserving cases, but the maintenance of the vehicle will have to be met by the health centre and this is very high. It will normally include:

- cost of petrol of diesel oil
- cost of taxes and insurance policies
- cost of maintenance and minor repair of the vehicle
- salary of the driver.

Beside this, you will have to foresee a depreciation of 20% per year on the price you originally paid for the vehicle so that, after five years, the vehicle can be replaced.

In many cases a small health centre would not have such a big Community Health Programme and thus the expenses of the vehicle cannot be expected to be met by the people. Can your Centre afford this expense year after year?

b. Stipends of Village Health Workers:

Some health centres, who have Village Health Workers in their Community Health Programme, want these VHWs to be given a fairly substantial stipend. This principle is good, as it is a kind of recognition given to the VHWs for their service. But how to pay them, how much to pay them and who should pay them?

These questions have to be well looked into before starting.

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Once, where VHWs were part of the programme, the Programme Director decided to pay the VHWs to Rs.50 each. The VHWs were serving very small villages of about 200 people each. The community was unable to meet the expenses of the VHWs stipends and thus the programme started paying them. After 6 months the donor agency who financed the programme stopped their grant and the project director was unable to meet this expenses. He stopped paying the VHWs. You can easily imagine what happened. Can't you?

We said earlier, that resources are limited. That is all right, but where are resources <u>available to maintain a Community Health Programme</u>? Where to look for them?

a. <u>In the community to be helped by the programme</u>: There you will find people with different skills-craft, you will find raw material, land, animals houses, food, money.

People are poor, so how can we ask money or food from them? Many of you will certainly think that way, and it is true, people are poor. But, are all the people poor in the villages? Far from it, So would it be so difficult to raise fund from the people? This will depend how you will work out your programme. People, as a rule, are much more understanding than we credit them to be. They understand that service is expensive and expenses have to be met by some one.

In one instance, a group or workers were planning to start a small first aid dispensary in village. They also wanted to attach to it a good mother and child programme. The programme was discussed with the people who were very interested it it. The expenses of the programme was also discussed. The people worked out an approximate budget for the programme and ways to meet the expenses. They fixed what should be the service cost so that the workers would have enough to live on.

In another case, the workers discussed with the people before starting a Community Health Programme in the village. The workers requested the village to be ready to give them accommodation, meet the cost of the bus for them to come to the village and cost of drugs when it would be required. The people of the village agreed and so the workers started visiting the village twice a week and spent the night there. They were very surprised when the first day they went to the village food was also provided to them by the people. This had not been asked for because this village was very poor. During the three years of intensive programme in this village, the people met most of the expenses of the programme themselves. The only expenses they could not meet was the salaries of the professional Community Health Staff.

In a case where people would not have been in a position to give money, paddy was collected once a year for the programme.

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b. From the Government: Help is available from different government schemes:

- medicine (vaccine - iron - folic acid - vit.A)
- benefit of special schemes under the block such as seed, sewing machines, trees, chickens
- service of qualified personnel: for animal husbandry, agriculture
- special training organised by the block for village people
- in case you are working in a small dispensary: referal of your patients to the PHC.

Money is available for special programmes such as well digging, pond deepening etc. Such programmes are under the supervision of the BDO and he is the person to approach for it.

Money is available for special health programmes such as TB Control, Leprosy Control Programme. In such cases we must follow all the rules of the government for such programmes and the programme we will undertake will have to cover a specified, fairly big area.

c. Companies: Business companies can be contacted for kind and money. This is mainly applicable in case of emergency.

d. Clubs: Rotary - Lions - Wheels etc. give mainly funds for short term programmes and charitable activities. Most of them are much interested in immunization programmes and eye camps.

e. Red Cross: In case of emergency only. Generally the Rod Cross run their own programmes but in some cases voluntary programmes got substantial help from them.

This was the case during the drought of 1966-67 in Bihar. The Red Cross supplied important food and medicine stock to a voluntary agency working in Palamau.

f. Social Welfare Board: Is a state welfare association. It helps with grants in womens' development programmes and childrens programmes.

g. Specialised Welfare Boards: The specialised Welfare Boards are governmental, such as Tribal Welfare Board. They help in programmes for the marginal groups of the society.

h. Donor Agencies in India: Caritas-India, Indo German Social Service Society, Catholic Relief Service, Care, CASA etc.

i. Donor Agencies outside India:

As far as possible the cost of a Community Health Programme should be met by local resources: community - government - local clubs and companies.

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In case all the cost of the programme cannot be met from local resources appeal can be sent to a donor agency either in India or outside India. But we have to remember that no donor agency will assume the financial responsibility of a Community Health Programme for a long time. At the most a donor agency will be ready to help meet the recurring cost of a programme for 3 to 4 years. After that time it will still be your problem how to meet the recurring cost of the programme. This is why we strongly advise you to try, from the beginning, to have the cost of the programme met by the local resources and to plan your programme according to the availability of the local resources. In case, the community cannot bear the full cost of the programme you could of course ask a donor agency for a grant to begin with. But then you should seriously study how the programme is to become self-sufficient. Perhaps it could be possible to have an income generating programme supporting part of the expenses of the community health programme.

V. CONCLUSION

In this paper we have tried to help you in becoming aware of what should be done before starting a Community Health Programme. We have seen the necessity for you to have a good knowledge of the area where you intend to have your programme and where most of the information you require can be obtained from.

We have seen that it is important to consider carefully the professional staff necessary for such a programme and the cost to be foreseen.

You should thus, at this stage, be able to choose a target area and plan for a small programme to be taken up by your centre.

But before you start implementing the programme you will have to go a step further and select a few villages, situated in the target area, where you would start the programme. In another paper we will study with you how to select villages for starting a Community Health Programme.

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Prepared by:

Community Health Team
Voluntary Health Association of India
C-14, Community Centre, S D A,
New Delhi-110 016

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

PLANNING A PROGRAMME

All health teams basically want to improve the health of the people. In doing this the team already has some guidelines. For example, we all know that there are national priorities such as Mother and Child Health, Control of TB and Leprosy, raising the level of literacy, reafforestation etc. In the villages we have chosen, there will be other problems also such as lack of sanitation, water, migration etc. We cannot deal with all the health related problems of a village at the same time. We will have to set priorities. This means that we will have to decide which problems we want to deal with first. We should also be clear about how we are going to deal with these problems. It is therefore important that we plan our activities.

PLANNING HELPS US IN:

- identifying the problems clearly
- deciding what we want to achieve through our action
- working systematically
- making better use of our limited resources
- studying the results of our action

STEPS IN PLANNING:

STEP 1. Identifying the problem: We must first find out the in our villages. This can be done:

- through observation (keeping our eyes and ears open
- through discussions with village people, formal and informal leaders
- by studying the out patient records
- by doing a survey

STEP 2. Set priorities: To do this we make a list of all the problems we have found in Step I. These may be medical ones:
Eg. Malnutrition, Diarrhoea, Malaria, Scabies, Tetanus etc., or non-medical ones: eg. illiteracy, migration, deforestation etc.

A health team cannot deal with all these problems at the same time. So we need to set priorities by asking ourselves for each of the problems:

- What is the extent of the problem (How many people are affected by it)
- how serious is the problem
- how concerned is the community is solving the problem
- how easily can the problem be solved

We give points (0-4)* for each of these answers and multiply the points for a problem to get the result.

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* Note:
0 means not at all
1 means little
2 means somewhat
3 means quite high
4 means very high

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Our priority problem will be the one which gets the highest score.
FOR EXAMPLE, let us take four problems and work out the priority.

Diarrhoea
- is common (about 60% of our OPD cases are diarrhoea)
- is serious because it causes death
- community is concerned because so many children die of diarrhoea
- we can do something to solve the problem

Scabies
- is very common (every second person in the village has it)
- It is not serious (people do not die of it)
- community is not concerned about it as the people can continue their day to day work
- we cannot do much about it unless the whole community is interested in removing this disease from the village

Illiteracy
- is common (only 13% of the population is literate)
- is serious because it leads to a lot of exploitation
- community is somewhat concerned
- we can do something to solve the problem

Deforestation
- is common
- is serious because it leads to decreased rainfall and poor soil
- community is concerned about it
- it is difficult to take immediate action

Problem	How widespread		How serious		Community concern		Can do something about it		Score
Diarrhoea	3	x	3	x	3	x	3	=	81
Scabies	4	x	1	x	1	x	1	=	4
illiteracy	3	x	3	x	2	x	3	=	54
Deforestation	4	x	4	x	3	x	1	=	48

From the above it is clear that diarrhoea, though less common than scabies and deforestation, needs immediate action. So diarrhoea becomes our priority problem. Illiteracy is the second priority.

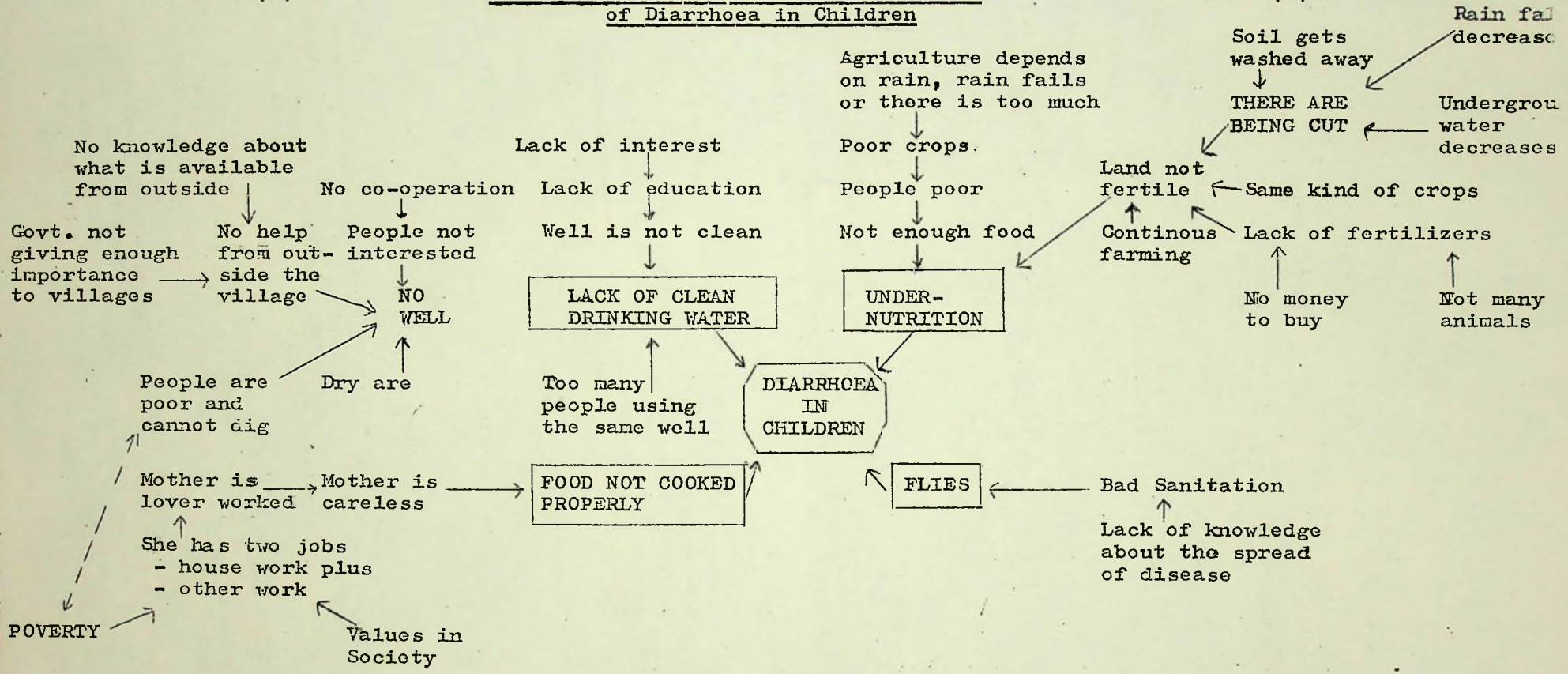
We should remember that the scores for each problem can be different for each village. Also we must select our priority problems after doing the four factor analysis for all the problems we listed in Step I.

STEP.3 Find out how the problem is caused: After we decide on the problems that we want to deal with first, we find out reasons and causes of the problem. This is called community diagnosis. For example, if we take our priority problem of diarrhoea our community diagnosis may look like this.
(see next page).

: 11 (a) :

COMMUNITY DIAGNOSIS
of Diarrhoea in Children

: 11 (a) :



REMEMBER: This Community Diagnosis is not complete. There can be many more reasons which lead to diarrhoea in children. Find out the actual reasons from the people in each of your villages. A complete diagnosis leads to a complete treatment.

The above chart is only an example. We must talk to the people in the village and find what are the reasons for the problem in that village.

STEP 4. Decide on a Plan of Action

In Step III, we will have found many reasons for our priority problem. It is now our task to see, with the community, what can be done about the problem. For example, from the community diagnosis of diarrhoea we can see what are the main causes of diarrhoea and whether we can do something about them, like this.

Main reasons for Diarrhoea	Can do something about	Difficult to do something about
1. Lack of clean drinking water	- educating people to keep well clean - help people to get help from Govt. for digging a well	
2. Food not cokked properly	- educating mothers about feeding practices - organizing women to share responsibility of all under fives - motivating elder children to help in proper feeding of under fives.	Difficult to change values in society
3. Flies	- educating people about how disease spreads	Difficult to deal with bad sanitation immediately
4. Malnutrition		Difficult to deal with agricultual problems right now.

Other ideas

-training VHW's to provide medical facility in villages

-educating mothers and VHW's on danger signs of diarrhoea, preparation of rehydration drink, need for early actin etc.

In the above example, we notice that it is easier to do something immediately to reduce deaths caused by diarrhoea. However it is more difficult to decrease the number of cases of diarrhoea. For this we would need to do something about undernutrition and sanitation also. It will take a long time to think of ways of solving the problems of undernutrition and sanitation.

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STEP 5. Making plan: We have decided with the community what we are going to do about the priority problem in Step 4, now we must discuss who will do what, how and when. If money or equipment is required, how will we get it? For example, we consider what is needed for two of the activities we decided in Step 4, column 2.

Activity as decided in col.2 of Step 4	What needs to be done	Who will do it	by when	require money/ equipment
1. Educating people to keep well clean	-Find out the reasons why well is unclean			
	-Talk with people individually and in groups to deal with reasons			
	-Find out possibility of building platform around the well			
	-Contact PHC staff to get bleaching powder			
2. Help people to get help from Govt. for digging a well.	-Find out where the well is to be dug.			
	-Find out how many people will benefit from this well.			
	-Contact Gram Sevak, BDO			
	-Get the village representatives to write a petition to the B D O.			
	-Fix up meetings with BDO and representatives			

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Prepared by:

Community Health Team
Voluntary Health Association of India
C-14, Community Centre, S D A,
New Delhi-110 016

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ANALYSIS OF THE PRESENT HEALTH CARE DELIVERY SYSTEM IN INDIA

To start with, let us examine the rationale and relevance of an analysis of the existing health care delivery system.

Let us have a look at the following statements based on authentic statistical information:

India has the highest mortality rate - 133/1000, among all the Asian countries.

In India diarrhoea alone kills 3 children every minute or 1.5 million each year. Every minute an Indian child is exposed to it.

Infant mortality rate of India is 125 (1978).

There are about 60 million children in India who are malnourished.

There are an estimated 3.2 million leprosy patients in India.

Tuberculosis accounts for 3% of the 1 crore annual death in India.

Severe degree of anaemia has been detected in 12% of preschool children.

90 million children are supposed to be in the polio danger zone and 13 million are added to this figure every year.

Of these, 80% victims are below 3 years and 15% below 5 years. There are 2.5 lakh totally blind children. There are about 1.8 lakh partially blind. There are another 2.5 lakh who are deaf. Of the 9 million blind persons in the country, 5 million could be cured by proper surgical interference.

All these are certain important indicators of the health status of India's 70 crore population. India adores tenth place among the industrialized nations of the world. Planners and leaders narrate success stories of various development programmes and the progress achieved in various sectors. But the lot of the common man and the labourer continues to be the same and becomes worse even. The ill-health and the high death rate are but the manifestations of the miseries that majority of the population undergo in this country. Here it rightly follows that development and health are integrally related. At the very outset of this discussion let us try to situate the sick man in the context of this socio-economic situation prevailing in India.

Development means the satisfaction of the basic needs of the poor who constitutes the world's majority; at the same time, development also means ensuring the humanization of man by the satisfaction of his needs for expression, creativity, and the capability for deciding his own destiny. Here again the stress is on the poor man - the satisfaction of his needs and ensuring the removal of all dehumanizing forces and enabling him to be master of his own destiny. Health forms one of the basic needs of man; and more than

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that, sound health is primary for human existence. The first part of this paper presented few instances showing the grave denial of this right to existence. The 'Alma-Ata' declaration of the International Conference on Primary Health Care (organised by WHO, Sept. 12,1978) also reaffirms the importance of health and goes even further to state that health is essentially a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. If viewed against this background, provision of"health for all" which is a declared objective of WHO and that of the Government of India, demands of comprehensive state of national welfare based on equity of distribution in which none denies the right of the other for health. Hence health demands the good harmony of social, economic, political, cultural, and religious forces conducive to the promotion of healthy existence of man.

In the existing society, the health care system is part of the wider social, political and economic system. The social, political or economic capability is not equally distributed. According to the 1981 census, 48.44% of the Indian population are below the poverty line. Unofficial calculations, which often picture the real state of affairs, suggest the figure to be 75%. This figure goes on increasing. According to 1981 price scale, a person who does not have Rs. 3/- a day is considered to be under poverty line. This phenomena is due to the anomalies of the distribution system which prevents the poor from meeting his needs. In the wider economic and political relations, the health system alone cannot be thought of as being isolated. Unequal distribution of health care facilities denies the right to sound health to the majority of our population. Social and economic inequalities and powerlessness prohibit the people from the knowledge and the capacity to afford the health care of their family the pregnant, the children, the adult and the aged. Hence, inequalities exist at two levels - (a) in the distribution of the health care service (b) in the capacity of the people to afford to maintain good health. Precisely, these two areas constitute the central theme of this paper. We shall follow a sequence and order based on the points given below:

a. The present health care delivery system in India and its distribution in the rural and urban centres.

b. Availability of these facilities to different economic classes and medication practices.

c. Problems of medical personnel in rural areas.

d. Manufacture and distribution of drugs.

Prior to the discussion on the above let us have a brief look at our national health policy.

Our National Health Policy

The constitution of India aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given

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opportunities and facilities to development in a healthy manner. Hence with a view to providing health for all by 2000 AD., the Government of India has revised its health policy in relation to the economically under-previleged sections of the Indian population, and especially those in the rural areas who constitute 80% of the total population. The revised statement on the National Health Policy covers areas as population stablization, reorienting medical and health education in relation to the health needs of the rural and urban poor, need for providing primary health care with special emphasis on the preventive, promotive and the rehabilitative aspects, reorientation of the existing health personnel, promotion of indigenous and other systems of medicine, etc. The policy statement considers the problems of nutrition, food adultration, quality of drugs, water supply and sanitation, environmental protection, immunization programme, Mother and Child health service, school health programme, occupational health service, medical industry and medical research as areas deserving urgent attention. All these are geared to providing all the citizens of India sound health, especially those in the rural areas who forms India's majority of population.

Yet alarming statistical figures glare at us. We have to admit that the existing health care delivery system does not cater to the needs of the majority of the people. The poor and the under-previleged, especially those in the rural areas, form the majority of the victims of ill-health. We have to admit that based on this status-quo we have to implement one by one the meaningfully laid down policies of our National Health Policy. Now let us pass on to discussions on the various points mentioned already.

(a) Health Care Delivery System in India:

i. Administrative set up at the Centre, State and District levels

The official organs of health at the national level consist of (1) The Ministy of Healthand Family Welfare (2) The Directorate General of Health Services (3) The Central Council of Health.

The functions in the union list for the ministry of health and family welfare are international health relations and administration of port quarantine, administration of Central institutes, promotion of research and research bodies, regulation and development of medical,pharmaceutical, dental and nursing professions, establishment and maintenance of drugs standards, immunisation & emigration, regulation of labour and working of mines and oil fields, co-ordination in the States and other ministries for promotion of health. For functions in the concurrent list both the Central and State ministries are jointly rosponsible. They are prevention of extension of communicable diseases, prevention of adulteration of food stuffs, control of drugs and poisons, vital statistics, labour welfare, etc. Both Centre and State Governments have simultaneous powers of legislation.

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The Directorate General of health services is the principal advisor to the union Government in both medical and public health matters. The functions are surveys, planning, co-ordination, programming and appraisal of all health matters in the country. In brief, the specific functions are inter-national health relations and quarantine, Control of drugs standards, management of medical stores depots, post graduate training, medical education, medical research, Central Govt. Health Scheme, national health programmes, Central Health Education Bureau, health intelligence, and maintenance of National Medical Library.

Since many health subjects fall in concurrent list, continuous consultation, mutual understanding and cooperation are necessary between Centre and States. The Central Council of Health, constituted of the State ministries of health with the union minister as the chairman, looks into these. Briefly, the functions are - to consider and recommend broad lines of policy in matters related with health, to make proposals for legislation, to recommend to Central Government for distribution of grants-in-aid to States and to review the utilization of that, to establish organisations for promoting cooperation between State and Central health ministries.

II. At the State Level

The health subjects generally fall in three headings - federal, concurrent and state list. The state has complete autonomy for the functions prescribed in the State list. Generally, this includes the provision of medical care, preventive health services and pilgrimages within the State. And, the State is the ultimate authority responsible for all the health services operating within its jurisdiction.

In all the States the management of health sector comprises of the State Ministry of health and the directorate of health. The State Ministry of health is headed by a minister of health and family welfare. In some States the Health Minister is also incharge of other portfolios.

The Director of Health Services (known in some States as Director of health and medical services) is the chief technical advisor to the Government on all matters relating to medicine and public health. He is also responsible for the organisation and direction of all health activities.

With the advent of family planning programme, in some States, the designation has been charged to Director of health and family planning. In some States a separate Director of medical education is also appointed to be in charge of medical education. The Director of health and family planning is assisted by a suitable number of assistant director, whose appointment may be either on regional basis or functional (specialists in different branches of public health) basis.

III. District Level

There are wide differences in the pattern of district health organisation. The following types are seen (a) One district chief, one District Medical Officer of health, assisted by two or more deputies. (b) Two district chiefs - in this set

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up the civil sugeon/District Medical Officer looks after the district hospital, and sometimes all medical facilities in the district, and the District health Officer is incharge of public health.

People's Participation

The rural local self Government of India, 'Panchayati Raj' institutions are meant to ensure people's participation for the various welfare programmes including health. Panchayati Raj institutions are elected bodies. It functions at three levels:

1. Panchayat - at the village level
2. Panchayat Samithi - at the block level
3. Zilla Parishad - at the district level.

The appointed persons of the Government infrastructure at the district and the block level are the implementing agencies. The local self Government functions as a supervisory and coordinating body.

ii. Health Care System - distribution

The health care system of India may be defined as the "industry which provides health services (health activities) so as to meet the health needs and demands of individuals and the community." It operates in the context of the socio-economic and political system of the country. It is represented by the 5 major sectors or agencies which differ from each other by the health technology applied and by the source of funds for operation. These are:

I. Public agencies

1. Primary Health Centres
2. Hospitals - Rural hospitals
   - District hospitals
   - Specialist hospitals
   - Teaching hospitals
3. Health Insurance Schemes
   - Employees State Insurance
   - Central Govt. Health Scheme.
4. Other agencies
   - Defence Services
   - Railways.

II. Private agencies

1. Private hospitals, Polyclinics, Nursing homes and dispensaries.
2. General practitioners and clinics.

III. Indigeous Systems of Medicine

- Ayurveda and Sidha
- Unani & Tibbi
- Homeopathy
- Unregistered practitioners.

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IV. Voluntary Health Agencies.

V. Vertical Health Programmes.

I. Primary Health Centres: The primary health centre is defind as an "institution for providing comprehensive (i.e. preventive, promotive and curative) health care services to the people living in a defined geographic area. It seeks to achieve its purpose by grouping under one roof or coordinates in some other manner all the health work of that area". It is the minimum infrastructure for the delivery of health care services to the rural people. The scheme started in 1952. The Centre is usually located at the headquarters of the Block, and serves the population of the Block coming upto 80,000 to 1,20,000 spread over in about 100 villages.

To bring the services closer to the people 'sub-centres' are established at the rate of one sub-centre for every 10,000 population. At present there are 5372 PHC's and 37,775 sub-centres (1979). The PHC provides accommodation for an outdoor dispensary, a consultation room, accommodation for MCH/FP services, minor surgery, a small laboratory and a ward of at least 6 beds, out of which 4 are maternity beds. Since the PHC is not equipped to deal with complicated medical, surgical and obstetric and gynaecological cases, it is linked up with the subdivisional and district hospital in the region where X-ray, laboratory and specialist services are available.

Function of PHC:-

1. Medical Care
2. MCH and Family Planning
3. School health
4. Improvement of environmental sanitation with priority for providing safe drinking water and disposal of human wastes.
5. Control and Surveillance of Communicable diseases.
6. Collection and reporting of vital statistics.
7. Health Education
8. National Health Programmes - as relevent
9. Referrel Services.

Health Team

P H C:

Medical Officers	- 2	Computer	1
Compounder	- 1	Auxillary Nurse midwife	1
Sanitary Inspector	-1	Driver	1
Health Inspectors	2	Ancillary staff	2
Extention Educator (F.P)	1		

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Sub Centre:

Health Worker Female (HWF)	- 1
Health Worker Male (HWM)	- 1
Health Assistant (Male)	- 1 (for 4 HWM)
Health Assistant (Female)	- 1 (for 4 HWF)

The PHC thus provides a team work to the health problems of the community.

The sub-centres are established at the rate of one per 10000 population. Health Planners visualise one sub-centre for a population of 5,000 or even less, in the near future, when resources permit.

A sub-centre with a population of 10,000 would yield:

i. Target population for family planning	- 1,500
ii. Deliveries	- 400
iii. Infants	- 400
iv. Pre-School children	- 1,500
v. School children	- 2,500

2. Hospitals:

Apart from primary health centres, the present organisation of medical care by the Govt. sector consists of Rural Hospital, International hospitals (2 to 3 lakhs population), District hospitals (1 to 2 million), specialist hospitals (eye, TB, leprosy, cancer etc.) and Teaching Institutions.

In addition mobile hospitals are also under trial.

Difference between Hospitals and PHC's:

Hospitals	PHC's
- Curative	- Curative, preventive, promotive and all integrated
- No particular catchment area	- Catchment area - 80,000 to 1,20,000 people of about 100 villages
- Only curative staff	

3. Health Insurance

Limited only to Govt. employees, eg., ESI., Central Govt. Health Scheme.

4. Other agencies: Medical services to employees of Railways, Defence personnel etc.

II. Private agencies

There are private hospitals, clinics, dispensaries and private medical (allopathic) practitioners.

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III. Indigenous system of medicine: The practitioners of indigenous system of medicine - Ayurveda, Sidha, Homocopathy, etc., provide the bulk of medical care to the rural people.

IV. Voluntary health agencies: They occupy an important place in Community Health Programmes. They supplement and guide the work of official agencies. Eg. - Indian Red Cross Society, T.B. Association of India, Family Planning Association of India etc.

V. Health Programme in India: Since India became free, several measures have been undertaken by the union government to improve the health of the people. Prominent among these are a number of vertical health programmes known as National Health Programmes which have been launched by the Central Govt. for the control/eradication of communicable diseases, improvement of environmental sanitation, nutrition and rural health. Eg. - National Malaria Eradication Programme, National T.B. Control Programme, VD Control Programme, National F.P. Programme etc.

The following table gives the number of hospitals and PHC's in India.

1. Number of hospitals and dispensaries	- 17607 (1977)
2. Number of PHC's	- 5372 (1979)
3. Number of Subcentres	- 37775 (1979)
4. Hospital Beds	-449212 (1979)

This table represents the totals at the all India level. These do not, however, represent the rural and urban split up figures.

In spite of all the schemes briefed in the previous paragraphs, eight out of ten Indians have little or no access to modern medicine. The number of doctors in 1980 was 2,53,631. A WHO study mentions that India has sufficinet number of doctors. But the problem is the lack ofadistribution system which equally gives importance to rural and urban areas.

Thus the existing health personnel can hardly meet the needs of the people. The ratio of the hospital bed and population, is 0.49 per 1000 population. The doctor population ratio is 1:4400. When taking split up figures for the rural and urban areas, rural area has the ratio 1:20,700 and the urban area has 1:1,300. Thus the rural folk suffers seriously from lack of enough number of doctors. 80% of the Indian population live in villages. But 80% of our health care facilities and personnel are in the urban entres catering to the needs of a minority of the Indian population (20% of population). This fact explains the ill-health of the majority of Indian population. The very same fact explains the high incidence of infant mortality, spread of communicable diseases and high death rate. The Indian child succumbs to death due to some diseaseswhich are generally preventive if sufficiently cared for at the proper time.

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Here again, the reason could be attributed to the general inaccessibility of the Indian population to the health care facilities in spite of continued establishment of hospitals both in the government and private sector.

(b) Availability of health care facilities to the Poor:

We have already seen the disparity in the distribution of health care facilities and the doctor population ratio for the rural and urban areas. As mentioned already, this disparity itself is one of the main reasons as to why majority of our population - poorer sections of the society dwelling mostly in rural areas - are denied the right to adequate health care.

Government and private health care services are available in India. As already mentioned the Government has started some rural health programmes. But certain impediments stand in the way as:-

a. Lack of participation of the people - which develops a certain apathy and disinterest towards the Governmental programme, thus affecting seriously the desired objective of being of help to the very same people. Co-operation of the people and the health personnel is vital.

b. There is a certain attraction to work in the urban areas and the health personnel lack the motivation to work in the rural areas. This is a very clear phenomena found everywhere. This problem is dealt with under a separate heading. Hence when the medical officer or health worker is placed in a rural area he will not commit himself fully but will try for a transfer to the more convenient urban centre.

c. In the annual budget allocation, sufficient funds are not available to the rural centre for the purchase of medicines and the maintenance of other facilities of the health centre. Lack of follow up thus gravely affects the health programmes. 75% of the budget allocations are for maintaining staff, 12% for transport, 12% for drugs and 1% for innovative experiments. When we take rural outlays it is seen that they are remarkably lesser when compared with the corresponding urban allocations.

The Constitution of India has considered health care as a basic need of the citizens and has assured that it should reach to the people. But the people cannot expect good service from the Government health centres. Poor maintenance and lack of facilities are two main reasons. Health care centres as PHC's and sub-centres present a very poor show. District hospitals also do not come upto to the mark. Medical colleges and sophisticated Governmental institutions are generally equipped with all the modern medical accessories with specialists for each branch. Medication at these Centres are, however, controlled by money power. Corruption has eroded public life and health care institutions are also no exception to this phenomenon. Private

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to approach the commercialized modern medicine. Distance to the medical centres and lack of enough competent medical personnel in backward areas make the situation still worse. Problems connected with the dearth of competent personnel are being dealt with under the next heading.

c. Problems of medical personnel in rural areas:*

The training and motivation of the health personnel is very important as regards rural health work. Speaking of training, just like any other branch of education, medical education also should be sensitive to the social environment of the community which it seeks to serve, and constantly adapt itself to the changing requirements. The motivational part of the person is greatly influenced by the content and value orientations of the training. In the paragraphs that follow the descriptions are mainly about doctors, since, in the present set up, even in the rural areas, the graduate doctor remains the chief person as regards health care.

The present medical educational system is strictly hospital based and westernized and hence the doctors do not inher it an aptitude or attitude to work in the circumstances and atmosphere of rural India. The doctors also lack an understanding of the social, cultural and religious concepts of health and disease in rural India as well as the attitudes and practices concerned with food, child-birth, child care and general health care. Similarly there have been very many traditional systems of medical care. The modern system of medicine takes much time to gain acceptance in Indian villages. It is a basic question of cultural difference. Also it should be noted that certain traditional ways of health care are advisable for certain diseases. Thus it counter acts the many adverse effects of modern medicine. The modern medical education does not consider these cultural factors in health care. And also, generally a modern doctor has but contempt for the "uncivilized, uneducated" villager in the place of respect as an individual.

Apart from these, a doctor working in rural area is exposed to the following problems:-

- Inadequate living conditions and inability to maintain an urban standard of living which most medical students become used to.
- Poor or relatively poor financial remuneration and/or allowances/compensation.
- Problems of adjustment when accompanied by wife and young children, especially the education of the latter.
- Objection of families to rural work especially because of a lower social status in the profession.

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* This part of the paper was prepared after closely referring 'Trends in under-graduate medical education in India', prepared by Dr. Ravi Narayan.

- Social isolation because of an inability to fit in with the simple rural way of life. (more pronounced when the doctor comes from a predominantly urban background) Lack of rapport and contact between urban and rural communities to an extent, which makes a doctor feel completely 'out of place' or 'cut off' in the rural areas.
- Intellectual isolation and inadequate opportunity to maintain professional competence or to gain post graduate experience under supervision.
- Problems of political interference in work and often poor relations with local government officials, leading to frequent transfers.
- Problem of interpersonal relationships with other members of the team, especially when many are older to him and have had longer contact with the local people.
- Presence and, often, professional competition with practitioners of other indigenous systems of medicine.
- Another major obstacle to attracting doctors to rural areas is the attitude of the medical profession to rural work, especially in the light of the present day 'ideal' of specialist practice in the large cities. This reflects a general trend towards an intensely materialistic orientation of the medical profession. Consequently, the preparation and motivation for rural work in the medical college curriculam has always been inadequate.

Now, with this we shall pass on to another important area of concern 'DRUGS'.

(d) Manufacture and Distribution of Drugs:

The structure of drug industry embodies all the essential features of the industrial economy of India. Thus, like in the case of any other industry, profit orientation, monopolization, promotion of multi-national corporations, complimentary role of public sector etc., are seen here also. Drug costs represent 40-60% of the total health care expenditure in developing countries like India. In developed countries the corresponding figure is only 10-20%.

Let us have an enquiry into the reasons for such an undesirable state. Let us now examine some of the evil effects the industrial and commercial nature of drug manufacturing brings in:

Production for profit:- Just like any other industry here too production is based on demand and hence profit. Since majority of the Indian people are below the poverty line they find it hard to purchase medicine. The per capita consumption of medicine in India is only Rs. 5/-. According to 1973 calculation, 80% of the drugs produced in India are bought by 20%. The rest of the population shares only the remaining 20%.

Monopolies:- According to 1973 calculation, out of Rs.370 crores worth of drugs produced by 2300 firms in India. Rs. 296 crores worth of drugs were produced by 110 firms (4% of the total). Of these 110, 28 are foreign owned or

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collaborated firms and they account for 40% of the total production. Always production is meant for profit. Artificial scarcity is created by few monopolies coming together. This is to increase the price. If the full capacity of the factories are utilized the common man would have got medicines at a comparatively low price. The monopolies decide the price which does not at all correspond to the real cost of production.

eg: Bulk selling price of chloramphenicol is 3 times its production cost.

Tetracycline it is 2.7 times.

Retail price will be still higher

Chloramphenicol - Bulk selling price - Rs. 400/- kg

Retail price - Rs. 3,050/- kg

For Vit. B_{12} the retail price is 20 times the bulk selling price.

For Vit. C the retail price is 5 times the bulk selling price.

Corresponding figures for Folic acid & Tetracycline are 9.2 and 4.5 times respectively.

Multinational corporations:- As stated earlier, they account for 40% of total production. In pricing they are still worse.

Eg. while we import Librium at Rs. 312/-kg it is produced by a Swiss firm in India for Rs. 5555/- kg.

Another foreign firm was charging Rs. 60,000/-kg for Dexamethasone which was later reduced to Rs. 16,000/-kg.

Another usual practice is that the subsidiary of the foreign firm in India buys the penultimate product from its parent company at high rates, makes the final product, stamps it as made in India and sells it at fantastically high rates. The aim of production and research either in India or abroad remains that of maximizing profits.

Public Sector:- The public sector do not curb the fraudulent practices of the private firms but they compliment it. One example could be that Hindustan Antibiotics Ltd. sell Streptomycin at Rs. 345/- kg in retail, where as the same medicine is sold to private sector at Rs. 195/-kg which in turn takes the profit.

Another public sector firm sell 54% of its bulk production to private firms. Just like other fields of industry here too public sector sells its semi-finished products to the private firms which take huge profits on the finished products. Thus the people's taxes are used to make profits to few giants. All these are some of the examples to show the fraudulent practices in drug industry. The data regarding the pricing had been of 1973 - 1974 period. After that the

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situation might have become worse or in few exceptional cases improved little. It has yet to be found out. The data presented above are a few indicators as to how the drug industry exploits the common man. With the development of pharmacology and chemical engineering it is possible to distribute comparatively cheap drugs on a large scale to all needy. But the social organization of our economy is such that the aim of production becomes profit oriented.

Advertisements: The advertisements cheat the people miserably. Even medical practitioners are deceived by attractive advertisements of different medicines. A case of deception of the common man by advertisements could be "breast-feeding". The people are attracted by baby-foods and there had been instances to show that while a poor man had even no sufficient income to feed his family he resorted to baby-foods thinking of breast feeding as secondary.

Use of Drugs: The promotional practices of drug companies, aimed at maximizing profits, have been directly counter to the health needs of the poorest. The brunt of wasteful spending falls on the poorest, as the rural dispensaries run short of vital life saving drugs. Apart from promotion of unnecessarily expensive, but necessary drugs, doctors are also encouraged into wasteful over prescribing of non-essential tranquilizers, symptom- allaying drugs and tonics. Similarly drugs freely promoted in the absence of distribution controls can also cause serious dangers.

The existing system of quality control of drugs is not satisfactory. 600 drug inspectors in India have to check 30,000 drug formulations. The beurocratic defects worsen the situation still-decision making, implementing decisions, etc. The marketing of most brand - named drugs especially by the multinationals in the third world works against the health of the poor. Also, drugs banned in the west or used under severe restrictions always continue to be liberally used in India eg. anabolic steroids, analgin etc.

Bearing in mind the very limited effectiveness of drugs and curative medicine in tackling the health problems - malnutrition, infections and parasitic diseases - public funds would be far better spend on preventive health measures and the basic primary health care infrastructure. For this, WHO estimates that 200 genuine drugs would be more than sufficient to meet the health needs.

Orientation towards "appropriate use of drugs" has to yet be developed. Our prescription practices have to be modified according to the needs of the people. Our choice of drugs for stocking in the pharmacy should be according to this. Most important of all, the emphasis has to be on people taking responsibility for their health and avoiding these drugs as far as possible and trying those "non-drug therapies" that have been recognized to have good therapeutic effect. Education and awareness as to how to avoid disease and then how to handle it appropriately at the lowest possible cost is the crux of our approach in low cost appropriate health care.

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Conclusion:- A brief enquiry has been made into the general edistribution of health care facilities and health personnel in India. Availability of service to the rural (poor) population has been the c.ore of the discussion, since the problems of villages represent the problems of the entire country. Health care in India is being situated in the context of the existing socio-politico-economic realities. Problems and issues have been raised in this context. It is hoped, these would serve as certain indicators in the search for the right type of health services for this underdeveloped country.

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PREPARED BY: THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA
C.B.C.I. CENTRE
ASHOK PLACE, GOLDAKKHANA
NEW DELHI 110 001.

The Catholic Hospital Association of India
C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

Sr. JOSE CASE STUDY

Sr. Jose has just completed a 10 months post graduation training in Public Health Nursing and is told by her superior to join the convent of Rasi. Rasi is a village of about 2,000 people situated 20 km. away from the district town, where the Catholic Mission is well established. The Catholic Mission has a higher elementary school, co-educational, with 500 children out of which 300 are boarders with the Mission. These boarders come from villages situated as far as 50 km. away from Rasi. There is also in the Mission, a Grihini Training School which can up to 50 boarder girls and a health centre under the management of one sister RNRM, sister Mary, helped by one lay ANM and two locally trained girls.

Sr. Mary has been visiting the nearby villages whenever she could find time. She generally goes to the villages with one of the sister catechist. Sr. Jose is to take over the programme in the villages and is told by Sr. Mary, that one of the villages, Serpur, appears to be ready for selecting their village health worker. Sr. Mary advises Sr. Jose to concentrate her efforts on this village and see that the people select their VHW as soon as possible.

Questions : Before Sr. Jose can go ahead with the plan what should she know ?

Once she decides to go ahead what should she do ?

Sr. Jose started regular visit to the villages and gave special care to Serpur. She took time to meet the leaders and the people of the community and discussed with them the need for change and the important function of the Village Health Workers in their community. People and leaders listen but do not react as positively as expected by Sr. Jose. In fact, they hardly show any interest in the idea at all.

Questions : What was the reason for this disinterest ?

What should Sr. Jose do ?

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Realising the people's lack of enthusiasm Sr. Jose started to ask them questions and to listen to them more carefully. What was their worry ? What were their problems ? All of them were talking of one problem and one problem only: "the railway tract passes through our village but no train stops here". If a train could be made to stop in the morning on its way to the district town and inthe evening on its way back this would be a big boost for the development of the village. The milk of the cooperative could easily be taken to town, the children could go to high school, products of the village would find their way to town at a better price.

Sr. Jose went to the district town and discussed this problem with the railway authorities there. She learnt that, in fact the railway authorities had already decided to make some of the trains stop nearby and the plan was to be implemented soon. Sr. Jose communicated the good news to the village leaders.

After one week, when she visited Serpur, the village leader presented her one women who had been chosen by the village to be their village health worker.

Questions : Why did the village decide suddenly in one week to choose their village health worker ?

Comment on Sr. Jose's approach ?

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Prepared by

Voluntary Health Association of India, C-14 Community Centre S.D.A. New Delhi - 110016.

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MICRO LEVEL VOLUNTARY HEALTH PROGRAMME

A Case Study

Village S is situated off the national highway on the main bus route to the taluk headquarters. It has a population of 3000 people. The main occupations of the people are agriculture, sericulture and dairy. A few families weave carpets out of unprocessed sheep wool. The land is owned by 65 per cent of the families. The plots range from half an acre to twenty-five acres. 35 percent of the people are landless labourers. Most of them are harijans and they live in a separate part of the village.

The village has a primary and middle school, few shrines and a chawki rearing centre. The Government health centre (PHC) is 8 kms away and one of its subcentres is 2 kms away. The highlight of the village is a milk cooperative which collects 3000 litres of milk per day and sells it to a government dairy in the city 45 kms away. The cooperative provides feed, fodder, fertiliser, tractor facilities and loans to all its members which include 45 percent of the families.

Health Programme

1973-75 : A voluntary agency (VA) based in the city and interested in community health work initiated discussions with the leaders of the milk cooperative to start a health centre in the village. As an experiment in self-support the cooperative agreed to set aside 3 paisa per litre of milk for health activities. From the Rs.2400 - 2700 that was available each month through this scheme, the VA assisted the cooperative in identifying a doctor and nurse from the city to work in the centre. Three villagers were identified, to be trained informally as record clerk, compounder and dai.

The health cooperative (HC) was run by a committee which consisted of leaders of the milk cooperative and representatives of the VA, government dairy and PHC. The doctor was the secretary of this management committee. It met every month to assess and plan the work of the centre.

The HC rented out an old hotel for the centre and some accomodation for the staff. Medicines were brought at wholesale rates from the city. Tonics and injections were stocked to prescribe to non-members and supplement the income of the centre. Some medicines, vitamins and vaccines were tapped from the PHC. The VA provided technical advice and obtained donations of medical equipment and a motor-bike for the doctor from foreign donor agencies.

He provided curative services through a daily clinic. Preventive and Promotive services which included maternal and under-five child care, immunizations, vitamin and iron supplementation, chlorisation of wells and film shows were also organised. Curative services were available free to members while non-members had to pay a nominal cost. Preventive services were available to all free of charge. Poor non-members families were given concessional or free treatment depending on their situation. The HC Committee agreed to set aside Rs.200/- per month for this purpose.

The doctor and his wife started a Mahila Mandal which organised a balwadi, child feeding programme and obtained a sewing machine for the village women. A young farmers club was also started which organised games for village youth and helped the centre during immunization, health and education programmes and specialist camps.

1976 : The cooperative stopped setting aside Rs.200/- per month for concessional treatment for poor families. The VA took up this responsibility. The doctor left the centre after differences of opinion with the leaders and started private practice in a neighbouring village. The VA helped the centre to identify another doctor. The Mahila Mandal closes down and the sewing machine is kept by a panchayat leaders wife.

1977: The nurse left the centre after training the dai in all aspects of the centre's work. The committee tried to find a replacement but ultimately decided to appoint the trained dai as the 'nurse' of the centre. Committee meetings were held once in 3-4 months.

1978 : The milk production in the village came down drastically while sericulture increased in the area. The health cess per litre became too high to run the basic health services. Since it was difficult to cooperatise sericulture the milk cooperative after some hesitation invested some money it had kept aside for a chilling plant, into a fixed-deposit endowment for the health centre.

Because of the increase in sericulture, landless harijan families began to get more work and many acquired a local milch animal. They tried putting some milk into the common pool to get membership status and free health facilities. The cooperative committee closed membership to keep them out.

1979: An evaluation was done to study the impact of the centre. It found that though all families were aware of the centre, some of them did not utilise its services. Some richer families preferred private practitioners in neighbouring villages. Many landless families had apprehensions about theattitudes of some of the staff. Triple antigen and polio immunizations had been given to 85 percent of the children. Malnutrition and Vitamin A deficiency had not improved - in fact there were indications that it had become worse. There was no change in environmental sanitation. The centre did no family planning work, because of the church connections of the VA.

1982: The centre got its fourth doctor since 1977. Each of the previous ones had stayed for periods ranging from few months to two years / with the help of government subsidy and some savings the cooperative also built a health centre and medical officers quarters. The VA donates furniture and more equipment to the centre.

Task: 1. What are your impressions about this health programme ?

2. Formulate questions which will help you to evaluate the approach and efforts of this health programme.

INCOME-EARNING PROGRAMME

Sr.Lucy loves the poor, feels committed to them and has the real to work for them. Earlier she was in a town community where she was able to help the cycle richshaw wallas to own richshaws through bank loans instead of hiring from rich people who owned 100-150 rickshaws. With this experience she came to the village Russelpura.

In Russelpura she had with her Sr.Leela who was equally committed to the cause of the poor. Together they went to the village and spent time with the people. The sisters found that most of the villagers worked for daily wages and the income was not sufficient to meet the daily needs. Since the people had to go to work everyday, there was no proper care given to the children or to the surroundings of their houses. The sisters reasoned the major problem here was economic and if the menfolk could get some occupation which brought them enough money. Then the womenfolk will not have to go out for work and thereby more care could be given to their houses and the children will be healthier.

The sisters applied to Church Agency for the Poor(CAP) and got funds sanctioned for income earning programmes in the village. A village meeting was convened. The sisters explained to the group the necessity of unity and mutual concern. She also explained the economic benefit schemes. First 10 people will be helped to start some income earnings programme. This will have to be repaid and repaid amount will be given to another 10 people.

A village committee was sent up to select the 10 people who would be helped first. So 10 names were suggested by the committee and money was distributed.

As months passed it was observed that the income of the 10 increased and thereby their standard of living. It was also observed that the milk of the cows bought with the money was sold in the village at a higher rate. The man who started provision store was charging a higher price from the villagers. Two people who got the money used it to give loans at an interest rate of 60% to the villagers. The repayment was prompt for two months. Slowly one by one stopped repaying and within six months none of the ten were repaying their dues.

The income earning programme could not progress further and the sisters sat down and analysed the situation. They felt they failed and they would adopt a different strategy.

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The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

THAKURPUR CASE STUDY : FREE GIFT TO PEOPLE OR NOT ?

For the past six months, two health workers have been working in Thakurpur village. During these months, they met the village people and tried to identify their main health problems. At the end, the health workers concluded that the people of Thakurpur were not really concerned about their health and were resistant to any changes suggested to them by the health workers.

For instance, even though malnutrition was such a problem in the village children, nobody accepted to change the children feeding habits and the age of starting weaning food and despite repeated health talk and advice given during the home visits.

Some of the people had expected the health workers to give them something free and in fact, the health workers had discussed between themselves the possibility of dealing with the malnutrition problem by distributing free food to the children under five years.

One of the health workers, Chandra, felt that food distribution would certainly same some of the chidren lives. But the other workers felt that food distribution would create difficulty in the community, alienate the people and at the end, the evils such distribution would bring, would be greater than the benefits. Chandra, then pointed out that when distributing food they would be able to give good health education to the mothers and thus bring the hoped for changes in the feeding habits of the children.

Questions : Can you help them to solve their dilemma ?

1. What do you think is probably the most important reasons for under nutrition of these children ? Why are the people so reluctant to change their habits ?

2. Should we use free gifts in order to develop the people ? Explain your position ?

3. If the answer to the previous question is YES, what could be the unexpected effect of a MCH programme fully based on food supply from foreign countries ?

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Prepared by

Voluntary Health Association
of India, C-14, Community Centre
S.D.A. New Delhi - 110016.

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MARIAPURAM CASE STUDY

Sr.Kamala is an experienced nurse working in a dispensary. Since she could not find time to visit the villages, she appointed Shanta and Lakshmi to help her to carry out the village programmes. They should assist Sr.Kamala in the morning 8 to12 in the dispensary and go to the villages in the afternoon. They had to be back to the dispensary by 6.30. Both the girls strictly kept up the schedule.

During the village visits, they could not meet many people. Sr.Kamala was annoyed at the people because they were not coming together. At that time CRS became available. Sr.Kamala decided to start CRS MCH Programme in the village so that she could conduct immunisation and health education. CRS help was sanctioned.

With enthusiasm they explained the programme to the villagers and put down the following rules:

1. Mother should come to the centre with the child.
2. Registration fee will be Rs.3/- and monthly collection will be Rs.2/-
3. The distribution of food stuffs will be twice a month.
4. The children should be weighed once a month.
5. The mothers should bring their child's growth chart every time they came.
6. Every child should umdergo immunisation.
7. All mothers should attend health education classes.

In the beginning the programme went on well. Slowly the number of mothers for health education decreased. Sr.Kamala also found that only 10% of the total number of children had been immunised within six months of starting the programme.

Sr.Kamala was very much discouraged at the lack of co-operation from the people and blamed Santhamma and Lakshmi for this. She decided to discontinue village work for the time being.

VALUES & VALUES (F)

Miss Sumati was from a very poor family. She lived in a hut near the bank of a river. She was in love with Mr.Sunil, who lived on the other side of the river, and was also from a poor family. This love affair was known to both the families.

One day Sumati heard that Sunil is seriously ill. It was monsoon time and the river was overflowing. She had to cross the river by a country boat. But she had no money to pay the boat man. She approached Suresh, her neighbour to borrow some money, but he refused to give. She then met Shankar, the boat man and explained to him the situation, and assured him that she will pay him the boat fare later. Shankar insisted that only if she pays the boat fare (Rs.2/-) he will take her to the other side of the river. She pleaded with him and told that her lover is seriously ill, and that she must meet him immediately. Shankar told her that if the matter is so urgent he will take her to the other side on the following day provided she is prepared to sleep with him that night. When Sumati realized that arguments were of no use she agreed to the condition.

On the following morning Sumati reached Sunil's house, and in the course of their heart to heart talks, she narrated the hardships she had to go through inorder to meet him. Sunil got a shock of his life when he realized that Sumati is no more a Virgin, and in his anger he beat her and chased her out of the house. Sumati returned home very sad and frustrated.

When Sathish, her brother asked Sumati the reason for her sadness she told that Sunil rejected her and she was ill treated and beaten by him when she visited him at his sick bed. Infuriated by this Sathish rushed to Sunil's house, pulled him out of his bed and killed him.

Who is the most virtuous character in this story? Why?

Who is the worst character in this story? Why?

Community Health Department
Catholic Hospital Association
of India, P.B.2126,
Secunderabad - 500 003.

17/11/1987.

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RAMAKK'S STORY

Ramakka, wife of Veerabadrappa has two children. She goes to work in Periaswamy's field for the wage of 1 rupee a day. Her younger son, Linga, only 11 months old, got diarrhoea which is a common problem leading to death in the village. With one rupee which she got as that day's wage, she bought 50 paise worth of powder medicine from the nearby petty shop. 50 paise worth of flowers she offered in the temple for the cure of her son. As the diarrhoea continued she approached the local Dai Yellamma for help. She gave her some herbal medicines. But the situation became worse and so Ramakka, with the money her husband borrowed, took the child to the local doctor, who has no training but some knowledge received by watching his uncle who was a compounder. He gave an injection worth Rs. 7/-. The child got temporary relief. When the sedation power of the injection got over, the diarrhoea started again. The local Dia, advised Ramakka to take the child to the district hospital 20 Kms away. She borrowed Rs. 20/- from the money lender on the condition that the amount with the one third of it as interest will be paid pack in paddy, during the harvest season.

Thus they reached the hospital. She was ignorant of the proceedures of the government hospital. She had to give Rs. 2/- to the gate keeper for entry. The hospital personnel were so busy that they could attend to the child only very late. They scolded Ramakka for the delay in bringing the child for medical care. She could not tell the doctor that their trip cost her three week's pay which she should pay back with interest. The doctor also scolded Ramakka for not bringing the child early, and furiously wrote a long prescription including four I.V. fluids. The pharmacist billed her Rs. 60/-. But Ramakka did not have that much money. She bought few tablets and returned home. While on her way back home, the child breathed it's last on Ramakka's shoulder.

* * * * * * * * * *

EXERCISE
IN
COMMUNICATIONS
B. MANOJ GUPTA

Manoj Gupta is a devoted artist running a studio in the City and according to him, his life-long ambition has always been the creation of a piece of art that will be of eternal value. He wanted to give expression to a female form that will surpass Venus. And he was on the look out for a model for achieving this ambition. He used to visit all places where he could find beautiful ladies, but nowhere could he find the form that he had in mind. Then one day...(the same scenes that we saw earlier follows with Manoj's comments put in brackets).

Scene (1)

Manoj was sitting one evening in a restaurant with a girl friend. An extremely beautiful lady appears at the entrance along with a gentleman; they occupy a table at the other end of the hall. Manoj is enchanted with the beauty of the lady (I realise that at last I have found the form that I was searching for long) and he becomes restless. For the moment, he forgets the fact that he is in the company of a girl friend and he doesn't even listen to her. Growing impatient, he brushes aside the girl friend and walks over to the other end of the hall where the beautiful lady and the gentleman were sitting. He says "Excuse me" to the gentleman and beckons the lady to rise up and come to him. They go together to the lobby and he whispers something in her ears to which she nods. (I requested her to act as my model; she agreed. I fixed an appointment with her at my studio at 9.00 am the next day.) They come back, the lady goest to the gentleman and Manoj comes back to his old seat. Being restless, he could not remain any longer in the restaurant; he takes the hand of the girl friend and they walk out of the restaurant. One of the two waiters, who were watching all this, tells the other: "What a woman-hunter?"

Scene (2)

Next morning Manoj gets up early from the bed and putting on his dress hastily rushes out of the house. Mother brings a cup of coffee and requests him to take coffee before going out. He brushes her aside saying "I have no time now; I have an appointment to keep." Without listening to the repeated entreatics of his mother, he hurries down the stairs and out into the street. (I did not mean any disaffection towards my mother; I only wanted to get to the studio in time). The mother wails: "What has happened to my Manoj who was such a good boy? He has been moody and difficult."

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Scene (3)

Out in the street, he spots out a taxi, but the driver was talking in the telephone booth nearby. Manoj requests him to come away, but the man continues to talk. Growing impatient, Manoj bawls out at him to hang up and come away. The driver is stunned, but he hangs the phone and comes back.

Once inside the taxi, Manoj pulls out a pad and begins making line sketches of the pose, form and other details of presentation of the great piece of art that he is going to create. He draws one one sheet, then tears it off and tries another. Like this, he makes a number of trial sketches and he is deeply absorbed in the thought of how to give expression to the idea that he was carrying in his mind for long.

During the drive, as is usual with all taxi drivers, he talks about the weather, last night's crimes in the city and petty politics. Manoj tells him that he is not interested in any of these and that he wants to have a quiet time. The taxi driver chuckles thinking what sort of a man is this. Unable to resist the temptation after a while, he again resumes his talk. Manoj becomes furious and thumps him first at the back of the seat shouting "shut up". The driver becomes mortally afraid to open his mouth again. After leaving Manoj at the appointed place, he wonders, "What a rowdy?"

Scene (4)

Getting out of the taxi as Manoj was entering the building, the landlord stood at the foot of the stairs and wished him, "Good morning." (He is a terrible bore and if I allow him to have his way, I would be delayed at least half an hour. So, I decided to play foul with him.). Manoj runs into a fury and, catching him by the collar, asks him: "What did you say? Good morning? It may be good morning to some, may be bad morning for others. What the hell do you want with me?" The man is completely taken aback and wonders loudly, after Manoj had gone up the stairs: "What a lunatic?"

Scene (5)

Inside the building the Janitor woman notices Manoj coming much earlier than usual and getting into his room. Shortly afterwards, she also sees a beautiful lady coming up the stairs and going into Manoj's room. She could not help smiling meaningfully.

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As the lady knocks at the door, Manoj comes and opens the door. He removes and hangs up her coat. After requesting her to take the seat, he begs her pardon for making her wait for a little while and arranges the drawing board, dishes, colours, etc. Then he walks over to the lady still holding the rod of the stand in his hand and directs her to pose for the model. Instead of posing as directed, she makes overtures to him. Manoj gently tries to make her sit down telling her that after the work is over, they will have a nice time together. But, she continues with her flirtations with him in a more and more passionate manner in spite of all his entreaties to let the work be finished first and after a while she tries to put hands around him and embrace him. Losing all hope of doing the work and feeling frustrated with the shattering of his lifelong ambition, he pushes her hand against the sofa and she screams aloud.

The janitor woman hears a scream from the room. She rushes up, opens the door and sees Manoj with an iron rod in his hand and the lady lying motionless on the sofa. She jams the door shouting, "Murder" and frantically runs away.

& & &

Now what do you think of Manoj? (Give a one-word expression summarising his character).

* * *

THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

Community Health Department

Grams : CEEHAI
SECUNDERABAD 500 003
Telephones : 84 82 93, 84 84 57
Telex : 0425 6674 CHAI IN

Post Box 2126
157/6 Staff Road
SECUNDERABAD 500 003

CASE STUDY : YESHUBAD

Fr. Ashok was a nice person, gentle, kind and always ready to help others. He was intelligent and loved people very much. He was concerned about many of the problems that the village people faced and wanted to do something to help them.

One of the needs of the village was a school. There was no primary school within 5 kms. of Yeshubad. Therefore the children remained illiterate and ignorant. So father opened a primary school with facilities up to IInd standard primary education. It was a free school, admission being restricted to Yeshubad village people only. He was himself the principal and teacher, and Seminarians passing through also helped sometimes. With the geneous food supplies gifted by Excess Relief Supplies Inc. (ERS) USA, Father was able to distribute free school lunch to all schoolmates. This attracted more and more parents and children. Within the first two months the school had 170 children on its register. After six months, ERS stopped supplying any more food due to unavoidable circumstances. Father had to stop distributing any school lunch. The parents got upset and some of them were very angry. Slowly they started taking out their children one by one till only 10 children were left on the school's roll. The parents said loudly to each other "What is the use of learning and reading so many books, anyway. That dowsn't help. Nor does it feed empty stomachs. Let the children go to the field, help their elders, learn some practical and useful things which fills their stomach". It was the harvest season. (Later on it was found that out of the 10 remaining students, 6 were the children engaged by the Parish. They kept their children in the school as they thought it would please father.)

Father very soon closed the school. He felt let down and demoralised. Within a few months Father regained the enthusiasm and decided to start a housing scheme as this was another need of the people. Hardly any one had a nice house in Yeshubad except the landlord Sarpanch, and himself. People lived in cramped, filthy, unhygenic houses with no windows. With ERS' donation he built 20 houses for a few of the Yeshubad villagers. The houses were nice and spacious with concrete roofs. They were well ventilated with huge windows. Each flat was an independent unit and had one living room, a kitchen and a toilet.

Except for the 20 lucky families receiving free houses, others were bitter and angry. They felt Father was partial to them. Father explained to the people that he had money only to build 20 houses. The people felt that the Father could have got more money. That summer father took some guests to see the new houses. The guests, to their surprise, found that the houses were not being used as planned. Most of the families had converted the kitchen room to store grains, household rubbish etc. and the living room was used as a good cattle shed. All the windows were sealed with stones. The toilets had no tap water facilities. People felt that it was a dirty thing, to have a toilet right inside the house and that too without any water. The families

explained: "We love to live in the open, we are strong and can bear any weather. But the cattle cannot. They are poor dumb animals, precious to us and need such great care. Also our grain is precious, so we have sealed the windows to keep it safe from thieves. That is why our cattle and grain is inside while we live happily under the clear open sky".

"But what about the small children?" - Father asked. "Oh Fatherji, they are Farmer's kids. If God wills to take one, He will give another little one."

Community Health Department
of Catholic Hospital Association of India,
Secunderabad-500003.

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SETTING GOALS (Training paper VIII)

Most of us live and work far below our capacity. We are like bits of wood, floating passively on a river. We are carried here and there by the currents of the river without any aim of our own.

Setting goals for ourselves can free us from the aimlessness and inertia of floating on the river. Goals can help to give meaning and direction to our lives. They can help us to use our capabilities more fully and effectively. They can help us to develop our potentials. They can help us to use our resources, our time, and our energies more effectively. They can guide us when we have to take decisions and make plans. They can help us to change ourselves. They can help us to work for change in society.

Research has shown that commitment to clearly stated goals leads to the achievement of these goals. Yet this commitment is not acquired easily. Commitment to personal life-goals can be especially costly. To choose one goal is to reject others. You can't be a development worker and a businessman too.

Further, once we set goals for ourselves, we must have the courage to risk failure in reaching those goals. One who sets no goals for himself does not run the risk of failing to reach his goals.

Often we confuse activities-doing things-with achieving goals. We invest ourselves and our own resources (our time, our capabilities, our efforts, our commitment) into activities (work, talk, journeys, visits, leisure, social events, training or whatever it may be) without thought for the end-result of such activities. Unless the end-result is clear, the purpose of the activities may not be clear. Setting goals, which are the end-results we want to achieve, can bring purpose and meaning to our activities.

To be able to set meaningful and attainable goals, we must know ourselves. What do we do best? What do we enjoy doing? What are our strengths? How can be build on our strengths? How can we change ourselves?

If we want to change ourselves-to acquire and practise new skills, or to behave differently-goals can help us. For one thing they help us to compare what we want to do with what we actually do now. They also, in themselves, help to motivate us us to achieve the changes we want, and they reinforce our efforts to change. Goals that are associated with an enahanced self-image will help to motivate us further.

Our goals must be challenging. If they are not sufficiently challenging-ro. if we are not going to make the necessary efforts-there is no point in getting goals. We might as well continue as we are doing already.

On the other hand, we must be realistic in setting goals. We must assess our opportunities and situation carefully. What goals would be realistic and within our reach? If we set unrealistic goals, we shall not be able to achieve them, and this will lead to frustration and disappointment. Moreover, once we have set goals, we must have enough self-confidence to reach out towards them. If we feel our situation to be hopeless, our goal-setting will be in a vain and will again lead to frustration.

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The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001
Tel. 310694, 322064

ARCOT CASE STUDY (Y.O.M.)

Mr. Sunder was a social worker, working in a Community Development Programme in Arcot district. He was interested im improving the health status of the people. He understood well that the problem of ill health was mostly related to the low economic status of the people and the best way to solve this was through economic development with people's participation.

The main problem in his village was water for irrigation. Although most of the families had some land, the produce was very little and the food was not enough for all the villagers.

Mr. Sunder visited the sarpanch of the village and discussed this problem with him. The sarpanch was very happy to hear about Mr. Sunder's plan for water development. The sarpanch called for a village meeting the next day in which Mr. Sunder was allowed to present his plan. The plan was to build a large tank to help collect the rain water. As the people were very poor, he proposed that the village contribute free labour and the building material would be provided by Mr. Sunder's agency.

The site was chosen and the work started. After two weeks Mr. Sunder noticed that the number of people working at the site was decreasing. As the days went by, more and more people dropped out. Mr. Sunder was unable to find way any reason for this. Finally, only a handful of people were left.

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Questions :

1. a. Why, do you think did the people drop out of the programme as they did ?

   b. Who, do you think will benefit if the tank is built ?

2. Comment on Mr. Sunder's way of dealing with the problem ?

3. If, in your area water is the need, what information would you need before taking up any definite programme ?

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Prepared by

Voluntary Health Association of India, C-14 Community Centre S.D.A. Delhi - 110016.

IMAGES

Lazy	Insecure	Impersonal
Dependable	Conservative	Progressive
Mature	Emotional	Uncommunicative
Uncooperative	Restless	Helpful
Professional	Frustrated	Concerned
Irresponsible	Confused	Backward
Enthusiastic	Dogmatic	Hard-working
Money-minded	Efficient	Immature
Loyal	Insincere	Idealistic
Undependable	Over-productive	Apathetic
Encouraging	Risk-taking	Responsible
Supportive	Self-controlled	Unprofessional
Over-sensitive	Impulsive	Appreciative
Superficial	Naive	Exploited

1. From the list of adjectives given above, which seem to you best to describe the urban worker? Select as many words as you wish. If you wish to add one of your own, feel free to do so.

2. From the same list, which adjectives seem best to you to describe the unemployed?

3. From the same list, which adjectives seem best to you to describe the villager?

4. From the same list, which adjectives seem best to you to describe the average student?

5. From the same list, which adjectives seem best to you to describe your parents?

6. From the same list, which adjectives seem best to you to describe yourselves?

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