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US 74.1

S P A N october 1974 pp115

M E D E X

help for the family doctor BY urmila devgon

A UNIQUE PROGRAM DRAWS ON THE SKILLS OF EX-MEDICAL CORPSMEN AND TEAMS THEM WITH THOSE OF GENERAL PRACTITIONERS TO PROVIDE COMMUNITY HEALTH CARE IN MANY PARTS OF RURAL AMERICA.

IF it weren't for Medex - a new program representing a significant break with traditional methods of providing health care services - the small town of Davenport in the Pacific Coast State of Washington would probably have lost its last doctor.

Located in a prosperous wheat farming area, Davenport (population 1,363) once boasted three physicians to serve the town and its surrounding area. Then one of the doctors left; soon another decided to do the same. As a result, Dr. Marshall Thompson faced the prospect of handling alone a practice he estimates was close to 3,000 patients. "The task was monumental," he recalls. "If I didn't get help, I palanned to leave." As it was, he had little time to spend with his wife and five children or to keep up with new developments in the field of medicine - and almost none for relaxation or recreation. His plight was a familiar one to rural doctors throughout the United States: There just aren't enough doctors to go around.

Yet today Dr. Thompson is still in Davenport. His practice is thriving, his patients happy. The answer is Medex (from the French medicin extension or extension of the physician). "MEDEX," says Dr. Thompson, "has been a lifesaver for me".

What Medex accomplished was to give him an extra pair of hands--and highly qualified ones at that. They belong to Ron Graves, 29, an ex-U.S. Navy hospital corpsman who had six years of medical experience during his service career. Ron is one of some 30,000 medically trained personnel discharged annually from the American armed services. About 6,000 of them have provided what is called primary medical care and have often served as the only medical man abroad a ship or at an isolated station. Highly skilled, they have had from three to 20 years of valuable experience and may have received upto 2,000 hours of formal medical training in such fields as medicine, surgery, pharmacology or orthopedics. Yet when they returned to civilian life they were rarely able to use this specialized knowledge. Until recently, the only civilian medical job open to them, says the president of the American Medical Association, has been that of hospital orderly.

This paradox in American medicine--a shortage of family doctors on the one hand and an untapped pool of highly skilled medical corpsmen on the other - is what gave birth to Medex, the brainchild of Dr.Richard A. Smith, an innovative young black physician who is associate professor of health services at the University of Washington in Seattle and director of the Medex program. Medex draws on the skills of the ex-medical corpsman, teaming him with a general practitioner and making him what Smith calls "the first totally new health professional in family medicine in this century".

Smith, who holds both doctor of medicine and master of public health degrees, was senior Peace Corpos physician in Nigeria and served later in Peace Corps headquarters in Washington, D.C., and in the office of the

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U.S. Surgeon General. When he went to Washington State in 1968 he learned there was not only a severe manpower shortage in the medical profession but a constantly declining physician-patient ratio in rural areas. In addition, the age of general practitioners in rural areas was steadily increasing. Something had to be done, Smith felt, to increase the capacit of doctors already in rural areas and also to make small town general practice more attractive to new physicians. In the Seattle area, he noted, there was one doctor for about 500 patients; in some rural areas the ratio was one doctor to 5,000 patients! We found doctors who were working 14 to 16 hours a day, he said. Some hadn't had a vacation in seven years.

Enlisting the cooperation of a group of general practitioners who volunteered to participate in the program, Medex was launched in mid-1969 as a demonstration project sponsored by the Washington State Medical Association and the School of Medicine of the University of Washington. Funding was provided by the Federal Government. Interested medical corpsmen were contacted at military installations and, after careful screening, 15 were selected to begin a three month intensive training program at the university. This academic phase emphasized areas like pediatrics and geriatrics, in which the corpsmen had had the least experience, and stressed the psychological adaptation from military to civilian medicine.

Meanwhile the Medex met the participating physicians and,with their families, visited them in the communities where they practiced. The physicians agreed to train the Medex in their offices during a 12 month preceptorship of following the academic training and then to hire them if the team arrangement worked out. Great care was taken in matching Medex and preceptor for, as Dr. Smith noted, "the Medex is an extension of the physician, not a substitute." It was essential that the two work well togethrr.

Medex (the term applies both to the program and to the new professionals) take patients' histories, do delegated parts of physical examinations, stuture minor lacerations, apply and remove casts and assist physicians in surgery, all under the supervision and responsibility of their physicians. Statistics from eight doctors indicate they handled 25,000 more patient visits in the first year as the result of their Medex. One rural physician saw 63 per cent more patients during his first year with a Medex than he had the previous year when he was alone.

So successful has the project been that it is continuing in the State of Washington - and several other states have started similar Medex programms.

Medex is an excellent program, says Dr. Thomspson. It provides relief for a lot of overworked physicians. It is a plan that works. It established a goal and got the job done.

Fr Dr. Thompson, Ron Graves provides a much needed addition to the health care team. Graves screens patients, takes histories, conducts physical examinations. "He knows when something is wrong, says Thompson, even though he may not know exactly what it is - and this is important.

The two men share night and week end duty. Thompson estimates that each typically works a 65 hour week. People have a great deal of confidence in Ron's judgment, Thompson says, and I have a great deal of confidence in his judgment. Patients know that if the feels more advanced care is needed, be willcall me. He never ceases to amaze me. Sometimes the practice of medicine is intuitive.

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He's beginning to develop this sense. It's part of the art. They can't teach it to you in medical school. Some of the art of medicine, I think is lost in our technological society. You'are treating people - not diseases but people with diseases, Ron gets on very well with people; I have yet to meet anyone who did't like him.

Ron and Linda Graves, both from small towns in Iowa, feel at home in Davenport. They are active in their church, have bought a house and look forward to raising their three small children in Davenport. People have gone out their way being friendly to us, says Linda.

Medex offered Ron the career he wanted but hardly dared hope for. In fact, he almost did't aply when he first heard about the project because it just sounded too good to be true. Now, he admits, I could't be any happier. He likes the wide range of experiences Medex offers and the opportunity for further training. He has alrady taken courses in cardiology, electrocardiogram interpretation, pharmcology and drug interaction. He sees over 300 patients a month, schedules appointments at the clinic every half hour (Dr. Thompson's are every 15 minutes). It takes me more time to evaluate a case, he says, and then I like to let people talk. If you listen long enough they tell you what they really came for. It isn't always what they said at first.

Ron has the knack of putting people at ease. He is especially good with the young and the old. "Being lonely is probably the worst disease older people have," he observes. "They want to talk. I have the time to listen. They need to know someone cares. He visits the local nursing home about four times a week, making a point of spending time with each patient.

The people who go to the Davenport Clinic are delighted with Medex. "It's a wonderful program," says Connie Walker, mother of three, who travels 45 miles to the clinic. Graves has taken care of her baby since the child was two months old. He is very careful, very thorough and efficient, Mrs. Walker says. "He explains things so well that you know exactly what to do when you're at home. He just doesn't take chances."

Another Graves enthusiast is Debra Portch who lives 40 miles away. "My little girls just love him," she says. "He's really got a way with kids. We wouldn't travel 40 miles for nothing, would we?

A medical assistant at the clinic adds: He is certainly an asset not only to the clinic but to the town. He and Dr.Thompson have a fabulous relationship.

What do the professionals think of Medex? Dr. Walter Bornemeier, former president of the American Medical Association, raises a question that occurs to many. "Are these men competent?" he asks. "Well, one of them found a hairline fracture in a patient which both the doctor and a hospital radiologist and missed. That is one example of competence".

Medex founder Dr. Smith, who has traveled widely in Africa, the Near East, Asia, Latin America and Europe, believes the basic elements of the Medex program provide a technological tool that can be used to train individuals with or without previous medical experience. That is part of our objective, he says, to adapt the concept's techniqe of training and deployment of health personnel to the existing needs and available resources in any geographic area. I do not think I would be exaggerating if I said this approach can be applied in most of the 45 countries that I have visited or worked in.".

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THE CHIMALTENANGO DEVELOPMENT PROJECT, GUATEMALA

Carroll Behrhorst, MD

The following account of this project was given by its director, Dr. Behrhorst, at the last annual meeting of the Christian Medical Commission in July 1973. Its most innovative features are of special interest, namely, that health care should be made available to people on their terms; that the provision of basic health care requires a multifaceted approach to development; and that it also requires a liberal experimentation in manpower training of those selected for this purpose by the communities to be served. The project seriously challenges many of the presuppositions on which health care systems are designed - and it works very successfully!

Guatemala is a Central American country which shares one unique feature with Bolivia and Peru: the majority of the population is Indian. In Guatemala they represent two thirds of the population, and their life style, habits and value system are still very much as they were before the Europeans came. They have held on to their culture very tenaciously and very successfully. This has to be clearly understood when you are working with them. In fact, it makes your work easier because you are dealing with people who do not try to be like you or to copy your ways. You are obligated to work with them on their terms.

Guatemala is a very poor country economically. Its gross national product is the lowest in Latin America. Only 2 percent of the children finish the sixth grade of school. Where we live, in Chimaltenango, which is the capital of a political department and only 50 km from Guatemala City, only 10 percent of the children attend school. This is because the Indian is mostly interested in practical things which he considers useful. To him it is most important that he be a useful and loving human being, and therefore it is hard for him to accept theories. For this reason he has little time for formal education, because he does not consider it very useful and, moreover, it is a part of the European culture which he is not prepared to accept.

These people have serious health problems. Malnutrition is very high, and 80-85 percent of the children are at least moderately malnourished. The death rate is also high, especially among the Indian population in the highlands of Guatemala. Approximately 50 percent of the children die before they are five years old. Another problem related to health is that of land tenure. It is estimated that 2 percent of the population own approximately 90 percent of the tillable land. Therefore, you cannot avoid this problem when dealing with the health and development of the Indian people. However, it is an extremely difficult problem to deal with, because those who own the tillable land are most reluctant to see the Indian have ownership. So, one has to move slowly in developing a model of land resettlement, but we have started, even though there is little to show for our efforts thus far.

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Let me tell you how I became involved in this work. After finishing my medical education in Missouri, I was anxious to find a field of service outside the USA. One day I read an appeal in the Lutheran Witness, which is a publication of the Lutheran Church - Missouri Synod. It called for a doctor to serve in Guatemala. I telephoned the director of the Latin American section of the mission, and he told me that they were anxious to reopen a hospital which was located in the ancient capital, Antigua. After several visits to the country, I decided to settle there, but I was doubtful whether Antigua offered an opportunity for meaningful service. I suggested to the mission that we move 20 km from Antigua to the town of Chimaltenango, which is the capital of a large department, with about 200,000 population, and where the only medical facility consisted of a small clinic handling 15 patients three times a week. The place was bereft of services, whether for health, agricultural extension, or any other kind of social service. Having made the choice to work here, it became difficult to continue with the local mission, which seemed more interested in promoting its own organization than in service to others. Nevertheless, I must admit that, though I may be critical of Christian missions and their organizations, it is they who pioneered in this field of service for others, and without their inheritance I would never have been moved to work in Guatemala; and without the help of Christian workers I would never have been able to develop our programme. I owe a great deal to Ivan Illich who has a very healthy and basic understanding of what people and communities need. His recent book, "Rebuilding Society", provides an excellent diagnosis, although I am less sure about the therapy. Two others who have helped me in the development of programme are Dr Wolfgang Bulle, the medical director of the Lutheran Church - Missouri Synod, and the Reverend Ralph Winter of the United Presbyterian Mission, who is now teaching at the Fuller Seminary in California. I must also point out that when I talk about the programme in Chimaltenango, I am referring to the whole team of 55 workers. Some work in the hospital and clinics; other work in the medical and agricultural extension and family planning programmes. We work as a team, with each entering into the decision-making process. The doctor helps with the cleaning. The cleaners assist with injections.

In Chimaltenango we felt that we must begin by knowing the people - what they were like and what they thought they needed. This is easily said, but not so easily done. The more usual pattern is to start by recognizing that they have no medical services and putting up a building immediately, with a big sign outside "Open for service". However, we had to discipline ourselves in order to think with the people on their terms, so as to see what their needs really were and what they thought they needed. Most of us, in this kind of situation, see that children are dying of diarrhoea, measles, and so on. There is a high incidence of tuberculosis. We want to start treating these people by giving immunizations, for this is what the average doctor is trained to do; and it is also very gratifying to do the things you think are needed. The only difficulty is that you are then helping people on your terms, and not on theirs. Yet if you are really going to help people and be concerned about them and love them, you must love them on their terms, not yours. This is very difficulty for a technocrat who comes out of a US medical school, because he has become accustomed to think in terms of what he can do FOR people and not what he can do WITH them. After all, we have the technological tools; so we decide that we will lower the infant mortality rate and lower the

measles rate, and that people will have fewer children - but always on our terms. It rarely occurs to most of us to sit down with people and simply ask, "What do you think you need?" You might be surprised by what other people think they need. We think they need triple vaccine and more protein in their diet, and while it is true that they need these things, they are probably much more interested in other things altogether.

About three months ago, we visited a village high up on a mountain. We did have a programme for the women of the village at one time, but for various reasons it failed. There were no services of any kind available in this village, and we decided that we would try again to reactivate the women's club. After calling the women together, we told them that we would like to work with them again, but that nothing would be done until they had had an opportunity of discussing their needs with their husbands and neighbours. We knew that most of the children in this village suffered from diarrhoea, but we did not want to start with a medical programme until we had first listened to the people's own expression of their needs. A month later we returned and spoke with the women again. They did not say that they wanted medicine for diarrhoea. Instead they said: "All our chickens died." That was really a problem for them because they were 15 kilometres from the nearest market which only opened once a week, and so meat was no longer available to them. Normally, chicken is their only source of meat. They also complained that there were no eggs for their children, and that the new eggs were good for them. They then went on to say that another need was to grow apples. They grew well at that altitude and could be sold profitably in the market. These then were the things they needed - chickens and apples. Nothing else was discussed, and we promised to send them an agricultural extension worker who would teach them to build proper checken houses and how to feed and immunize the chickens. And when the right time of the year comes around, he will help them plant apple trees - nothing else. When you help people on their terms, you have no acceptance problem. You may think I have overemphasized this point, but I think it is very necessary. Even though community health programmes may look very good on paper, they often fail because they have been designed solely by professionals and have not started by helping people on their own terms. Religious organizations are often the worst offenders in this respect.

When we first began in Chimaltenango, I did nothing but walk around the town and get acquainted with the people and play with the children. Gradually I would be invited into their homes to have coffee with them or to sit down to a meal of tortillas and beans. This went on for three months until I was well-known in that town and accepted. Then we rented a building for $25 a month, so there was no investment. One hundred and twentyfive patients came that first day, and we have never had less than that number since. They now average 200 per day. Giving curative services is no problem. It is easy to cure someone, but not so easy to keep him well. The orientation of our programme is not to think in terms of medicines or in terms of disease, but rather to think in terms of health and life, and vital life, or what Ivan Illich calls convivial living. Curing is not the important thing. It is much more important to encourage life; and this is not very difficult in Guatemala because the Indians themselves are dedicated to life. They are a very biophillic race. They do not think in terms of death, because death is considered to be a perfectly natural thing. After some experience working with these people, we came to realize that they were in need of other services besides health care.

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The following list represents our present estimate of priorities:

- social injustice
- land tenure
- population control
- agricultural production and marketing
- malnutrition
- health training
- curative medicine.

You notice that I put curative medicine at the bottom, which is where we regard it in our list of priorities.

We soon realized that all the things I have listed above are part of a total community problem. Moreover, they are all interrelated. For instance, the incidence of tuberculosis is related to land tenure. In San Juan Comalapa, each Indian family owns a small tract of land. And so they can produce vegetables and corn. In fact, they often have more than they need for their tortillas, so that they can buy some meat occasionally and some eggs. They not only eat better, but they tend to be less crowded. Now, it is known that tuberculosis is a disease of poverty, primarily because of poor diet and crowded living conditions. On the other hand, in an area around San Martin, the land is owned by wealthy landowners, who are always white, and it is in this area that the incidence of tuberculosis is very high. Therapists tend to think of treating tuberculosis with drugs, although they will concede that the the best way to treat tuberculosis is to improve the diet. But this method of therapy is not the way to treat tuberculosis in the Department of Chimaltenango. Such treatment would have a negative effect if you simply treated the people who are clinically sick, because then you would divert too much of your energy to this technological gimmick, whereas the basic problem lies in the maldistribution of land. Until you work with that basic problem, you are probably wasting your time. You may think you are doing something effectively, but you are not. This illustrates how you get into all kinds of activities, once you become involved in total community service. This is the reason why a doctor like myself has to become involved in a land development programme in order to make land available to farmers through our land loan programme. Some of our Indian population had to break up their families in order to go down to the south coast to work on coffee plantations. They would be away for three or four months at a time and be exposed to diseases they had never been exposed to before and would come back half sick and spend all the money that they had made in trying to get well again. The only way we could help them was to give them loans in order to buy a small piece of land for themselves. In one project we have made money available to 56 families who now own their own land, consisting of five-acre tracts. All of them have increased their corn production at least four times, and one even increased it ten times through good land management. After the first year, most of them were able to pay back as much as a third of their loan. The money is loaned over a five-year period at 8 percent annual interest. Repayment is no problem. The problem is to find the capital to make loans available, and we are always searching for more money to add to the loan fund for land development.

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I have mentioned that Indians are a very biophilic race. They do not take kindly to limiting their families. Yet, if they continue to have an average of six to eight children, the next generation is going to be in serious trouble again, in spite of the fact that they now own some land. For this reason we have a family planning programme, but it requires patient education for people to see the consequences of overly large families.

We have a programme for the training of health promoters. It is not difficult to train to train people to apply and to accept a Western style of health services. The Indians are ready to accept anything which has proved itself useful and successful. They are willing to accept that a little boy with high fever and a lot of cough gets more benefit from an injection of penicillin than from drinking some kind of tea or putting leaves on his chest. In fact, they use very few so-called traditional drugs. Before we came, the Indians would purchase their Western medicines from the pharmacists, and every little town had someone who would give injections. These pharmacists were primarily indigenous. They had no idea what the patient was suffering from; they just sold him some medicine. The situation has now changed somewhat, because the Government is training health workers who visit local clinics twice a week. But ten years ago nothing like this existed, and so we had to develop a training system so that Indians could be taught how to recognize common medical problems and how to treat them - not to be para-medical workers but actually be curers themselves and really be responsible for offering total community health services.

We have found that it is very important to be careful in the selection of those who are to be trained. Originally we took those who were recommended to us by a local priest or a Peace Corps volunteer. We have since learned that this is not the ideal way to select people. Our approach now is to assist each local community to set up a community betterment committee which includes a health committee. The the community health committee selects someone within that community whom we are to train. This has worked very well because it avoids some of the pitfalls that we have in the medical monopoly in the Western world. The man that we train represents the community, and the community then is responsible for him and can discipline him. We had to withdraw one of these health promoters because the local community health committee was not happy with the way in which he was offering his services. This local committee has a list of the prices of the medicines. Each man is allowed to charge according to this price list, and the community knows what the medicine costs. In addition, he can charge a 25-cent fee for his call or for his services. Since the community is involved in setting the charges, it becomes impossible to develop a monopoly like we have in the United States and many other places in the world, where the doctor can charge any fee he likes. Where doctors hold a monopoly, as they do in most countries, they are then able to set the fee and the conditions for their services. We wanted to get the service out of the hands of this monopoly, and so we insisted that the community which wants a community health leader must first form a committee which will be responsible for him, both during his training and later.

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The training is very practical. They spend a good deal of time making rounds in the hospital and seeing actual clinical cases. They learn to know what they can do in their own village for a particular problem when they are responsible for it. Treatment is by symptom only. They are not taught to interpret symptoms. In my experience, this is very important. When I was in Africa recently, I visited a hospital where an American doctor was training medical assistants, and he told me that when he checked their reliability, he found that they mistreated 45 percent of the patients. That is very serious indeed. These medical assistants had received very sophisticated training, but they were getting into serious trouble because they were trying to interpret the symptoms in order to make a diagnosis. It is in interpreting symptoms that doctors make too many errors. A lot of them would get in less trouble if they would simply listen to the patient and then treated what he told them, instead of relying on complicated gadgets. I think it is very important to understand that in order to treat people, you have to spend time listening to them. It is a big defect in modern medicine that doctors do not take sufficient time to listen. The average patient will tell you what is wrong with him. For this reason we teach our health promoters to treat symptoms, and their reliability is quite high. In a study which was made about five years ago, 91 percent of the patients were treated properly. If a well-trained doctor treats 91 percent of his patients properly, then he has an excellent record!

We are now developing a two-year study of the reliability and acceptability of our health promoters. We also want to know whether their position is affecting their status in the local community. You will be surprised to hear that some of those we have trained have never gone to school. However, it is not necessary to go to school to be able to practise medicine. The complicated training which the doctor receives is perpetuated by the medical monopolists in order to continue their monopoly. One of the necessary components in the success of our programme lies in the careful supervision of each health promoter. This again is rather different from normal medical practice. The only supervision an average doctor receives is when he gets too far out of line and a lawsuit is brought against him. If he does something very bad indeed, he might be discharged from the medical society; but that is a rare thing to happen because doctors are not very good at disciplining each other.

Our health promoters are supervised in various ways. Each one has to come for at least three days every month. On one of these days they will have to under take a written examination in which they are given patients to see, and then they have to describe what they would do for this particular problem at home and what they would recommend to the family so that the problem need not recur. If they make a failing grade in the examination, they are not allowed to buy medicines for a month until they have passed the next examination. Some people would say that if they do not have medicines, other people in the village will suffer. That may be true, but we believe that it is more important that these health promoters act in a responsible way and are capable. If they are not capable, they should not be allowed to work.

We have also used a visiting supervisor. Until three months ago, we had a British doctor doing this. He would visit each one of the health promoters and spend three days a week with him, also visiting the neighbours and looking into the quality

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of the promoter's work. He would note if the house of the promoter was clean and if he had adequate medicines and observe his methods for cleaning syringes, etc. We now have one of our own health promoters who has taken the place of the British doctor as a visiting supervisor, even though he had only gone through the second grade. He is already doing a remarkable job - even better than the British doctor who went to school for 22 years. This is no reflection on the doctor but is because of the nature of the local supervisor, who is an Indian himself and can understand his fellows and discipline them more effectively. This again supports my contention that we must break down the medical monopoly if we are going to bring health care effectively to people who now have no service of any kind. When most people think of health, they think of the doctor; but the doctor actually has very little to do with health, even though he takes credit for it. Nature cures most problems. Seventy-five to 80 percent of most illnesses are self-limiting. The patient goes to the doctor who gives him an injection or some drugs, and after about a week or ten days, nature takes care of him itself. The doctor takes credit for nature's work and is paid for it, and yet sometimes the doctor has had a negative effect because his drugs have delayed the patient's normal, natural recovery. It will not be easy to break this medical monopoly, but perhaps in the next generation people will realize that they do not have to go to the doctor for their health. People have to be taught to take care of themselves and to know what to do when these self-limiting illnesses occur. We still need doctors to diagnose and treat some of the more complicated conditions.

Finally, let me summarize the salient features of our community programme in Chimaltenango. Some of the principles enunciated here may be of help to others who wish to start such programmes:

- The concept of complete orientation to those to be served. This is the first essential step.

- If you do a demographic survey, be sure it includes the questions, "What do you think your needs are?" and "How do you think we can help you?" Avoid offering services on your terms.

- Community health committees of local people should first be organized and functioning before first aspirin is given out or a band-aid put on. These grass-root committees in each community then themselves select the people to be trained to offer the services, supervise them, discipline them, report on them, and are in complete charge. The community committee will set the standards of services and the prices charged for it.

- Community services are just that - total service for the whole community, including all types of services required, depending on local needs and custom and availability of materials. The practice of medicine is only a small part of the total pattern, which includes responding a total community needs, whether that be in the field of agriculture, marketing, housing, home-crafts, nutrition, family planning, schooling, transport, etc. The hospital compound will not be

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possible in such a scheme, and the compound walls that do exist will be battered down so that all services and work and love freely flow in all directions.

- Outside input is obviously needed in materials, manpower, head-power, direction and supervision - but always in terms of local custom and tradition, along with a complete dedication by the expatriate to training his local counterparts.

- Community health promoters (or medical assistants, or dressers, or whatever label they might bear) should always be selected by the community to be served.

- Training should be arranged so that the trainee can continue his usual work, continue his family and community identity, with absence from his home at a minimum. Training programme at distant centres too often disrupt family and community identity and may corrupt the trainee with exposure to a foreign culture and life style which make return to his family and community difficult, if not impossible. If absence from home is necessary, the courses should be short, with frequent return to family and community.

- Medical training demands use of clinical patient-teaching material in either a dispensary or hospital-type service, so that the clinical picture is seen and appreciated and understood.

- Treatment of ailments is done by symptoms, not by diagnosis. Even people with the most sophisticated training, with years in school to understand the mechanism of disease, too often err in their interpretation of the symptoms to make the diagnosis. Our experience is that symptom treatment results in a relatively low error in management, realizing that most medical problems are rather simple and, with nature's help, actually heal themselves.

- Medical training demands that the trainee know equally well what not to treat as well as what to treat and how to treat it. The future of nonprofessional curing demands that this concept not be violated.

- Supervision of lay curers is obligatory, and the nature of this supervision depends on local circumstances. In the Guatemala programme this supervision is done by requiring regular attendance at clinical training sessions, regular examinations (both oral and written), regular visits by the supervisor to the health promoter's site, and regular reports from the local community health committee about the health promoter's work, its quality and acceptance and the fees charged.

- Fee-for-service should be decided locally, but the central agency should not, under any circumstance, put anyone on the payroll. The community is being served, so the community pays - with no exceptions. If this work is undertaken by a mission or a church, the only people to be on the payroll should be trainers and supervisors - nobody else.

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- Medical curative services should pay for themselves, without exception. Dependence on outside input adds nothing to the development of local responsibility and supply of services and materials.

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CMC NEWS IN BRIEF

(EPS) - For the remaining two years of its current mandate, the Christian Medical Commission (CMC) will concentrate on the development of basic health services for deprived peoples. This decision was made by the Commission's six-member Executive Committee, which met in Tubingen (West Germany) on January 11 and 12, under the chairmanship of Dr John H Bruant, director of Columbia University's School of Public Health, New York.

"For the past five years we have been trying to persuade the Christian churches to look at the needs of the 80% of people in developing countries who still have no access to health care", said CMC's director, Mr. James McGilvray, at the close of the meeting. "But most of the churches remain committed to the maintenance of hospital services. These hospitals, in turn, are trying to follow the high standards of medical excellence taught in the West, even though they realize that millions of poverty-stricken people cannot provide the support base for a Western-style hospital system."

Now the CMC is acting to implement a mandate drawn up last July which said a just system of health care delivery must work out new ways of providing a basic minimum of services for all.

Specifically, this will mean focussing on national agencies doing joint planning and coordination of all existing resources in health care, whether Protestant, Roman Catholic or governmental. These already exist in several countries.

In the past six months the CMC has helped to activate additional agencies in Botswana, Lesotho and Nigeria. And Kenya seems likely to follow in the next few weeks, according to Mr. McGilvray.

CMC will work closely with these groups to develop projects providing such basic services as immunization, maternal and child care and advice on family planning, safe drinking water and waste disposal, health and nutrition education, diagnosis and treatment of simple common diseases and facilities for referral of acute ailments.

An essential condition is that the services be available where people live. Towards this end, the CMC is promoting the idea of training such people as school teachers, Bible women and evangelists, so they can aid in basic health programmes. It is essential to give enough training, but not so much that the person leaves the area where the service is needed.

The Executive Committee's decision to concentrate on work with national planning agencies does not prevent the CMC from responding to any opportunity to promote the same principles elsewhere, as it has already done in Koje Do (South Korea) and Jamkhed (India). But a situation must offer promise of more than local impact, the CMC director stated.

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74.3

THE SCOPE OF HEALTH PROJECTS

- By Imrana Qadeer

(Background paper for the 4th Annual Meeting of MFC)

The present decade in our country can be described as a decade of widespread disillusionment among doctors who uptil now have been used to considering their profession a panacia for all human sickness. This disillusionment is a result of the very obvious reality of excess of death and disease in the society inspite of all the technological advances made in the field of medicine and all the efforts put in education and training of doctors. Our proclaimed 'progress' and 'developmemnt' in the field of health fails to stand up to any objective scrutiny of its achievements.

This disillusionment has compelled a number of young doctors into actions of various kinds(we shall here not tamper with the broodings of the cynics who are themselves a product of this same disillusionment). The nature and the direction of such action obviously varies with an individuals own understanding of the nature of health problem, the nature of health problems, the nature of technology, the forces which govern the growth of technology and its application for the benefit of the masses and the nature and dynamice of society itself.

This difference gives rise to the possibility of these action programmes working at cross purposes or becoming less effective due to the limitations of their own understanding. The important thing therefore for those involved, is not to get confined to their own experience but to make it a part of a wider effort at collective learning, Inspite of wide variations in the details of their health activities -at various levels and of different kinds- the workers can easily recognise certain common issues. Even negative findings and methodological errors, if recognised, become tools for improving ones' comprehension of disease in society and hence future action. Exchange of ideas and experiences therefore is an essential component of the effort in lessening the subjectivity of our thoughts and action.

It was with this objective in mind that we decided to take up an analysis of some of our own projects this year. Unfortunately out of the eight expected reports only three have come and therefore the methodology of this background paper has to be slightly different from what was agreed upon. Interestingly enough the three reports which we have received have entirely different approaches to the problem of community health. It is not intended to compare and contrast these projects, however, certain issues are raised on the basis of the material provided regarding project work and the lessions which we can draw from them. The reports from Midnapur, Thaltej and Dharnampur together with others will form the basis for discussion on the issues raised in this paper.

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Project work as a learning experience:

I. What does it teach us about

i) Occupation(Productive activities) and working conditions of the people.

ii) Their social and cultural background.

iii) Economic status.

iv) Living conditions- Housing,water supply,sewage, drainage,food,clothing,education and transport.

v) Class distinctions and stratific-ations within the community and the dyanamicity of social relations.

vi) Nature of exploitation in the community.

vii) Welfare activities in t he community.

viii) Political forces.

II. How do we relate the above factors to health issues:

i) Nature of health problems and the above factors: For example how do we relate the incidence and prevalen-ce of diarrhoeas,intestinal parasites,respiratory infec-tions(including T.B.) Malaria,anaemia,under-nutrition and scabies in Midnapur,Dharampur and Thaltej with the prevailing ecological set up?

ii) Health Behaviour of people and its relationship with the above factors:

There are two ways of looking at this probleL accord-ing to one,human behaviour regarding health problems is determined by inherent characteristics of man and can be assessed as medically correct or incorrect independently of the surrounding social,biilogical and physical environment. According to the other view point,health behaviour of people is determined by their experience of traditional and modern means of health care within the limits of their environment. Hence, all health behaviour must be analysed within the socio-cultural and economic frame of the community rather than within the paradigmes of medically corre-ct or incorrect.

Given the experience of the three projects which of these two ways appear logical to us? It may be easier to come to a conclusion if we try to explore the follow-ing questions:

a) What is the reason for the tenacity with which birth practices and supermacy of the grand mother's in Midnapur is maintained?

b) What is the reason of poor hygiene and irregularity in treatment of chronic illness(and even acute ones) among the tribals of Dharampur?

c) Why are they lazy and lack initiative?

d) Why even after 10 years of services their health behaviour has changed so little?

e) Why in Midnapur health education is being taken up indirectly through nightsoil disposal programme?

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f) Why in all these areas inspite of high infant mortality people continue of depend upon traditional dais and their services.

iii) The limits which the above factors impose upon health care:

These limits are a result of the difference between the socio-cultural and economic status of the providers and the recipients of health care and the poor living conditions of the majority of recipients.

a) The CBC programme at Thaltej has an extensive structure but its very structure due to its composition is its limitation. Similarly, the extreme poverty in Dharampur and Midnapur is a barrier between people and project workers.

b) Poor living condition limit the impact of medical care for example the effectiveness of treatment of diarrhoeas in malnutrition and of malnutrition in a child with chronic diarrhoea or of both when the child continues to live in the same environment, becomes less.

Are any of these limitations effectively demonstrated in the project areas? Here Thaltej may be a good example since poverty is not as evently distributed as in the other two.

III. Can we then tackle health problems independently from socio-cultural and economic problems?

IV. Are majority of our health problems emenable to the available preventive techniques? If so, have they been quantified. For example, of the respiratory illness how much is prevented by DPT immunisation?

V. What is and what should be the role of curative medicine in health care programme?

VI. What is the real meaning of health education and how best can it be achieved?

Is experience a part of health education or can transmission of knowledge alone serve the purpose?

B. Projects as alternative for health care:

I. What are the requirements of evolving an alternative stratey?

i) Are we clear about our goals?

ii) Have we assessed the quantity and quality of problem?

iii) Have we set the priorities according to the felt needs of the people and epidemiological status of the health programme?

iv) Have we assessed our resources both in terms of man power and material?

v) Have we considered the choice of techology for handling the health problems on hand?

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vi) Have we evaluated the training needs for the proposed project? Of the various projects,how many can fulfill these criterias?

II. Give the resource inputs of the projects what are the chances of their being reproducable?

III. What is the population coverage of these projects and is total population coverage feasible through similar efforts?

IV. Can these projects be sustained and become self-sufficient?

C. Projects as an instrument of social change

1. Given the fact that the direction of social change can he varied, the role of these projects has to be understood clearly.

i) A means of easy money(which comes in abundance through national and international funds) and a source of prestige.

ii) A means of social service to somewhat lessen the burden of the poor((Philanthropic).

iii) A means to reform the society where the sores are healed but the disease persists. (Reformism).

iv) A means of establishing contact between doctors and people so that both sides understand each others limitations, needs and objectives.

v). A means of reorganising ourselves. If we are interested in the later three roles then which aspects of the project work nedd to be strengthened?

D. Some issues regarding running of a project

Given the voluntary nature of work and the main objective of learning about community health, some of the following issues need to be taken note of. It is also worth looking into projects to see how these issues are taken care of in practice.

i) A personality oriented programme has the danger of becoming dependent on one person.

ii) In projects run by studdnts the problem of continuity and regularity threatens the success of the programme or not?

iii) permanent employes either make the project personality oriented or undermine the objective of voluntary participation and sharing of responsibility.

iv) Administration of the project in itself takes too much time of doctors.

v.) Doctors tend to become the centre of all wisdom in these projects.

vi) Since donation in kind and otherwise comes from richer sections and they have more time for and knowledge of medical care services,they tend to get more out of the project work than the rest of the community.

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vii) Not enough attention is paid to systematic evaluation of objectives and achievements.

viii) Interference by and interaction with government and non-government health organisations and individuals.

ix) Training of workers and its assessment.

x) Should the worker be outside or local? Advantages and dis-advantages of the two.

B. Poeple's participation in projects.

I. What should be the quality of participation?

i) To seek help and treatment.

ii) Donate land and money

iii) Taking part in decision making

iv) Taking part in implementation of programmes

v) Taking part in evaluation.

II. What factors influence the quality of participation? Can we take example from the projects to demonstrate the influence of the following:

i) Social cultural and economic barriers.

ii) Technical know how.

iii) Access to health services.

iv) People's experience of effectiveness of services.

v) Distances between places.

vi) Educational status.

vii) The health team itself.

Taking the above points it may be possible to see which sections have what quality of participation and why. This helps in unddrstanding the needs and requirements for a better participation.

III. What efforts have we made in our projects to mobilise people.

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WORKING PAPER

ROLE OF FRONT LINE WORKERS IN DELIVERY OF HEALTH CARE IN INDIA

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INTRODUCTION:

1. The Health status of hundreds of millions people in the world is far from satisfactory and in fact unacceptable. More than half the population does not have the benefit of adequate health care. There is a wide gap between the developed and the developing countries in the level of health and in the resources they are devoting to the improvement of health. Moreover within individual countries whatever their levels of development, wide disparities exist between health facilities and health conditions of different groups of population.

2. The present medical manpower produced both in the developed and in the developing countries has been inadequate and more important still incapable of delivering health care to the people who need it and in places where it is needed the most.

3. The World Health Assembly has in its 31st Meeting in 1976 decided that the main social target of governments and W.H.O. in the coming decades should be "the attainment by all citizens of the world, by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

4. The Alma-Ata declaration stressed the need to provide Primary Health Care. This was to be the key to attaining the target of health for all by the year - 2000.

5. The main people for delivery of primary health care would be the Front Line Workers. It is to be noted however that neither primary health care not front line workers are a new concept. At best one could say it is a new jargon. But new jargon is not a bad thing, for it evokes renewed interest. But it is bad, if it does not take into consideration our past experiences. It is based on the sharing of experiences of various countries on utilisation of front line workers in delivery of primary health care that this concept has come to be envisaged as one of the main pillors of the National Health Care Delivery System. One must also note that in India projects like Jamkhed in particular and others like Mandwa, R.A.H.A. etc. have been utilising front line workers even before the Alma-Ata Conference.

6. The Government of India launched the C.H.W.'s Scheme on October 2, 1977 in an attempt to strengthen the health services at the grass roots, and solve the two main problems our countries' health services has been facing namely:

a) Outreach b) Active community participation.

7. Projects in various countries like Bangladesh, Burma, Thailand, Indonesia, Nepal, Ceylon and India and in some Latin American countries have since long been trying to deliver primary health care through front line workers known as either village health workers, community health workers, village health communicators village health volunteers, village health promoters etc. These workers are either part-time or full time, paid or unpaid, literate or illiterate or both, male or female or both etc.

8. In our country the former government launched the C.H.W.'s scheme on Oct. 2nd, 1977. This new rural health policy incidentally is supposed to reflect the ideological concept and rural bias in the field of health. By September, 1979, it was estimated that 180,000 C.H.W had been trained. The scheme had been extended to 981 PHCs. The scheme covers all states in India except Kerala, T.N and Jammu and Kashmir, Karnataka agreed to the implementation of the scheme only since April, 1979.

It is to be noted before we proceed that in 123 blocks (out of 892 blocks in the tribal areas) PHCs have yet to be set up.

9. Front Line Workers in India:

The front line workers in different projects in India are;

a) Village Health Workers in Jamkhed & Mandwa.

b) The village health promoters in Raigarh (RAHA)

c) The Anganwadi workers in the 100 Integrated Child Development Services Scheme in the various tribal, rural and urban blocks in different parts of the country.

d) Link workers in the Tea and Coffee Plantation in the South.

e) The Community Health workers in different parts of the country in our villages, etc.

10. What is the role of the front line workers in delivery of primary health care? Different projects have assigned different roles varying from mainly a role of an informant and an educator, as in the plantation, to treatment of minor ailments and collection of data and treatment of malaria, sanitation and health education as in the case of village health promoters, C.H.W's etc. In projects like Jamkhed the VHW's have besides delivery of primary health care, also been involved in total socio-economic development and in social change in the community.

a) What according to you should be the role of these front line workers, taking into consideration in particular the C.H.W.'s Scheme?

b) Should they involve in activities besides health?

11. Criteria and process of selection: In Jamkhed the community is informed about the type ofworker required by the doctor, and the social workers and ANMs, and the community select the worker.

In the plantation, the selection is made by the supervisor and the manager of the tea garden in consultation with the medical officer and the community.

In the Integrated Child Development Service Scheme, the Block Development Officer and Child Development Project Officer are the main selecting authorities. In Raigrah Ambikapur Health Association the church authorities in collaboration with their social worker and community select the worker - The CHW's should ideally be selected by the Gram Sabha - but this seldom happens and it is largely the Panchayat workers and the Medical Officers and other political workers who eventually select their protegees.

a) Which system according to you is better? Why?
b) Do you have any suggestion as to how the workers could be selected?
c) Considering C.H.W.'s scheme in particular -how could one ensure that the right people get selected?
d) What should the sex/caste/economic class/education of the worker be?

12. TRAINING: The mode of training differs from place to place. In Jamkhed an initial training in the headquarters for a week is followed by in service training in the field in their respective villages and coupled with refresher session they work for a whole day, where working come to the headquarter every Friday stay and eat together (this gives them an opportunity to share their problems and occasionally find solution from each other experiences). This is followed by another day (Saturday) of review of the weeks' work, collection of data and checking of records (done by M.O. and A.N.M. Social Worker), teaching of a new lesson and solving their problems or rather helping them to find solutions.

Link workers from different gardens come in batches to the headquarters in Coonoor or to their respective garden hospitals for weekly training mainly in data collection, sanitation and are also thought the methods of production and transmission of disease and treatment of the same by the Medical Advisor or the Medical Officers.

In R.A.H.A. training is given by social workers and Nurse-Midwives in one of the villages for 15 days and followed up with refresher session for 15 days every 6 months.

The Anganwadi Workers are trained in different institutions selected for the purpose by the Project staff. They are trained by doctors,

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social workers etc. for 3 months. Some of them receive in service training.

The CHW's are trained by the M.O. and M.H.W. with occasional guest lectures at the P.H.C. and some field training.

Most of the projects utilise Audio-visual aids, but much stress is laid in Jamkhed and plantations and R.A.H.A. and some of the PHC's. Jamkhed utilised locally relevant audio-visual aids.

The methods of training vary from mainly didactic lectures with not much stress on in service and field training to much stress on field training and purposeful, problem solving meetings as in Jamkhed and Plantations.

a) Who should actually give the training?
b) Are the doctors in our PHC capable of imparting training to CHW's.
c) Should these doctors receive a training themselves?
d) If so, where should they be trained? For how long?
e) What type of training should they be given?
f) Should the PHC-MO's train their MHW's to teach the CHW?
g) Could Medical colleges involve themselves in training of the M.O. + M.H.W.'s.
h) What according to you would be the best way of training the CHW's.
i) Contents of training, skills imparted to VHW's and the level to which they should be trained. Should the training be uniform?
j) What educational methods and principles should be utilised in training the VHWs.
k) Main training emphasis on professional (health work) skills or on how to conscientise people about socio-economic problems and actions? or Both?

13. a) Should workers be part time/full time?
    b) Should they be honorary or paid?
    c) If paid, how much? Cash/Kind?
    d) Who should contribute the money and through whom should the payment be done? One who does payment will effectively control V.H.W.

14. Reactions of Community to CHWs.: In projects like Jamkhed, R.A.H.A., Mandwa and Plantation majority of people are happy to have somebody to give them basic health care.

However there is a large amount of dissacisfaction with the government in various parts of the country also in some of the projects. Some of the reasons are:

i) Not a dedicated worker   ii) Not enough knowledge
iii) Does not give injection   iv) Not accepted by the community
v) Helps only the rich and affulent.

What according to you are the main reasons for this?

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15. a) What should be the sex/age of the worker?
    b) Could religion/educational status/sex/age affect performance?
    c) Should socio-economic conditions be a criteria for selection?

16. Evaluation: What should be the methods of evaulation of performance of front line workers?

a) Decrease in morbidity and mortality in the community/vulnerable groups.
b) Immunisation status of the community.
c) Nutritional status of children?
d) Soci:-economic changes
e) Changes in Knowledge Attitude Practices in the community.
f) Acceptance by the community.
g) On going evaluation/terminal evaluation (for projects)?
h) Decrease B.R. improvement of M.C.H. services?
i) Any other.
j) Who should evaluate? How can the community participate in evaluation of CHW and in supervision and control of their workers.

17. REMUNERATION: Workers are most often part-time and are expected to devote 3-4 hours a day per month.

In the I.C.D.S.S. the workers are full-time drawing about Rs.100/- to Rs.150/- per month.

In most other projects workers are paid Rs.30/- to Rs.50/- per month. The Govt. CHW get Rs.200/- per month(full time during their initial training) and Rs.50/- per month later on after their initial training.

In R.A.H.A. and Plantations the workers are honorary. Evaluation of workers in most projects and PHCs, shows that the workers want higher honorarium.

17. i) What population should each worker cover?
    ii) How many villages should he/she cover?

18. Supervision:
    a) Should the CHW be responsible to the village? Or the MHW's and PHC - M.O.?
    b) Should village health committees be formed?
    c) Should Block Development Officer supervise?

19. a) Should CHW's scheme be part of the PHC - set up?
    b) Should it be independent?
    c) What should be the interphase between the District Health Authorities and other development authorities and CHW's?
    d) What should be the interphase between the C.H.W. and the community?

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20. a) Should there be refresher training for the workers? How frequently? For how long?
    b) Should avenues for promotion and increment in wages be worked out for CHW's? If so how?

21. A) How could medical colleges with the new schemes for take over by 3 PHCs - take responsibility for the scheme?
    b) Could they involve in the training of the workers and evaluation of the scheme?

22. Primary health care envisages the involvement of health department with various departments like agriculture, social welfare etc. in development of the community.
    a) How could front line workers do this?
    b) Are the doctors capable of functioning in unison with other development agencies.

These are only a few facts about front line workers and a few questions to stimulate discussions in view of what he have observed in Jamkhed which perhaps is one of the best projects today. We must attempt however to project how some of the things done here, could be implemented in other pockets and parts of India.

Primary Health Care it has been said, marks the changing point which a future historian would perhaps call the beginning of health revolution.

Let us all hope the future historian gets an opportunity to do this!

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GENERAL APPROACH TO RURAL COMMUNITY HEALTH SERVICES

Fundamentally, the health services have to be viewed in the context of overall integrated development of the villages. Health services cannot be fully successful if they are pursued in isolation from the general development activities of the area.

The community health services must be area based and population based — providing the total spectrum of health services to the total populace living in a defined geographic area. Primary health care must be available at the doorstep of the receipients.

1. Area Coverage — Regionalization:

We must accept responsibilities to provide health coverage to the population of a defined area.

Selection criteria of the area:

A) Need - Poverty and illiteracy
high incidence of diseases
no -availability of health services.

B) Suitability:-

The area should not be too far nor should the area be too near to Patna — then the people will be visiting Patna for health needs.

Assurance by the community for full cooperation and help.

HOW ? for example:

i) If there is an already existing useful organisation that can provide us useful assistance.

ii) If the village is well united and there is an effective panchayat.

iii) If the village has, or is willing to immediately start, a Village Health Committee, which could help us in several ways, acting as an effective link between the health workers and the villagers. Such a health committee should preferably be considered a specialized organ of the panchayat unless the panchayat is divided and ineffective. Then the Village Health Committee can be an independent institution. But it must enjoy the confidence of the entire village population.

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iv) If the villagers are willing to contribute their share by:

1. Agreeing to pay a small insurance charge
2. Agreeing to do Shramdan for some health projects
3. Agreeing to contribute volunteers that will help run the health programme.

v) If some date is already available about that area due to previous or on-going survey etc., either in connection with a health programme or as a part of general development activities.

2. Total Population Coverage:

The whole population must be covered.

Priorities: The weak and the vulnerable: Children below 6
Expectant mothers
Nursing mothers

Promotion of health and prevention of disease.
Nutrition, Sanitation, Immunisations & Health Education
Adequate simple records.

3. "Health Insurance":

Every body pays.
There may be a graded scale, depending upon the economic status.

Advantages: Greater interest taken by the community.
Greater community participation.
People feel they own the programme-and it is their (as indeed it always should be).
People who pay can also ask for good services, and who can complain if the services are not good.
Keeping accounts develops the idea of accountability.
People do not value the treatment that is given free.
They may even throw away expensive drugs, thinking them worthless.
Getting things free is not a good habit. It should be discouraged.
Some people consider it ethically wrong to give mor take things free.
There is no such thing as FREE. If the villagers are not paying for it, somebody else must be paying for it.

4. The National Context and Constraints:

Ours is a poor country.
Our health services should be affordable on a countrywide basis, perhaps adding upto a few rupees per head per year.
It is no use creating an IITAL or achieving "excellence", which cannot be copied on a large scale.

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We must keep in mind the replicability of our health services. We should be able to demonstrate a pattern of health care which is practicable and effective-not after 50 years, but for the next five year plan.

Thus our efforts should have national relevance. We have wasted our opportunity if our health services and experience cannot be multiplied and does not have any relevance for the creation of effective health services on a country-wide basis.

5. <u>Coordination with the State Health Organisation</u>:

Health is a State subject.

We should avoid dual control or parallel and competing health services. We should have a clear understading with the State health Ministry and the District Chief Medical Officer. We should clearly deine our respective roles and establish clear channels of communications and cooperation.

Broadly, our plan for community health services should follow the state pattern. We can fill in the lacunae and strengthen weak link, but we should not drastically alter the overall health plan or health strategy. Otherwise we again face the risk of wasting our opportunity and losing all relevance.

6. <u>Utilisation of Existing community Resources</u>:

They include:

Indigenous and homeopathic practitioners Ordinary simple home remedies.
The common lore and grandmas recipes Yoga.

Health practices of our people, such as personal cleanliness, boiling of milk, breast feeding of children self reliance etc.

Local educated young men and women, including teachers, post-man etc., that can be roped in for various types of "help" that comes to villages" atrophy of local leadership and initiative and fostering an attitude of dependance and passive acceptance. We must guard against the tendency to pull people up by their ears, instead of encouraging them to pull themselves up by their boots-traps. We should resist all well intentioned effort to spoonfeed the people.

(#) We must never allow

Instead, we should encourage local leadership, local initiative and self reliance. At a practical level, we should select suitable educated young men and women from the villages themselves, and train them as health workers. We should also involve the community in all health work, right from the stage of planning onwards.

9. Community Participation:

A community should consider the health services as their own. Community participation is the sine qua non of any successful community programme. This is one reason why the community must pay for its health ~~servic~~ services partly, if not wholly.

The community must be involved in all stages of the community health programme, including decision making.

Important areas of community participation:

Planning.

Financial contributions.

Selection of workers from the community.

Evaluation of their work.

Village Health Committees can play a very useful role here, as already mentioned.

10. Social Role of Health Education:

Health education is essential in a democratic set-up in order to elicit the willing and enlightened cooperation of the people

It increases peoples competence to look after their own health, thus fostering self-reliance.

It helps people take greater interest in their health services.

It helps people identify incompetent workers or incorrect measures.

EveryBody is interested in the working of his/her body, and in health. They will pay attention if health education is imaginatively carried out, using for example puppet shows, one act plays, practical demonstrations, mobile exhibitions, etc.

The following topics should be covered:

First-aid

Simple nursing

Body knowledge

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Yoga

Personal hygiene

Balanced diet

Some simple preventive measures etc.

11. Phasing and Pilot projects:

We should start with a small area or start with only a few services or both.

We should expand and multiply health services as we gain more: -

insight
experience
confidence
acceptability
efficiency

12. Essential Steps:

To Implement the Community Health Programme Objectives:

To create comprehensive integrated community health services for the total population of defined rural areas, with emphasised on vulnerable groups and on prevention.

Such a service should be made available on aregional basis alongwith effective referral facilities.

Summary of Steps:

1. A managing committee of overall ~~Jayaprabha Hospital, Research Centre and~~ [for the] Community Health Programme should be established. (if necessary)

2. Constituting a "Planning and Implementation" Committee for the Community Health Programme.

3. Selection of suitable area or areas of work. Selection criteria already mentioned in the general approach.

4. To study the area(s) to define its problems and assets.

Surveys: This will involve planning and conduction of surveys covering the following variables:

Demographic

Socio-economic

Health - Existing problems

- Existing facilities

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5. Planning: Preparation of preliminary plan
Discussions
Readjustments
Finalization of the broad plan

6. Implementation: Selection and training of workers
Building and furnishing of hospitals, health centres etc.,
Phased beginning of health services

7. Records -- Should receive special attention.

8. Evaluation of Community Health Services -- both concurrent and terminal. This should help better plannings:

Planning
Programming
Administration
Evaluation.

* * *

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THE VILLAGE HEALTH WORKER --

LACKEY OR LIBERATOR?

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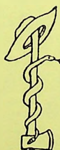
Prepared for:

International Hospital Federation Congress

Sessions on Health Auxiliaries and the Health Team

Tokyo, Japan

22-27 May, 1977



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THE VILLAGE HEALTH WORKER -- LACKEY OR LIBERATOR?

-- David Werner --

1977

Throughout Latin America, the programmed use of health auxiliaries has, in recent years, become an important part of the new international push of 'community oriented' health care. But in Latin America village health workers are far from new. Various religious groups and non-government agencies have been training *promotores de salud* or health promoters for decades. And to a large (but diminishing) extent, villagers still rely, as they always have, on their local curanderos, herb doctors, bone setters, traditional midwives and spiritual healers. More recently, the *médico practicante* or empirical doctor has assumed in the villages the same role of self-made practitioner and prescriber of drugs that the neighborhood pharmacist has assumed in larger towns and cities.

Until recently, however, the respective Health Departments of Latin America have either ignored or tried to stamp out this motley work force of non-professional healers. Yet the Health Departments have had trouble coming up with viable alternatives. Their Western-style, city-bred and city-trained M.D.s not only proved uneconomical in terms of cost effectiveness; they flatly refused to serve in the rural area.

The first official attempt at a solution was, of course, to produce more doctors. In Mexico the National University began to recruit 5000 new medical students per year (and still does so). The result was a surplus of poorly trained doctors who stayed in the cities.

The next attempt was through compulsory social service. Graduating medical students were required (unless they bought their way off) to spend a year in a rural health center before receiving their licenses. The young doctors were unprepared either by training or disposition to cope with the health needs in the rural area. With discouraging frequency they became resentful, irresponsible or blatantly corrupt.

Next came the era of the mobile clinics. They, too, failed miserably. They created dependency and expectation without providing continuity of service. The net result was to undermine the people's capacity for self care.

It was becoming increasingly clear that provision of health care in the rural area could never be accomplished by professionals alone. But the medical establishment was--and still is--reluctant to crack its legal monopoly.

At long last, and with considerable financial cajoling from foreign and international health and development agencies, the various health departments have begun to train and utilize auxiliaries. Today, in countries where they have been given half a chance, auxiliaries play an important role in the health care of rural and periurban communities. And if given a whole chance, their impact could be far greater. But, to a large extent, politics and the medical establishment still stand in the way.

* * *

My own experience in rural health care has mostly been in a remote mountainous sector of Western Mexico, where, for the past 12 years I have been involved in training local village health workers, and in helping foster a primary health care network, run by the villagers themselves. As the villagers have taken over full responsibility for the management and planning of their program, I have been phasing out my own participation to the point where I am now only an intermittent advisor. This has given me time to look more closely at what is happening in rural health care in other parts of Latin America.

Last year a group of my co-workers and I visited nearly 40 rural health projects, both government and non-government, in nine Latin American countries (Mexico, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, Venezuela, Colombia and Ecuador.) Our objective has been to encourage a dialogue among the various groups, as well as to try to draw together many respective approaches, methods, insights and problems into a sort of field guide for health planners and educators, so we can all learn from each other's experience. We specifically chose to visit projects or programs which were making significant use of local, modestly trained health workers or which were reportedly trying to involve people more effectively in their own health care.

We were inspired by some of the things we saw, and profoundly disturbed by others. While in some of the projects we visited, people were in fact regarded as a resource to control disease, in others we had the sickening impression that disease was being used as a resource to control people. We began to look at different programs, and functions, in terms of where they lay along a continuum between two poles: community supportive and community oppressive.

Community supportive programs or functions are those which favorably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision making and self-reliance at the community level, that build upon human dignity.

Community oppressive programs or functions are those which, while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian,paternalistic or are structured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which in the long run are cripplong to the dynamics of the community.

It is disturbing to note that, with certain exceptions, the programs which we found to be more community supportive were small non-government efforts, usually operating on a shoestring and with a more or less sub-rosa status.

As for the large regional or national programs-- for all their international funding, top-ranking foreign consultants and glossy bilingual brochures portraying community participation-- we found that when it came down to the nitty-gritty of what was going on in the field, there was usually a minimum of effective community involvement and a maximum of dependency-creating handouts, paternalism and superimposed, initiative destroying norms.

I don't have time to elaborate here, but anyone who is interested in a more detailed account of community supportive and oppressive health programming may send for a copy of a paper I presented in England last year entitled

Health Care and Human Dignity.*

In our visits to the many rural health programs in Latin America, we found that primary health workers come in a confusing array of types and titles. Generally speaking, however, they fall into two major groups:

auxiliary nurses or health technicians	health promoters or village health workers
--at least primary education plus 1 - 2 years training	--average of 3rd grade education plus 1 - 6 months training
--usually from outside the community	--usually from the community and selected by it
--usually employed full time	--often a part time health worker supported in part by farm labor or with help from the community
--salary usually paid by the program (not by the community)	--may be someone who has already been a traditional healer

In addition to the health workers just described, many Latin American countries have programs to provide minimal training and supervision of traditional midwives. Unfortunately, Health Departments tend to refer to these programs as 'Control de Parteras Empíricas'--Control of Empirical Midwives--a terminology which too often reflects an attitude. Thus to Mosquito Control and Leprosy Control has been added Midwife Control. (Small wonder so many midwives are reticent to participate!) Once again, we found the most promising work with village midwives took place in small non-government programs. In one such program** the midwives had formed their own club and organized trips to hospital maternity wards to increase their knowledge.

* * *

What skills can the village health worker perform? How well does he perform them? What are the limiting factors that determine what he can do? These were some of our key questions when we visited diferent rural health programs.

We found that the skills which village health workers actually performed varied enormously from program to program. In some, local health workers with minimal formal education were able to perform with remarkable competence a wide variety of skills embracing both curative and preventive medicine as well as agricultural extension, village cooperatives and other aspects of community education and mobilization. In other programs--often those sponsored by Health Departments--village workers were permitted to do discouragingly little. Safeguarding the medical profession's monopoly on curative medicine by using the standard argument that prevention is more important than cure (which it may be to us but clearly is not to a mother when her child is sick) instructors often taught these health workers fewer medical skills than many villagers had already mastered for themselves. This sometimes so reduced the people's respect

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*Health Care and Human Dignity by David Werner. 1976. Available through the Hesperian Foundation, P.O. Box 1692, Palo Alto, California 94302 U.S.A. Please send $2,00 U.S. to cover copy and postage.

**In Pinalejo, Honduras.

for their health worker that he (or usually she) became less effective, even in preventive measures.

In the majority of cases,we found that external factors, far more than intrinsic factors, proved to be the determinants of what the primary health worker could do. (See Outline 1.) We concluded that the great variation in range and type of skills performed by village health workers in different programs has less to do with the personal potentials, local conditions or available funding than it has to do with the preconceived attitudes and biases of health program planners, consultants and instructors. In spite of the often repeated eulogies about "primary decision making by the communities themselves", seldom do the villagers have much, if any, say in what their health worker is taught and told to do.

"PRIMARY DECISION MAKING BY THE COMMUNITY" -- INTERNATIONAL STYLE

The limitations and potentials of the village health worker--what he is permitted to do and, conversely, what he could do if permitted--can best be understood if we look at his role in its social and political context. In Latin America, as in many other parts of the world, poor nutrition, poor hygiene, low literacy and high fertility help account for the high morbidity and mortality of the impoverished masses. But as we all know, the underlying cause--or more exactly, the primary disease--is inequity: inequity of wealth, of land,of educational opportunity, of political representation and of basic human rights. Such inequities undermine the capacity of the peasantry for self care. As a result, the political/economic powers-that-be assume an increasingly paternalistic stand, under which the rural poor become the politically voiceless recipients of both aid and exploitation. (See Figure 3.) In spite of national, foreign and inter-

national gestures at aid and development, in Latin America the rich continue to grow richer and the poor poorer. As anyone who has broken bread with villagers or slum dwellers knows only too well: health of the people is far more influenced by politics and power groups, by distribution of land and wealth, than it is by treatment or prevention of disease.

Political factors unquestionably comprise one of the major obstacles to a community supportive program. This can be as true for village politics as for national politics. However, the politico-economic structure of the country must necessarily influence the extent to which its rural health program is community supportive or not.

Let us consider the implications in the training and function of a primary health worker:

If the village health worker is taught a respectable range of skills, if he is encouraged to think, to take initiative and to keep learning on his own, if his judgment is respected, if his limits are determined by what he knows and can do, if his supervision is supportive and educational, chances are he will work with energy and dedication, will make a major contribution to his community and will win his people's confidence and love. His example will serve as a role model to his neighbors, that they too can learn new skills and assume new responsibilities, that self-improvement is possible. Thus the village health worker becomes an internal agent-of-change, not only for health care, but for the awakening of his people to their human potential. . . and ultimately to their human rights.

However, in countries where social and land reforms are sorely needed, where oppression of the poor and gross disparity of wealth is taken for granted, and where the medical and political establishments jealously covet their power, it is possible that the health worker I have just described knows and does and thinks too much. Such men are dangerous! They are the germ of social change.

So we find, in certain programs, a different breed of village health worker is being molded . . . one who is taught a pathetically limited range of skills, who is trained not to think, but to follow a list of very specific instructions or 'norms', who has a neat uniform, a handsome diploma and who works in a standardized cement block health post, whose supervision is restrictive and whose limitations are rigidly predefined. Such a health worker has a limited impact on the health and even less on the growth of the community. He--or more usually she--spends much of her time filling out forms.

* * *

In a conference I attended in Washington last December, on Appropriate Technology in Health in Developing Countries, it was suggested that "Technology can only be considered appropriate if it helps lead to a change in the distribution of wealth and power." If our goal is truly to get at the root of human ills, must we not also recognize that, likewise, health projects and health workers are appropriate only if they help bring about a healthier distribution of wealth and power?

Outline 1

Factors that Influence What a Primary Health Worker Can Do

Intrinsic factors

factors influencing personal potential of VHW:

--cultural background

--level of literacy

--personal factors
  compassion
  integrity
  judgment
  initiative
  perceptiveness
  special talents
  learning capacity

local conditions:

--acceptance of VHW and program by community

--health priorities within the community

--available funding (from within the community)

Extrinsic factors

outside decisions and control:

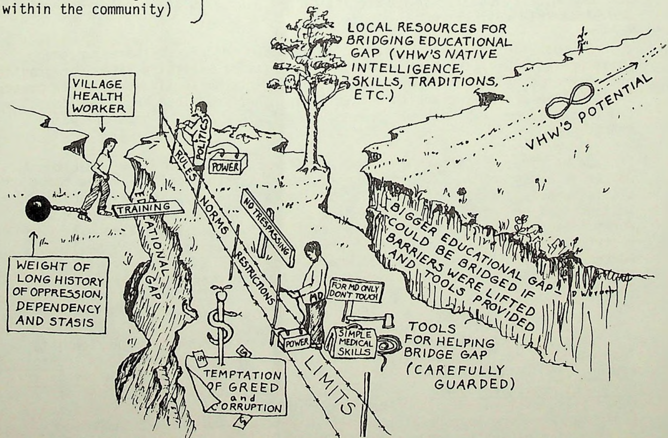
--attitudes,open or preconceived,as to what the VHW should be taught and permitted to do

--length,content,quality and appropriateness of training

--limitations of 'norms' imposed on health worker by outside authorities (e.g. Health Dept.)

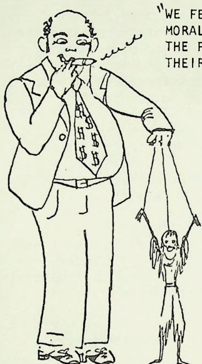
--ability or inability of instructors and supervisors to build upon the existing knowledge, skills and cultural perspectives of the VHW.

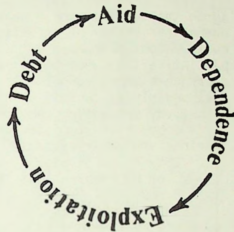
--available funding (from outside the community)



What the health worker can do is too often limited by external factors (doctors and politics) rather than determined by his personal capabilities and potential.

Fig. 3 Too often aid and exploitation go hand in hand.





COULD IT BE A VICIOUS CIRCLE?

Increased aid (with strings attached)

Increased dependency of poor on rich, of rural community on central govt., and of central govt. on foreign and multilateral agencies.

Humiliation, decreased dignity, increased irresponsibility, sense of futility, misdirected anger.

Increased outside manipulation and control

Increased exploitation

Increased debt (poor owe rich)

Stronger central power (national, foreign, multinational)
Weaker people

THE AID CYCLE

We say prevention is more important than cure. But how far are we willing to go? Consider diarrhea:

Each year millions of peasant children die of diarrhea. We tend to agree that most of these deaths could be prevented. Yet diarrhea remains the number one killer of infants in Latin America and much of the developing world. Does this mean our so-called 'preventive' measures are merely palliative? At what point in the chain of causes which makes death from diarrhea a global problem (see Outline #2) are we coming to grips with the real underlying cause. Do we do it . . .

...by preventing some deaths through treatment of diarrhea?

...by trying to interrupt the infectious cycle through construction of latrines and water systems?

...by reducing high risk from diarrhea through better nutrition?

...or by curbing land tenure inequities through land reform?

Land reform comes closest to the real problem. But the peasantry is oppressed by far more inequities than those of land tenure. Both causing and perpetuating these crushing inequities looms the existing power structure: local, national, foreign and multinational. It includes political, commercial and religious power groups as well as the legal profession and the medical establishment. In short it includes . . . ourselves.

As the ultimate link in the causal chain which leads from the hungry child with diarrhea to the legalized inequities of those in power, we come face to face with the tragic flaw in our otherwise human nature, namely greed.

Where, then, should prevention begin? Beyond doubt, anything we can do to minimize the inequities perpetuated by the existing power structure will do far more to reduce high infant mortality than all our conventional preventive measures put together. We should, perhaps, carry on with our latrine-building rituals, nutrition centers and agricultural extension projects. But let's stop calling it prevention. We are still only treating symptoms. And unless we are very careful, we may even be making the underlying problem worse . . . through increasing dependency on outside aid, technology and control.

But this need not be the case. If the building of latrines brings people together and helps them look ahead, if a nutrition center is built and run by the community and fosters self-reliance, and if agricultural extension, rather than imposing outside technology encourages internal growth of the people toward more effective understanding and use of their land, their potentials and their rights . . . then, and only then, do latrines, nutrition centers and so-called extension work begin to deal with the real causes of preventable sickness and death.

This is where the village health worker comes in. It doesn't matter much if he spends more time treating diarrhea than building latrines. Both are merely palliative in view of the larger problem. What matters is that he get his people working together.

Yes, the most important role of the village health worker is preventive. But preventive in the fullest sense, in the sense that he help put an end to oppressive inequities, in the sense that he help his people, as individuals

Outline #2

WE SAY PREVENTION IS MORE IMPORTANT THAN CURE—
BUT WHERE SHOULD PREVENTION BEGIN?

EFFECT

Needless Suffering and Dehumanization

↑

Disproportionately high morbidity and mortality
(especially infants, mothers, and young men)

↑

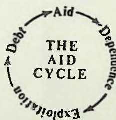
Infections, such as diarrheas and pneumonia, violence, etc.

↑

Poor nutrition, poor hygiene; low literacy, high fertility
Low initiative, misdirected anger

↑

Inequity of:
- Wealth
- Land
- Health Care →
- Education
- Representation
- Human Rights



↑

Existing Power Structure
- -financial power groups
- -political power groups
- -medical establishment
- -legal profession
- -religious power groups

{ Private
Governmental
Foreign
Multinational } ← GREED (short sighted self-interest)

CAUSE

PREVENTIVE MEASURES:

Social reform (or revolution) ↑

Humanization (Evolution) ↑

and as a community, liberate themselves not only from outside exploitation and oppression, but from their own short-sightedness, futility and greed.

The chief role of the village health worker, at his best, is that of liberator. This does not mean he is a revolutionary (although he may be pushed into that position). His interest is the welfare of his people. And, as Latin America's blood-streaked history bears witness, revolution without evolution too often means trading one oppressive power group for another. Clearly, any viable answer to the abuses of man by man can only come through evolution, in all of us, toward human relations which are no longer founded on short-sighted self-interest, but rather on tolerance, sharing and compassion.

I know it sounds like I am dreaming. But the exciting thing in Latin America is that there already exist a few programs that are actually working toward making these things happen--where health care for and by the people is important, but where the main role of the primary health worker is to assist in the humanization or, to use Paulo Freire's term, conscientización of his people.

* * *

Before closing let me try to clear up some common misconceptions.

Many persons still tend to think of the primary health worker as a temporary second-best substitute for the doctor . . . that if it were financially feasible the peasantry would be better off with more doctors and fewer primary health workers.

I disagree. After twelve years working and learning from village health workers--and dealing with doctors--I have come to realize that the role of the village health worker is not only very distinct from that of the doctor, but, in terms of health and well-being of a given community, is far more important. (See appendix.)

You may notice I have shied away from calling the primary health worker an 'auxiliary'. Rather I think of him as the primary member of the health team. Not only is he willing to work on the front line of health care, where the needs are greatest, but his job is more difficult than that of the average doctor. And his skills are more varied. Whereas the doctor can limit himself to diagnosis and treatment of individual 'cases', the health worker's concern is not only for individuals--as people--but with the whole community. He must not only answer to his people's immediate needs, but he must also help them look ahead, and work together to overcome oppression and to stop sickness before it starts. His responsibility is to share rather than hoard his knowledge, not only because informed self-care is more health conducing than ignorance and dependence, but because the principle of sharing is basic to the well-being of man.

Perhaps the most important difference between the village health worker and the doctor is that the health worker's background and training, as well as his membership in and selection by the community, help reenforce his will to serve rather than bleed his people. This is not to say that the village health worker cannot become money-hungry and corrupt. After all, he is as human as the rest of us. It is simply to say that for the village health

The primary health worker lives and works at the level of the people.

His first job is to share his knowledge.

(Illustration from the forthcoming English edition of Where There is No Doctor by David Werner)

worker the privilege to grow fat off the illness and misfortune of his fellow man has still not become socially acceptable.

Forgive me if I seem a little bitter, but when you live with and share the lot of Mexican villagers for 12 years, you can't help but feel a little uncomfortable about the exploits of the medical profession. For example, Martín, the chief village medic and coordinator of the villager-run health program I helped to start, recently had to transport his brother to the big city for emergency surgery. His brother had been shot in the stomach. Now Martín, as a village health worker supported through the community, earns 1,600 pesos ($80.00) a month, which is in line with what the other villagers earn. But the surgeon charged 20,000 pesos ($1000.00) for two hours of surgery. Martín is stuck with the bill. That means he has to forsake his position in the health program and work for two months as a wet-back in the States--in order to pay for two hours of the surgeon's time. Now, is that fair?

* * *

No, the village health worker, at his best, is neither choreboy nor auxiliary nor doctor's substitute. His commitment is not to assist the doctor, but to help his people.

The day must come when we look at the primary health worker as the key member of the health team, and at the doctor as the auxiliary. The doctor, as a specialist in advanced curative technology, would be on call as needed

by the primary health worker for referrals and advice. He would attend those 2 - 3% of illnesses which lie beyond the capacity of an informed people and their health worker, and he even might, under supportive supervision, help out in the training of the primary health worker in that narrow area of health care called Medicine.

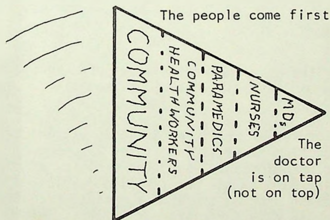
Health care will only become equitable when the skills pyramid has been tipped on its side, so that the primary health worker takes the lead, and so that the doctor is on tap and not on top.

TIPPING THE HEALTH MANPOWER PYRAMID ON ITS SIDE

THE TYPICAL PYRAMID

The community is on the bottom of the stack. Each level is rigidly delineated.

THE PYRAMID AS IT SHOULD BE



The community health worker assumes the lead role in the health team.

Appendix

COMPARISON OF THE MEDICAL DOCTOR AND THE PRIMARY HEALTH WORKER

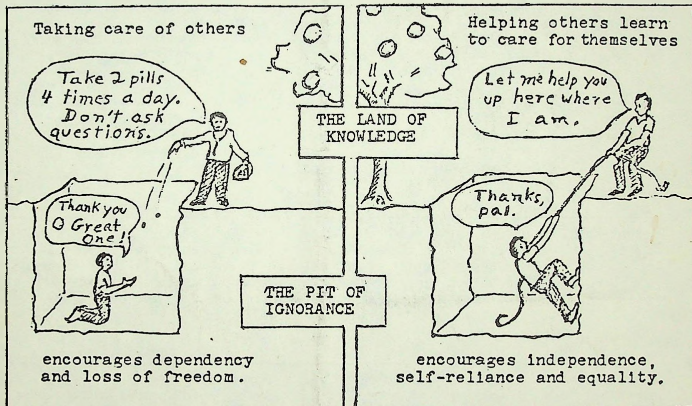
(Note: The medical doctor as described here is the typical Western-style M.D. as produced by medical schools in Latin America. Clearly, there are exceptions. Most Latin American medical schools are beginning to modify their curricula to place greater emphasis on community health. However, not modifications but radical changes, both in selection and training, are needed if doctors are ever to become an integrated and fully positive part of a health team that serves all the people.)

	CONVENTIONAL DOCTOR	VILLAGE HEALTH WORKER (at his best)
Class Background	Usually upper middle class.	From the peasantry.
How chosen	By medical school for: grade point average; economic and social status.	By community for: interest, compassion, knowledge of community, etc.
Preparation	Mainly institutional, 12-16 years general schooling, 4-6 years medical training. Training concentrates on • physical and technological aspects of medicine, • and gives low priority to human, social, and political aspects. (This is now changing in some medical schools.)	Mainly experiential. Limited, key training appropriate to serve all the people in a given community: • Dx & Rx of important disease • Preventive medicine • Community health • Teaching skills • Health care in terms of economic and social realities, and of needs (felt and long term) of both individuals and the community. • Humanization (conscientización) and group dynamics
Qualifications	Highly qualified to diagnose and treat individual cases. Especially qualified to manage uncommon and difficult diseases. Less qualified to deal effectively with most important diseases of most people in a given community. Poorly qualified to supervise and teach VHW. (Well qualified in clinical medicine, but not in other more important aspects of health care; he tends to favor imbalance; wrong priorities.)	More qualified than doctor to deal effectively with the important sicknesses of most of the people. Non-academic qualifications are: Intimate knowledge of the community, language, customs, attitudes toward sickness and healing. Willingness to work and earn at the level of the community, where the needs are greatest. Not qualified to diagnose and treat certain difficult and unusual problems; must refer.

	CONVENTIONAL DOCTOR	VILLAGE HEALTH WORKER (at his best)
Orientation	Disease/Treatment/ Individual patient oriented.	Health/Community oriented. Seeks a balance between curative and preventive. (Curative to meet felt needs, preventive to meet real needs.)
Primary Job Interest	The challenging and interesting cases. (Often bored by day to day problems.)	Helping people resolve their biggest problems because he is their friend and neighbor.
Attitude toward the sick	Superior. Treats people as patients. Turns people into 'cases' Underestimates people's capacity for self-care.	On their level. Treats patients as people. Mutual concern and interest because the VHW is village-selected.
Attitude of the sick toward M.D. or VHW	Hold him in awe. Blind trust (or sometimes distrust).	See him as a friend. Trust him as a person, but feel free to question him.
How does he use Medical Knowledge?	Hoards it. Delivers 'services', discourages self-care, keeps patients helpless and dependent.	Shares it. Encourages informed self-care, helps the sick and family understand and manage problems.
Accessibility	Often inaccessible, especially to poor. Preferential treatment of haves over have-nots. Does some charity work.	Very accessible. Lives right in village. Low charges for services. Treats everyone equally and as his equal.
Consideration for economic factors	Overcharges. Expects disproportionately high earnings. Feels it is his God-given right to live in luxury while others hunger. Often prescribes unnecessarily costly drugs. Overprescribes.	Reasonable charges. Takes the person's economic position into account. Content (or resigned) to live at economic level of his people. Perscribes only useful drugs. Considers cost. Encourages effective home remedies.
Relative Permanence	At most spends 1-2 years in a rural area and then moves to the city.	A permanent member of the community .

	CONVENTIONAL DOCTOR	VILLAGE HEALTH WORKER (at his best)
Continuity of Care	Can't follow up cases because he doesn't live in the isolated areas.	Visits his neighbors in their homes to make sure they get better and learn how not to get sick again.
Cost Effectiveness	Too expensive to ever meet medical needs of the poor--unless used as an auxiliary resource for problems not readily managed by VHW.	Low cost of both training and practice. Higher effectiveness than doctor in coping with primary problems.
Resource Requirements	Hospital or health center. Depends on expensive, hard-to-get equipment and a large subservient staff to work at full potential.	Works out of home or simple structure. People are the main resource.
Present Role	On top. Directs the health team. Manages all kinds of medical problems, easy or complex. Often overburdened with easily treated or preventable illness.	On the bottom. Often given minimal responsibility, especially in medicine. Regarded as an auxiliary (lackey) to the physician.
Impact on the Community	Relatively low (in part negative). Sustains class differences, mystification of medicine, dependency on expensive outside resources. Drains resources of poor (money).	Potentially high. Awakening of people to cope more effectively with health needs, human needs, and ultimately human rights. Helps community to use resources more effectively.
Appropriate (future?) Role	On tap (not on top). Functions as an auxiliary to the VHW, helping to teach him more medical skills and attending referrals at the VHW's request. (The 2-3% of cases that are beyond the VHW's limits.) He is an equal member of the health team.	Recognized as the key member of the health team. Assumes leadership of health care activities in his village, but relies on advice, support, and referral assistance from the doctor when he needs it. He is the doctor's equal (although his earnings remain in line with those of his fellow villagers).

TWO APPROACHES TO HEALTH CARE



VILLAGE HEALTH WORKERS

CAN HELP DOCTORS LEARN

THE SECOND APPROACH

(SFV)

74-7

HEALTH SCIENCES

Effective Health Care for All ! is the slogan of the seventies and great strides are being taken all over the world in the development of alternative approaches in 'Health Care Delivery' so that Health which has been defined by the World Health Organisation as "a state of complete physical, mental and social wellbeing" may become a reality to the millions in the developing and developed world. The Health Sciences have advanced greatly in recent years and the challenge today, lies in making the scientific medical knowledge, available to the common man in the rural and urban areas so that he can begur to participate in the process of breaking out of the vicious cycle of poverty, malnutrition and disease.

This challenge has three important components -

a) The development of appropriate health care programmes and delivery systems which have evolved out of a close interaction of modern medical knowledge and the local economic, socio-cultural and manpower resources.

b) The development of an 'appropriate' health care technology which includes cheaper drugs and simple but scientific equipment and processes.

c) The development of an 'appropriate communication technology' by which the components of a) health care programmes and b) health care technology are made common knowledge so that the people, having been equipped with this knowledge will then actively participate in the planning, organisation, management and evaluation of

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their own health programmes. The word 'appropriate' here has been used to signify that which is scientific but economical; that which is based on indigenous local resources; that which is suited to the technical level of the user; that which does not create major cross-cultural conflicts.

This column of science for the villages will in future be devoted to the discussion of all innovative approaches and 'technologies' that have evolved in the developing world in general and the Indian scene in particular. We see Health Care as an integral part of rural development and we are convinced that all development workers have in one way or the other to deal with health issues in their work. This column will therefore attempt to create a link between the development workers who have community health problems and related issues to deal within the field and the research institutions and field projects where solutions and suggestions to tackle these issues are being researched. We must all begun to adopt a new research technique and i.e.

'Go to the people,
Live with them,
Love them,
Serve them,
Start with what they have
Build upon what they know'

and we hope that this column will keep you in touch with the important and relevant answers arising out of this new technique. We invite all our readers to send us their suggestions and experiences for this column.

In issues Nos 4,5 and 6 of volume 1 we published a tentative list of frontliness in health care in the country. This was not expected to be a complete and exhaustive list since from time to time we come in touch with more and more projects. If any groups were left out, this was unintentional and when we know of them we shall include them in a supplementary list that will be published soon.

In this issue we have begun a bibliography of reference material from India and abroad pertaining to community health. This list is again not exhaustive but only an indication of the type of material that is already available in this field. Here again we would be glad to hear from any of our readers of any other material that they have found useful.

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Book Review

Alternative Approaches To Health Care: Published by the Indian Council of Medical Research and the Indian Council for Social Science Research; Pages 242.

THIS volume is the report of a symposium organised jointly by the ICMR and the ICSSR at the National Institute of Nutrition, Hyderabad, in October, 1976 at which on-going operation research projects in the field of health care were discussed. Some 16 health care projects are described and eight more have been discussed in brief.

The papers in the book may be broadly classified under four major heads : i) Projects relating to nutrition and integrated child health care, ii) Hospital-based project, (iii) Comprehensive rural health projects, and iv) Projects on the basis of health cooperatives. All these projects have been much talked off in the recent times. Though there are many other on-going projects in the country which have not been covered, the volume serves as a useful compendium. This symposium must have affected the 'Jan Swasthya Rakshak Yojna' of the new health ministry as a number of suggestions made have obviously been adopted. It is however ironical that the recommendations are almost similar to that made by the Bhore committee in 1946.

Dr. Thimappaya's paper has tried to identify the needed areas of study, on the basis of the knowledge from these alternative models. The guidelines proposed by Dr. Kamla Gopal Rao to develop new models will be useful for those who wish to start new projects. Some of the important conclusions of the symposium are i) the need for inclusion of safe water supply, sanitary latrines, and disposal of waste within the purview of health care programmes, ii) health intelligence for communicable diseases cannot effectively work within the existing framework. Maintenance of health records in the family is also not a feasible proposition in the existing social and administrative structure, iii) health education and school health in villages are matters which must receive immediate attention.

The symposium also emphasized the need for maximum utilisation of existing resources rather than duplication or under utilisation.

The symposium rightly recommends that the existing rural health care models must be given a fair trial. It does not, however, seem to have realised that this cannot happen as long as 70 per cent to 80 per cent of our health budget continues to be spent in urban areas and a majority of that on big hospitals and super-specialised centres of excellence in medical care, teaching and research—the so-called 'disease palaces'.

Everybody seems to be asking for more funds to improve the health care system. On the contrary, what is needed is the reorganisation of the whole health care structure; to change the priorities from a hospital-based health care system to a people-based health care programmes. Obviously this needs change at far deeper levels and the questions involved are complex. If only front line workers are supposed to work in the existing framework without meaningful involvement of P.H.C. doctors and without any change in the whole attitude towards the health care to the rural poor, the problem cannot be ameliorated. In fact, under such circumstances the resources channelled will only go to help the vested interests to continue their exploitation and maintain the status quo.

The issue of community participation and motivation has not been discussed with sufficient clarity. Though it is commendable that agencies like the ICMR, NIHAE, and ICSSR came together to discuss these important issues, it would have been better had actual field workers with first hand experience in community participation and motivation also been invited to participate. However the Hyderabad seminar is worthy of consideration.

—Narendra Mehrotra
—Ravi Narayan.

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someone had gone on a vehicle to inform the Jorhat Hospital. The crowd was gradually swelling to see the P.M. and I joked that "the public meeting could be held here instead of Jorhat."

It was only at the village I saw that the wound on my right leg was quite deep and went down to the bone. The villagers said 'Bhagavaner leela' (God's play). I replied 'Bhagavaner kripa' (God's mercy). I even repeated a small couplet from an Assamese devotional song that I knew which meant God has saved us. When my wound was being washed a woman from the village offered some Dettol and another brought some clean cloth. Morarjibhai suggested that it would be good to keep a wet pack on the wound. Someone asked 'why not urine?' Morarjibhai said 'that would be better'. I said 'why not my own.' Morarjibhai said 'that would be the best!' So a urine pack was put on my leg by Hasmukh Shah and I was bandaged. At about 10 'O'clock the ambulances started arriving.

From the village 'Tekala Gaam', Kantibhai Desai and I were taken on an ambulance to the Air Force Hospital at Jorhat. Each one of us was checked at this hospital. I was given anaesthesia at about 3 a.m. Later on I was given to understand that I had fractured one bone on the joint of my left shoulder, another on the right wrist, and a third one on the little finger of my right hand. They had also put several stitches on the right leg and that leg too was plastered. Luckily there was no fracture there.

It was indeed a miraculous escape. While five members of the crew gave their lives, the passengers were all saved. I had heard of forced landings where all the passengers would be saved and of crashes where nobody would survive. But there was an incident where five died and the rest survived.

Morarjibhai's luck was seen to be the greatest because all those who died were only a few feet ahead of him and all those who were injured, were sitting a few feet behind him. Among those who were injured, we who were sitting on the right hand side had serious injuries and those who were on the left hand side got away with very slight injuries. Here again Morarjibhai was sitting on the right side but hardly sustained any injuries at all. Among those who were injured and survived I sustained maximum injuries but that too was nothing compared to what could have happened.

Now a few impressions on the whole event. Composure and discipline were the two factors that helped in the evacuation from the aircraft.

Morarjibhai's undisturbed attitude was exemplary. He slept soundly as soon as he went to bed, after being satisfied that everyone was being looked after.

My own feeling was that of gratitude to God for having been merciful on us. I was also naturally happy to have escaped so narrowly from what was certain death. These two feelings kept me cheerful throughout. My cheerfulness definitely helped me to tolerate the pang of the injuries. It might have also helped me in the healing process.

A Roman Catholic bishop and some nuns from a nearby church came and prayed for me in front of my bed. I requested them to read from the 13th Corinthians and sing the hymn 'The Lord is my Shepherd, I shall not want.' A friend brought us some Sikh devotional songs and another a selection of bhajans. The religious atmosphere of Bapu's ashrams was revived in my memory.

Training in Bapu's ashrams seemed to me to be one of the factors that helped me most in getting out of this ordeal, and I would rate faith, hard living, sharing your comforts with your neighbours, and appreciation of music as some of the main aspects of this training.

My stitches were cut on November 14th and I am recouping quite fast. The hospital discharged me on November 25th. But it will take two to three months for complete recovery.

A Model for Village Development in Bangladesh

MD. AMINUL ISLAM*

SAVE The Children Federation/Community Development Foundation, an International Community Development Agency, operates in the U.S.A., Asia, Africa, Latin America, the Middle East, and Europe, to help the children of the Third World by helping them and their parents to change their own communities for a better life. In Bangladesh SCF/CDF began relief operations after the devastating cyclone of 1970. Work continued through 1971 and then in early 1972 as assistance to wartorn refugees. As the critical need for relief subsided, SCF/CDF started housing projects in Chittagong and assisted in irrigation for rice cultivation, adult literacy, and road construction programmes there.

After 1972 we began a new programme called *Community-Based Integrated Rural Development (CBIRD)*, in three villages in Rangunia Thana, Chittagong District. This programme, now expanded to nine villages of four thanas (Rangunia - Chittagong; Mirjapur - Tangail; Ghior - Dacca; and Nasirnagar-Comilla) is serving a population of over 31,000 people in close cooperation with the Local Government and Rural Development and Cooperatives Ministry, Government of Bangladesh.

The agency's programmes carry out a model of development which relies on the ability of rural people to make their own decisions, aided by rural extension workers' encouragement and training to maximize the use of the local resources—its people and its land.

Objectives of SCF/CDF are the following:

i) To help the target population create effective grassroots infrastructure and processes of decision-making for the articulation of activities to meet their priority needs;

ii) To develop the incentive for cost-effective appropriately scaled programmes in agriculture, health services, education, and other activities of social and economic benefit;

iii) To encourage development of local financial networks and investment policies which recycle the added income of the rural poor back into the economy of the target population;

iv) To comprehensively attack the basic deficiencies of the target population through an integration of component services rather than through a single specialized emphasis;

v) To involve local target communities with appropriate regional and national agencies and institutions at the time when such linkages are necessary for further development.

vi) To work on experimental basis for establishing a model of Community-Based Integrated Rural Development (CBIRD) and to sell the idea to the National Government for replicating.

In beginnning a new village programme the first task is to arrange for the villagers to elect a Village Development Committee (VDC). This Committee is generally composed of a cross section of village people such as, farmers, landless cultivators, share-croppers, day-labourers, school teachers, women, and others including traditional leaders. In some cases, however, a few members of the VDC may be nominated by SCF/CDF. The task of the Committee is to: a) assess their own needs, b) prioritize their needs, c) plan projects, d) implement the projects, and e) to evaluate these projects.

These tasks are carried out with the assistance of the SCF/CDF extension worker (Field Coordinator). The Committee is a liaison between SCF/CDF and the village. This Committee also evalu-

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ates the utility of projects, selects projects on the basis of priority and mobilizes the village people to participate in the work needed to get a project completed. The projects are of different kinds. We encourage income generating projects such as Agricultural Project, Pisciculture, Sericulture, Handicrafts like Tabla making (musical instrument), Biri (Cigarette) making, Pottery, etc. to develop individual and community income. In addition to these villages also carry out social infrastructure projects such as health clinics, road construction, school maintenance, family planning, nutrition, health, etc. Project expenses are generally shared by villagers and SCF/CDF. Costs of materials are generally borne by SCF/CDF, with the villagers contributing a share. Indirect expenses such as land or labour are always contributed by the village folk. We gradually decrease the SCF/CDF share and the villagers in turn assume the responsibility of paying total costs for social infra-structure projects with a portion of the profit from income generating projects.

One example of this is that the expenses of the Health Nutrition and Family Planning Programme in one of our project villages is borne by the Village Development Committee. In this way at some point SCF will not remain in that village and the VDC will be self-sustaining to run their programme by their own created funds. The CBIRD programme is designed to demonstrate the concepts and processes of : a) involving community people in planning, b) identifying problems and opportunity in villages, c) assessing needs and priorities, d) mobilizing local resources, and e) pooling external inputs and assistance for implementation of different activities in order to establish a community in continuing development for self-reliance.

Local training staff provide regular guidance and stimulation through training to the villagers. Development of community spirit, leadership and equality in leadership, and skills for development are the centre of the assistance given to villages. We have developed a set of very simple visual materials—"Village Planning" and "Needs Assessment" kits in order to help villagers; a) participate in discussing problems in their community, determining the major problems and in setting priorities for project planning in solving their own problems to develop their life situation; b) how projects for income generation can support social service projects through the creation of a village fund; c) how inputs and outputs can be casted to determine whether or not a village project will be really benficial; d) how village goals can be derived by understanding village condition; and e) how projects succeeded in village and could be tried in another. These materials were all developed and field-tested in the project villages and are all accompanied by instruction for their use. We have used our this visual planning kit in all of our project areas and it had great impact in presenting our philosophy of rural development.

Experiences in Jabra

Jabra is a village under the Ghior Thana in Manikganj Sub-Division of Dacca District. The village is adjacent to the Dacca-Aricha highway and is about 40 miles from Dacca. It is an ordinary village with its share of poverty, food deficit, lack of employment facilities and the many other signs of economic backwardness which are characteristic of the villages of our country. Population of the village is 4,400. The approximate average annual income per family is Tk. 3600/-. 60 per cent of the people are farmers of whom 40 per cent are landless. There are both Muslims and Hindus in the village but mostly the people are Muslim. There are two sections of a Hindu community and they were suppressed by all others. But their artisanship in leather work and pottery has a good potential to raise their economic status and create employment opportunities in the community.

The main agricultural crops are paddy, jute, and tobacco. Of 360 acres of cultivable land, only 180 acres were irrigated. One fulltime SCF representative is posted there as field coordinator who also stays in this village. During October 1975 SCF/CDF started programme in Jabra village. Initially they started with a test project, (roads and embankments) which proved successful and ultimately then CDF started working in full swing.

The Jabra VDC which is formed with the cross section of people is participative, sincere and in-

terested and committed in developing their life situation through the CBIRD programme. The able and efficient field coordinator of SCF/CDF who has two years practical field experience in rural development, worked with the Jabra VDC to guide and assist them.

The most distinguishable achievement among the projects is the "Leather Project" for lower caste Hindus. This project has changed their fortunes. There are about twenty-five families involved in this project. They were poorest of the people working as cobblers and sometimes playing musical instruments was the only source of their income. Socially these people were outcastes and such was their plight that other people even refused to talk to them. Now under the project they have been taught and encouraged to make bags, drums, and tablas. SCF/CDF has been providing the necessary finance, and returns from the sale of the goods enabled them to develop their life and to stand on their own feet.

The other achievement of VDC is the Bidi factory (cigarette). The land and buildings for the factory have been contributed by a village family. The cash capital for the project has been provided by SCF/CDF. The number of workers in this factory are 43 mostly women of very poor class and many were beggars. The VDC with the guidance of SCF field coordinator organized and motivated them to work under this factory. They come to the factory at certain time and take raw materials to their homes, then they work, filling in the Bidi papers with tobacco. There is a paid manager to supervise the worker and to make arrangement for marketing the products. In the initial stage the workers are getting Tk. 4/- per one thousand Bidi. One officient worker can fill up 4-5 thousand Bidi with tobacco in a day. Though it seems that this is very low —still they have a chance to earn which previously they could not. We hope that after certain period they will be able to earn more—when there will be enough facility for marketing.

In another project the VDC has purchased five rickshaws and given them to five landless labourers. These labourers were generally unemployed or underemployed. The persons who received the rickshaw pay Tk. 5/- daily from their income of the village fund as a repayment of the price of the rickshaws. They are earning Tk. 12/- to Tk. 18/- per day in average which ensures a better life than previously.

There is one youth furniture project. Furniture is given on a rental basis to people on occasions such as marriage and other ceremonies and provides source of income for the youth group. They can use this income in purchasing their materials and may spend for recreational activities.

The VDC also started a sericulture project for producing raw silk in collaboration with the *Canadian University Services Overseas* (CUSO). They helped the VDC to train one lady of this village from Rajshahi and this lady is giving training to few other ladies on the job. This is expanding very quickly and seems very impressive. Primarily landless families will receive benefit from this project.

Another project which has been planned this year is the *cattle raising* project for the destitute women and landless families. A total of twenty families, each will receive a milk cow and they will return the cost of the cow in instalments and give a part of their income to the VDC fund for general community welfare.

There are some social service projects. The population problem has been noted as the number one problem of the country and as a development organisation we also have an integrated family planning programme, *Family Planning Through Village Leadership*. The VDC planned this as Health, Nutrition, and Family Planning project. The rate of acceptance through our approach is also impressive. The rate of current users is 24 per cent among the eligible couples. And total 38 persons have been sterilized during this year. The sewing project is intended for women so that they not only learn sewing, but also meet each other and come into clearer social contact. Besides these construction of earthen village roads, culverts, school maintenance, community centre, etc. are included here. These show a broad range of successful projects.

As we are carrying out an experiment in estab-

lishing a model for rural development, not all are stories of success. Similarly we have failures also. In Jabra village, the VDC tried vegetable gardening with a youth group . Dacca office staff arranged for seeds of different kinds of vegetables and they tried to establish a model kitchen garden in the village. The project failed. The reason for their failure was lack of knowiedge as it was not the proper time to grow these vegetables.

To increase the rate of adult literacy in the village, the VDC tried to establish a functional literacy programme. Classes began, but most dropped out quickly as we found that the adult students are working throughout the day to maintain their family and at the end of the day they are tired, just as the class of functional literacy is to start.

The VDC undertook an irrigation project fo farming to increase the food production. But the result was less than 20 per cent of the expected yield, due to low understanding of HYV rice techniques. A similar project was undertaken in one of our villages in Rangunia thana under Chittagong District and that was a successful project in recognition of which the village received government award. Their project had received good agricultural advice.

The CDF staff have reviewed the problems of the project in Jabra in detail and have assisted them in the preparation of a second year plan. The reasons of the failure of Jabra irrigation project are—the seeds were planted late, seedbeds were prepared incorrectly, fertilizer applied too late or too early, and pumps rented from BADC broke down at a critical point. CDF didn't have any agriculture expert also. But recently we have hired an agriculturist who is a graduate from Agricultural University and has three years field experience.

The non-formal visual training materials we have developed in the SCF/CDF office in Dacca began in Jabra village. At our take-off stage we started to design and test the materials with the efficient field coordinator of this village who is experienced in materials development. Then we also tested some materials in Rashiddeohata village of Mirapur under Tangail District. After field testing we finally prepared the visual materials and user's manual for the same. It is a continuous process of field testing, use and modification which takes place continuously. We arranged training for the Jabra VDC with our Needs Assessment Kit, and Village Planner Kit which helped the VDC to understand their village problems, discover the major problems and plan projects in a better way. The VDC is very interested in this visual system of training and villagers were clearly enthusiastic.

Some lessons from our experiment are :

(a) Community leaders are able to assume day to day management and supervision of the programme if they are trained.
(b) Leaders are willing and able to assume responsibilities.
(c) Intensive meetings with local workers coupled with assistance from resource persons can help the village to be self-reliant and to have a better environment in the community.
(d) Sequential visual training materials accomplish at least two major objectives:
    (i) Provide non-literates the opportunity to effectively plan income-generating projects, and
    (ii) Greatly broaden participation in project choice and planning.

Very recently we have developed our non-formal approaches for training (during February 1977 onward). We are still modifying the materials through using in the villages. We used the non-formal approach during our recent project planning session. In all our villages we used the '*Needs Assessment*' kit and accordingly all projects were planned. It is helping the people in open and easy communication among themselves, increased the participation of all sects of people in discussion. We cannot show any clear evidence regarding the impact of the approach on programme now but it appears to use that this approach will be very much useful to the illiterate poorest of the poor to participate in discussions, understand their problems and means of overcoming the problems.

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Vol. I No. 1 May/June 1981.

LINK

Newsletter of the Asian Community Health Action Network.

Editorial

This is the first issue of **LINK**, the ACHAN newsletter. With its publication we initiate a formal communication link with our membership. The preliminary format of the newsletter will include an editorial, a feature article on issues of community health, a review of ACHAN's activities and plans, a report on the programme of one of our members, a "Co-ordinator's Corner" reporting the co-ordinator's activities and a review of publications of interest to our membership with information about how to receive these publications. ACHAN was created to respond to the needs of its members and **LINK** is an arm of ACHAN. In otherwords, the newsletter is designed to provide information which its membership finds useful. It is designed to respond to and reflect **your** wishes. For this reason, the format is flexible. If you feel certain articles are not useful or if you want information about areas we do not cover at present PLEASE LET US KNOW. In addition, we want to **LINK** various community health individuals and programmes with each other. We can do this if you provide information about your programmes, your views, your experiences. Again, PLEASE WRITE TO US. **LINK** is your newsletter. It will be of use if you give your contributions. We look forward to hearing from you very soon.□

Susan B. Rifkin
ACHAN Co-ordinator

Feature

ACHAN : A Brief History

In the past decades a growing number of people have become committed to and engaged in exploring ways by which helath of large numbers of people can be improved rapidly. Under the umbrella of "community health" several groups and individuals have created alternatives to traditional systems of health care delivery which are plagued with the problems of limited resources availability. They have been able to do so, in part because 1) they have analyzed health in terms of its social, political and economic implications, 2) they have viewed community health as the active participation of the community in health care, not as merely the extension of medical services to the community and 3) they have considered health as an integral and crucial part of national development programmes. The more innovative programmes often have grown out of the voluntary agency sector. They have influenced policies and programmes of both the national governments and the international agencies such as the World Health Organization and UNICEF.

Many of these innovative programmes have developed in Asia. Programmes like Jamked in India, Solo in Indonesia and Sarvodaya Shramadana in Sri Lanka have attracted international interest. Community health programmes which share the orientation of integrating health, development and participation have a number of experiences which can benefit everyone who is engaged in this work. Yet, to date there has been no attempt to systematically co-ordinate an exchange of information, personnel and training experience among these groups, secular and religious, on a sustaining basis:

The idea for a formation of an Asian community health network began two years ago among members of an ad hoc planning committee, (see Appendix 1) all of whom had experience in community health work at the local and/or international level. Members of the Committee had made the following observation about community health work in its present stage of growth: Firstly, the term community health could cover a range of programmes from the mere extension of medical services to the community to the active involvement of people in their own health care. As the majority of people in most countries still used the first definition, people committed to the participation of the community in their work found great comfort and support in continuing contacts with others who shared their views. Secondly, people in this latter group found it stimulating, helpful and even necessary to participate in conferences and workshops with others in the region doing similar work. However, they became disappointed in and skeptical of the purpose of these gatherings when these meetings produced no follow-up work or ways of continued contacts and exchanges. Thirdly, efforts for exchange of information, materials and personnel depended on chance rather than systematic coordination. If people knew about the activities or developments in another prog-

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ramme at the national and/or regional level, it was most often only that by chance they met a person associated with or had information about that programme. Thus, in programmes with already scare resources, unnecessary waste and duplication occured due to the lack of knowledge about experiences of other groups dealing with similar problems and/or developing similar activities.

In an effort to discuss and reflect upon these observations with people who had a diversity of experiences and lived in different Asian countries but who shared committment to community health in which members of the community actively participated, during October, November, December, 1979, various members of the ad hoc planning committee visited people throughout the region. These people, representatives from a wide range of national, cultural and religious background validated the observations of the committee and, for the most part, gave support to the idea of the creation of an Asian community health network.. As a first step, plans for a small exploratory meeting were drawn up.

The ad hoc planning committee met in December, 1978 gratefully accepted Dr. Ding's (Chinese Medical Research Centre) offer of sponsor ship and reviewed discussions that had been held with a wide range of people involved in community health in Asia. After considering the interests of various people with whom the ad hoc planning committee had met and the various groups which these people represented, it was decided to invite a group of about 15 people to join the planning committee for a meeting in Bangkok June 21–24, 1980. The committee applied for and was granted a sum of money to convene this meeting by EZE (Protestant Central Agency for Development Aid, West Germany).

The Bangkok meeting created the Asian Community Health Action Network (ACHAN) and mandated it with a three year life span. At the end of this period, the consultation agreed that members present would review the network to see if it had fulfil led the objectives and expectations of the consultation and to recommend either its continuation or demise. The mandate called for a small office with a co-ordinator and a secretary to administer ACHAN activities. It was proposed and accepted that the office in the first instance be located in Hong Kong where both the Chairman of ACHAN and the coordinator live. The consultation suggested that ACHAN begin to function officially on January 1, 1981. In preparation for its work, however, the executive committee of the Board accepted an invitation to travel to Japan to advise and consult the Asian Health Institute which is in the process of establishing a training programme for rural community health workers in Asia.

OBJECTIVES

ACHAN is an explicitedly secular organization and is a functional rather than structural group which has two basic objectives.

The first is to propagate, popularize and pursue a philosophy of community health which:

1. sees health as the physical, mental, social and spiritual wholeness of the individual and the community not the mere delivery of a medical service;
2. gives priority to the deprived members of any community;
3. makes health understandable and accessible to all, using tools such as auxiliary care, indigenous remedies, appropriate technology, concepts of community development, and involvement of the community in planning, implementing and evaluating health care programmes;
4. stresses comprehensive approaches for improving the total health of the community;
5. helps the community to become aware of the broad range of development problems through health work; and
6. views health problems and priorities in the terms in which the community sees them.

The second objective is to facilitate the exchange of infomation, materials and personnel among its members and to help initiate, support and sustain community health work among non-governmental organization in Asia by:

1. providing documentation of Asian experiences in community health done by Asian themselves (this documentation includes research, analysis, scientific evaluation, study and reflection on various community health programmes in Asia);
2. establishing communication and exchange of information among its members through newsletter, exchange of materials and visitations;
3. assisting members when requested to develop training techniques and programmes;
4. assisting the development of national community health networks where they do not exist;
5. facilitating the exchange of programme personnel;
6. in the long term, developing a data bank of people, programmes and technologies as a catalogue of resources.

PLAN OF ACTION

In pursuing these objectives while, at the same time, remaining a facilitating network rather than a bureaucratic organization, ACHAN seeks to expand its membership to include those who accept its philosophy of community health and wish to be involved in the described exchanges. Membership of ACHAN is developed in three catagories. The first is members of the Board of Directors which compose the managing body of ACHAN's activities. The second is ordinary members consisting of programmes, individuals and national organizations who subscribe to ACHAN's philosophy of community health as described above and live in Asia. The third is Friends of ACHAN who subscribe to the philosophy and live outside Asia. All members pay a membership fee.

ACHAN is governed by a Board of Directors working through an executive committee. The Board of Directors consists of one person from each country represented at the Bangkok Consultation in June, 1980. The executive com-

mittee consists of six people including the Chairman of the Board, the Honorary Secretary, Honorary Treasurer, the Co-ordinator and two other appointed members. A list of the executive committee, the Board and the present membership can be found in Appendix 2. The Bangkok Consultation mandated the network to function beginning January 1, 1981. A co-ordinator with a 3-year term of office has been appointed. An office is located in Hong Kong.

ACHAN's activities are geared to reflect the facilitating nature of the network. As mentioned above, a first activity was to send, at the request of the Asian Health Institute, five members of the executive committee to consult on training programmes of the Institute for community health workers in Asia. Other activities will build upon the requests and needs of the expanded ACHAN membership. In order to define concretely such actions, the first step will be to identify prospective ACHAN members, record information about their programmes and/or interests and analyze their potential needs and contributions to the development of community health. To collect this information, a brochure about ACHAN's operations will be printed with a simple ACHAN addressed return form to be completed with programme operations, needs and contributions described. It is forseen this exercise will occupy the first months of ACHAN's official existance.

On the basis of this data, through a continuing dialogue with ACHAN members and with the specific recommendations of the ACHAN executive committee which is scheduled to meet every six months, specific activities will be developed that will help the membership to develop their particular needs. It is already forseen that one such activity will be a regular newsletter containing relevant information about programmes, technologies and other defined interests. Another will be to help develop training programmes for community health trainers in the region. It also is forseen that channels will be developed whereby ACHAN members will be available for consultation upon request by member programmes and other agencies. Other activities also will focus on promoting, assisting and maintaining the philosophy of community health articulated in the objectives.

APPENDIX I

Members of the Ad Hoc Planning Group for an Asian Health Action Consultation.

1. Dr. L.K. Ding, Chairman
2. Dr. Prem John
3. Mr. Samuel Isaac
4. Dr. Hari John
5. Ms. Susan Rifkin

APPENDIX 2

BOARD OF DIRECTORS OF THE ASIAN COMMUNITY HEALTH ACTION NETWORK (ACHAN) :

Executive Committee Members :

Dr. L.K. Ding, Chairman
Hong Kong

Dr. Qasem Chowdhury
Bangladesh

Dr. Lukas Hendrata
Indonesia

Dr. Prem John
India

Dr. Kim Il Soon
Korea

Members :

Dr. Abhay Bang
India

Dr. Manolet Dayrit
Philippines

Dr. Hiromi Kawahara
Japan

Dr. H. Kusnadi
Indonesia

Dr. Park Kyong Wha
Korea

Dr. Sant Hathirat
Thailand

Dr. V.L. de Silva
Sri Lanka

Co-ordinator :

Susan B. Rifkin
Hong Kong

Program Report

Programme	:	Gonoshasthaya Kendra (People's Health Centre)
Director	:	Dr. A.Q. Chowdhury
Address	:	P.O. Nayarhat via Dhamari District Dacca, BANGLADESH.

Short Description of the Programme:

Gonoshasthaya Kendra is a rural community health and development programme. The health programme is designed to operate primarily with paramedics providing preventive care in the village. This includes health/nutrition and sanitation education, immunization (BCG, DPT & Tetanus), family planning (with necessary follow-up), and observation of pregnant mothers for what could be complications. There are four sub-Centres which serve as a working base with facility for simple pathology, minor surgery (including tubal ligation) and doctor referral service one day per week. There is a back-up main Centre with a 15 bed ward and pathology, X-ray and operating facilities.

Apart from providing training of its own staff in paramedic work, pathology, X-ray, operating theatre (most sterilization is carried out by paramedics) and ward duty, training programmes are available for other Government and non-Government groups in community health work, from illiterate grass-roots level through post-graduate level workers.

The main emphasis of the entire programme is on women and their participation/ involvement in various activities which we see as essential if there is to be a change wrought in the socio-economic structure which now exist. We try to recruit workers from the lower levels in the class structure and by giving them appropriate training and responsibility help them prove to themselves (and others) that they are capable of many things which present society considers outside their 'traditional' role (child bearing and domestic 'servant').

Short History of the Programme:

Gonoshasthaya Kendra began as a field hospital during the Liberation War in 1971, using village youths to carry out simple medical procedures. The Organizers, after the war, realized the need for village-based health programme and began training young villagers (mostly girls) to carry out paramedic work. As a result of their work among the villagers, these young prople realized that more than a health programme was needed for the development of the entire village system and gradually various other programmes have been added.

Social Context in which Programme operates:

The workers themselves live and work (in the main and sub-Centres) in a system based on the concept of total community participation and this is carried over into their work which is done entirely in the rural villages of Bangladesh.

Objectives:

To provide preventive health care to the villagers within the Project area, but more importantly, to train the villagers themselves to the realization that good health is their responsibility and help them find means to make this a reality, given their socio-economic situation.

Structure of the Programme:

The Project Director has overall responsibility for the training and implementation of work, but this is not done in an isolated manner. Senior paramedics are in charge of all the sub-Centres and their works and needs of departments responsible for the work in their sectors. An effort is made to make all aware of their particular responsibility in the programme if the overall effect is to be satisfactory.

Personnel in the Programme:

There are 3 doctors for overall participation in/supervision of, the various training programmes, both theoretical and practical. They also serve as the back-up referral at the main and sub-Centres and are responsible for those aspects of professional care for which paramedics are not equipped.

Of the 43 trained paramedics, 11 are village-based (remain in the village working out of their own homes and reporting in to the main or sub-Centres periodically), 20 work out of the sub-Centres and the remaining 12 either work out of, or in (ward, pathology, X-ray, operating room), the main Centre. 15 trainee paramedics are presently doing their field work under the direct supervision of senior paramedics.

Another 15 persons are involved in administrative/clerical work.

Area of operation:

Savar Thana (an administrative unit) with a service population of approximately 100,000 is the base of operation. This is mainly farming and fishing communities, located about 23 miles from the capital city of Dacca.

Target Groups:

Our priority group is the landless and marginal farmers and poor fishermen in the area who must have health care provided in the village as they cannot afford (monetarily or time-wise) to go to clinics or hospitals for this service.

Training :

Paramedic training is conducted through classes in anatomy and physiology treatment of simple diseases encountered in the village, vaccine/immunization procedures and recording, family planning and follow-up methods, ante-natal care, etc. Trainees usually go to the villages with a senior paramedic during the day with the above-mentioned classes being held in the evening. Included in the evening sessions is discussion on various problems/situations encountered during that days work in the village. Training is usually 6–12 months, depending on the progress of the trainee. Refresher courses on various topics are available for seniour staff members.

Other training programmes are dependent on the requirements of the various requesting body, e.g. UNICEF, IRDP, Medical College, Post-Graduate, etc., but in all of these, the emphasis is on getting the student into the village where community health is (or more accurately, isn't), rather than sitting in a classroom discussing how it should be done according to the Western textbook.

Finances:

Gonoshasthaya Kendra is a non-Government organization. The health insurance scheme finances about 45% of the health programme with contributions from NOVIB of Holland and OXFAM, England contributing the rest. The training programme receive assistance from Inter Pares of Canada.

Ways of achieving self-sufficiency:

Complete self-sufficiency will probably only come when the poor finally control enough land and water resources to keep themselves healthy. Our task is to help provide the education and motivation which may help bring this to a reality.

Evaluation methodologies:

Each department head submits a monthly report on all aspects of the programme family planning, births & deaths, immunization, infectious diseases, night blindness, pregnant mothers, etc. These are presented at a regular meeting of all health staff. There is also discussion on whatever problems they may be encountering in their work.

Relationship with Government agencies:

Our working relationship with Government agencies is good and as previously mentioned, a number of their community health training programmes are conducted at Gonoshasthaya Kendra. There is also interaction in planning and presentation of various seminars, workshops, etc.

Significance of the Programme in relationship to government:

92% of the people of Bangladesh live in rural areas and 70–80% of these below subsistence level. Since our programme is village-based and directed at this target group, it is in direct accord with services Government is attempting to provide. However, this does not mean our views on basic problems and the means to solve these are always in agreement with Government and we make use of various Government organized seminars, etc. to present healthy arguments with the hope of reconsideration and change of policy on some issues.

Achievements :

The health programme has a 60 – 70% coverage of BCG, DPT & Tetanus immunization in the service area. As a result of family planning and follow-up activities, it has one of the lowest birth rates in the country. Because of the intensive supervision of pregnant mothers, there were no deaths from eclampsia in our insurred area during the past year. There is a decrease in the death rate from diarrhoea resulting from the training of mothers to treat it early with sugar-molasses (however, due to lack of clean water, there is no decrease in the incidence of diarrhoea).

Shortcomings :

Our health programme has not been able to reach as much of our "target" group as fast as we would like it to due to the powerful socio-political-economic control of the elite. This keeps us searching for and trying to promote some type of programme which can put at the disposal of these poor people, the means to better their socio-economic condition and thus improve their health situation.

As the Project has grown and additional staff has been needed, some have come without the idealism which the "founding" members had. Also, there are people in the country who do not wish to see a programme such as this succeed. A combination of these elements led to a 'strike' early in 1980 which made it imperative for each member of the organization to take a good look at himself/herself, why they were here and who do they really wish to serve – a painful, but hopefully growth-filled experince. A programme such as this has to be a challenge which all accept for the good of all we aim to serve.

Plans for the future:

Success with the villagers themselves taking responsibility for the running of the agriculture loan co-operatives has led us to hope that in the near future they will also be able to take on responsibility for their own basic health care. We would like to train one of the villagers to do this work (unpaid by the Centre) in his own village and our paramedics would be available in a supervisory capacity. We also hope to start 2 more Centres.

Things possible for programme to share:

The success and failures of 9 years' experience and some of the reasons for these.

A training programme which seems to equip the worker to deal adequately with the normal, simple health problems encountered in village life.

Needs of programme:

Dedicated people, able to understand village life and willing to work in a village situation.

Ways and means of becoming more self-sufficient.

Other Comments :

As mentioned previously, due to various situations being constantly met in our village health programme, it become evident that there were other needs which also had to be met – health could not be done in isolation from the realities of daily living. For this reason the programme expanded into a development programme. There is a large vocational training programme (with emphasis on women's training) including jute handicrafts, shoe factory, metal workshop, carpentry and a bakery.

A school was started for the children of the landless and marginal farmers who would otherwise have no opportunity of education. To help the farmers break their dependency on the landowners and money-lenders, our agriculture loans programme began (and seems to be succeeding well). A publications department was added for the purpose of providing relevant health information to village doctors and the villagers themselves in the local language and also for developing teaching aids for our school and adult (village) literacy/education programme. The most recent venture is a pharmaceutical factory for the exclusive manufacture of generic name drugs at low cost.

ACHAN Plans and Programs

Although ACHAN only began to function officially Januari 1, 1981, the executive committee accepted the invitation of ACHAN member, the Asian Health Institute in Japan, to talk with AHI staff about their training programme for Asian community health workers. The first training group was in residence in Nagoya when the consultation took place allowing for some in depth conversations with participatns in the programme. The consultation proved mutually beneficial to both ACHAN and AHI. It gave all of us a chance to express and explore ideas about courses, objectives and methodologies in training programme which would be relevant to the needs of rural Asia. One proposal was to establish a series of training modules from which trainees might chose the subjects most relevant to their own work. These modules might include oriental medicine, basic medical treatment, community development skills, community health worker training, etc. We recently received tenative plans for the next AHI course. When the plans are finalized we shall give details in **LINK**. The executive committee of ACHAN met in Indonesia, March 24–29, 1981 to review ACHAN's early activities and plan for the future. It was decided that a major effort for the next two months would be to publicize the creation of ACHAN and to expand the membership. Brochures are being printed and letters written to help in this effort. Membership forms are attached to this newsletter. Please distribute them to other potential members.

Another area in which ACHAN is beginning to take a serious interest is that of developing programmes to help train trainers of community health workers. It is hoped that within the next year ACHAN in co-operation with other groups interested in this area will be able to create a training course to help those working in community-based health programmes to exchange experiences, materials and skills and to help those who wish to initiate these type of programmes.

ACHAN executive members also discussed the possibility of ACHAN providing consultancy services to people in community health programmes. Giving priority to programmes who are just in the beginning stages. ACHAN will provide exchange and advice upon request. Fees will probably be charged for this service as another means of making ACHAN self-supporting. Consultancy activities need to be examined in greater detail at future meetings.☐

Co-ordinator's Corner

Although only officially in existence for less than six months, ACHAN has received a rather enthusiastic response and support for its objectives and activities. In addition to the one-quarter financial support contributed by its core membeship, ACHAN has now received other large financial contributions to support its administration from the Canadian International Development Agency, Appropriate Technology International (USA) and EZE (Germany). For this assistance we are very grateful. In order to discuss ACHAN and to discover the needs and interests of members and potential members, I travelled to India in February. In Delhi, Prem John joined me and we had discussions with the Voluntary Health Association of India (VHAI). We also met with Dr. Daleep Mukarji, of the Rural Unit of Health and Social Affairs (RUSHA), Vellore, who told us of their plans to introduce a community health management course for graduates in their project area. ACHAN has been asked to co-sponsor a workshop for curriculum course planning in November. We shall provide details in a future issue of Link.

While in Delhi, Prem and I visited WHO regional headquarter and spent a short time with Dr. Mutalik, Director of Development of Comprehensive Health Services. He was very interested to know about ACHAN and told Prem to keep in touch with him about developments.

I then left Prem and travelled to the Third International Congress of Public Health Associations meetings in Calcutta. Here I was able to discuss the creation of ACHAN with members of Asian Public Health Association, WHO, UNICEF and several European friends. It was a good opportunity to exchange views and to learn about developments and concern in the area of Primary Health Care and community based health programmes.

I now sit in Hong Kong until June working to establish office routines, handling membership applications, etc. In June, Prem and I travel to Sri Lanka to meet ACHAN members, Lashman de Silva and Joel Fernando, and to visit others who have expressed interest in ACHAN's work.

One of our members, the International Hospital Federation, with whom we have reciprocal membership, is offering a number of study tours in 1981. These tours are listed below:

10 – 17 May (now fully booked)	Hospitals and Primary Health Care (PHC) in the German Democratic Republic
31 May – 12 June	Child Health Services in Canada
20 – 29 July	First-Line Hospitals and PHC in Mexico
8 – 18 September	Fire Safety in Hospitals and Homes for Elderly and Disabled People

If you are interested, as an ACHAN member, you are eligible to join. For further information write us at the coordinating office: ACHAN, Flat 2A, 144 Prince Edward Road, Hong Kong or to : Mr. Miles Hardie, International Hospital Federation, 126 Albert Street, London NWI 7NX, ENGLAND.

Another member, AHI (Asian Health Institute) is exploring the possibility of holding seminars on herbal medicines in Asia. Could you please send to us any information you have on this subject, any ideas about how such seminars might be executed, any contributions you or anyone you know could make and any other comments you might have. We would very much appreciate your help and reactions to this idea.

Finally, a personal request. We would very much like to hear from you. So please write to us with your questions, comments and ideas. In this way ACHAN can serve you.☐

Publications

Note :

In this first issue of **LINK** we are reviewing some of the publications which appear regularly in the form of journal or newsletters and have international, mainly Third World, coverage. They all can be obtained free; that is without any payment. To receive any of these publication, simply write to the address provided and ask to be put on their mailing list.

Comparative Health Systems Newsletter

Address :

Departement of Community Medicine, University of Connecticut Health Center, Farmington, Connecticut 06032

"This newsletter is sponsored by the Northeast Program for the Cross-National Study of Health Systems, and is supported in party by a grant from the U.S. Dept. of Education to Harvard U and the U of Connecticut" (quoted from **Comparative Health Systems Newsletter** vol. 2, no. 2, December, 1980). Oriented to the academic, this newsletter presents views about issues of health care, reports on recent meetings, summaries of up coming meetings, and information about people engaged in the research of comparative health systems. It also provides information about organizations working in this area. It has a rather extensive review of recent publications which summarizes selected books and theses on the subject of comparative health systems. It provides a fairly comprehensive view about work and activities in this research field.

Contact

Address :

Christian Medical Commission, World Council of Churches, 150 Route de Ferny, Geneva 1211 SWITZERLAND.

Contact is published six times a year in four languages: English, French, Spanish and Portuguese. It presents descriptions, of innovative community health programmes in the developing world discussions about various community health issues such as healing and wholeness and use of traditional medicine and reports of various CMC meetings. To date over 50 issues have been published over the past five-six years. Through its circulation of over 14,000, it provides a range of world wide experiences which focus on the importance of the human factor in health care. **Contact** also reviews meetings, publications activities in the area of community health.

Diarrhoea Dialogue

Address :

AHRTAG, 85 Marylebone High Street, London, W1M 3DE, ENGLAND.

This is a quarterly newsleter published by the Appropriate Health Recources and Technologies Acting Group in London. Concentrating on the problem of child care for diarrhoeal diseases, it uses this problem as a launching point to explore areas such as use of appropriate technology, health education, health auxiliary training programmes and other policies and potentials in the field of maternal and child care. It reports news about MCH programmes, types of treatments, approaches to health problem solving and feature articles on broad policy issues. It also contains a section on practical advise and one on questions and answers about treatment and prevention of diarrhoea and other health-related problems. Articles are written by noted authorities in the field of primary health care and MCH work. Oriented to people working in the rural areas of the less developed countries, the journal focuses on practical information relating to MCH care.

Newsletter (of the National Council for International Health)

Address :

National Council for International Health, 2121 Virginia ave. NW Suite 303, Washington, DC 20037, USA.

This newsletter reports the activities of the National Council for International Health in the United States and news, such as US governmental international health policy, which affects the functioning of the council. It reviews health publications which can be ordered from the Council, announces Council sponsored meetings and reports activities of Council members. It is an information sheet which familiarizes readers with the activities and concerns of US agencies, both private and governmental, in the field of international health care and development policy.

Salubritas

Address :

American Public Health Association, 1015 Fifteenth Street, N.W., Washington, DC 20005, USA.

Salubritas is a quarterly publication in English and Spanish sponsored by the American Public Health Association and the World Federation of Public Health Associations. It is funded by the United States Agency for International Development. It contains feature articles on proramme experiences on both the national and local private agency level, use of appropriate health technologies, and discussion on disease control and other public health problems. In addition, it publishes notes about activities of public health conferences and health training courses and a list of health and health-related publications. World-wide in coverage and concentrating on developments in the less developed countries, this newsletter is designed to exchange experiences and ideas of and for public health practitioners who need practical information about how to confront broad health problems.

World Health Forum

Address:

Dr. A. Manuila, Director,
Health and Biomedical Information Programme,
World Health Organization,
1211 Geneva 27,
SWITZERLAND.

World Health Forum, and international Journal of health development, is a new quarterly intended for health planners and administrators, teaching staff in schools of public health and similar institutions, and anyone else interested in primary health care.

Meant to be a forum for ideas, the editors hope readers will submit articles, letters, essays and book reviews for publication. The first issue (Vol. 1, Nos. 1 and 2, a trial issue) carries articles on mental health awareness in Honduras, drug costs in Sri Lanka, and an essay entitled "The malaria programme - from euphoria to anarchy." World Health Forum is published in English and French.

Application For ACHAN Membership

Do you want to join ACHAN?

Members of ACHAN are those who subscribe to the ACHAN philosophy of community health, and pay membership fees.

As ACHAN is working toward self-sufficiency, we are asking for the membership fees listed below. This amount is a **minimum** contribution. We would be grateful for any additional payments.

Ordinary membership (those who live in Asia):

Organization and Programme	US$ 25.00 (or equivalent in local currency)
Individual	US$ 10.00 (or equivalent in local currency)

Friends of ACHAN (those living outside Asia)

Organization and Programme	US$ 100.00
Individual	US$ 25.00

These dues cover the period until December 31, 1983. Checks are made payable to ACHAN. They may be sent to our Hong Kong office at the following address :

ACHAN,
Flat 2A, 144 Prince Edward Road,
Kowloon, HONG KONG.

or in local currency, where possible to the Board member of your country whose address is listed below:

Bangladesh :
Dr. Qasem Chowdhury,
Gonosasthaya Kendra,
Nayarhat via Dharmari,
Dacca.

India :
Dr. Abhay Bang,
Friends Medico Circle,
Gopuri, Wardha 442001.

Dr. Prem John,
Deenabandu Medical Mission,
R.K. Pet 631 303,
Tamil Nadu.

Indonesia:
Dr. Lukas Hendrata,
Director,
Yayasan Indonesia Sejahtera,
P.O. Box 3028,
Jakarta.

Dr. H. Kusnadi,
P.K.U. Mohammadiyah,
Jalan Menteng Raya No. 62,
Jakarta Pusat.

Japan:
Dr. Hiromi Kawahara,
Director, Asian Health Institute,
Hara Hospital,
3–17 Wakatake–Cho,
Chikusa-ku, Nagoya 464.

Korea:
Dr. Kim Il Soon,
Professor and Chairman,
Department of Preventive Medicine,
Yonsei University College of Medicine,
Yonsei University, P.O. Box. 71,
Seoul.

Philippines:
Dr. Manolet Dayrit,
c/o Dr. Mite Pardo de Tavera,
AKAP, 66 J.P. Rizal St.,
Project 4, Quezon City.

Sri Lanka:
dr. V.L. de Silva,
117 Uyana Road,
Lunawa, Moratuwa.

Thailand :
Dr. Sant Hathirat,
387, Soi Soon Vijai 4,
New Petchburi Road,
Bangkok 10.

Vol. 1 No. 2 Sept/Oct. 1981.

Newsletter of the Asian Community Health Action Network.

Editorial

ACHAN, as most of you know, was established to answer a need of people and programmes in the non-government sectors for exchanges of materials, information, personnel and ideas. However, the network encourages members from government offices and recognizes the importance of governmental resources and programmes in improving the health of the vast majority of the Asian people. The interface and interaction among the voluntary agencies and government departments is one of great interest to ACHAN. For this reason, our "Feature" this month begins an exploration into these dynamics by focusing on the case study of India. Written by ACHAN executive committee member, Prem John, it is the first in a series of articles to look at this relationship.

There is no doubt that the majority of expenditure for health services of a nation must be borne by the government. Only the government has the necessary income and resources to provide a nation-wide health network. In many Asian countries in the past, voluntary agencies notably the Christian Church, supported a sizeable portion of nation-wide health services. However, with the emergence of Asia from a colonial era and a strengthening to national independence and pride, Asian countries now have both the desire and responsibility to provide adequate health care for their nationals.

The voluntary agencies still have an important role in national health care. Because of flexibility, their committment to the poor and oppressed and their new and innovative ideas, they often chart new directions for government health care delivery system. The national policy to train community health workers in India is one example of the impact of non-government programmes who experimented with the CHW's long before government had any interest.

The greatest value of the voluntary agencies is that they are concerned with people. They are able to live and work with individual persons rather than a whole bureaucratic system which must be seen to be giving all persons equal access regardless of need or income. The voluntary agencies have had an important impact on moving government priorities from curative institutional care to community health in many countries. ACHAN seeks to support this movement and support the voluntary agencies in exchanging ideas about how their impact on government can be the greatest.

Susan B. Rifkin

ACHAN Co-ordinator

Feature

The Health Care System in India — An Overview

Prem Chandran John

" . . . . . medicine . . . . . superb in its technological breakthrough but woefully inept in its application to those most in need".

– Rex Fedall [1]

The health care situation in India today truly reflects Fendall's concern. A system that is wholly inappropriate for the needs of the majority has been allowed to flourish. A 'Western' scientific approach has produced a view of health and a system of health care delivery which is acceptable and available to a minority of people and often only to those who have financial resources to afford doctors, drugs and a healthy environment[2]. This article seeks to analyse the present trends, the past statistics and plans for the future as expressed by both the government and the voluntary sectors.

Inequitable distribution of resources:

Thirty four years after Independence, the health care system continues to be broadly patterned on the colonial system with very few modifications. It was assumed that 'medical interventions' i.e. training of doctors and other health professionals, provision of services and taking of modern medicine into the countryside will improve the health status of the majority. (Table I)

Table I

	1947	1980
No. of Medical Colleges	29	106
No. of Doctors Registered	47,500	253,631 (1978)
No. of Dental Colleges	4	15
No. of Dentists	1,000	7,419

Not taken into significant account was the inequitable distribution of health professionals, then and more so, now. That 80% of the doctors are concentrated in the larger towns serving a population of 20% while 80% of the population of India lives in the villages has become a well worn cliche but is a painful fact. Also, out of those who register, migrations and deaths are not removed and continue to stay on the register. Under the circumstances, to say that India has achieved a doctor-Population ratio of 1:4,500 is a delusion but increasingly quoted by knowledgeable circles to the world at large. (see Table II)[3]

This paradoxical situation is also seen in the statistics relating to hospitals, (see Table III) beds and registered nurses.

An earnest attempt at providing medical care to the rural communities was made with the introduction of Primary Health Centers (PHCs) designed to serve populations of 100,000 each, roughly based on the National Development Blocks[4].

Very often though, these centers were situated in unlikely places as a matter of political expediency and were subject to enormous interference by various functionaries of the Government which impeded their usefulness[8]. Not taken into account was also the fact that doctors when posted to rural areas went on leave, practised in nearby towns (since private practice is permitted by many states), and in many instances, spent only an average of one hour in the PHCs per day. (For a fuller account please see 'The Health Center Doctor in India, 1972, Johns Hopkins University Press').

Medical Education:

Medical education in India (which is another topic that deserves in depth treatment by itself) continues to be curative oriented, urban based, almost a personal fiefdom of the ruling elite and out of touch with the realities of rural India. Inspite of all expansion, doctors are still largely urban-based; and their distribution between different states is uneven. Standards have improved in some institutions and some sectors, but the average has declined considerably because of the proliferation of sub-standard institutions (that is what has happened in all branches of higher education). The medical education system and the health care delivery system have each gone their separate ways. There is little congruence between the role of the physician and the needs of society, little equilibrium between medical education and health care. Medicine is still regarded essentially as an enterprise of science and technology. The physician is the repository of all knowledge and dispensation.

Specialization is the hallmark of progress; and the training ground is the teaching hospital. Recent efforts to change this unhappy situation to produce the 'right' kind of doctor and to give a community orientation to produce the 'right' kind of doctor and to give a community orientation to medical education have yet to make any meaningful impact[3]. Thus indicts "Health for All".

Table II

Population	660 million (1979)	Rural 80%	Urban 20%
Doctors Doctor-pop. ratio	235,631 1:4500	20% 1:20,700	80% 1:1,300

Table III

		1950	1977
No. of Hospitals		6,168	17,607
No. of Hospital beds		113,000	449,212
Distribution	Urban 90% Rural 10%		
No. of Nurses		7,000	120,401
Distribution	Urban 90% Rural 10%		

Table IV

	1951	1961	1971	1979
No. of PHC's	Nil	2,800	5,195	5,423
No. of Sub-centers	–	–	32,218	40,124

Table V
Per capita expenditure on Health

Year	Per Capita Rs.
1956	1.50
1961	2.35
1966-67	3.79
1973-74	7.72
1974-75	9.47
1975-76	10.63

Table VI
Outlays on the Health Sector

Plan	Total (in millions of Rupees)	% of total Plan outlay
I	1,009.0	4.98
II	2,378.2	4.58
III	2,255.6	2.60
IV	4,335.3	2.14
V	7,960.0	2.13

Resource allocation:

The "health plan" in India is conceived by the Central Government and implemented largely by the States. Both the Centre and the States expend money on health.[5]

The apparently impressive in-increase of per capita expenditure from Rs.1.50 to Rs.10.63 and of the allocation from Rs.1009.0 million to Rs.7,960 to the Health Sector does not accurately reflect the situation. The purchasing power of the Rupee has declined proportionately (to the present Rs.0.24 in relation to 1954 base)[6] and the population has increased from 350 million to the present 686 million. Thus we probably spend the same amount on health as we did in 1956. Of more concern is the disparity in allocation between rural and urban areas. Only 1/5 of the total health budget goes directly towards rural health care while 4/5 go towards maintaining sophisticated facilities inaccessible to the majority (for e.g. in the IVth plan out of the total outlay of Rs.4333.53 million only Rs.700 million was allocated for rural health care). Also to be taken into account is the increasingly large (from Rs.4.0 million in this Ist plan to Rs. 3,009.3 million in IVth plan[5]) and often wasteful allocation to Family Planning. (Of interest also is the estimate that over 75% of the health budget goes towards salaries and maintenance 12% towards transport and 12% towards drugs leaving little for innovative community care). The point is, that in terms of real allocation it has probably remained at the same level since 1956.

Drugs:

"Health for All" puts the situation pertaining to drugs and their availability succinctly. "It is not enough to see that drugs are produced by Indians and in abundance. It is even more important to see what drugs are produced and for whom."[3] Out of a total production of Rs.1000/million (in 1976) 25% was taken away by vitamins and tonics, 20% by antibiotics[4]. The drug industry in India is patterned on the West and in many cases depends upon the West for ideas, raw materials, the latest technology and marketing techniques through their parent companies. It is not surprising therefore that the pattern of drug production is very similar to that in the West and reflects the needs of the richer, longer living Euro-Americans, while diseases of poverty get scant attention (e.g. Dapsone for Leprosy and INAH for TB are constantly in short supply.)

The medical profession, actively in collusion with the drug industry and aided by Madison-avenue type of advertising, and pushy medical representatives, tend to over-prescribe, resort commonly to multiple drug regimens when a single drug would do, use combination drugs when not indicated (eg. Tetracycline + Vitamin C separately and generically are 50% cheaper than the combination Resteclin), and have developed the habit of prescribing glamourous brand name drugs promoted by multi-national companies. As a result, most prescriptions are beyond the reach of the common man.

The Common man:

Who is this 'Common man'? The Reserve Bank of India in a recent study has found that 75% of the rural poor live below the poverty line. This is corroborated by the Planning Commission which says that those living below the poverty line have crossed the midway mark and for the first time constitute 50.26% of the population.[11]

This large segment of the population does not earn enough to have purchasing power to provide themselves with even 1500 calories per day per head.[7,10] The planning commission also says that at the prices prevailing in 1980, this level is pegged at Rs.660 per head per annum.[5] Various surveys by various agencies show that the great majority in rural areas live on about 50 paise a day per head[10]. That leaves little scope for them to compete in the same market for services and goods pertaining to medical care. The uncontrolled market economy patterned on the 'capitalistic' West in the face of wide disparities has left the majority of the population to the tender mercies of the cartel consisting of the drug industry – drug stores – and the medical profession. This has resulted in medical care being out of the reach of the common man in the absence of concerted efforts at analysing and identifying forces which cause ill-health, that are primarily socio-economic. If, as Mahler says, "Health is politics on a Social Scale", what are we doing about it in India? Are the present health plans including "Health for All An Alternative strategy" relevant to the needs of the country? What has been the role of Voluntary Agencies in health care so far and what should be their role? We will seek to analyse these in the next installment of this paper.

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4 Pocket Book of Health Statistics of India Central Bureau of Health Intelligence, 1976, Government of India, New Delhi.

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6 "On the Incidence of Poverty in Rural India", 1971, P. Bardhan, ISI Planning Unit, New Delhi.

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8 The Health Center Doctor in India 1972, Johns Hopkins University Press, Baltimore.

9 Poverty in India, Dandekar & Rath 1971, EPW, Bombay.

10 Church and Social Justice – CSI Synod Bangalore, 1976.

11 The Statesman, Calcutta 19.3.81.

Program Report

Programme : AKAP

Director : Dr. Glorioso V. Saturay

Address : c/o Dr. M. Pardo de Tavera, Chairman, AKAP
2226 Paraiso St.,
Dasmarinas Village,
Makati, Metro Manila,
PHILIPPINES.

Short Description of the Programme:

AKAP is a private non-profit, non-stock, organization duly registered under the Securities and Exchange Commission designed to meet the vast health needs of the poor especially those in rural areas.

Short History of the Programme

In 1974 a 3-year research program was initiated in urban/rural depressed areas with the objective of testing the operations of a TB-control program within the framework of a primary health care community-based program. (see Appendix A)

Based on these experiences AKAP was organized in 1978 and a larger scale version of this program was designed to meet the health needs of rural people.

Social Context in which Programme operates

In selecting areas the choice was narrowed down to depressed rural areas with scarce or non-existent health facilities with overwhelming problems of malnutrition and a high rate for communicable, preventable diseases.

Objectives

To provide an effective low-cost community participative, self-supporting program to cover the primary health needs of people with special emphasis on the control of TB and other communicable diseases.

Structure of the Programme

Since eventual self-reliance is the basic principle of AKAP's community based health/TB control program, local support and participation is the main thrust of the program, the role of AKAP's professional staff is one of health promoter, trainer and resource person.

Personnel in the Programme

Organization of the community is the role of the community health educator.

The volunteer community health workers (CHWs) elected by the community receive training in health-related issues and in primary health care after first being made aware of the problems affecting their lives and community.

From trainees the CHWs later become trainers.

The brunt of the training is done by the nurse/health educators. Upgrading, re-training and keeping optimum standards is another responsibility of the nurse.

The regional physician participates in ground-breaking i.e., introducing the program maintaining good working relations with community leaders, health agencies, establishing linkages, assisting in trainers-training and supervising the program.

There is a training team who aside from supervising the areas responds to the needs of other communities and organizations interested in adopting the same program.

Area of operation

Through numerous linkages AKAP is involved in propagating the program and directly or indirectly involved with many programs throughout the country.

The types of services are:

a) training of CHWs, health professionals and other sectors in primary health care.
b) rendering health services to economically depressed areas.
c) conducting research on various aspects of the prevalent health problems and needs for the purpose of identifying possible solutions.

Target Groups

Rural people who are beyond the reach of government/private health.

Training

Training is done in the community. A requirement for establishing better rapport with the community is for the training staff to integrate with the community so as to understand their needs and devise methods how best to reach them within the framework of their culture, beliefs and superstitions.

Training materials have been adapted to the comprehension level of the recipients of the program and is based on an evocative method.

Finances

Entirely from private donors.

Ways of achieving self-sufficiency

Through contributions of the community members for health services, medicines received are used to fund their health program.

The health workers do not receive renumeration for their services. In return for their time the community assists the health workers in endeavors from which they are kept away from in the discharge of their duties.

Evaluation methodologies

Evaluation is done by the community itself through a series of dialectic sessions. Strong and weak points of the program are openly discussed. Self-criticism is part of the process. These meetings are held periodically with the visiting AKAP staff.

Relationship with government agencies

On the whole there is a workable relationship with government health agencies. In areas where they are unable to penetrate for lack of manpower AKAP's services are welcomed, in fact, sought by the local health units who for lack of manpower, technology, medical supplies and laboratory facilities make use of AKAP's resources.

Significance of the Programme in relationship to government

To use the words of UNICEF and WHO, AKAP is a bridge between government and people and, therefore,

partners in the government's endeavors to reach more people especially in line with their primary health care program.

Achievements

AKAP has shown the workability of CBHP (Community Based Health Program) using local manpower resources and adapting to the prevailing situation.

In the field of TB control the results obtained support the stand that in developing countries with budgetary constraints and plagued by problems of maldistribution of health personnel, widespread poverty, malnutrition, a high rate of communicable diseases and overpopulation, a CBH Program involving people is the rational approach to meet the basic health needs of people.

Shortcomings

Because of different ethnic groups in the country the approach has to be modified and adapted to suit the community in question.

Plans for the future

To attempt setting-up other models, such as a multi-disciplinary approach to health involving agronutritionist, community developers, veterinarians, environmental sanitation, cooperative experts-the thrust of such an approach being more health-promotive and disease preventive.

Things possible for Programme to share

Training materials and a modest amount of expertise.

Needs of Programme

Funds to conduct field researches on various aspects of the program, such as, the application of folk medicine in present-day primary health care programs; search for ways of controlling malaria and other protozoan diseases other than thru chemical means.

Other Comments

AKAP looks forward to the creation of a resource center on Asian Primary Health Care Programs.

APPENDIX A

TB TRANSMISSION IN THE PHILIPPINE SETTING ENVIRONMENTAL AND SOCIO-ECONOMIC FACTORS*

M. Pardo de Tavera, M.D.

INTRODUCTION

There are rare occasions when one feels truly honored, like this morning. Selected from among many TB specialists to speak on tuberculosis, and the environmental and socio-economic factors affecting its transmission rate. Rather curious that among the speakers I should be the lone representative from the non-government health sector perhaps expected to be less restrained in my assessment.

PART I

1. ENVIRONMENTAL / SOCIO-ECONOMIC FACTORS.

To begin, let us take a critical look at the prevailing TB situation. Despite the millions spent to control TB, WE HAVE FAILED in our efforts for many reasons. The persistence of TB, its high mortality and morbidity rates as compared to our ASEAN neighbors is reflective of our ailing health/TB delivery system.

We developed specialists when we should have developed generalists, in order to meet the challenge of a prime disease among Filipinos, a problem of alarming and serious proportions and consequences.

Instead of fighting TB within the rigid walls of hospitals and centers we should have been right there where the action is – with people.

Lamentably, the curative approach to TB received maximum attention, over and above the public health/preventive approach. In our haste to emulate sophisticated western methods that tend to favor the institutional/curative approach we forgot the time-honored proverb that "an ounce of prevention is worth a pound of cure".

Since TB is a threat to the health of people, instead of curing TB on a case-to-case basis we should have adopted a more relevant strategy, a community approach. Because we failed to do so TB has reached the status of being a family disease widely spread in cities and communities. Moreover, the indications are that the incidence of TB is increasing and not decreasing.

Erroneously, TB was viewed as a medical problem and, therefore, we searched for and applied medical solutions forgetting that TB is a social disease requiring socio-economic solutions of a preventive and curative nature aimed at improving the quality of life of people. Curing the environmental/socio-economic ills is as important as medical treatment. TB and poverty are intertwined. Poverty breeds TB and TB breeds poverty. Drugs, super-specialists, clinics, hospitals, centers do not cure poverty.

Tuberculosis is unique in that it exposes the defects of a social system. It is a social disease, the underprivileged being particularly susceptible to it. The "haves" are those possessing material means, as against the "haves-nots". Another dimension to this is that the "have-nots have TB" and the "haves don't have TB".

From the viewpoint of the social scale, the poor are the more prone to diseases and malnutrition. Their environment is hostile. Their lives are miserable, subjected to a constant scarcity of essential goods, facilities and money, a high rate of unemployment or underemployment, inadequate health facilities, illiteracy, ignorance, isolation of communities by distance and poor communication, inequitable land distribution and tenure systems prevalent in a rigid class structure. These are people who are not heard, are not represented and have no-say nor influence in shaping their lives and future. They live in a "rut" from birth to death.

The single most important factor influencing the mortality rate is the deficient nutritional state of the deprived sector of the population. Riding on the crest of malnutrition is tuberculosis. TB and malnutrition are the result of poverty, squalor and ignorance.

Overcrowding brings people closer together, which favors a high incidence of airborne infections like TB. Visualize one-room barong-barongs measuring

3. A REFORMED HEALTH/TB SYSTEM.

Controlling TB has become a numerical nightmare. On one hand, we have a widespread communicable disease responsible for an annual loss to the economy of 600 million pesos, and on the other hand, a centralized rigid health system saddled with budgetary limitations, shortage and maldistribution of health manpower, not enough to meet the demands of such a big health problem.

It is felt by the pioneers in primary health care in the country that, in order to effect a reform in health care it is necessary to effect a change in the social/cultural structure. Instead of dictating and imposing a health system with people as passive recipients the thrust should be to involve people as active participants in planning and promoting community health. The spirit of "one for all and all for one" has to be instilled and hitched to a higher ideal.

Initial efforts in community-based health program saw its genesis in the local scene, in 1974. At the same time the Alma-Ata conference on primary health care was held in Russia in September 1978, a report was read in Brussels at the International Union Against Tuberculosis based on a research entitled, "A model of community participation in the prevention and short-term therapy of TB among the poor in Asia – A Philippine experience".

This research proved that if people are properly motivated they are willing and eager to accept the responsibility of their primary health care. The motivation goes beyond the health program because it symbolizes people's struggle to free themselves from the bondage of ignorance, poverty and disease. It embodies an ideal bigger than self. This is the driving force.

From a rigid centralized health system the wind of change is towards decentralization involving people. It is a health program of people, by people. In many ways it is humanizing a system that has become insensitive and impersonal. The change was predestined to occur because of people's growing dissatisfaction with health services. The handwriting was on the wall but it was ignored.

People are aware of their health requirements but do not possess the necessary skills anymore. At one time, one or two generations before, they had been able to attend to common ailments through the use of medicinal plants and applying hand-me-down household remedies. Carried by the wave of westernization all this was forgotten or disparaged. The poor were left with nothing except dehumanized, offending "charity services" inaccessible to most. Only the economically favored could afford the high cost of drugs and medical care.

To be successful, a health program should be patterned after the life style of the people it is designed to serve. Teaching aids should use symbols they understand. Teaching should be based on an evocative method so as to elicit response for it is through response that barries are overcome.

Since TB has reached the status of being a prime disease it is our opinion that TB control services should be available at the primary level. The Carmona experience has proven that primary health care/TB control program of people and by people is feasible, inexpensive and assured of success. Properly trained and supervised voluntary community health workers are the best harbingers of health. They have a way of echoing and reechoing health messages that are easily understood. Power is with people. Properly guided, only people can transform society.

In primary health care/TB control programs, nurses are best suited to perform the functions of generalist, educator, motivator, supervisor and organizer. They have the capability to harness the potentials of people. Their educational background has well prepared them to expertly deliver primary health care from the comprehensive, preventive, promotive and rehabilitative approach to simple curative and emergency interventions. The nature of their profession has identified them closely with people, with the human more personal side of health care.

TB is not the exclusive problem of an individual. His problem is the problem of his family, contacts and community. Approaching TB on an individual basis achieves only individual TB cures. But what we need is to control TB on a nationwide basis. The methodology for TB control consists of: health education, BCG vaccination, case-finding of contagious cases by sputum microscopy and adequate treatment of all infectious cases.

CONCLUSION

Independently and unknown to each other a small band of disenchanted health professionals turned their backs to the conventional practice of their vocation, from the curative approach to health promotion. This was less than a decade ago. Despite the traumatic personal experiences of steering away from the "establishment", the driving force was compassion for the poor and the meek scattered throughout the countryside representing the majority of the population and for whom the existing sophisticated medical system had not been designed to serve. The evidences supportive of this statement are undeniable. They are day-to-day reality and passively accepted as a way-of-life. Foremost among the endemic communicable diseases sapping the strength and decimating our people is tuberculosis.

In the field of TB great discoveries have been made. We know what causes TB. We know how it is transmitted and how environmental and socio-economic factors favor its transmission. Furthermore, we know how to prevent TB; how to cure TB. Equipped with all this technical knowledge we should have controlled TB like many of our ASEAN neighbors but have we? Awareness of the shortcomings of the national TB control program in terms of its implementation has not effectively dented the armor of resistance to change. In fact, the few who have dared to speak out the truth are not looked upon with favor for truth hurts.

Looking beyond constructive criticisms and theories and in search for a new direction efforts were exerted in delivering TB services together with primary health care. The results obtained in poor communities proved the wisdom of bringing the health program to the level of the community and through community participation. It

also proved that people are willing and capable of change if given the skills. People's education, organization and mobilization is the key to progress and liberation from poverty and disease.

The experiences of the non-government health sector in the delivery of primary health care continues to be enriched. Recently, the government health sector has expressed its intention to go into the same field of endeavor and not counting with actual experience would do well to support the successful primary health care efforts of the private sector beyond mere words thus maximizing joint efforts to return to people what is due them. The right to good health is a basic human right. Hence, the issue of health is a political issue.

* Presented at the University of the Philippines College of Medicine/University of the Philippines Medical Alumni Society Post-Graduate Medical Course on December 21, 1979.

Co-ordinator's Corner

ACHAN now has a cable address. It is HEALTHNET, HONG KONG.

ACHAN work took me on a six week trip to Sri Lanka, Amsterdam, Geneva and England. In Colombo, Sri Lanka I met Prem and we spent time with ACHAN executive Board member, Dr. V.L. de Silva, and Dr. Joel Fernando. Meetings were arranged in Colombo to meet various people engaged in community health and we did field visits to Hatton, to the tea estates, and to Kandy. An ad hoc committee for a consultation on co-ordination of community health activities has been set up. They are planning to hold a consultation in November to which the ACHAN executive committee has been invited. Reports of the meeting will appear in LINK.

Also in Sri Lanka, we met Dr. H. Weyers of the UN Volunteers. Weyers and his replacement Mr. P.T. Kurikose are beginning to support a programme of exchanges among people in community health programmes in Asia. Many of the programmes who will accept trainees are already ACHAN members. If you are or know of people interested in spending some time in another Asian country working in a community based health programme, please write us and we will supply details of these exchanges.

In the Netherlands, I attended the conference on Social Science and Medicine and met some old friends and new people. There were few representatives from the Asian region, in fact from the third world, as funding has become such a problem. For this reason, interest in third world health problems was not as great as it might have been. There is great interest, however, in both self-help/self-care movements and women's health movements. During these discussions, points were put forward that had some applicability to non-Western countries. I also visited an old friend of many ACHAN members, Dr. H. Middlekoop and received both advice about and support for ACHAN's work. I spent an afternoon with Interchurch Coordination Committee for Development Projects (ICCO) where we receive a positive response about funding the RUSHA consultation.

In Geneva, I had discussions with the Christian Medical Commission staff and told them about ACHAN. I spent some time at WHO visiting various offices and meeting various people involved in PHC work. While most discussions were primarily information exchange about ACHAN and some of WHO's policy work, I did have a most interesting talk with Dr. David Pitt and Dr. P.M. Shah in the Division of Maternal and Child Care. They are exploring various innovations in the area of PHC and MCH and are open to any ideas that might come along. One area of activity is publishing a variety of papers which discuss issues and activities in health care. As some of these papers are quite controversial, WHO has not officially given their stamp of approval. However, they are being mimeographed and circulated on an individual basis. Pitt and Shah are also interested in exploring non-government programmes in terms of community involvement. They are considering holding a workshop in Asia concerned with MCH work and community participation.

In England, I spent time with Dr. David Morley of the Institute of Tropical Child Health, Dr. Patrick Vaughn of Evaluation and Planning Centre for Health Care, The Ross Institute of Tropical Hygiene, London School of Hygiene and Tropical Medicine and Dr. Katherine Elliott of AHRTAG (Appropriate Health Resources and Technologies Action Group). We exchanged ideas, information and materials on matters of mutual interest. I also visited Michael Hawkes and Ken David at Christian Aid and Bernard Llewellyn and Glen Williams at OXFAM.

I also met with people at the King's Fund and the International Hospital Federation. John Ranken of the King's Fund is keen to begin training of health workers in the field rather than in London. They have a fledging programme in Africa and he is interested in expanding in Asia. Just now they are training hospital administrators and health workers from third world countries in course in England. However, they realize how inappropriate this setting is and wish to investigate the possibility of doing some courses in the third world, perhaps Asia. We exchanged ideas about this approach and I asked he keep us informed. I also spent time with Emanuel de Kadt, IDS, Sussex who tells me that IDS is considering holding a health seminar in Asia next year.

ACHAN Plans and Programs

When the ACHAN executive committee met in March, it was asked to consider the possibility of jointly sponsoring with an ACHAN member, the Rural Unit on Social and Health Affairs (RUSHA), India a consultation on the possibility of creating a course for rural community health managers in Asia and particularly India. After discussions, it was agreed to join the sponsorship of this consultation. It will take place in India in February, 1981.

The consultation is the result of many years of interest and experience of the Voluntary Health Association of India (VHAI). VHAI is the largest co-ordinating body of non-government health programmes in India and is a strong supporter of community health as defined in the ACHAN consultation. For some time now, VHAI has wanted to create a training course for local people which could teach people how to become good managers of rural community health programmes in the same manner that it taught people to do good hospital administration. It saw no reason that it was necessary to send people to countries, like the U.S. and the U.K., to get training in conditions almost totally opposite to those existing at home.

After several experimental courses including short term training and an internship programme which lasted one year, it was decided to create a course equivalent to a diploma in health management. The site and administration of the first course is to be RUSHA in K.V. Kuppam North Ascot District, Tamil Nadu.

The training course would be useful to people who are managers and leaders in both voluntary agencies and government community health programmes. The general objectives of the course are to train people to do the following:

1. Ask effective questions –
   (a) about health issues in the country;
   (b) related to socio-economic and political systems of the national level and how these affect local community;
   (c) which challenge people to think about and find solutions to their problems;
   (d) which lead to the creation of true communities with common purpose and goals for the betterment of the life of all members.
2. Use problem-solving methods in cooperation with other team members and in collaboration with communities to find solutions to common problems.
3. Plan, organize, implement and evaluate community health and development programmes effectively through
   (a) ability to relate effectively to communities;
   (b) assisting communities in identifying their needs and resources and organizing them to become actively involved in their own health and self development;
   (c) providing for technical assistance needed to carry out programmes in the community;
   (d) coordinating with government and other agencies needed;
   (e) ability to discover and understand the special dynamics in any situation affecting the health and development of the people.
4. Act as a change agent in order to make health a means and a measure of development.
5. Understand the team concept, and will have shown the ability to take a leadership role in the team.

It will stress learning experiences rather than methodology and stress field rather than classroom. It is hoped that based on the RUSHA experience, other training centers will be established in India.

In light of ACHAN's training priority and the recognition of the necessity of training people who can function in their own existing rural conditions not in the medical schools of the Western countries, the ACHAN executive agreed that sponsorship for a consultation on developing a curriculum for the RUSHA course would be an appropriate ACHAN activity. We noted that RUSHA wished to train others in addition to Indians and expressed a strong desire to get advice from other Asians about how to make the training appropriate. Thus, it was decided to help RUSHA with fund raising for the consultation and with suggestions of appropriate Asian participants.

The executive committee meets in November in Madras, India at which time it will join VHAI and RUSHA for a three day meeting to further plan the consultation. Reports of the consultation itself will appear in LINK after it has taken place.

Publications

This issue of LINK reviews some of the publications available for training community health workers.

Brown, Judith and Richard Brown. **Finding the Causes of Child Malnutrition.** Task Force on World Hunger, 1979.

Available from. Task Force on World Hunger, 341 Ponce de Leon Ave., Altanta Georgia, 30308.

Price: US$2.00

This Handbook is for Health workers who want to attack Protein-Energy Malnutrition of children in their own communities.

This Handbook is written to help answer 3 important questions:

I. How do you measure community malnutrition?

II. What are the food problems in your community?

III. Which problems should you attack?

This Handbook is written in basic English. A person who has finished six years of school will be able to read and follow this book.

Durana, Ines. **Teaching Strategies for Primary Health Care.** The Rockefeller Foundation, 1980.

Available from: The Rockefeller Foundation, 1133 Avenue of the Americas, New York, N.Y. 10036, U.S.A.

Price: no charge

This book is designed for trainers of primary health care workers in the developing countries and is to be used by both the medical professional and the non-physician. It presents ideas on how to teach both social process skills and technical health skills. Presented in outline form, learning strategies are given to help the user in teaching the described skills in which the instructor gives relevant exercises to the trainee. It combines ideas on integrating theory and practice of developing a primary health workers training programme. It does lack, however, suggestions on how to make the content relevant in local situations and tends to ignore the social, political constraints on some of the ideas.

Morley, David and Margaret Woodland. **See How They Grow.** Macmillan, 1979.

Available from: TALC, Institute of Child Health, 30 Guildford Street, London WC1N 1EH, London, England.

Price: Unknown

This book discusses in detail the development and use of Road to Health Growth Charts developed by Morley. It uses this discussion to get involved with wider mother and child care and community health issues. The book is designed for a literate group but to help trainers teach primary health care workers how to use the growth charts. It will be useful to those training people in MCH care.

Rural Missionaries of the Philippines. **Guide to Community Health.** 2 vol. revised, 1978.

Available from: Rural Missionaries of the Philippines, 2215 Pedro Gil, St. Ana, Metro Manila, P.I.

Price: about US$2.50 each

These two volumes provide both the theory and practice of community based health programmes (CBHP) and a training guide for community health workers. They contain articles which argue the necessity of community participation in health care by such notables as Dr. John Byrant, Dr. Joe Wray, Dr. J. de la Paz and Bishop Layben. They also share the analysis of the valuable experiences of the Rural Missionaries in beginning to establish community-based health programmes with principles of community organization, selection of CHW's and review of training programmes techniques and skills. The second volume is a text for health knowledge most useful for the CHW work. These two books have provided textbooks for training CHW's in CBHP in the Philippines.

Werner, David. **Where There is No Doctor.** Hesperian Foundation, 1977.

Available from: The Hesperian Foundation P.O. Box 1692, Palo Alto, Calif. 94302 or TALC, Institute of Child Health, 30 Guildford Street, London WC1N 1EH, London, England.

Price: Unknown

This is the most well known and praised of the CHW manuals. Originally intented as a manual for CHW's in a voluntary community health programme in Mexico, it now has been translated and adopted in numerous languages. Geared to the circumstances and educational level of rural village people, it explains in words and pictures how to treat and care for the most common health problems. It also discusses prevention, use of locally available herbal treatments and health education. It has been a model volume for community health workers in poor rural areas throughout the world.

WHO. **The Primary Health Worker** (Revised Edition), 1980.

Available from: WHO regional offices or WHO Headquarters, 1211 Geneva, Switzerland.

Price: 12 Swiss Francs or pounds sterling, US$ equivalent.

This working guide outlines the structure and contents of training for the primary health workers on the basis of the most common health problems in developing countries.

Part I can be used by the primary health workers as a learning text and also as a guide in his work. Part II is addressed to the health workers' teachers, tutors and supervisors. Part III discusses the adaptation of the book to local conditions; this can be done only in the country where it is used.

Positions Vacant

ACHAN has received request to find people who might be interested in the positions described here.

AUSTRALIA

Doctor with qualifications registerable in Australia for work in an aboriginal tribal area 150 miles west of Alice Springs. The programme is government funded but is able to define its own health care policy on many principles of community health in developing countries.

Programme description

Papunya Community is one of four communities in Central Australia that is funded to provide its own independent medical services. Papunya was funded for a medical service by the Australian Commonwealth Government because of the recognised problems that the community has had over the twenty years since it was founded as a show piece of the assimilation policy. Twenty-one different extended family community groups from five different tribal/language groups were compelled to move to Papunya in the early sixties and the last of the desert Pintobi people who had never seen europeans before came into Papunya in 1965. As you could no doubt guess both adult and child mortality and morbidity were high in the early years and the continuing social pathology continues to be reflected by poor health, high rates of malnutrition in children, abuse of alcohol by adults and petrol sniffing among kids. There has always been a fairly high rate of turnover of european staff there. In 1975 the National Health and Medical Research Council funded a study of Papunya to look at the possible benefits of an alternative approach to health care. The model proposed by the researcher Dr. Trevor Cutter (who is currently Senior Medical Officer with the Central Australian Aboriginal Congress-Aboriginal Medical Service in Alice Springs) incorporated most of the generally accepted principles of appropriate health care in developing countries. – namely respect for and working with traditional healers, working through community selected Aboriginal Health Workers, a high emphasis on training and prevention rather than purely curative care. European staff were to be appointed by and accountable to the community controlled medical service. Although the Northern Territory Department of Health had been fairly supportive of moves to establish independent Aboriginal Medical Services such as the Urapunga Health Service based on Utopia, an Aboriginal owned cattle station, and the Central Australian Aboriginal Congress-Aboriginal Medical Service which operates as a general practice in Alice Springs itself, there was opposition to the idea of Papunya becoming an Independent Medical Service. After a long struggle the Commonwealth Government funded the community for a medical service in 1978. The Northern Territory has always been known for attracting "missionaries, mercenaries, or misfits" and staffing of the Papunya Health Service has always been a bit of a problem.

The Nursing staffing situation is much more stable now and there is quite a good team there, but apart from one good year the community has had difficulties in finding a doctor who combined the necessary wide clinical competence with a passion for community medicine and an ability to create team work.

The conditions of the job are fairly good. Accommodation and vehicle are provided, salary and leave are adjusted to the Department of Health Medical Officer Class 2 level, namely A $25,000 to $28,500 per annum with six weeks annual recreation leave. The doctors qualifications would, of course, need to be registerable in Australia.

More about Papunya. It is situated to a beautiful mountain range three hours drive or 150 miles West of Alice Springs. The climate is an arid zone climate with hot summers and cold winters, the rainfall is usually 8 – 12" per annum. About two thirds of the community lives in Papunya itself and the rest live on outstations. Aboriginal ceremonial life is alive and well. There are a number of very skilled and experienced and respected traditional healers or Nangkaris and in the past there have been very useful dialogues and meetings between the medical staff and the healers, although only on rare occasions has the style of work and relationships allowed the healer to play a continuing role as a health worker in a health centre. The primary health workers are selected by the community and the base of operation is the Hospital, which was unfortunately designed and built by bureaucrats in Canberra and is a real hindrance to getting the focus of attention on the community rather than the health centre. The Aboriginal Health Workers receive training at Papunya from the staff there which include a Health Educator who has some equipment. A selected number of Health Workers also come in at regular intervals to attend courses run by the Department of Health. The Aboriginal Health Worker Training Programme has been widely recognised as one of the best things that the Department of Health is doing. There are approximately 150 Aboriginal Health Workers employed and in training around Central Australia some of whom are employed by the Independent Medical Services.

Although Papunya community has quite a few amenities, a school, a good shop, regular films, sporting facilities, with a permanent swimming hole a few miles away, the atmosphere is not as encouraging as that of the outstations where there is a vigour and energy and optimism about the people which is lacking at Papunya due in part to its oppressive history. If the doctor and his family are able to form good relationships with aboriginal people then it will be a very enjoyable time at Papunya. If they are not about to form good relationships with the aboriginal people, then Papunya would have very little to commend it in the long term.

If you know of any doctors who would be interested in finding out more, I would be grateful to hear of them or enquiries could be directed to Dr. Trevor Cutter, Central Australian Aboriginal Congress, 78 Hartley Street, Alice Springs, N.T. 5750. Telephone: (890) 523377, (A/H) 524537); or Dr. Hugh Nelson, District Medical Officer, Department of Health, P.O. Box 721, Alice Springs N.T. 5750; or direct to the community.

BANGLADESH

A health planner/trainer is needed for a village development training programme in northeastern Bangladesh in order to respond to village development needs in 25 villages by providing extension and advisory services. The major health activities included maternal and child health, family planning, nutrition and hygiene. The focus is on developing village self-reliance for their health needs. The ideal person would have a degree in public health or health education, three or more years field experience in a developing region and experience in planning and training para-professionals.

Programme description

The Village Development and Training Program in Sylhet District in northeast Bangladesh is administered by Friends in Village Development Bangladesh, an indigenous private, non-profit agency established in 1979 and officially registered in 1980. FIVDB, formed from among senior Deshi staff of IVS, assumed full management control of the VDTP in January 1981.

In Bangladesh, as in many parts of the world, poorer villagers all too often fail to benefit from Government technical and social service programs because the administration of such programs is remote and fragmented, and villagers are not sufficiently organized to take advantage of them. At the same time, the private economic sector is more responsive to power and leverage which the poorer villagers simply do not possess. In the VDTP, the emphasis is on making services readily accessible – with extension workers based in the villages – and on organizing community groups through which needs can be articulated and assistance channeled. FIVDB hopes that the VDTP can be of immediate, practical benefit to the villages where it operates; and that the program will demonstrate a viable alternative structure for service delivery that might be used elsewhere by Government to make its national programs more effective at the village level.

The VDTP, as its title implies, has a dual purpose.

The program, operating in some 30 villages in Kotwali Thana of Sylhet District, is primarily designed to help poorer villagers meet their basic needs and improve their living standards. Service centers have been set up in each of three "clusters" of villages, and multipurpose development workers, based at these centers are available to counsel villagers on their problems. These resident extension staff offer advice and assistance in agricultural production (rice, vegetables, fish culture, duck-raising etc.); health and family planning; functional education and literacy; and activities like handicrafts that can yield a cash income for women. The resident extensionists can call upon a pool of specialists from the VDTP headquarters staff as needs arise. The program encourages the formation of village organizations – cooperatives, mothers' clubs, youth clubs – which can be focal points for production and training. The organizations are also proving effective in increasing the villagers' access, on more favorable terms than before, to needed goods and services from both the public and private sectors.

Secondly, the program provides field training for trainee development workers from three local Government institutes in Sylhet District: the Rural Development Training Institute, the Agricultural Extension Training Institute and the Family Welfare Visitors Training Institute. As part of their course work, the students spend up to three months in village homes as arranged by the FIVDB staff; and work alongside the local villagers and the FIVDB staff. The experience gives the students a direct and practical appreciation of the possibilities for closing the gap between village needs and relevant Government resources.

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National Conference on Evaluation of Primary Health Care Programmes

April 21-23, 1980

Abstracts

INDIAN COUNCIL OF MEDICAL RESEARCH
NEW DELHI

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PRIMARY HEALTH CARE TO URBAN SLUMS - EXPERIENCES AND EVALUATION

by

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Since independence, there has been tremendous and rapid expansion of the health services for the rural areas in India. A network of primary health centre complexes was established, and has been functioning during the last 25 years or so. In addition, many national health programmes were specially developed to deal with some specific public health problems. Although there have been substantial gains in improving health status of the people, there is a growing concern about the ineffectiveness of the existing health care delivery system to provide primary health care to all, especially to the underprivileged and poor.

The Multipurpose Health Workers' Scheme and the Community Health Volunteers' Programme were started with a view to reorganizing the health services and ensuring community participation in the task of health promotion through self-reliance. Embhasis has been always on the rural population. However, the plight of the slum dwellers and urban poor is perhaps worse than those of the poor villagers. It is often observed that the slum dwellers in urban areas are not only poor but are also socio-culturally maladjusted to urban life. In the light of this, a project was taken for developing an alternative model for delivery of health care to the urban poor at the Urban Health Centre of the All India Institute of Hygiene and Public Health, Calcutta. There have been attitudinal, psychological, administrative and social diffculties that cropped up in the implementation of the programme. These will be presented in the paper.

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Many experiments in primary health care have been undertaken in India in different States. These experiments have provided valuable experiences which should serve as guidelines for development of future programmes for improving the efficiency of the health care delivery systems in the country. Some of the experiences in this field, specially in the process of evaluation of the Community Health Workers' Scheme, will also be presented.

One of the basic problems is the lack of primary concern in improving the efficiency of the health care delivery system. It is noticed that various schemes and programmes are being taken passively and not with strong motivation, or active involvement, or initiative.

SOME THOUGHTS ON EVALUATION

by

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(presented by Brig Ramaswamy)

The evaluation should really start from the top, the political and administrative leaders of the Community. Some of the problems connected with evaluation at this level are discussed with illustrative examples.

The evaluation of the workers at various levels ending at the health post, most peripherally is also dealth with as well as the community's reaction to the health programme which can be done in several ways, which are discussed.

1. Duplication of efforts by Govt/Pvt agencies
2. Referral services complex
3. Evaluation of Mo-PHC /MPW /CHW

SOME THOUGHTS ON THE STRATEGY OF EVALUATION FOR PRIMARY HEALTH CARE PROGRAMMES IN DEVELOPING COUNTRIES

by

Dr.S.N.Chaudhuri, Emeritus Prof.,
Institute of Child Health, Calcutta.

Primary health care is basically a self-care process where professional know-how and the lay interest should interact for internalization of health needs and demands of the community for their spontaneous management at the level of individual micro-units.

This social control demands compliance, which can only be ensured in a developing community through a holistic programme, wherein the health-demand should be integrated with other psycho-social needs of the community. This bundle model with multidimensional interacting components will be more acceptable to the indigent people because some of the felt-needs with benefits known to the people will facilitate adherance to the programme. Any evaluative exercise should reckon these special and specific features for proper alignment of variables and assessment of outcomes as a developing continuum with different intermediate indicator for different stages of development.

The appropriate method of analysis, establishment of valid intermediate indicator, assessment of reactions and suitable method for the quantification of popular participation will form the special attributes and will be discussed in the presentation.

ABSTRACT PAPER ON
DEVELOPMENT OF HEALTH MANPOWER (ALLOPATHIC PHYSICIAN CATEGORY) FOR PRIMARY HEALTH CARE

By. Dr. S. Krishnaswamy Rao.

Growth of institutions since 1947 for training of physicians of western system of medicine in India has been haphazard. It lacked a conscious effort to fit-in the short-term policies and plans to be in tune with the long term perspectives. This has resulted in an uneven growth and development of medical colleges in the country and a glut in the market for physician manpower.

For any sensible planning a well designed and efficiently functioning information system is essential. Here again no effort is forthcoming in that direction.

Compared to Nurse Manpower, the wastage in medical colleges is minimal. This could still be bettered by improved selection techniques and changing for more scientific techniques available for performance evaluation of students.

The magnitude of withdrawal of physicians from the profession in the country by emigration is of a sizeable order. This has economic significance for the country.

Unemployment problem amongst the graduate and post-graduate level qualified physicians is rapidly mounting. While this being so, states with high unemployment rate have kept positions created for physicians unfilled. This is conspicuous in the National Family Welfare Programme and Primary Health Care Programmes.

While community preference for obtaining health services from physicians of western system of medicine is high, some states have preferred to provide health services through physicians of indigenous systems of medicine.

The unemployed, underemployed and recently employed physicians in the governmental sector have been resorting in some states to revolutionary methods to draw attention of the policy makers to undertake measures without delay to correct the unemployment situation.

There is a big question as to why the problem of unemployment amongst physicians should even occur while this is a profession which can stand on its own when demand for their services have been mounting rapidly.

It is no use talking of providing Primary Health Care without a conscious health manpower policy and planning.

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HEALTH SERVICE SYSTEM SUPPORT TO PRIMARY HEALTH CARE PROGRAMMES

by

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During the last decade, with the growing acceptance of primary health care as a key alternative approach to meet the basic health needs of the people, a very large number of primary health care projects/programmes have been developed both by governmental as well as non-governmental agencies. While conceptually most of these programmes attempt to effectively bridge the gap between the official health services and the community, varying stress in laid on the other dimension of primary health care viz a dynamic and self-reliant movement of the community itself towards the betterment of the quality of life of its members through intersectoral integrated efforts. For the successful delivery of primary health care package to the doorsteps of the people through such projects a well-planned and coordinated support from the health service system is absolutely necessary. However, in practice, such support is often unorganized, disjointed, ineffective and generally not well-planned, with result that primary health care projects/programmes often develop a lopsided preference for delivery of those components of the package which are easier to deliver such as day to day medical care. Such vital components as MCH, Environmental Sanitation including Water Supply, preventive programmes often do not receive due attention.

The organizational aspects of primary health care including its implications to the health service system and its interface with other sector interventions to ensure the appropriate mix timing and emphasis to evolve an integrated community development activity will be discussed.

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RESEARCH ON HEALTH SURVEY TECHNIQUES

[RESEARCH ON TECHNIQUES FOR IMPROVING THE HEALTH DELIVERY SYSTEMS IN THE COUNTRY]

by

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There is a growing demand and concern to improve the delivery of health services in rural areas in our country. Many health administrators have realized the inadequacy of the existing primary health centre complex to cover the population effectively, although they are providing some curative health services. It is also felt that increase in staff strength is not the best solution to improve the outreach. This has brought out the necessity to find alternate strategies to evolve, implement and evaluate a second line in health services delivery presently done by the PHC personnel. The rural school may be one of the ideal portal of entry to the rural community. To evaluate the effectiveness of involving the school teacher in the delivery of health care to the rural population, the ICMR initiated a collaborative research project during the year, 1976 with the objectives of: i] to study the feasibility and effectiveness of involving school teachers in the delivery of specific components of health care to communities through the existing PHC set up; ii] to identify the specific roles and tasks that can be performed by school teachers in health care delivery and to develop training program, (including job descriptions and a mechanism of supervision of these task); iii] to assess the relative effectiveness of teachers in their specific roles in relation to health education and health care delivery tasks under varying inputs, like training and incentives, training only as compared to control; iv] to identify problems of teachers in performing their role; and (v) to suggest methodology for involving school teachers in delivery of health services, based on the findings of the study.

The study is being carried out at three centres viz. National Institute of Health and Family Welfare, New Delhi, Rural Institute of Health and Family Planning, Gandhigram and Mahatama Gandhi Institute of Medical Sciences, Sewagram. The study was planned under three phases i.e. Diagnostic, Intervention and Evaluation phases. At present the intervention phase is under progress.

The study is planned as a randomized control trial with having both Control and Intervention areas. The Intervention areas will have a package which consists of trained school teacher in the health care delivery, provision of drugs and incentives to teachers/ schools.

The study has evolved a curriculum for training of school teachers and a set of parameters for measuring the effectiveness of school teacher in rendering the Primary Health Care. The methodology of evaluation of primary health care through school teachers adopted in the present study will be described in detail.

U.P. 74.12

Reprinted from the Proceedings of the VII International Congress of Rural Medicine, of the Congress held 17-21 September 1978, Salt Lake City, Utah, U.S.A.

COMMUNITY HEALTH SERVICES AS A COMPLEMENTARY FACTOR IN THE PROCESS OF RURAL DEVELOPMENT WITH SOCIAL JUSTICE

E. B. Sundaram

I. INTRODUCTION

Health is a God-given gift and it is often said that a person may possess all the good things of this world and yet if he does not have health he cannot live an abundant life.

Yet basic requirements for promoting good health are denied to about 80% of the population, especially in rural India. WHO in 1970 after an extensive survey made a revealing statement that 80% of the people of India live in the rural areas producing 70% of the gross national product, and only receive 25% of the health services. This is blatant social injustice. In other words, rural India is not only supporting the economy for better living in the cities, but it is at a disadvantage due to lack of health facilities.

II. The purpose of this paper is threefold:

1) To examine factors which are necessary to develop a practical role for health services in socio-economic development at the micro level.
2) To suggest how community health services can complement in the total development at the micro level.
3) To examine the specific role of community health services in breaking age-old barriers so as to produce social justice.

1.a Factors necessary for a health care delivery system

Economists of developing countries have justifiably cautioned that socio-economic development is more important than health services. This trend is usually shown when budget allocations are made. It will be readily seen that at the national level in India 13% of the budget is allocated to defence, and only 7% to health (Figure 1). This factor (one of the many) at the micro-level, has caused the following:

1.b Health services even at the district level, especially in Uttar Pradesh are extremely disorganized and have not produced the desired result even though on paper the organisational structure meets acceptable standards.

1.c At the block level there does not seem to be an effective infrastructure, for example finances are not available to pay for several months the medical and paraprofessional workers. The budget for medicines amounts to around Rs. 2,500/- per year, for a population of one hundred and twenty thousand. A closer examination of a block shows that resources are available, but socio-economic development has not occurred at the rural level. A simple and adequate health service is possible as shown by many workers in India, Africa, China, Thailand and Indonesia. Hence the main problems can be categorised as follows:

1.d Lack of proper planning at the micro level.

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1.e Whatever planning exists is so inadequate that large sums of money are spent ineffectively. At many block levels we see beautiful structures with insufficient budget for running a health programme. Or in several blocks we have noted that large sums of money are spent for large vehicles without adequate budget for maintenance or petrol. Hence, in trying to develop resources at the micro level, due to the Government's inability to mobilise their own resources, effective health care delivery at the infrastructure level has failed to a large extent. This failure has caused very serious economic repercussions. Probably the best summary of these factors has been given by the Intermediate Technology Group, U.K. which has developed a "cycle of misery" which is explained in Figure II. It is said that even though health programmes probably only contribute about 30% to the economic growth of a population, it serves a very urgent and acute human need of the community, which no other service can provide. For example, if a person has a renal colic or a child has diarrhoea, or a farmer meets with an accident, or a man has a heart attack, he will need a hospital and the services of the medical profession to meet this human need. Hence even though an economist may state that health programmes should not be given priority, it has been noted that as the level of socio-economic development and education increases, a community will demand better health services. To put it in another way, health programmes are essential for economic development.

In several developing countries extensive studies have been made of the economic benefits of health programmes at the micro level. These health programmes have shown that the investment must be on man. For example, in Haiti it has been shown that a simple Yaws eradication programme returned 10,000 workers to the labour force. Yaws is a disabling skin condition of the lower extremities and can be very effectively treated with penicillin. All that was needed was:

1.g Orgnaization,
1.h Provision of a simple budget,
1.i Paraprofessional workers trained to identify the condition and treat the same effectively,
1.j An efficient follow-up system.

The economic benefits of a simple anti-malaria programme reduced absenteeism in the Philippines from 35% to 4%. Hence even though there has been a certain amount of uncertainty of the priority of the health programmes, and serious doubts were raised of their contribution towards general development at the micro level, yet it has been proven that when health programmes can be integrated with agriculture, education, small scale industries and other social welfare programmes, the masses are lifted out of general poverty and its consequences.

In analysing integration of health and development at the micro level the basic results are shown in the following:

a) In the child, it gives an opportunity for concentrating on his education. Several times we see children in a village school who are ill-nourished and cannot concentrate on their studies. Their concentration span is exceedingly low. They get tired very easily and the teacher has a hard time trying to teach them even for a few minutes. These children are usually found to be mal-nourished, with protein and multi-vitamin deficiencies, and are unwilling to play games as they get tired very easily.

We cannot expect these children to grow into normal adults. The work of Bacon Chow of Taiwan, and our own studies with the Japanese hospital at Agra (Colombo Plan Experts) have shown that the grey matter of the brain of these children does not possess the normal number of cells which are usually found in healthy children. In other words, it has been shown that these children, if they continue to be under-nourished, will have low intelligence quotients and the whole community can even develop into morons. It is difficult for these children to grow into normal adults and develop highly specialized skills for which knowledge is required. Scientists have stretched a point by stating that it is not possible for developing countries to produce many discoveries probably due to lack of proper nutrition (probably this is only one factor among many others). In analysing the economic growth at the micro level one finds the following factors interacting so that at any phase of health and development the two factors meet to make total development a possibility in order to yield successful results: (Figure III)

1.k Organization. It is said that one of the weakest links in socio-economic development at the micro level is the failure to evolve proper organizational structures.

1.l However defective the organization, some form of it could have functioned if the principles of proper management were developed from the grass-roots.

1.m The education of the masses and also of the management at the micro level is, at best, at a very low level. The masses cannot grasp the principles of organization and management, and help is not given to the common man so that he could give supportive supervision in organizing and in the management for economic growth. Usually the individual is not aware of his basic human rights, and hence feels that whatever the organization offers, whether right or wrong, one has to merely accept philosophically and has no participative role to play. However, when a person realizes, or he is educated to know his rights, he starts looking at the management in a more critical way. This person realizes that he pays taxes; he knows the value of his vote; he knows what to expect of the management and the organizational structure, and if properly motivated, he is able to bring about a change wherein he can at the micro level give support to the management to implement their technology through a service or a programme.

1.n This technology has to be at a very basic level. However, basic principles of technology from highly specialized areas can be adapted at any level. Many times it has been noted that a doctor with a post graduate degree of six years in a rural area is unable to apply his technology because of organizational and management problems. In other words, he is not given proper supervision; he has no support, and arrangements are not made for him to have a sufficient budget or a technology is not available for him to mobilise local resources. Rarely is he given an incentive to use his ingenuity.

1.o This brings up factors of basic operational research. These is a large amount of practical research (applied) in nutrition, organization, management principles, health education, application of simple technology which can be useful at the micro level to develop socio-economic growth.

1.p The health workers at this micro level can contribute to the socio-economic growth of the area by participating in this basic research

so as to adapt local conditions of economics, health, etc., in the field of health education, management and organization of health care services so that this indigenous technology, when it is adapted and applied can utilize the indigenous physical capital to the best advantage of the local population.

When an economic growth analysis is made of a development programme all these above factors should be taken into consideration. In isolation they will not produce the desired results.

1.q When analysing the health standard of a given area, knowledge and attitude of a given population are extremely important. This has been many times shown when a health model cost-effective analysis has been made. The capital versus output ratio has shown that one should not over simplify and isolate socio-economic policies with factors of development. Probably one of the most important aspects that one has to consider at this stage is the investment in man at the micro level.

In this investment the following four factors play an interacting role with many ramifications:

1.r Policies at the national, state, district and also at the mirco level and how these policies are implemented and interpreted.

1.s In other words, the directions these policies stress at the micro level are extremely important. Very often the directives from the district headquarters to the Block Development Office are not filtered down in proper perspective and even if they are filtered down, they can be either effectively blocked or can be misinterpreted, or misapplied due to two very important factors: One being

1.t Political decisions and the other being

1.u the behaviour patterns of the local population.

However, if policies are good, if directions given are correct, if the local population is involved in the decision making at the grass roots level, which was so effectively demonstrated to the world by the Chinese, then the political decisions will be consistent with the policies, and the direction will be effective, so that the programme and its beneficial results can filter down to the grass roots level. This grass roots evolution of the policies and the consequent political decisions can give proper direction, which can then evolve into a behavioural change which will make all programme implementation extremely effective for the total development of a programme. Unfortunately, this type of involvement is not found in the micro level planning in our country and even though we have Gram Sabhas, Block Development Officers, and Primary Health Centres, due to policies which are not in the best interests of the local community or political decisions which are favouring only a few, even though the direction may be right, there is no behavioural change so that the investment in man does not yield the desired results.

The dichotomy between health programmes and general socio-economic development probably will exist for many years to come (see Figure IV). But still those who work at the micro level will find that this dichotomy has to end or at some time a compromise has to be made. An analysis of the coordination between government and voluntary organizations has been enunciated by John Bryant (see Figure V) wherein he has shown that the Government seems to interact between its various social welfare programmes and

the Church organizations are isolated. In Figure VI he has shown how this integration can take place. At the South East Asia Conference in Tokyo (1970) another model was provided for micro level participation in development and health (Figure VII) wherein a minority church's role is shown as an active presence for human and social development in all spheres of the society. Here many factors which a governmental agency does not take into consideration have been considered:

a) Personal faith
b) Supported by worshipping community
c) Family faith
d) Fellow Christians sharing in the task
e) Neighbours who are good, bad, or indifferent

Probably this concept can be applied to any community or to many communities who live together and of necessity their interests overlap in the total development of the area. In diagram No. VIII the major factors which control this development are shown as follows:

a) Politics and the role of the government
b) Religion and its diverse effects
c) Socio-economic factors and the services that they produce
d) Various types of education and media for recreation and leisure

In all these factors it must be noted that the individual and the family have decisive roles to play without which effective development cannot take place. This is shown to be true not only in India but also in other developing countries like Peru, and Bolivia. An analysis of the common causes of death in a Catholic country like Peru showed that in the males it was homicide. In children common causes of death were diarrhoea, malnutrition and pneumonia. In women the common cause of death was abortion or suicide. Hence if development has to take place at the micro level, general education has a very important part to play and health education especially depends on the social milieu, and this education cannot take place unless there are avenues for social reform. The late Dr. Ed. McGovran of the Ford Foundation mentions the "X" factor which is found mainly in Voluntary Hospitals in India. This "X" factors seems to be absent in most government health services.

III. Health Development and Population Growth

Development at the micro level cannot take place unless there is reduction in the fertility rate. To say that resources are available to take care of high fertility rates is a most impractical statement. Twenty years ago when this aspect was mooted, economists noted that this produced a dilemma for as population growth increases the health care services proportionately diminish causing lack of development in the particular area. If social numerator and rapid population denominator can be plotted on a graph, it will be noted that population growth has to be checked (see Figure IX). From the graph it will be noted that if the social numerator is 25, the population denominator cannot be more than 5. This simple graphic presentation is supported by demographic data that if birth rate is 3% the population doubles in 20 years; if it is 1.7% the population doubles in 41 years, and if it is 1.2% the population doubles in 60 years. Some demographers hence advocate a zero population growth as in Japan and Romania. However, it is not possible for the developing countries to attain this target as children who will be mothers in the next 11 years are already

born. The Malthusian theory that we should expect high mortality due to pestilence, war, and flood to control population is morally unacceptable. From 1960 the mortality rates have reduced and this has occurred both in adults and in children, but has produced the even more disastrous results of rapidly increasing population. Hence it must be noted that programmes reducing birth rate are not the total answer for improving the development of a given area. Most developing countries launched major family planning programmes and India is one of these countries which spent millions of rupees through USAID, World Bank, SIDA, etc.

Dr. Karan Singh, Health Minister of India stated in Bucharest at the 3rd World Population Conference (August 1974) that India sees Family Planning programmes as a massive attack on poverty. But merely introducing a family planning programme is not the answer as you can easily see in Figure 10. There is a vicious circle of high fertility with large, poorly spaced families, crowded in a home with a high infant mortality and keeping up with this high mortality, the farmer expresses the need to have many sons to take care of the farm or the weaver who would like to have his own children to take care of his unit of work. This produces a precondition for high fertility and in order to a certain extent slow this runaway population growth, two major programmes have to be introduced: (see Figures 10 and 11)

1) Basic health care with an emphasis on nutrition and preventive medicine, health education, and family planning is necessary. In the rural areas family planning has been a definite failure because basic health care does not exist. No nutritional programmes are available. Nutrition supplements or nutrition education are not available. Hence the childhood or infant mortality still is high and a family planning motivator is ineffective. Target couples refuse family planning as there is no assurance that their children will live. So the behavioural scientists came up with a questionable hypothesis, but others consider a very practical suggestion that if a family has to accept a small family norm the communities have to be influenced for behavioural change. A large force of paraprofessionals were then trained (many times inadequately) as motivators, and the programme did not produce adequate results.

2) Our own experience shows that unless the factors of social and economic development through agricultural and small scale industries are introduced at the micro level, so that basic requirements of food, shelter, clothing and education are available, the community and the family will not accept family planning.

IV. The Role of a Health Worker in Socio-economic Development

In Figure 12 the modern concept of supportive factors for family planning services at the micro level is shown. It is clear that socio-economic development has to be part of an integrated programme with preventive, promotive, curative, nutrition, and family planning services which are necessary ingredients to produce the desired results. To provide this type of services adequate indigenous man-power teams are necessary who can work closely with the family. These workers will form an integrated team, with their different expertise, in order to understand each other's roles. For example, the traditional doctor should be able to use the indigenous dai or paraprofessional workers. The indigenous menidcant or dai is the first person the villager seeks for health care. Paraprofessionals can be

taught simple health techniques in six months time. The health team must be formed into a well-knit unit so that they can work with not only the family, but the agriculturists, teachers, social workers, opinion leaders, engineers and experts in small scale industries. Unless this integration takes place, it will be impossible to train a team to work at the block level. Gandhiji gave the nation this concept which was an inspiration from a hymn by John Henry Newman, "I do not seek the distant scene, one step enough for me". This one step of a simple integrated programme, which the local community can organize, manage, and implement, is necessary for the development of a truly self-sufficient indigenous programme.

Economists and econometrists are quick to blame health and family planning workers that techniques of economics are not utilised by them in programme planning and budgeting. But it is also true that economists have given very little time and thought to health and family planning programmes and health workers are not equipped to utilise the techniques of economists. It is hoped that in future economists will actively assist health programmes at the macro and micro levels.

V. Social Justice and Health

Unfortunately when development takes place, factors of social injustice come into play. In one survey we noted that when the Pradhan knew that he would not be directly benefitted, he lost interest. However, the local people gave a great deal of cooperation in the survey for they knew that they will be directly benefitted economically by the programme. The elite money lender also was disappointed by the development programme but the local people continue to help and responded with the opinion leaders. In other words, socio-economic development can break age old barriers but to a certain extent can also irritate those with vested interests. The rift between the have and the have nots can increase. Strangely enough, when health care is given equally at the micro level to a population, especially through their own resources, barriers can easily break and caste, and creed will recede into the background. Probably the basic reason is that medical or health care transcends all barriers of race, caste, religion and status. This is inherent in the training of the health care worker. To give an example, general ward patients and private room patients have no hesitation in being together in the intensive care unit or in the recovery room. Furthermore, even male and female patients can be taken care of in a recovery room for it is clearly understood that here a sick patient, whether male or female, will receive the best care possible and actually this type of a service is requested by the community. Through the years our experience has been that the general hospital which caters to a secular society can cater to the total health needs of the community, whereas a private hospital or a private practitioner has to cater to the whims, fancies and prejudices of the elite. Furthermore, if the paraprofessional workers can be trained from an indigenous community, these workers can break social barriers. Occasionally we have found the head of a high caste village home, who refuses entry to one of our paraprofessional workers, especially when this household knows that this paraprofessional worker comes from a lower caste. When this occurs we take a rather serious view of the situation, and explain to the head of the family that actually he is harming himself, as he is denied of services to his own household. We never force ourselves into such a home, but when the head of the house

realises that his children are denied immunization through home visits, or health education, or domiciliary maternity services, because he has refused our paraprofessional entry to his home, for obvious reasons he will start having second thoughts. Many times we have found that when a member of his family suddenly is taken ill, and then this very same outcaste attended to this patient in a very sympathetic way, immediately this prejudiced head of the house will realise that he made an error in barring this paraprofessional from giving him the services that he requires. These types of barriers are many times extremely easy to break. What is more difficult is to give equitable services at all levels in a village area. It is a common platitude that the very rich and the very poor do not get proper health care. The very rich because they are many times exploited and they are unable to utilise common services which are easily available. Usually they have too much advice, too many consultations, too many x-rays (not knowing the hazards of radiation) and they find that in spite of the fact that they have financial resources they have been misguided. The very poor do not get proper health care because of lack of resources to pay for simple mecicines, and also lack of knowledge on simple sanitation and basic health care. Many times the prejudices are so strong that even when simple health care is provided to them, free of cost, taboos and customs prevent them from accepting what is right. To give an example of the first, we know of a Dy. Collector who came to us with about 40 x-rays of his chest which were taken to diagnose a crack in his rib, which was due to over-weight and diabetes. He merely coughed and his rib gave way! All this person needed was a good clinical examination and probably one cone view x-ray of the rib. By taking 40 x-rays in the civil hospital, whose quota of x-rays is probably 150 per year, this civil servant has denied 40 poor patients who needed an x-ray to make a proper diagnosis. This is how the rich, the influential and those in positions of authority misuse health care facilities and resources.

Hence in order to be able to give equitable health care the system should be at the grass roots level which can mobilise local resources, which needs to be extremely simple, and very close to the home so that the health care system will become an integral part of the everyday life of the villager. Many times health clinics are developed far away from the villages so that the villager is unable to reach the place, the health worker cannot reach the village, transportation costs are very high and in many areas it has been shown that the farther the clinic the fewer the number of patients who will utilize it. In our own rural experience, both in the public health services at Mursan and 5 other villages we have developed a low cost health care system which caters for basic health care, nutrition, maternal/child health and preventive medicine. Even a loop is inserted by our Public Health nurse under a tree. A woman with bleeding who needs a termination of her pregnancy can be taken to a two-bed unit if proper organization and expertise is available. In other words, low cost health care is not merely an anathema (and has proven to be practical) but a reality. Even less common conditions like dental health care can be given at the rural level. The new dental alloy equipment can provide a new denture at a cost of Rs. 50/- which in most cities will cost Rs. 1,000/-. This is being investigated in the Methodist Hospital, at Jaisinghpura. Anaesthesia at a two-bed hospital can be provided, without oxygen, by using an EMO

apparatus. Hence in our rural units we do sterilization operations, hysterectomies, and many other obstetrics and gynecology procedures using very simple inexpensive techniques. The delivery fee at Mursan clinic is still Rs. 5/- (about 75 cents) and in the semi-urban clinics if this person accepts a permanent or semi-permanent method of family planning it will cost her only an overhead charge of Rs. 30/- (about 4 dollars and 40 cents). An immunization programme can be set up purely through government resources as small-pox vaccines, triple antigen, BCG and cholera biologics are available through government sources. Typhoid vaccination will have to be bought. Any institution which has curative services can support a simple community health programme with rural resources. In our experience of the last 3 years at the CFC Hospital, Vrindaban, Methodist Hospital, Jaisinghpura, and the Public Health Services, Mursan where we have chosen selected populations of 37,000, 2,500, and 9,000 and in the 5 rural centres which have a population of not more than 4,000 to 10,000, we have proven that this low cost health care is a feasible programme. Through the CMAI and SIDA the Methodist Hospital, Jaisinghpura has a programme which takes care of 2,500 people who are mostly refugees. Our patients accept intra-uterine contraceptive devices because of improved technology and this is true of immunisation with a jet gun. Nutrition supplement and a basic health care system have been initiated which the local population can support. However, while we are confident, and to a certain extent satisfied with this beginning, we are immediately faced with a task that these very people are not provided with basic amenities of life - adequate food, shelter, clothes, and education and any amount of health care cannot improve the quality of life unless it is integrated with general socio-economic development of the area.

SUMMARY AND CONCLUSIONS

1) An attempt has been made to depict the role of health in the socio-economic development of a rural area. All aspects could not be covered, as this is a very extensive problem.

2) Those interested in the subject must study in-depth the principles of "Area-wide Comprehensive Health Planning" (Figure 13).

- a) Concept
- b) Investigation
  - i) Problems needs and scope
  - ii) Data gathering surveys and research
- c) Synthesis
  - i) Compilation and tabulation of data
  - ii) Preliminary review, planning standards and data projection
- d) Evaluation
  - i) Evaluation
  - ii) Alternate solutions and conclusions
- e) Development: development of final solutions and detailed planning

f) Realisation: Implementation phase

g) Operation

3) This presentation has highlighted some factors of coordination, planning, management and control of an integrated programme, and has suggested that without socio-economic development health programmes do not produce the desired results.

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[This paper was to have been presented with slides to which the Figure numbers in the body of this paper refer. For more information please contact the author]

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HEALTH SERVICES -- INTEGRATED RURAL DEVELOPMENT

Introduction

Before 1947, the year of Indian Independence, the rural areas had been almost completely neglected in so far as the development of health or medical care was concerned, though the country's population was predominantly rural. In 1946, the Health Survey and Development Committee (popularly known as the Bhore Committee) submitted a health plan in two parts, a short term plan covering two five year plans and a long term one covering the set targets to be reached. One of the most important recommendations in the long term programme of the Bhore Committee, was that the District Health Organizations would have as their smallest unit of administration, the Primary Health Centre (PHC), which would normally serve an area with a population of about 10,000 to 20,000 and have a hospital with 75 beds, 6 medical office s, 6 public health nurses and the requisite nursing and para medical staff for 75 beds. Later on the Mudaliar Committee, appointed in 1961, strongly supported the recommendations of the Bhore Committee and evaluated progress made since 1946.

Primary Health Centres were started as part of a national rural development scheme, called Community Programme in 1952 with a very modest staff in each centre, to form the nucleus of integrated health services to cater to the need of about 60,000 population in a block. There are now approximately 5373 PHCs. Each Centre serves a population of 80,000 to 120,000 nearly. The annual amount now allowed for medicines for each Centre ranges from 10,000 to Rs.12,000 and this has to take care of the above mentioned population,

More recently a Master Plan for rural health was chalked out with a participation of principals of Medical College, eminent medical educationists, representatives of various medical associations, the Medical Council of India and the Indian Council of Medical Research and finally approved in October 1971 by the Central Council of Health consisting of the all the States and Union Territories. The eight schemes included in the Master Plan are:-

1. Provision of two doctors to every PHC
2. Provision of a basic health worker and an Auxiliary Nurse Midwife (ANM) to every 10,000 population
3. Upgrading of at least one out of every five PHCs into a 25 bed hospital with a Junior Specialist each in Medicine, Surgery and Obstetrics, in addition to the two PHC Doctors. These Specialists will periodically visit the surrounding four PHCs for providing specialist consultation to patients referred to them by the PHCs.

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4. Provision of financial assistance according to an approved pattern to voluntary agencies for setting up hospitals in rural areas.
5. Involvement of all the existing governmental and non-governmental rural hospitals and dispensaries in preventive and promotive health care in addition to curative medicine.
6. Extension of Pilot Mobile-cum-Training-cum-Service Hospital scheme to all medical colleges with a view to orienting the Medical and Nursing students to rural community medicines, to enable them to work in rural areas and also to render competent medical care to the rural people near their homes with the help of teachers from medical colleges who would work in well equipped tented hospitals which would move from one camp to another, every three months.
7. Improvement of village sanitation and imparting health education in nutrition, maternal and child care and family planning.
8. Organisation of special camps for cataract operations, vasectomy and tubectomy.

In April 1975, a programme for immediate action in rural areas was included in the Report of the Group on Medical Education and support Manpower. This was followed by the new policy of the present Government of India regarding Health Care Delivery system and Medical Education, where "every home in rural areas was to become its own health centre", by transfering simple h health skills to the people themselves, through Health Education.

In this connection it is important to note that if the Govt. of India during the last few years has established many medical colleges, it was with the sole purpose of providing rural health services, as the bulk of our population of nearly 80% live in the rural areas. In 1947, there was an admission capacity of less than 2,000 students in medical colleges, and now there are 106 medical colleges with an admission capacity of more than 13,000 per year. About 11,000 graduation are coming out of these colleges every year.

The St John's Medical College has been trying to incorporate in their teaching programme, the rural dimension in a significant way. As the college happens to be situated at the outskirts of Bangalore, there is an ACTION GROUP area whihh includes many of the slums lying around the college and its hospital complex. In addition, Rural Health Centres at Uttarahally, Siluvepura and Mallur (Health Cooperative) have been running since quite some years. Recently in January 1978, the Govt. of Karnataka has been pleased to allocate the PHC Dommasandra in Bangalore District, Anekal Taluk, for purposes of training the Undergraduates, Insterns and the various para-medical and health workers of St John's Medical College.

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Rural Development Schemes

The Department of Rural Development, Ministry of Agriculture and Irrigation, Govt. of India, has given guidelines for intensive development of Blocks under the programme for "Integrated Rural Development".

Special beneficiary oriented programmes like Small Farmers Development Agency (SFDA), Marginal Farmers and Agricultural Labourers (MFAL), Drought Prone Areas Programmes (DPAP) and Command Area Development Programme (CADP) are covering nearly 3000 blocks of our country. It is now proposed to intensify rural development work in 2,000 blocks covered by any one or more of these special programmes during the year 1978-79.

In addition to these 2,000 blocks, it is also proposed to take another 300 blocks for INTENSIVE BLOCK LEVEL PLANNING AND DEVELOPMENT every year for a period of five years starting from the current year 1978. In this process, 3500 blocks would be covered by the end of the Sixth Plan period.

The main objective of all these Integrated Rural Development Programmes in selected Blocks, is to provide full employment and a better standard of living through productive programmes within a definite time frame and with sufficient emphasis on the weaker sections of society. In the execution of programmes, the family is to be taken as the unit and the attainment of economic viability as the objective.

Primary Health Care in Rural Development Areas

Health does not feature in any of the Schemes to be taken up under the programme for intensive development blocks although Health and Development are closely linked areas for the total development of a community. Neither of them can be tackled in isolation.

The planners may be of the view that the existing structure of health services available at the block level (PHC Complex) for providing primary health care to the people would be adequate as a support service for their development programmes. Since independence, we have made substantial investments in rural areas but the health status of our people is till far from satisfactory. Health service hithertofore has been basically a service "distributed" by a group of health professionals to a community whose role was that of a passive recipient. There has been very little participation from the community in solving its own health problems.

If the Integrated Rural Development Schemes are to succeed, we must provide concurrently, a COMPREHENSIVE HEALTH SERVICE SCHEME particularly in the preventive, promotive, curative and rehabilitative fields so that the rural people, taking the Family as a Unit, are in a

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positive state of health, to actively participate in all complementary development activities.

The health of the mother and child is the fulcrum around which the health of the village turns. The priority areas to be tackled will include:

a. Antenatal, maternity and postnatal care
b. Family Planning
c. Care of under-fives including immunization
d. Prevention of malnutrition in children
e. Health Education
f. Environmental Sanitation
g. Control of leprosy
h. Prevention of blindness
i. Control of tuberculosis

The health professionals in the Planning Body of any development scheme should be adequately oriented and with experience of community development and rural health problems.

Providing primary health care to the rural masses in our country is a gigantic task and both government and voluntary agencies need to collaborate and cooperate to meet the situation. The St John's Medical College can, not only provide the technical assistance required for training of doctors, para-medicals (including Community Health Workers) and research, but it could also, through its Directorate of Rural Health Services and Depratment of Community Medicine, deal with organisational aspects of rural health service, in selected project areas of Community Development.

Any project which seriously tackles the village rural health scheme, should also be concerned about making more effective those specific training programmes which are intended basically for rural health, like courses of training for para-medical workers and doctors (interns) and lay the required stress on rural orientation, as they will be mainly responsible for delivering the goods. Through such training, service will also be provided to the community. The St John's Medical College and its Rural Health Services Organisation/Department of Community Medicine, will be catalytic agent for the starting of village rural health services, wherever it is feasible. Our Health Component Scheme, described later, for the Integrated Rural Development of Anekal Block, envisages such an integrated approach.

There are two areas to be taken into consideration while talking of rural health services. One is the delivery of the package of rural health services in the villages and the other consists in all that goes into the formation of personnel and transport that will deliver this package of health services.

Mobility and supervision are essential to run an effective service particularly in rural areas. This is unfortunately not possible or is a serious lacuna, in the present set up of the PHC complex. The Extension Team of St John's Medical College to function in these development schemes will play the role of a task force, to achieve the objectives laid down. It will be the aim of St John's Medical College to whole-heartedly cooperate with Government and other agencies in achieving their goal. For effective coordination it is desirable that the Dean/Director of Rural Health Services/Professor of Community Medicine/District Health and Family Welfare Officer, are included in the Apex Body directing the Block Development Scheme.

At a later stage (Phase II or Phase III) it may be possible to tackle health problems, by trying new methods in pilot projects. If these are successful, there might be a chance for multiplication of such projects to the benefit of larger sections of the community. For instance, self-supporting rural health schemes could be organised in selected areas by:

a. tagging health services to existing cooperatives which are being run effectively eg. sericulture, cooperative dairying and so on
b. starting with services (through Government or other funding agency) and evolving a health cooperative at a later date with the help of the community served
c. Assistance from Panchayat

In some villages, the Panchayat and people may be interested in health services and are willing to contribute to a health fund both voluntarily and through services provided
d. running health services with some assistance from the factory administration where labourers are from villages. As small Scale Industries are being set up in rural areas, no single industry will be in a position to establish its own factory medical service. A co-operative can serve the health needs of a group of factories/industries.

In all our peripheral health schemes in rural areas, special consideration has to be shown and greater attention given, to the worker sections of the community, particularly Harijans, who for many reasons are comparatively neglected in the health coverage.

With a view to organise Primary Health Care delivery in the intensive Block Level Planning and Development of Anekal Block, it is contemplated that the entire Anekal Taluk be taken over for organising the health care and training programmes.

Anekal happens to be one of the Taluk Head Quarters of Bangalore District, situated about 22 miles from Bangalore. The Head Quarters at Anekal is also the Head Quarters for the Community

Development Block. In this Block of Anekal there are 2 PHCs. one located at Anekal itself commanding a population of 78,000 and another located at Dommasandra commanding a population of 72,000. The total number of villages included in the Taluk coming under the jurisdiction of both these PHCs, works out to 287 including the town of Anekal.

A Health Component for the Integrated Rural Development - Anekal (Appendix A).

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APPENDIX - A

A HEALTH COMPONENT FOR THE INTEGRATED RURAL DEVELOPMENT-ANEKAL

AREA : Anekal Taluk in Bangalore District with a population of 1,50,000 distributed over a town (Anekal) and 287 villages is chosen. There are two Primary Health Centres (Govert. of India pattern) already functioning in the area with the HCs at Anekal and Dommasandra, respectively. The SJMC, Bangalore., has taken over PHC Dommasandra for organization of Primary Health Care Delivery and Implementation of several training programmes (which includes undergraduates, interns and other para medical workers).

It is now proposed to include the PHC Anekal also for implementation of the various community health programmes. The entire Taluk of Anekal will thus be the area where the Integrated Rural Development will be in operation with its Health Component when the project is implemented.

STAFF: The present infrastructure at PHC Dommasandra and Anekal will continue to function but with the following additional inputs (pattern of Nelamangala PHC) for each PHC.

1. Medical Officer of Health	1
2. Senior Health Inspector	1
3. Lady Health Visitor	1
4. First Division Clerk	1
5. Senior Laboratory Technician	1
6. Second Division Clerk	1
7. Cook	1
8. Part time Engineer	1

SUPERVISION:

Assistant Director Rural/Associate Professor-1. To effectively supervise all the activities over the entire taluk of Anekal and also health components of the Integrated Project, a senior Officer with the designation of Asst. Director (Rural Health) would have to be in position at SJMC. He will work under the administrative and Technical Control of Director of Rural Health Services and Training Programmes/Professor & Head of the Department of Community Medicine, St.John's Medical College, Bangalore.

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TRANSPORT : Since it is envisaged to deliver the Primary Health Care Community as near to their doors as possible and the transport available at PHC, is fully engaged with the National Health and other routine programmes, one extra vehicle (Jeep station wagon) at each PHC and one for the Director/Professor/Asst. Director at SJMC would be required. A total of three Diesel Jeep station Wagons would meet the requirements.

PROGRAMMES: The present programmes will be intensified and the quality of care improved. Besides involving the interns and paramedicals, the specialists and other faculty members of the SJMC will be participating at all levels. The routine programmes would be:

1. Medical care.
2. Communicable Diseases Control (Immunizations)
3. Environmental sanitation
4. MCH 7 FP
5. Nutrition
6. School Health
7. Health Education
8. Vital statistics and Maintenance of records
9. Training and Research

The interns and paramedicals would be stationed at HQs of the two PHCs at Dommasandra and Anekal. Besides these two places there are various types of dispensaries catering to the needs of the community in the Taluk. These are Sarjapur, Attibele, Bannerghatta, Jigani, Marsur.

In the phase I of the programme, interns could be assigned to these dispensaries which would form the centre for their community health activity. As resources become available, accommodation for interns and clinic buildings could come up and the coverage and activities could increase to its maximum.potential.

A project report (see Annexure I) prepared to cover the Dommasandra and Anekal areas is enclosed. This report gives greater details of objectives, Implementation Mechanics and Finances involved. This is the total Project Report Phase I of the Health Component of the IHP Programme including staffing pattern, Transport, Area of Operation and Expenditure is placed at Annexure II for immediate Implementation.

/ ANNEXURE - I /

ORGANISATION OF PRIMARY HEALTH CARE DELIVERY AND THE IMPLEMENTATION OF INTERNS TRAINING.

(IN COMMUNITY MEDICINE)

The Training programme for both Interns and Paramedical envisages a large service element for delivery of Primary Health Care to the Communities in the development areas.

SPECIFIC OBJECTIVES:

Rural experience should train the interns to become the leader of the Health Team comprising of various types of paramedical personnel and which will provide service to the community. It should involve:

a) Supervisory responsibilities -
   Administrative & Techinical
b) Community based health activities,
   Organisation and implementation:
   i) Control of communicable diseases
      (special emphasis on diseases like Tb, Leprosy)
   ii) Implementation of National Health Programmes
   iii) The Health Team will render comprehensive health care to the community - curative, promotive, preventive.

HEALTH PROMOTIONAL ACTIVITIES:

i) Health Education
ii) Nutritional rehabilitation and education - especially vulnerable group
iii) Importance of exercise, rest recreation

SPECIFIC PROTECTION:

i) Immunisations (BCG, Smallpox, DPT and ORAL Polio)
ii) Disinfection of water
iii) Introduction of Sanitary Latrines
iv) (a) Supervision and guidance in the mid-day meal Programme in Schools and implementation of Applied Nutrition programme - vitamin A
   (b) Iron and Folic Acid tablets distribution
   (c) Distribution of contraceptives
v) Introduction of compost pits, soak-pits, etc.,

EARLY DIAGNOSIS AND PROMPT TREATMENT:

i) General medical check up of all population in the development area once a year.
ii) Detection, treatment and follow-up of patients suffering from Tuberculosis, Leprosy, Malaria, Filaria, Trachoma, Smallpox, Diphtheria, Whooping Cough, Tetanus, etc.
iii) Conduction of antenatal clinic, domiciliary Delivery, Post-natal care and family planning advice
iv) Organising under 5 clinic
v) School Health Programme
vi) Organising Specialists Camp as and when necessary

a) Obstetrics & Gynaecology Camp

b) Paediatric Camp

c) Dental Camp

d) Dermatology Camp

e) Ophthalmology or Eye Camp

f) ENT Camp

g) Camp for minor surgery, etc.

N.B: Organised with the assistance of Specialists of St. John's Medical College.

DISABILITY LIMITATION:

Organising full treatment and follow - up of cases in all chronic diseases and disabilities

REHABILITATION:

Survey for handicapped shall be conducted to know the nature and magnitude of the problem. Such of those dependents who are suffering from chronic defects, disabilities and diseases will be detected and registered. Depending upon the individual merits of the case, further action will be taken in consultation with respective specialists.

MECHANICS OF IMPLEMENTATION OF INTERNS TRAINING (VIDE MAP APPENDED) (Annexure III)

Place	Dommasandra	Anekal
Population	72,000	78,000
No. of centres	16	16
Approximate population in each centre	4,500	5,000
No. of births per year	175-200	200-250
No. of families in each centre	1,000	1,000
No. of deaths per year	80-100	100-120
Population of under 5 (15%)	700	800
0-14 years (40%)	2,000	2,400

PROPOSAL:

At each of the 32 centres, where an ANM and multipurpose worker located, two interns will be assigned the responsibility of community health to look after the population of 5,000, Thus 32 x 2 = 64 interns could be trained at a time. However this Health Scheme will be operated in 3 phases extending over 3 years. In phase I only 7 subcentres with dispensary facilities will be x taken. The remaining over the next 2 years.

These interns will be exposed to the experience of community medicine. This will be an integrated approach and delivery of comprehensive health care as envisaged earlier in this proposal.

At the outset, the interns will survey and collect base line data and open family dossiers for all families under their care (1000 approximately).

Besides daily attention to diagnosis and treatment of sick persons that attend the centre the interns will be involved in general medical check up of all members in the family, once a year.

The abnormalities detected will be noted, discussed and dealt with either by the intern at his level or referred to appropriate levels including Specialists. Periodical camps involving specialists of various disciplines will be organised whenever needed.

AS A ROUTINE:

Antenatal clinic (with the help of ANM, Health visitor and faculty of the Department of Obst. & Gynae assisted by ANM)

Domiciliary delivery (Lady Interns)
Post-natal care (with the help of ANM)

Family Planning advice and services

Under 5 clinic (with the help of ANM, MPW and faculty of the Department of Paediatrics)

will be organised and the intern will pay particular attention to promotive and preventive services such as - Health Education, Immunization, etc.

The Intern will use his initiative and motivate families to introduce Sanitary Latrines and Soak-pits, etc., with the assistance of MPW & ANM.

He will also supervise and guide the MPW to disinfect drinking water wells periodically.

The intern will also draw up priority felt needs of the population in fields other than health. The need based multi-disciplinary approach would be attempted wherever the activities of other departments could be coordinated (Education, Agriculture, Animal Husbandry, Community Development Block, etc.).

The entire PHC offers a wide field for Research and studies to be undertaken by interns under the guidance of their faculty members.

FACILITIES AND AMENITIES REQUIRED:

ACCOMMODATION: 1) At each of the sub-centre headquarters accommodation for the interns will be required. One hall 12' x 10' with a small bath room and latrine would be needed. The structure need not be pucca. A dwarf wall of 4' right around, cement flooring and thatched roofing or tiles (on the pattern of Baptist Hospital ward) would suffice. The entire structure may not cost more than about Rs.5,000/- at each centre or 32 centres x 5,000 will cost Rs. 1,60,000

Alternatively, if in some centres, suitable accommodation is available, we can hire on monthly rental basis.

In order to start the programme interns could be located at Central places like, Dommasandra, Attibele and Anekal (Annexure II & III) where accommodation could be available and the interns could travel on their cycles between centre and village.

FURNITURE: Each student will have a cot and a chair (64 cots and 64 chairs), one table for two students (32 tables).

Total cost will work out to: Rs.150 per cot x 64 .. Rs. 9,600/-
Rs. 80 per chair x 64 Rs. 5,120/-
Rs.150 per table x 32 Rs. 4,800/-
One steel or woodenalmirah) at Rs.500/- x 32) Rs.16,000/-

TOTAL : Rs.35,520/-

Besides, the above, mattresses, pillows, utensils and sundries may cost about Rs.1000/- per centre, totalling to Rs.32,000/-

TRANSPORT: Each intern will have to be supplied with a cycle for his movement within the jurisdiction of the centre. 64 cycles at Rs.350/- each, totalling Rs.22,400/- will be fequired.

Each of these 32 centres will have to be provided with drugs, certain minor equipments, instruments, appliances, etc. The capital cost may work out to Rs.3,000/- per centre or total R .96,000/- and recurrent cost of Rs.200/- per month per centre or Rs.2,400/- (less than 50 mm), for Rs.2,400/- x 32 = Rs. 76,800/-. Provision will have to be made for offring all facilities for Primary Health ~~Centre~~ d care delivery.

A small library of reference books to each of these sub-centres would be necessary, at a nominal cost of Rs.700/- per centre and the total cost will work out to Rs.22,400/-.

2 mini buses and 1 Jeep (Diesel) with 3 drivers and necessary provision for fuel, oil, lubricants, servicing, repair and replacements will have to be detailed at PHC and one at the College for use of staff (Rs.3,00,000/- for three vehicles plus 15,000/- per annum).

TEACHING: Supervision and guidance by Staff:

The faculty members will have to pay at least one visit every week to one or two sub-centres and involve themselves in teaching supervision and providing the necessary guidance in the day-to-day problems, in the field of general medicine, obstetrics & Gynaecology, paediatrics, surgery, etc. It would also be necessary for all faculty members to meet all interns at a meeting once a week at the Headquarter of the Primary Health Centre, where all matters pertaining to clinical, administrative and other matters are fully thrashed out.

HEADQUARTER OF THE 32 SUBCENTRES — PHCS DOMMASANDRA & ANEKAL:

DOMMASANDRA	DISTANCE FROM H.Q.	ANEKAL	DISTANCE FROM H.Q.
1. Dommasandra	H.Q.	Anekal Town	H.Q.
2. Sarjapura	6.4 km	Anekal Town	H.Q.
3. Neriga	9.6 km	Anekal Town	H.Q.
4. Kuthaganahally	9.6 km	Samandur	9.6 km.
5. Bidaragumpe	22.4 km	Venkanahally	4.8 km
6. Handenahally	16.0 km	Indalvadi	6.4 km
7. Muthanallur	6.4 km	Sidi-Hosakote	3.1 km
8. Attibele	16.0 km	Hargaddo	8.4 km
9. ~~Maj~~ Mayasandra	22.4 km	Jigani	10.8 km
10. Ramasagara	9,6 km	Begehally	15.0 km

...5

DOMMASANDRA	DISTANCE FROM H.Q.	ANEKAL	DISTANCE FROM H.Q.
11. Chandapura	12.8 k.m.	Bannerghatta	16.8 km
12. Huskur	11.2 k.m.	Hulimangala	19.2 km
13. Bommasandra	12.0 k.m.	Hennagara	11.2 km
14. Mugalur	10.8 k.m.	Hebbagodi	14.4 km
15. Bikkanahosahally	18.0 k.m.	Marsur	8.0 km
16. Yadavanahally	16.8 k.m.	Karpur	4.8 km

EXPENDITURE

CAPITAL	PHASE I (1st Year)	PHASE II & III (2nd & 3rd year)	TOTAL
1. 3 Jeeps (station wagons-diesel) at Rs.75,000/-each	2,25,000.00		2,25,000.00
2, Buildings	35,000.00	1,25,000.00	1,60,000.00
3. Furniture	11,840.00	23,680.00	35,520.00
4. Mattresses, utensils etc.	10,666.00	21,334.00	32,000.00
5. Cycles	7,466.00	14,934.00	22,400.00
6. Equipment to sub-centres	32,000.00	64,000.00	96,000.00
7. Library at Rs.700/- per centre	7,466.00	14,934.00	22,400.00
			3,93,320.00

RECURRENT:			
1. Pay and allowances including TA. DA etc.			
a. Asst. Director/ Assoc Prof.	21,000.00	45,000.00	66,000.00
b. Clerk (U.D.)	6,000.00	12,900.00	18,900.00
c. Drivers - 3 yrs.Nox.	14,400.00	30,960.00	45,360.00
2. Drugs	25,600.00	51,200.00	76,800.00
3. Library	7,466.00	14,934.00	22,400.00
4. Stationery	3,000.00	5,000.00	8,000.00
5. P.O.L. Charges at Rs.5,000/- per year per vehicle	15,000.00	30,000.00	45,000.00
6. Electricity water etc.	3,500.00	32,000.00	35,500.00
7. Contingencies	5,000.00	10,000.00	15,000.00
8. Printing forms and dossiers	6,000.00	4,000.00	10,000.00
		TOTAL:::	3,42,960.00

- - -

ANNEXURE II

PHASE - I

1. Augmenting the staff of PHCs at Dommasandra and Anekal on the pattern of Nelamangala PHC. Details are furnished below (for each PHC-Dommasandra and Anekal):

1. Medical Officer of Health	1
2. Senior Health Inspector	1
3. Lady Health Visitor	1
4. First Division Clerk	1
5. Senior Laboratory Technician	1
6. Second Division Clerk	1
7. Cook	1
8. Part time Engineer	1

This would be a commitment on the Government of Karnataka.

2. Supervisory and supporting staff (to be located at the Department of Community Medicine SJMC, Bangalore).

a) Assistant Director Rural/Assoc. Professor	1
b) Clerk (U.D.)	1

3. Transport

Diesel Jeep Station Wagons	3

(expenditure on 2 & 3 would be a committed expenditure of the Development Project).

4. Areas of Operation/Training

The Health Development Operation would initially start at the following areas where facilities of medical cure is already existing through dispensaries.

Anekal PHC

i. Anekal
ii. Mersur
iii. Jigard
iv. Bannerghatta

Dommasandra PHC

i. Dommasandra
ii. Sarjapura
iii. Attibele

Dommasandra and its sub-centres are already under the technical control of St. John's Medical College (Department of Community Medicine). It would be necessary to place PHC Anekal and its sub-centres under similar technical control of St. John's Medical College.

EXPENDITURE

ANNEXURE II
(Contd.)

CAPITAL	PHASE I	PHASE II & III	TOTAL
1. 3 Jeeps (station wagons disel) at Rs.75,000/-each	2,25,000.00		2,25,000.00
2. Buildings	35,000.00	1,25,000.00	1,60,000.00
3. Furniture	11,840.00	23,680.00	35,520.00
4. Mattresses, utensils etc	10,666.00	21,334.00	32,000.00
5. Cycles	7,466.00	14,934.00	22,400.00
6. Equipment to sub-centres	32,000.00	64,000.00	96,000.00
7. Library at Rs.700/- per centre	7,466.00	14,934.00	22,400.00
			5,93,320.00

RECURRENT

	PHASE I	PHASE II & III	TOTAL
1. Pay and allowances including TA,DA, etc.			
a. Asst. Director/Assoc.Prof.	21,000.00	45,000.00	66,000.00
b. Clerk (UD)	6,000.00	12,900.00	18,900.00
c. Driver - 3 nos.	14,400.00	30,960.00	45,360.00
2. Drugs	25,600.00	51,200.00	76,800.00
3. Library	7,466.00	14,934.00	22,400.00
4. Stationery	3,000.00	5,000.00	8,000.00
5. P.O.L. charges at Rs.5,000/- per year per vehicle	15,000.00	30,000.00	45,000.00
6. Electricity water etc.	3,500.00	32,000.00	35,500.00
7. Contingencies	5,000.00	10,000.00	15,000.00
8. Printing forms and dossiers	6,000.00	4,000.00	10,000.00
		TOTAL:	3,42,960.00

Kerala-9

74.16

PRESERVATION OF EYE SIGHT PROJECT

AN EXPERIMENT IN PREVENTION OF BLINDNESS AT COMMUNITY LEVEL.

* DR. M.V. JOSEPH

INTRODUCTION

Preservation of Eye-sight Project is an experiment in prevention of blindness through grass root measures using trained Village Level Workers.

It is estimated that there are about 15 million blind people in the world of whom 5.8 million are in India. About 30 percent of the blind in India are said to lose their eye-sight from preventable childhood illnesses like Vitamin-A deficiency, Trachoma, Measles and other inflamatory diseases. In the context of the socio-economic and cultural background of a developing country like India, blindness is much more disastrous a handicap to people than it is in the more developed countries where facilities for educating and rehabilitating the blind are easily available. Hence, surveillance against blindness and its prevention assume great importance in the Third World.

The Project, Preservation of Eye Sight, has three basic aspects viz. 1) prevention of blindness, 2) preservation of eye sight and 3) rehabilitation of the incurably blind. Around a focal point of preserving vision, the project emerges as an almost comprehensive village health programme. The aspect of prevention of blindness includes services such as immunisations against common diseases, health and nutrition education, nutrition supplementation, personal & enviornmental hygiene and early treatment of eye ailments. The preservation of vision covers visual screening and correction of refractive errors, screening and corrective measures for cataract and glaucoma, house-to-house detection of diabetes mellitus, and vigilance against hypertension. The rehabilitation component of the programme aims at making incurable blind persons less dependent on their families by training them in trade and craft.

COMMUNITY HEALTH CELL
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BANGALORE - 560 001

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* Associate Director, Community Health and Development Projects, M.G.D.M. Hospital Kangazha & Honorary Consultant in Child Health to Christian Medical Association of India.

THE PEOPLE AND THE PROGRAMME.

The programme is being operated by the M.G.D.M. Hospital of the Orthodox Malankara Church of India. The target areas are situated in the rural hinterlands of Central Kerala. Typically, the population is made up of small-scale farmers, and farm hands. The latter earn their living by working in nearby rice-fields and rubber plantations. They form a hetrogenous community with different religious groups living side by side, each following its own religious customs. Nevertheless, there is homogenety in their attitudes and practices in matters of health.

The literacy rate is high and the people are generally receptive to new thoughts and ideas. Over 90% of those above five years of age are literate in this area. About 50% have primary and 40% have secondary education. The sex differentials in the literacy status are not so striking as would be expected in other parts of the Country. The literacy rate for males is 93% and for females it is 87%. Age and sex composition of the population is typical of a community in which the fertility has started declining in the past decade, mortality is moderate and migration prevalent to a small extent. Children under 15 years constitute 35% of the total population while those beyond 65 years number less than five percent. Adults and middle-aged persons belonging to the working-age group (15-44 years) constitute 60 percent. Dependency ratio, an estimate of economic dependence of the population obtained from the age distribution is 65. Two villages, Anikad and Kunnamthanam in Central Kerala, South India with a population of 30,000 were covered in the first phase of one year's duration. Kooropada, a third village with a population of over 20,000 was taken in the second year, and the programme has just commenced in a fourth village.

The concept of a Village Health Worker seemed strange to the people. The role of the Health Workers and their task had to be carefully explained. Once having understood the concept, the community's reaction was positive and the response enthusiastic. The project proposal was to recruit workers from the community. The people helped in identifying suitable candidates from among themselves, following guidelines given to them. Thus each community was able to propose its own Health Worker. The scheme was that the recruits work on a part-time basis; they do home-visiting, on a door-to-door programme. They are not attached to any work centre or health post. Eventually, a tiered system of operational strategy viz. a door-to-door service by Village Health Workers, with the necessary back-up services at the base hospital was evolved.

As the programme got under way, community contacts were enlarged. Local persons with leadership were involved in the work. They were drawn to a community forum for dialogue. These contact persons meet periodically to review project activities and make necessary suggestions. Through such meetings, community participation in planning, implementing and monitoring the programme was ensured. The contact groups helped to harness local resource for the running of the programme.

THE VILLAGE LEVEL HEALTH WORKERS AND THEIR TRAINING.

For the training of the Village Level Health Workers different models were experimented. The training session lasted eight weeks for the first batch of workers; but in the second batch, it was possible to cut down the duration of the training by a few weeks by adopting a more skill-oriented model, in which half of the training period was spent in the field under the guidance of the senior worker. For the third batch a fully 'Worker-to-worker' model, where the new trainees 'Learn-by-doing' under the supervision of the senior worker, was evolved. Under this scheme, the new trainee resides & works with the senior worker in the field area until the necessary skills are learned. This way, it was attempted to simplify the training process, eliminating the need for formal trainers and training centres. It was observed that the 3rd batch of trainees gained optimal knowledge and adequate skills for their task.

During the first few months of work, the Village Level Health Workers do data collection, health education, immunisations, and Vit-A prophylaxis, and screening and treatment of common eye ailments. In the next stage, services like, diabetes and hypertension screening and nutrition supplementation are undertaken. Glaucoma screening and screening of school children for eye ailments followed in the subsequent period. Thus the workers are progressively inducted to the full range of tasks. As shown in Fig.I more than 80% of the problems were effectively dealt with by the workers, the base facility being required mainly for surgical management. The Village Level Health Workers meet at fortnightly intervals at the base hospital for review, follow-up and continuing education. A field supervisor organises and oversees the work of the Village Level Health Workers.

PROGRAMME DETAILS.

1. Prevention of Vit-A deficiency.

Blindness due to deficiency of Vit-A is a serious public health problem in India, and Kerala State is included in the belt of endemicity for this deficiency. The Government programme of Vit-A supplementation which was existing, was strengthened through this work. The incidence of Vit-A deficiency was brought down greatly as shown in Fig.II. An intensive education on nutritive value of green

leafy vegetables was made and an attitudinal change was observed among the villagers. The Village Level Health Workers encouraged housewives to grow vegetables in their garden and helped them to exchange seeds with their neighbour for greater variety.

2. Prevention of protein calorie malnutrition.

The workers identified children suffering from protein calorie malnutrition by simple and inexpensive methods such as measurement of mid-arm circumference and bangle test. Suspected cases were weighed and nutrition supplements were given, periodic assessment of weight-gain being made. Peanuts, which were roasted &packed by the workers were distributed as nutrition supplements. The food supplements were given for short periods only mainly for demonstrating to the mothers that such simple measures can improve the health of their young children. Mothers of infants were also educated on the utilization of easily available weaning foods.

3. Disease Control.

Immunisations are offered as an anciliary service to make the programme as comprehensive as possible, Near hundred percent immunisation against diphtheria, tetanus, pertusis, and polio-myelitis has been achieved. Measles immunisation could not be undertaken because of the non-availability of the vaccines, although it was considered important to prevent measles and the complication of kerato conjunctivitis commonly encountered in poorly nourished children. An epidemiological survey has shown that whooping cough has been eradicated from children in the age group of 3 months to 5 years with only sporadic cases occuring in school-going children and in infants less than 3 months old. Tetanus and diphtheria have not been reported in the last one year and only one case of polio-myelitis has been reported from the target areas.

4. Early detection and treatment of eye diseases.

It is estimated that 15 million people in India have eye ailments and many of them go blind. Studies have shown that the average length of time between the onset of eye ailment and the commencement of appropriate treatment is atleast eight to ten days. This is largely because of the non-availability of medical services at hand and partially due to ignorance. Many of the cases are simple inflamatory processes and post-traumatic infections which can be treated by trained workers. In the project area, the services of the Village Level Health Workers were well utilized by the community and the statistics indicate reduction in morbidity from eye ailments. A study of trachoma, a common eye disease has shown 50% reduction.

The reduction is attributed to mass treatment through the net-work of Village Level Health Workers and the improved occular hygiene that resulted from the educative efforts made by them.

5. House-to-house detection of cataract and glaucoma.

Men and women over 35 years are screened periodically for cataract and glaucoma. Most cases of mature cataracts have been identified by the Village Level Health Workers and referred for suggical treatment. Figs. III & IV show the incidence of cataract (mature and inmature) and glaucoma in a 10,000 population.

6. Diabetes and hypertension screening.

A door-to-door survey for diabetes mellitus and hypertension was undertaken by the workers. Cases which were positive to urine test for diabetes were called for a blood sugar test followed by treatment wherever necessary. The workers continue to follow up the cases and offer treatment and guidance on diet. They also monitor the vision of these patients periodically. Anti-hypertension programme, however, has been restricted to identification of cases, guidance on dietary management and encouragement to seek medical adv[illegible]

7. Vision screening for school-going children and treatment of refractive errors.

All school-going children in the target community underwent visual screening. Refraction and follow up services were offered. Vision has been preserved in many children and adults by correction of refractive errors. Fig.III shows the incidence of refractive errors. Vision has been corrected in most cases of pressbiopics which required correction. This has helped many men and women to pursue their own trade such as tailoring, weaving, fibre work and so on.

8. Blind Rehabilitation.

The rehabilitation of all the incurably blind in the community was attempted. Those that could be trained, were taught chalk-making as a cottage industry. In the target area, houses are far apart and for the handicapped, the uneven terrain of hillocks and streamlets is difficult to travers. Training was therefore imparted to the blind individually, and in their own homes. The hazards and the inconvenience of going to a training centre being eliminated, greater co-operation and willingness to accept rehabilitative education was forthcoming and every one of the dozen trainable blind was taught chalk making. This craft, they are happily pursuing in the familiar surroundings and the safety and warmth of their own homes. The project continues to help procure raw materials and market the finished products.

PRESERVATION OF EYE SIGHT PROJECT

Assessment of Trainees

Total marks: 50

Part I - Multiple choice questions - Marks 25

* Read the question very carefully
* There is only one correct answer.
* Put ✓ mark on the correct answer only.
* If you put more than one ✓ no marks will be given.

Part II - Read the statement carefully. Please indicate whether the given statement is false or true by marking ✓
Wrong answer with carry — marks. (marks: 10)

Part III - Marks: 15

രോഗനിർണ്ണയം - ചികിത്സ

ഈ രോഗികളുടെ കാര്യങ്ങളാണ് ഈ ചോദ്യങ്ങളിലായി ഉപചാരിച്ചിരിക്കുന്നത്. ഓരോ ചോദ്യത്തിനും ഈ ഭാഗങ്ങളുണ്ട്. അതാതു ഭാഗത്തിലെ നാലു ഭാഗങ്ങളും ഒന്നിന് [illegible] [illegible] ഉത്തരം കൊണ്ട് [illegible] ശരിയായ ഉത്തരം മാർക്ക് ചെയ്യുക.

Part - I

1. Inflammation of the conjunctiva is known as
   (a phlycten (b) pterygium (c) conjunctivitis
   (d) Blepharitis.

2. Cornea has no
   (a) blood vessels (b) epithelium (c) nerves
   (d) all of the above (e) none of the above.

3. Treatment of conjunctivitis
   (a) local antibiotic ointment or drops
   (b) atropine (c) staining (d) all of the above
   (e) none of the above

4. Normal vision
   (a) 6/60 (b) 6/6 (c) HM
   (d) Light perception.

5. Vision in mature cataract will be
   (a) 6/6 (b) 6/24 (c) 6/36
   (d) Inches 2 and below

6. Inflammation of the lacrimal sac is

   (a) Dacryocystitis (b) Keratitis (c) Abscess

   (d) Scleritis.

7. Normal distance for vision chekking

   (a) 16 metres (b) 60 metres (c) 6 metres

   (d) 3 metres (e) None of the above

8. Fluid in the anterior chamber is known as

   (a) lacrimal fluid (b) Aqueous (c) Vitreous

   (d) All of the above

9. An active ulcer-on staining will

   (a) Take up the stain (b) appear green in colour

   (c) flourisin dye is used (d) all of the above are correct.

   (e) none of the above is correct.

10. Ulcer's are caused by

    (a) Injuries (b) by applying eye ointments

    (c) by simple rubbing over the lids. (d)by heat.

11. Treatment of corneal ulcer is

    (a) atropine, antibiotics local & systemic

    (b) staining. (c) scraping (d) Irrigation

    (e) none of the above is correct.

12. In Iridocyclitis pupils are

    (a) Fixed and dilated (b) Fixed regular

    (c) Irregular and non reacting

    (d) none of the above is correct.

13. Treatment of irdocyclitis

    (a) Pilocarpine & antibiotic oint.
    (b) Atropine & antibiotic oint.
    (c) Steroid, antibiotic oint. & atropine
    (d) all of the above are correct.

14. The transparent part of the normal eye
    (a) conjunctiva (b) Cornea & lens

    (c) sclera (d) lids.

15. Outer most thick elastic firm layer of the eye ball

    (a) sclera (b) lids (c) Retina (d) cornea

16. Visual impulses from the retina go to the brain via the

    (a) Choroid (b) Cornea (c) Optic nerve (d) All of the above.

17. Natural protection of the eye ball is

    (a) by hands (b) lids and lashes

    (c) eye drops (d) all of the above.

18. Normal intra-ocular tension is between

    (a) 10 & 20 mm. Hg. (b) 20 & 25 mm. Hg.

    (c) 5 & 10 mm. Hg. (d) 0 & 5 mm. Hg.

19. In acute conjunctivitis there is

    (a) Circum corneal congestion.
    (b) Discharge and corneal ulcers.
    (c) Palpebral congestion & discharge.
    (d) all of the above
    (e) none of the above.

20. Ophthalmic neonatorum is seen in

    (a) Adults (b) young people (c) babies

    (d) all of the above (e) none of the above.

21. Pannus is seen in

    (a) Angular conjunctivitis (b) Corneal ulcer
    (c)Chronic conjunctivitis (d) all of the above
    (e) none of the above

22. Treatment of Trachoma

    (a) Sulpha drops & Terramycin oint.
    (b) Surgery (c) Terramycin oint. & steroid
    (d) all of the above (e) none of the above.

23. Spring catarrh is caused by

    (a) Bacteria (b) injury (c) virus

    (d) all of the above (e)none of the above

24. Treatment of pterygium
    (a) Antibiotic (b) Atropine (c) Surgery
    (d) none of the above.

25. Hypopyon is collection of

    (a) Sterile pus in the anterior chamber.
    (b) Sterile pus in the cornea
    (c) Blood in the anterior chamber
    (d) None of the above.

26. In acute iritis there is

    (a) Discharge & iritation
    (b) Cirumcorneal congestion and pain
    (c) Sudden loss of vision
    (d) all of the above.

27. Action of Atropine is to

    (a) Dilate the pupil (b) Constrict the pupil
    (c) Reduce pain (d) all of the above.

28. Treatment of Blepharitis

    (a) Steroid ointments. (b) Antibiotics ointment to the eye lids.
    (c) Surgery (d)none of the above.

29. In congestine glaucoma there is

    (a) Reduced movements of the eye ball.
    (b) Swelling of the lids
    (c) Severe pain & redness
    (d) all of the above.

30. Pupillary size in acute glaucoma

    (a) normal size (b) very small
    (c) Large and oval (d) None of the above.

31. Treatment of glaucoma is

    (a) Antibiotics (b) Atropine & Antibiotics.
    (c) Pilocarpine & diamox (d) none of the above.

32. Pilocarpine drops is used to

    (a) Dilate the pupil (b) Constrict the pupil
    (c) Improve the vision. (d) None of the above.

33. Ectropion is

    (a) Turning out of the eye lids
    (b) Swelling of the lids
    (c) Turning in of the lids
    (d) None of the above.

34. Squint is
    (a) Abnormal position of the eye ball
    (b) Closing of the lids
    (c) Normal position of gaze.
    (d) none of the above.

35. Bitot spots are seen in
    (a) Acute dacryocystitis
    (b) In Vitamin-B complex deficiency
    (c) Vit-A deficiency
    (d) All of the above (e) None of the above.

36. Blepharitis is
    (a) Inflammation of the eye lashes
    (b) Inflammation of lid margine
    (c) Inflammation of the lacrymal gland
    (d) all of the above.

37. Diabetes compain of
    (a) Weight gain (b) Decreased appetite
    (c) Increased thirst & frequency of urination
    (d) None of the above.

38. Hypertensive complain of
    (a) Head-ache (b) Giddiness (b) Black outs
    (c) All of the above (e) None of the above.

39. Triple vaccine or DPT is given to protect against
    (a) Diarrhoea (b) Diphtheria, Pertusis & Tetanus
    (c) Diarrhoea, Pertusis & Typhoid (d) all of the above

40. Clealiness is essential to avoid
    (a) Bad smell (b) Promotion of good health
    (c) Tp appear clean & attractive
    (d) all of the above.

41. Myopia is
    (a) Unable to see distant objects
    (b) Able to see distant objects clearly
    (c) Difficulty in near vision
    (d) None of the above.

42. Presbyopia is
    (a) Difficulty in reading mainly encountered after the age of 40 years.
    (b) School-going children
    (c) Unable to read books
    (d) Unable to read the boards at a distance
    (e) none of the above

43. The vitamin essential for the eye is
    (a) Vitamin B-complex
    (b) Vitamin A & D
    (c) Vitamin C
    (d) Vitamin D
    (e) None of the above

44. Treatment of spring cataract.
    (a) Antibiotics (b) Steroids (c) Pilocarpine
    (d) all of the above.

45. Phlyctenular conjunctivitis is characterized by
    (a) a small raised nodule near the limbus
    (b) follicles (c) Pannus & corneal ulcer
    (d) None of the above.

46. Chalzion treatment is
    (a) Surgical removal
    (b) Steroids (c) Antibiotics
    (d) All of the above.

47. The Eye drop used for local anaesthesia
    (a) Vanmycetin (b) Sulphacetamide (c) Xylocaine
    (d) Pilocarpine

48. Checking of intraocular tension is doing by
    (a) placing the Tonometer on the cornea
    (b) On the conjunctiva
    (c) On the closed upper lid
    (d) None of the above

49. Part of the conjunctiva beneath the lids
    (a) Lacrimal (b) Bulbar (c) Palpebal
    (d) None of the above.

50. Number of muscles that help in the movement of the eye ball
    (a) 6 (b) 16 (c) 8 (d) None of the above

51. Limbus is the junction between
    (a) Cornea & Conjunctiva
    (b) Sclera & Iris
    (c) Cornea & Sclera
    (d) None of the above.

52. My aim in undergoing this cause is to
    (a) Learn something of the eye
    (b) To learn & keep it to myself & feel happy about it.
    (c) To learn & to help others
    (d) All of the above.

53. This cause was
    (a) very profitable to me
    (b) it was like any other learning
    (c) I would prefer some more teaching
    (d) very practical & useful

Part - II

True or False

I. A complete examination of the eyes consists of :
Acquity of vision, field of vision and colour vision
(True, False)

II. In myopia the main symptom the patient complains of will be blurring of distant vision (True, False)

III. In myopia or short sight - parallel rays come to focus in front of the sensitive layer of the retina.
(True, False)

IV. Myopia is corrected by covers or plus lenses
(True, False)

V. Bony orbit is round in shape & has 6 wall with two opening for the optic nerve (True, False)

VI. Glaucoma is a condition where the intraocular pressure is raised as a result of high B.P. & diabetes. (True, False)

VII. Lens is Biconvex () transparent and focuses the light falling into the eye on to the retina. (True, False)

VIII. The conjunctiva is this layer which covers the cornea & the sclera & gets reflected on to fornics upto the margin of the lids (True, False)

IX. Senili cataract is that which occurs in men & women over the age of 50 years, which is treated by surgical removal (True, False)

X. The full form of PESP is protect eye & save person
(True, False)

PART-3

രോഗനിർണ്ണയം, ചികിത്സ   Marks 15

I രോഗങ്ങൾ

a) 16 വയസ്സുള്ള ബിനോയിയുടെ വലത്തേ കണ്ണിൽ ഇന്നലെ മുതൽ പെട്ടന്ന് ചുവപ്പും കരുകരുപ്പും ഉണ്ട്. വെളിച്ചത്തിലേക്ക് നോക്കാൻ തീരെ വയ്യ. കണ്ണിന് വേദനയും ഉണ്ട്. ബിനോയിയുടെ രോഗം എന്തായിരിക്കും

(1) Conjunctivitis
(2) Iridocyclitis
(3) Glaucoma
(4) Corneal Ulcer
(5) All of the above
(6) None of the above

b) ഹെൽത്ത് വർക്കർ ചോദിച്ചപ്പോൾ ബിനോയ് തലേന്ന് ഇളയ സഹോദരനുമായി മണൽ വാരി കളിച്ചുകൊണ്ടിരുന്നപ്പോൾ കണ്ണ് തിരുമ്മുന്നതായി തോന്നു എന്ന് പറഞ്ഞു. അങ്ങനെയെങ്കിൽ ബിനോയിക്കുണ്ടാകാവുന്ന രോഗം ഏത്?

(1) Viral Conjunctivitis
(2) Trachoma
(3) Corneal Ulcer
(4) Myopia
(5) Pterigium

c) നിങ്ങൾ ഉദ്ദേശിക്കുന്ന രോഗം നിർണ്ണയിക്കാൻ ഏറ്റവും പറ്റിയ മാർഗ്ഗം ഏത്?

(1) Circum corneal congestion ഉണ്ടോ എന്ന് നോക്കുക.
(2) കൺപോളകൾ മടക്കി ഫോറിൻ ബോഡീസ് ഉണ്ടോ എന്ന് നോക്കുക.
(3) Fluorisine കൊണ്ട് stain ചെയ്യുക.
(4) Pupil irregular ആണോ എന്ന് നോക്കുക.

d) ബിനോയിയുടെ രോഗത്തിന് പറ്റിയ ചികിത്സ:-

(1) Atropine Antibiotic, Pad and Bandaid.
(2) Locula 20% Eye drops
(3) നേത്രമയൂര ഗുളിക
(4) Atropine steroid, Pad and Band aid
(5) All of the above.

II a) ഞോണി എന്ന സ്കൂൾകുട്ടിക്കു കുറേ നാളായി കണ്ണിൽ കിരുകിരുപ്പ് അനുഭവപ്പെടുന്നു. Health worker പരിശോധിച്ചപ്പോൾ conjunctivaയിൽ Follicls കാണുന്നു. ഞോണിയുടെ രോഗം:-

(1) Follicular conjumctivitis
(2) Trachoma
(3) Spring catarel
(4) None of the above
(5) All of the above.

b) ഞോണിയുടെ cornea യുടെ മുകൾഭാഗം പരിശോധിക്കുമ്പോൾ Pannus കാണുന്നു. ഞോണിയുടെ അസുഖം:-

(1) Palpebral conjumctivitis
(2) Follicular conjumctivitis
(3) Viral conjuntivitis
(4) All of the above
(5) None of the above.

c) ഞോണിയുടെ രോഗത്തിന് ഏറ്റവും അനുയോജ്യമായ ചികിത്സ:-

(1) Atropine and Antibiotic oint
(2) Steroid Ointment.
(3) Sulphacetamide drops
(4) Sulphacetamide and Teramycin Ointment.
(5) All of the above.

III

a) Damu ന് 45 വയസ്സായി. കണ്ണിൽ മൂടൽ അനുഭവപ്പെടുന്നു. കാഴ്ച കുറവാണ്. ദാമുവിന്റെ രോഗം താഴെപറയുന്നവയിൽ ഏത്?

(1) Cataract
(2) Corneal Opacity
(3) Presbiopia
(4) All of the above
(5) None of the above.

b) ദാമുവിന്റെ കണ്ണ് പരിശോധിച്ചപ്പോൾ ഇടതുകണ്ണിന്റെ vision 6/60 വലതുകണ്ണിൽ Finger counting PL+PR ഇടതുകണ്ണിൽ Iris shadow കാണുന്നു. ദാമുവിനു രോഗം

(1) ഇടതുകണ്ണിൽ Mature cataract

(2) വലതുകണ്ണിൽ Immature cataract
(3) രണ്ടു കണ്ണിലും Glaucoma
(4) ALL of the above
(5) None of the above

C) ഭാർഗ്ഗവിയുടെ ചികിത്സ:-
(1) ഇടതു കണ്ണ് ശസ്ത്രക്രിയ ചെയ്യുക
(2) വലതു കണ്ണിൽ Atropine ointment പുരട്ടുക
(3) രണ്ടു കണ്ണും ഒരുമിച്ച് ശസ്ത്രക്രിയയ്ക്കു വിധേയമാക്കുക
(4) ALL of the above
(5) None of the above.

FOR, DR. RAVI NARAYAN.

(critically evaluate)

VOLUNTARY HEALTH AGENCIES CELL - A RURAL HEALTH PROJECT.

Note: This write up only pertains to such voluntary agencies as are engaged in rural development that includes an element of health care. They will be referred to as Voluntary Health Agencies(VHAs).

INTRODUCTION:

Voluntary agencies are assuming increasing importance, both at the National and International level. In the field of health services, voluntary organisations have played a pioneering role. This is so because of the much greater freedom they enjoy to innovate and experiment. Some of the measures which are now an accepted practice in Government programmes, such as Community Health Workers and Balwadies, such measures were first tested and tried by voluntary organisations. As Brockington[1] has written in his classic ' World Health' " Both countries (USA and U.K.) used voluntary effort for much of the pioneer work".

However, our universities and other academic institutions of higher learning have often stayed away from voluntary agencies. This is unfortunate. On the one hand voluntary agencies are starved of trained manpower while on the other hand academic institutions run the risk of isolation from the common man and his problems. Bringing them together may catalyze new work of both high quality and immediate social relevance.

The desirability of starting a dialogue between grass roots voluntary organisations and academic institutions of higher learning would generally be conceded. But it may be more difficult to devise suitable modalities for joint work. Some experimentation may be necessary here.

Concept of Integrated Rural Development:

Till recently, our plans for rural development have mostly been in terms of sectoral planning (R.N.Haldipur)[2]. But now the emphasis has shifted to the functional and spatial integration of various activities for the formulation of area development plans (L.K.Sen)[3]. Today it would be difficult to find a rural development plan which does not call itself integrated rural development plan. The need for scientific micro-level planning sensitive to local variations is now generally understood.

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Health has to be viewed in the same broad context. The overall socio-economic status of a community is the most important determinant of its health. Further, what goes on in one sector almost invariably brings about a change in another. As all the factors involved in health problems are inter-related (Gunnar Myrdal)[4], it is more logical to have integrated area development plans, of which health plan is one component(functional integration), than to have isolated health plans. "Rationally, the health problem becomes integrated in the general problem of planning for development" (Myrdal)[4]. This is something which we can attempt if we work closely with voluntary organisations that are attempting integrated rural development.

Thus integrated health can become a component of integrated rural development plans, as indeed it should. "The integration of health policy with economic development and the building of health services into strategies of overall development are now considered valid concepts" (Ramalingaswami,V. and P.)[5].

Aims and Objectives:

The overall aim of this project is to bring together the specialized skills of a large academic institutions(AIIMS) and the field experience and community involvement of voluntary health agencies to the mutual advantage of either. This will open up diverse field practice areas for broad categories of health services and of research.

General Objectives:

a) To provide technical guidance to voluntary health agencies.
b) To carry out research in the field of rural health and health services, and
c) To utilise the facilities for teaching purposes.

Specific Objectives: are listed below. They can be broadly grouped into research oriented objectives, service oriented objectives and training oriented objectives. Naturally, the objectives overlap.

Research oriented objectives:

i) To collect systematic information on voluntary health agencies; and to prepare an inventory/directory of such agencies.

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ii) To carry out comparative studies of different approaches to health care.

iii) To study the economics of health care, such as cost accounting and cost-effectiveness of different health services and strategies.

iv) To carry out or support research in areas such as epidemiology and operational research.

v) To test the usefulness of Appropriate technologies in rural health work.

Service Oriented objectives:

vi) To organise an information service for the voluntary health agencies providing them information on:

The activities of other voluntary health agencies;
Health Care;
Availability of facilities such as:

Training facilities for health workers;
Consultancy services;
Funding of health programmes;
Conference and seminars.

(A News-letter may be started)

vii) To offer the following consultancy services to voluntary health agencies in order to help them initiate or extend their health efforts:

- Identification of major health problems;
- Micro-planning for health care;
- Evaluation;
- Information inputs for planning and evaluation functions;
- Selection and training of health workers.

viii) To organise meetings and seminars of voluntary health agencies.

ix) To utilize the available facilities for teaching purposes. (Postgraduate students can be involved in health surveys and in the actual planning of concrete health services for different regions, as opposed to merely theoretical exercises).

x) To undertake publications concerning all the foregoing.

Methodology of work:

Working with voluntary health agencies on a countrywide basis can be a vast undertaking, well beyond the capacity of a Cell

..... 4/-

or even an Institute. There is nothing modest about our needs ! But if the work is worthwhile, it aught to be done. Even a long journey starts with one step(Chinese proverb).

Some suggestions:

1. The Voluntary Health Agencies Cell should be a part of the Centre for Community Medicine. A senior member of the faculty can be asked to look after it.

2. An Advisory Committee may be constituted under the Chairmanship of the Director,AIIMS. Senior members of the Institute faculty interested in rural health may be invited; also perhaps one or two experts(for example Secretary,AVARD: Association of Voluntary Agencies for Rural Development).

3. Establishment of contacts with Voluntary health agencies by:

   a) publishing a NEWSLETTER biannually to start with, may be more often later. The Newsletter should contain information of interest to voluntary health agencies as given under Object No.v.

   b) The Cell Incharge attending meetings of voluntary health agencies' workers.

   c) The Cell Incharge becoming a member of certain associations having direct contact with voluntary health agencies such as AVARD, Gandhi Peace Foundation and certain Catholic Associations etc.

   d) The Cell should establish contacts with certain Government Departments dealing with voluntary health agencies;(such as Deptt.of Rural Development and Central Social Welfare Board etc.)

   e) The Cell should also establish contact with certain social science and other institutions that are interested in rural work, such as Delhi School of Social Work, National Institute of Community Development, UNICEF, I.C.A.R., I.C.M.R. and several others.

   (Steps b,c,d and e have already been taken)

4. Office and Records:

An Office should be established. It should, among other things, maintain individual files on voluntary health agencies. The relevant information can be collected in several ways: such as by mailed questionnaires, personal visits and from published or unpublished records of several agencies(Central Social Welfare Board is publishing a multivolume state-wise directory of all agencies

doing social work". UNICEF has published an Inventory of "Basic services to children in India". AVARD and Gandhi Smarak Nidhi have published nationwide directories. Files are also maintained by several other organisations such as OXFAM, Catholic Hospital Association, CARE, Indo-German Social Service Society(IGSSS) and many others. Most well established societies are registered with State Governments under Societies Registration Act of 1860. Indeed a plethera of information of variable quality is available from a large number of diverse sources. The Cell will have to sift and evaluate such information before it can be used. One State-wise list of voluntary health agencies has already been prepared, including the nam of the contact person.

5. Requests from Voluntary health agencies for assistance:

These should be processed according to a pre-set procedure. The voluntary health agency should be screened first. If it is decided to help the agency, it should be visited by the Cell Incharge, for on-the-spot evaluation. After this visit, the Cell staff can hold a meeting to finalise the strategy. Generally a detailed investigation of the health problems of the area and of the facilities available, will be required. It may be necessary to visit the field area periodically.

In the preparation or execution of area health programmes, the local or state health authorities must be involved-- as our efforts should be to supplement, and not supplant, the state health organisation

6. Research:

Some of the routine activities of the Cell can come within the ambit of research. The Cell can start other research programmes either individually or with the help of some Departments of the Institute. Concurrence of the voluntary health agency would be a necessary precondition. On the other hand, some types of community studies may be easier to carry out because of the already existing infra-structure and the community cooperation created by the agency.

7. Funding:

The A.I.I.M.S. is expected to provide the basic facilities or seed money, to put the Cell on its feet.

....6/-

Many voluntary health agencies may be able to pay for the expenses incurred by the Cell in order to help them--- such as transportation, Secretarial or statistical assistance etc.

Although the Cell can be started on a shoe-string budget, its cost will escalate quickly once its usefulness is established. However, arranging for funds from Government or non-Govt. agencies will not be difficult, if the Institute considers this desirable.

8. Other Inputs:

They will depend on the work-load. A research officer and a Statistician may be required within a year. A good Social Scientist can be most useful. Further requirements will depend upon the performance of the Cell. It can become a fairly large undertaking if the Institute so desires.

Advantages of the Voluntary Health Agencies Cell.

The benefits of this project are not far to seek. Apart from the advantages accruing to voluntary health agencies, and the better health services reaching the rural communities, the Cell will have t[illegible] following advantages for the Institute.

1. It will provide the Centre for Community Medicine with detail[illegible] insight into the actual health problems of the rural communities at the grass-root level- in several parts of the country.

2. Several large field practice areas will become accessible for study and research, especially O.R.

3. Various project areas can become demonstration centres for community health services. Such efforts are more likely to succeed as they will be implemented through local voluntary agencies that already possess a record of useful community service and that can ensure effective community participation the sine-qua-non for a successful community health programme.

4. Several alternative strategies for health care can be tried and their relative merits evaluated.

5. The teaching potential of such work must not be lost sight of Apart from the demonstration of effective community health services the postgraduate students can be involved in all important steps, including surveys to determine the health profile of an area, planning of actual community health servi[illegible] training of health workers, etc. instead of doing theoretical exercises.

...7/-

6. The Cell offers the unique opportunity of planning for integrated rural development where the health plan has to be devetailed into a general development plan, of which it is an integral component. It also offers the possibility of testing the hypothesis of Dr.Melanbaum(6), who thinks nutrition and health programmes give a great boost to overall development.

7. The Centre for Community Medicine will have the opportunity to experiment with the training, especially in-service training of community health workers and volunteers and para-medical workers.

8. In all general development plans, the use of appropriate technology is an important item. Where the atmosphere is conducive, the Centre for Community Medicine can experiment with the usefulness and acceptability of certain appropriate technologies for rural health. A list of such technologies has already been attempted.

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2. Haldipur, R.N. "Integrated Area Planning: Concepts and Methods" Foreward. Published by Training Division of Department of Personnel, Cabinet Secretariat, New Delhi -- 1972.
3. Sen L.K. ibid. p.3.
4. Myrdal,Gunnar " Asian Drama" Vol.3, pages 1617-8; Published by Twentieth Century Fund.Allen Late the Penguin Press,London,1968.
5. Ramalingaswami; V and P. "Health Service Prospects" p.196 published by the Lancet and the Nulfield Provincial Hospitals Trust,London,1973.
6. Melanbaum, W. "International Journal of Health Services,Vol.3, No.2,1973.

On-going activities for Voluntary Health Agencies:

A certain amount of work in the field of voluntary health has already been attempted. It involved:

1. Preparation of a State-wise list of voluntary health agencies. This list is constantly being extended (Ref.Objective No.(i)
2. Collection of information on various appropriate technologies for rural health work. (Ref. Objective No.(v)
3. Paying visits to villages served by certain voluntary health agencies in order to study the health profile of the area and the existing health services. This was followed by preparation of micro-plan for the health needs of the area. Collaborating VHAs are given below. (Ref.Objective No.(vii) Population covered: 1 lak.

4. Plannin g and co nduction of household surveys covering demographic, socio-economicand health variables.

   Ref. objective No.(vii)
   Population covered: 15000
   (Sample size: 5000)

5. Involvement of Postgraduate students in surveys and health planning. (Ref.Objective No.(ix).

6. Attemps have been made to establish contacts by becoming a member of institutions working closely with voluntary health agencies namely AVARD and Gandhi Peace Foundation.

7. Some voluntary work is being attempted through National Service Scheme also.

Collaborating voluntary health agencies:

The type of help mentioned above has been provided to the VHAs described below. They are all well known and well established voluntary organisation working in the villages at grass-root level. This effort was confined to a population of about 1 lakh because of personal limitations; there is no dearth of interested VHAs.

1. Vedchi Intensive Area Scheme(VIAS),Valod Taluka, Dist.Surat. Population covered: 52,000.

2. Tagore Society Simulpur Project, Dist.24-Parganas(W.Bengal) Population covered: 12,000.

3. Gram Niyojan Kendra's project in Block Manbazar,Dist.Purulia, (W.Bengal) Population covered: 17,000.

4. Vivekananda Seva Sadan,Village Mandra,Dist.Hooghly(W.Bengal), Population covered: 15,000.

5. GRAVIS(Reg.) It is a voluntary organisation based in a large village called Daula, Dist.Meerut (U.P.). This is a rural project that was initiated by the writer of this note in order to (among other things) gain experience in integrated rural development work. Health will be an integral part of the overall development process. Therefore a multi-disciplinary approach has been adopted with the collaboration of workers belonging to Delhi School of Social Work, Pantnagar Agricultural University, G.K.U.P. Engineers and Architects etc. Gandhi Peace Foundation has also joined hands and has contributed an experienced Social worker who is now staying permanently in the village with his family.

6. AVARD - I am helping AVARD prepare a Community Health Programme for the Jayaprabha Hospital and Research Centre coming up in Patna in honour of J.P.

.-.-.-.-.

Ravi Narayan

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d) The cell should establish contacts with certain Govt. Departments dealing with voluntary health agencies (such as Deptt. of Rural Development and Central Social Welfare Board etc.)

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....5/-

7. Funding:

The A.I.I.M.S. is expected to provide the basic facilities, or seed money, to put the Cell on its feet.

Many Voluntary health agencies may be able to pay for the expenses incurred by the Cell in order to help them - such as Transportation, secretarial or statistical assistance etc.

Although the Cell can be started on a shoe-string budget, its cost will escalate quickly once its usefulness is established. However, arranging for funds from Govt. or non-Govt. agencies will not be difficult, if the Institute considers this desirable.

8. Other Inputs:

They will depend on the work-load. A research officer and a Statistician may be required within a year. A good Social Scientist can be most useful. Further requirements will depend upon the performance of the Cell. It can become a fairly large undertaking if the Institute so desires.

Advantages of the Voluntary Health Agencies Cell:

The benefits of this project are not far to seek. Apart from the advantages accruing to voluntary health agencies, and the better health services reaching the rural communities, the Cell will have the following advantages for the Institute:

1. It will provide the Centre for Community Medicine with detailed insight into the actual health problems of the rural communities at the grass root level-in several parts of the country.

2. Several large field practice areas will become accessible for study and research, especially O.R.

3. Various project areas can become demonstration centres for community health services. Such efforts are more likely to succeed as they will be implemented through local voluntary agencies that already possess a record of useful community service and that can ensure effective community participation, the sine-qua-non for a successful community health programme.

4. Several alternative strategies for health care can be tried and their relative merits evaluated.

5. The teaching potential of such work must not be lost sight of. Apart from the demonstration of effective community health services, the postgraduate students can be involved in all important steps, including surveys to determine the health profile of an area, planning of actual community health services, training of health workers, etc. instead of doing theoretical exercises.

6. The Cell offers the unique opportunity of planning for integrated rural development where the health plan has to be dovetailed into a general development plan, of which it is an integral component. It also offers the possibility of testing the hypothesis of Dr. Melanbaum(5), who thinks nutrition and health programmes give a great boost to overall development.

....6/-

7. The Centre for Community Medicine will have the opportunity to experiment with the training, especially in-service training of community health workers and volunteers and para-medical workers.

8. In all general development plans, theuse of appropriate technology is an important item. Where the atmosphere is conducive, the Centre for Community Medicine can experiment with the usefulness and acceptability of certain appropriate technologies for rural health. Alist of such technologies has already been attempted(Appendix II)

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APPENDIX I

On-going activities for Voluntary Health Agencies:

A certain amount of work in the field of voluntary health agencies has already been attempted. It involved:

1. Preparation of a State-wise list of voluntary health agencies. This list is constantly being extended.
   Ref. Objective No.(1)
   Also see Appendix II. — ?

2. Collection of information on various appropriate technologies for rural health work.
   Ref. objective No.(v)
   See Appendix III ?

3. Paying visits to villages served by certain voluntary health agencies in order to study the health profile of the area and the existing health services. This was followed by preparation of micro-plan for the health needs of the area. Collaborating VHAs are given below.
   Ref. Objective No.(vii)
   Total population covered: 1 lakh.

4. Planning and conduction of household surveys covering demographic, socio-economic and health variables.
   Ref. objective No.(vii)
   Population covered: 15000
   (sample size: 5,000)

5. Involvement of Post graduate students in surveys and health planning. Ref. objective No.(ix)

6. Attempts have been made to establish contacts by becoming a member of institutions working closely with voluntary health agenc- namely AVARD and Gandhi Peace Foundation.

7. Some voluntary work is being attempted through National Service Scheme also.

Collaborating voluntary health agencies:

The type of help mentioned above has been provided to the VHAs described below. They are all well known and well established voluntary organisations working in the villages at grass-root level. This effort was confined to a population of about 1 lakh because of personal limitations; there is no dearth of interested VHAs.

1. Vedchhi Intensive Area Scheme(VIAS), Valod Taluka, Dist. Surat, Population covered: 52,000.
2. Tagore Societys' Simulpur Project, Dist 24-Pargnas(W.Bengal) Population covered: 12,000
3. Gram Niyojan Kendra's project in Block Manbazar, Dist. Purulia, (W.Bengal) Population covered: 17,000.
4. Vivekananda Seva Sadan, Village Kendra, Dist. Hooghly(W.Bengal) Population covered: 15,000.
5. GRAVIS(Reg) It is a voluntary organisation based in a large villa- called Daula, Dist. Meerut(U.P.) This is a rural project that was initiated by the writer of thisnote in order to(among other thing- gain experience in integrated rural development work. Health will be an integral part of the overall development process. Therefore a multidisciplinary approach has been adopted, with the collaboratio- of workers belonging to Delhi School of Social Work, Pantnagar Agricultural University, G.R.U.P. Engineers and Architects etc. Gandhi Peace Foundation has also joined hands and has contributed an experienced Social Worker who is now staying permanently in the village with this family. A detailed report on GRAVIS is attached as Appendix IV.

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HEALTH CO-OPERATIVE - A NEW STRATEGY IN THE DELIVERY OF COMPREHENSIVE HEALTH CARE - AN EXPERIMENT AT MALLUR

INTRODUCTION

Health facilities in rural areas in the country were provided through Primary Health Centres started as part of a 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 Primary Health Centres, each Centre serving a population of 80,000 to 120,000.

For establishing an effective and viable Primary Health Care system, the co-operation 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 co-operatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local health 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.

THE MALLUR MILK CO-OPERATIVE (MMC)

Mallur is a village in Kolar District of Karnataka, situated 35 miles from the city of Bangalore. The Mallur Milk Cooperative (MMC) was an established concern with a sound and progressive leadership and had been functioning for many years. In addition to production and sale of milk, it provided other benefits like provision of fodder and cattle foods, tractor facilities and looms at low rates of interest.

Besides the people of Mallur, two other villages, Muthur and Kachahalli were members of the Co-operative and the total population covered was about 3,000. These villages had a silk farm co-operative 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 (CAHP) and Fr Jonas of the Catholic Bishops Conference of India (CBCI). With these pioneers, the Dean and the Department of Preventive and Social Medicine of St John's Medical College, representatives of the Karnataka Government and Bangalore Government Dairy with leaders of the Mallur Milk Cooperative, worked out a scheme for tagging on a health service to the existing MMC.

The main objectives of the Mallur Health Project were:

(a) 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;

(b) to help in the establishment of rural health centres with the staff and rendering of effective health services to a wide circle of needy peopld without distinction of race, caste or creed;

(c) 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;

(d) to help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas; and

(e) to train intern doctors, nurses and other medical and para-medical staff for the purpose of rendering assistance in rural areas.

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

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

Table I (Contributions to the Health Co-operative)

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
1st	1 p.	2 p.
2nd	2 p.	1 p.
3rd	3 p.	nil

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 Dept of Preventive and Social Medicine,
St John's Medical College, Bangalore
Director/General Manager, Bangalore Dairy
Representative of State Health Service
Medical Officer, Mallur Health Cooperative (Secretary)

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

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The Health Cooperative got off to a good start by being inaugurated on 19 March 1973 by the Minister of Animal Husbandry. Dr VK Rajkumar, a Senior House Officer in St Martha's Hospital, joined as Resident Medical Officer in charge of the Co-operative.

The Health Cooperative, 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 Cooperative 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 Government Dairy, therefore, stopped its contribution of 2 paise per litre 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 Mallur and other villages. The Milk Cooperative was doing well and decided to contribute 5 paise per litre 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 Cooperative has borne the entire recurring costs of the health project ever since. Receipts/Payments position for the period 1975-76 is appended (Table II).

Although the Mallur Health Project is mainly financed by the Mallur Milk Cooperative, it also receives help and technical direction from St John's Medical College and the Government Health Service. These inputs are shown in Table III.

Table III

Source	Capital	Recurring
1. Mallur Milk Cooperative	Buildings, Furniture, Refrigerator, Health Education Materials	Salaries, Rents/Electricity, Drugs, General Stores, Petrol
2. St. John's Medical College	Physicians and Midwifery Kit, Minor Surgical Equipment, Lab Equipment Motor Cycle (on loan through UNICEF)	Interns services Specialist Services Rent and electrical charges for interns quarters
3. Government Health Service	Nil	Vaccines, Vit. A., Iron, Folic acid supplementary FP Devices, Surveillance of Communicable Diseases (through PHC Sidlaghatta) Health Education Films (through Health Education Departmentof DHS)

SERVICES RENDERED THROUGH COMMUNITY PARTICIPATION

The St John's Medical College adopted this Health Cooperative as a rural training centre for interns. Visits by specialists of other departments including specialist camps were organized. At present, 4 interns are attached at any one time for whom residential accommodation has been provided by the MMC on a rental basis. The interns conduct base line demographic surveys, immunization and school health programmes, special health projects and mass health education programmes.

The Health Cooperative Committee meets at Mallur periodically to discuss progress and plan for the future.

Dr Rajkumar after a dedicated service of nearly 4 years resigned from his post and Dr Kiriti Keshavan has taken over from 15 June 1977.

The Health Team comprising of Dr Kiriti, his staff and interns under the technical supervision of Department of Preventive and Social Medicine, St John's Medical College, has made good contact with the villagers and a comprehensive health care programme has been introduced. The community of Mallur and other member villages actively participate in all programme. They have no unreasonable expectations or demands, as the health project is their own programme brought about through their own contributions. This is a basic difference between Health Centre organised through Cooperatives and Governmental Agencies. The leaders are actively involved in the planning and organization as the Chairman, MMC is the Chairman of the Health Cooperative Committee and the Secretary, MMC its member. Paramedical workers are drawn from the village community and trained for Community Health work. The Young Farmers Association actively assists in any of the health programmes. They help interns in their survey programmes of immunizations 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 runs a nursery school and acts as a forum where health education, applied nutrition programmes are undertaken.

The Health Team and interns organise the following services with community participation.

PERSONAL SERVICES

1. Curative Clinic (daily out-patients)
2. Maternity and Child Health Services:

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

3. School health services for village schools
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and oral polio
5. TB and Leprosy case detection, treatment and follow up.
6. Motivation for family planning
7. Specialist Camps at Mallur (monthly visits by Specialists from St Martha's Hospital, Bangalore)
8. Hospital Referrals
9. Family record maintenance

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COMMUNITY SERVICES

1. Protection of well water by chlorination
2. Popularisation and construction of sanitary latrines and soakage pits and other advise on environmental sanitation
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 Cooperative 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 IV below shows the percentage of member and non-member families in each village.

Table IV (Percentage of member and non-member families in each village)

Village	Families		
	Member	Non-member	Total
Mallur	188	202	390
Muthur	63	124	187
Kachahalli	30	21	51
Bhatrenahalli	17	14	31
Harlurnaganahalli	6	18	24
	304	379	683
	45%	55.5%	

CONCLUSION

Our experience over the last two and half years have shown that

i) A health function can be grafted on to an economic cooperative

ii) A sound cooperative such as MMC 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 non-members who get indirect benefits of professional services, preventive and promotive programmes.

The Department of Preventive and Social Medicine and its staff, was mainly concerned in acting as a catalytic agent, in the formation of a self sustaining rural community health scheme. An experiment was embarked upon and the Mallur Project is this experiment. A Total Health Care Programme can be effectively delivered through

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a Cooperative in rural areas.

The Mallur Milk Cooperative is even contemplating construction of a 15 bedded hospital at Mallur, with the help of Government and its own funds. We are convinced of the responsible role of Village Leaders in such a programme.

Further, the Health Centre with its working philosophy has indirectly helped the Department of Preventive and Social 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. We are fully aware 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.

A drive to improve the education of the people including health education, is to be attempted through 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 introducing such self-sustaining Cooperative Schemes to other areas should receive active consideration. Challenges have to be met in rural India and we hope that with the cooperation and participation that is readily forthcoming from the simple rural folk, our economic and health projects will meet with success.

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Table II

MALLUR HEALTH COOPERATIVE CENTRE, MALLUR, KOLAR DISTRICT

Receipts and Payments Accounts for the year 1975-76

RECEIPTS	Rs. P.	Rs. P.	PAYMENTS	Rs. P.	Rs. P.
To Contribution from MPCS		38,500.00	By Salaries		16,421.73
" from MPCS, Muthur		174.81	" Hospital rent	1,200.00	
" Commission on sale of milk from Dairy		7,847.60	" Dr's Quarters rent	720.00	1,920.00
" Treatment of non-members of MPCS	21,082.04		" Proportionate charges to Dr. on housevisits		56.25
" Sale of tonics	7,543.68				
" Doctor's Home visit charges	278.00	28,903.72	" Repairs to hospital		331.42
" Rent for intern's quarters		1,869.50	" Purchase of drugs		39,487.48
			" Hospital necessaries		1,389.28
" Deposits from staff members		345.00	" Eye camp expenses		76.75
" Interest on deposits		30.74	" Advance to staff		300.00
			" Contingencies:		
			General	225.36	
			Elec. charges	672.97	
			Printing & Stationery	1195.65	
			Entertainment Charges	224.30	
			Conveyance	348.80	
			Repairs to Motor Bike	224.55	
			Repairs to Typewriter	40.50	
			Demorrhage charges	100.98	
			Miscellaneous	545.28	3,578.39
			" Furniture		4,421.45
			" Advances refunded to MPCS		200.00
			" Difference in Accounts		5,218.55
Total Receipts		77,671.37	Total Expenditure		73,401.30
Opening Balance			Closing Balance		
a) Cash	811.53		a) Cash		5,401.78
b) Bank	1,726.84	2,538.37	b) Bank		1,406.66
Grand Total		80,209.74	Grand Total		80,209.74

Sd/-
Approved Auditor

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Karnataka-9

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

by

*MAJ GEN B MAHADEVAN PVSM AVSM MBBS DPH., DTM & H., FRIPHH., FCCP., FIPHA

INTRODUCTION

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 assume 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.

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 co-operatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local health 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.

THE CONVENTIONAL APPROACH

Health facilities in rural areas in the country were provided through Primary Health Centres started as part of a 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 Primary Health Centres, each Centre serving a population of 80,000 to 120,000. The annual expenditure of medicine permitted for each Centre ranges from Rs. 4,000/- to Rs. 6,000/- and this had to take care of such a large population. The scheme was extended to involve Medical Colleges in rural health work and through deliberations of many committees, the status of health centres were improved both qualitatively and quantitatively. An integrated approach of providing health services to the rural people, with the provision of two doctors to every Primary Health Centre and a basic health worker 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 involving 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

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idea is to train doctors for rural areas, these doctors are not attracted to such areas. The migration of Indian doctors to the more developed countries continues. Even passing of a Parliament Act which empowers government to oblige doctors and engineers below age of 30 to work for a period of 4 years in rural areas, remains unsolved as we are unable to provide reasonable living conditions for them in villages.

Some Medical Colleges like Vellore Christian Medical College incorporated in their teaching programme, the rural dimension in a 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.

The Kerala Government with Government of India initial one time grants, has 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 rural section of the country.

A NEW STRATEGY

From the facts and figures just given, it is clear that 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 improvement 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 the formation of personnel who will deliver the same. At the same time, there is an inescapable need for complementary services which will develop the village 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 were conditions are favourable for the introduction of self-supporting schemes.

Funds for rural health schemes may be raised through many ways:

(a) 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 ready made

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frame work of community administration for integration of effective health services and community involvement, as channels of communication with the people have already been established. Co-operative Dairying and Marketing Co-operatives of different commodities like grains, cereals, cottage industrial products etc., lend themselves admirably to this type of health services.

(b) 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 is worthy of trial, in special areas.

(c) Assistance from Panchayat

Places 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.

(d) Starting with services and evolving a cooperative at a later stage.

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 cooperative and directly employ the doctor and essential para-medical 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 cooperative 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 MALLUR MILK CO-OPERATIVE (M.M.C.)

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

e) to train intern doctors, nurses and other medical and para medical staff for the purpose of rendering assistance in rural areas.

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 a self-sustaining rural community health scheme, fulfilling the above objectives.

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

TABLE I (Contributions to the Health Co-operative)

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
1st	1 p	2 p
2nd	2 p	1 p
3rd	3 p	nil

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 Dept of Community Medicine, St John's Medical College, Bangalore

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Director/General Manager, Bangalore Dairy
Representative of State Health Service
Medical Officer, Mallur Health Cooperative (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 Husbandry. Dr VK 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-sacrifices, made the Mallur Health Co-operative a successful enterprise.

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.

THE BREAK THROUGH IN THE ECONOMICS OF THE HEALTH CO-OPERATIVE

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 2 paise per litre 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 Mallur and other villages. The Milk Co-operative was doing well and decided to contribute 5 paise per litre 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 the table below gives the Income/Expenditure position for the period July 74 to June 75.

TABLE II (Recurring Costs)
(Year - July 74 to June 75)

Total Milk Production	6,27,898 litres
Income estimated at 5 paise/litre	Rs.31,394.90
Actual income received from MMC	Rs.33,100.00
Total expenditure for the year	Rs.33,790.74

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

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TABLE III (Shows the various inputs)

Source	Capital	Recurring
1. Mallur Milk Co-operative	Buildings, Furniture, Refrigerator, Health Education Material	Salaries Rents/electricity Drugs General stores Petrol
2. St John's Medical College	Physicians and Midwifery Kit Minor Surgical Equipment Lab Equipment Motor cycle (on loan through UNICEF)	Interns services Specialist services Rent for interns quarters
3. Government Health Services	Nil	Vaccines, Vit A, Iron, Folic Acid supplementary FP Devices Surveillance of communicable diseases (through PHC Sidlaghatta) Health Education Films (through Health Education Department of DHS)

SERVICES RENDERED THROUGH COMMUNITY PARTICIPATION

The St John's Medical College, adopted this Health Co-operative as a rural training centre for Interns. Visits by specialists of o ther departments including specialist camps were organised. At present, 4 interns are attached at any one time for whom residential accommodation has been provided by the MMC on a rental basis. The interns conduct base line 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 St John's Medical College, to discuss progress and plan for the future.

The Health Team comprising of Dr Rajkumar, Miss Maria and Interns under the technical supervision of Dpt 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 actively participate in all programme. They have no unreasonable expectations or demands, as the health project is their own programme brought about through their own contributions. This is a basic difference between Health Centres organised through Co-operatives and Governmental Agencies. The leaders are actively involved in the planning

and organisation as the Chairman, MMC is the Chairman of the Health Co-operative Committee and the Secretary MMC its member. Paramedical workers are drawn from the village community and trained for Community Health work. The Young Farmers Association actively assists in any of the health programmes. They help interns in their surveys, programmesof immunizations 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 programmesand mothe craft are taught to the womenfolk of the villages.

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. antental care;
   ii. midwifery (domiciliary)
   iii. postnatal care
   iv. under-5 clinics(domiciliary)
3. School health services for village schools
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and cholera
5. 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 and soakage pits and other advise on environmental sanitation
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 Cooperative 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 IV below shows the percentage of member and non-member families in each village.

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TABLE IV
(Percentage of member and non-member families in each village)

Village	Families		
	Member	Non-member	Total
Mallur	188	202	390
Muthur	63	124	187
Kachahalli	30	21	51
Bhateronahalli	17	14	31
Harrulunagenahalli	6	18	24
	304	379	683
	45.%	55.5%	

CONCLUSION

Our experience over the last two and half years have shown that:

i) A health function can be grafted on to an economic cooperative

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

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

The Department of Community Medicine and its staff, was mainly concerned in acting as a catalytic agent, in the formation of a self-sustaining rural community health scheme. An experiment 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 Mallur Milk Co-operative 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 incr asing enrolment. Other economic activities such as development of village/cottage industries and handicrafts and ensuring sale of products, are contemplated. We are fully aware 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 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 co-operatives in comparison with other areas in the vicinity, needs study and this has been taken up as a health project.

The question of introducing 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 we hope that with the cooperation and participation that is readily forthcoming from the simple rural folk, our economic and health projects will meet with success.

ACKNOWLEDGEMENT

I wish to thank the "Ad-hoc Committee" of the C.B.C.I. Centre, New Delhi, for in the compilation of this paper, I have drawn liberally on their report "Agency for Community Health Assistance in Rural Areas (ACHRA)".

I also would like to thank the staff of my department and Dr Rajkumar of the Mallur Health Centre, for their help.

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VOLUNTARY HEALTH AGENCIES CELL

Directory of Community Health Projects and Alternative approaches to Health Care.

(VOLUNTARY AGENCIES)

I N D I A

COMMUNITY HEALTH CELL
47/1,(First Floor)St. Marks Road
BANGALORE - 560 001

ANDHRA PRADESH

1. Indo-Dutch Project for
   Child Welfare,
   6-3-885 Somajiguda
   Hyderabad-500004.(Dr.H.W.Butt)

2. Community Health Project
   Philadelphia Leprosy Hospital,
   Salur District,
   Srikakulam (Dr.R.H.Thangaraj)

3. Arogyavaram Development Society
   Madanapalle Taluk,
   Chittoor District.

4. R ArogyaYaram Development
   Society,
   Madanpalle Taluk,Chittoor

5. Health Programmes
   Andhra Mahila Sabha,
   University Road,
   Hyderabad.

6. Village Reconstruction Organisation,
   6/9 Brodipet,Guntur
   (Prof.M.A.Windey S.J.)

7. Community Health Project
   Rayalaseema Development Trust
   Anantpur (Dr.Titaus)

8. Community Health Project
   CSI Hospital,Jammalamadugu
   Dist.Cuddapat (Dr.G.Arthur Samuel)

9. Swallows Hospital,
   Rajupete,Choldiganipalli P.O.
   via V.Kotu 517424
   Chittoor District
   (Miss Maria G.Zilloli-PHN)

10. Community Health Projects
    CSI Victoria Hospital
    Dichpalli,Dist.Nizamabad
    503175 A.P.(Dr.L.M.Hogorzeil)

II. ASSAM

1. Total Health Care Project
   Tamulpur Block,
   Kamrup District.

2. Tamulpur Anchalik Gramdan
   Sangh, Kumarikata 781360
   Dist. Kamrup.

~~xxx~~ BIHAR

1. Community Health Project
   Kurji Holy Family Hospital
   P.O.Sadaquat Ashram,
   Patna.

2. Agricultural cum-
   Development Project
   Krishi Samudayik Vikas
   Yojana,Palamau,
   Bhanderia Block,Bihar

3. Brothers to All Men
   International,
   P.O. Buniadganj,Gaya
   823003.

4. Xavier Institute of
   Social Service,PB No.9
   Ranchi-834001.

5. Samanyaya Ashram,
   Bodh Gaya.

6. Gram Bharati Sarvodaya
   Ashram,P.O.Simultala
   811316,Dist.Monghyr.

7. Community Health Project
   Holy Family Hospital,
   Kurji- Patna

~~xxxxxxx~~ DELHI

1. Okhla Neighbourhood
   Comprehensive Health &
   Welfare Project,Holy
   Family Hospital,
   Jamia-Okhla,New Delhi
   (Sr.Anne De.Souza)

2. Mobile Creches for
   Working Mothers,
   5B Telegraph Lane
   New Delhi-110001.

3. Voluntary Health Associati
   C-14,Community Dev.
   Centre,S.D.A. New Delhi
   -16.
   (Dr.Murray Laugeson)
   (Dr.Ruth Harner)

4. Rural Health Trg.Centre,
   Najafgarh,Delhi.

GUJARAT

1. Bochasan Gujarat Blind Relief and Health Association(GBRHA) Chikodara, Anand Taluka, Kaira Dist.(Dr.R.K.Poshi)

2. Medico Friend Circle 21,Nirman Society, Vadodara-390005 (Ashok Bhargava)

HARYANA

1. Family Survival Assurance Plan (FSAP) Phildelphia Hospital Ambala(Haryana)

HIMACHAL PRADESH

V.H.W.Scheme, Lady Willingdon Hospital, Manali,Kulu Dist. (Dr.S.A.Kaul Proj.Dir.)

KARNATAKA

1. MALLUR HEALTH COOPERATIVE CENTRE Mallur-Siddaghata, Kolar Dist.(Dr.Ravi Narayan) (Maj.Gen.B.Mahadevan) (Dr.S.V.Rama Rao)

2. Nirmala Health Centre, Sylurepura Near Hessaraghatta. (Dr.Percy Mupicken)

3. Community Health Project St.Marthas Hospital, Nruptunga Road, Bangalore-560009 (Dr.Para Amor)

4. Community Health Project C.S.I. Hospital,Bangalore (Dr.Benjamin)

5. Community Health Project Baptist Mission Hospital, Hebbal,Bangalore.

6. MEDICARE Medical Relief Society Kasturba Med.College PB 8,Manipal 576119 (Dr.A.Krishna Rao)

KASHMIR

1. Rehbar-I-Sehat Pilot Project, J&K Govt.

2. Village Health worker Trg. Scheme project (John Bishop Memorial Hospital) Chichurpura Area, Anantnag Dist. (Dr.M.Xavier MS)

3. Senathan Village Project John Bishop Memorial Hospital Anantnag.

KERALA

1. Family Survival Assurance Plan Mondakapadam,Mandiram Hospital

2. Dr.T.N.Jayachandran Registrar of Coop Societies, Kerala,Trivandrum.

3. M.V.George,Chief Evaluation Officer,State Planning Board Trivandrum.

4. Mitraniketan, P.O.Vellanad 695543, Dist.Trivandrum

5. Kerala Gandhi Smarak Nidhi Gandhi Bhavan,PO Thycaud Trivandrum 695014

MADHYA PRADESH

1. Community Health Project, Christian Hospital Chattarpur,Via Harpalpur.

2. Kishore Bharati Vill.Palia Piparia PO-Malharwada via-Bankhedi Dist.Hoshangabad-461990 (Anil Sadgopal)

Maharashtra

1. Integrated Health Services Project-Wanless Hosp.Miraj Med.Centre,Miraj,Dist.Sangli (Dr.Eric R.Ram,Project Dir.)

2. Rural Health Research Project The Foundation for Research in Community Health, 48 A,Abdul Gaffar Khan Rd. Worli Bombay

(Dr.N.H.Antia-Trustee)

...3/-

MADHYA PRADESH

1. PROJECT POSHAK
   CARE-India
   Greater Kailash,
   New Delhi.
   (Dr.Tara Gopaldas)

2. Padhar Hospital Community Health Project,
   PO Padhar, Betul Dist.
   (Dr.C.Ross Dir.)

3. MAHARASHTRA

Foundation for Research in Community Health,
V.Dhomawde PO
Awas Dist. Kolaba
(Mr.& Mrs.Aloke Mukherjee)

Comprehensive Rural Health Project,Jamkhed
Dist.Ahmednagar(Dr. R.S.Arole) Dir.

Family Survival Assurance Plan
Evangelvie Booth Hospital
Ahmednagar.

KASA Model Integrated Mother-child Health Nutrition Project-PHC KASA
Taluka Dahanu,Dist.Thana
(Prof.P.M.Shah)

Palghar Project
Dist.Thana
(Prof.P.M.Shah)

Kasturba Health Society,
Sewagram,Wardha 442102
(Dr.Sushila Nayar)

Appasaheb Patwardhan Memorial Trust
Mahatma Gandhi Seva Mandir,
252, S.V.Road,Bandra West
Bombay-400050

Maliwada (Deogiri)
Aurangabad Dist.
(Mr.Vinod Parekh)

Comprehensive Health Care & Dev.Project,
Mission Hospital,P.O.Pachoot
Dist.Aurangabad.

Community Health Project
Chichpada Christian Hospital,
Dhulia Dist.

Janta Shikshan Mandal
Sane Guruji Vidya Prabodhini
Khiroda,Jalgaon Dist.
(John.Sommer,Ford Foundation)

Rural Health Project,Sirur
Poona Dist.(Dr.H.S.Deodhar)

Uruli Derachi-Shajeevan
Audhyogik Sahakari Society Ltd.
Bade Satra Mali,Hadpsar-Poona-28
(Mr.Virendra Kabra)

Maharogi Sewa Samiti
Dattapur 442001
Dist.Wardha

NAGALAND

Teachers Training Programme,
Paramedical Trg.Institute,Kohima

ORISSA

Community Health Project,
Christian Hospital,
P.O.Nowrangpur,
Koraput District 764059

Community Health Project
Christian Hospital,
V.Diptipur,Dist.Sambalpur.
(Miss Marilyn Mills)

Agriculture Training Centre
Gopalwadi PO. Antanada
via Rajagoda,765001 Dt.Koraput

PUNJAB

Community Health Programme
Mac Robert Hospital
Dhariwal,Dist.Gurdaspur
(Dr.I.S.Oberoi)

....4/-

TAMILNADU

Voluntary Health Services Scheme,
V.H.S. Medical Centre,
Adayar, Madras.
(Dr.K.S.Sanjivi)

Family Survival Assurance Plan,
Bethesda Hospital,
Ambur.

Deenbandhu Medical Mission
R.K.Pet-631303
Dist. Chingleput
(Dr.Prem Chander John)

Comprehensive labour Welfare Scheme,
United Planterrs Association of
S.India(UPASI)
GlenView,Coonoor-Nilgiri
(Dr.Mrs.V.Rahmathullah)

Community Health Project
Kottar Social Service Society
Kanyakumari Dist.
c/o Bishops House,PB 17
Nagercoil 629001(Dr.James)

Community Health Project
Christian Fellowship Hosp.Centre,
V.Oddanchatram,624619
Dist. Madurai(Dr.Jacob Cherias)

Child Care Centre and Nutrition
Rehabilitation Centre
Madurai,Govt. Erskine Hosp.
(Dr.G.Venkataswamy)

Community Health Programme,
CSI Hospital,Woriur
near Tiruchirapalli
(Dr.Mrs.Stephen)

Health,Nutrition & FP Centre
Swallows in India,
Desia Nagar,New Washermenoct
Madras-81.

RAJASTHAN

Community Health Programme,
The social work & Research Centre,
Tilonia P.O.
Madanganj 305812(Ajmer)
(Dr.Arti Sawhny)

Sewa Mandir
Udaipur-313001
(Dr. Mehta)

UTTAR PRADESH

Community Health Programme,
Methodist Mission Hospital,
Jaisinghpura,Mathura
(Dr.E.S.Sundaram MS)

Community Health Project
Harriet Benson Memorial Hosp.
Lalitpur,Jhansi Dist.
(Dr.N.K.Bachan)

The Agrindus Institute
Banwasi Sewa Ashram,Govindpur
via Turra,Dist.Mirzapur.

Literacy House,
Lucknow

WEST BENGAL

Vivekananda Seva Sadan,
V.& PO Mandra,
Dist.Hooghly
(Dr.Ghosh)

Sewa Bharati
P.O.Kapgari,
Dist.Midanpore.

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0247	0344	0453	0648
0248	0347	0454	0658
0249	0348	0455.	0680
0[illegible]0	0349	0477	0683
0264	0356	0518	0686
0267	0366	0519	0688
0269	0367	0526	0690
0274	0368	0539	0694
0284	0370	0542	0696
0286	0371	0593	0697
0287	0377	0595	0780
0288	0379	0596	
0291	0381	0597	
0292	0388	0598	
0317	0390	0604	
0318	0415	0610	
0341	0424	0647	

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0711	0892	1050	1155	1336
0715	0909	1052	1156	1337
0734	0914	1053	1171	1347
0745	0922	1059	1175	1362
0750	0928	1065	1176	1367
0752	0931	1066	1205	1372
0753	0932	1070	1206	1381
0769	0936	1071	1223	1382
0772	0943	1073	1233	1383
0778	0952	1076	1238	1884
0792	0954	1077	1239	1395
0793	0959	1081	1244	1398
0797	0964	1082	1245	1399
0809	0966	1088	1246	1400
0822	0979	1089	1247	
0835	0980	1090	1250	
0836	0988	1093	1263	
0846	0992	1098	1279	
0848	0994	1112	1284	
0851	1001	1116	1287	
0863	1011	1117	1300	
0864	1016	1136	1304	
0874	1021	1138	1306	
0878	1027	1151	1307	
0881	1028	1152	1326	
0887	1029	1153	1331	
0888	1042	1154	1332	

Alternative Strategies in Health Care

Source
i) ICMR = I
ii) UNICEF/SCAR = U
iii) VHAI = V
iv) GPF = G

SNo	Name	Address	Features
1	Project Poshak Madhya Pradesh (Dr Tara Gopaldas)	Care-India New Delhi	Package of Services to Preschool Rural & Tribal Children in Madhya Pradesh (Food supplement, curative services, deworming, immunization maternal and child education)
2	KASA Model integrated Mother-Child Health Nutrition project (Prof. P.M. Shah Institute of Child Health Grant Medical College JJ Group of Hospitals Bombay)	PHC, KASA Taluka Dahanu District Thana Maharashtra (Palghar Project)	Effective surveillance of all Under sixes and Pregnant and Lactating mothers by Part Time Social Workers - PTSWs Male & Female Community level workers - 4 weeks training - Rs 80/= a month
3	Indo-Dutch Project for Child Welfare (Dr. H.W. Bult)	6-3-885, Somajiguda. Hyderabad Andhra Pradesh	Integrated Child Welfare Project. a) Training of well qualified workers for child health schemes b) Linking of Mahila Mandals with economic projects such as prepn of protein/spice packets c) Direct involvement of mothers in prepn of supplementary foods (Hyderabad mix)
		f) Establishment of creches, nutrition demonstration units, veg & fruit gardens	d) Experimentation c̄ different types of preschool education programme e) Dairy and Poultry - small scale family units

S.No	Name	Address	Features
4.	Child Care Centre and Nutrition Rehabilitation Centre Madurai (Dr. G. Venkataswamy Director Dr K.A. Krishnamurthy Hon. Director)	Govt Erskine Hospital, Madurai Medical College Madurai - Tamilnadu	Nutrition Education thru feeding demonstration Curative services / Immunization Road to Health Charts Village Health Workers - local middle aged women - 2wks training. Training of Balsevika Family Welfare Clinics
5	Community Health Project, Lalitpur (Dr. N.K. Bachan Medical Supdt. Director Community Health)	Harriet Benson Memorial Hospital Lalitpur Uttar pradesh	- Weekly MCH and Curative clinics - Village Health Committees - Village level Health workers - on Panchayat salary - (Weekly training Class)
6.	Padhar Hospital Community Health Project. (Dr. V.A. Moss) (Director.)	P.O. Padhar. Betul District. Madhya Pradesh (Tribal)	- Health Education - Immunization, FP facilities and minor medical care - Training of TBAs - Training of VHWs (trained, paid 50p/household per month) - Non formal education.
7.	V.H.W Scheme Manali (Dr. S.A. Kaul. Project Director)	Lady Willingdon Hospital, Manali Himachal Pradesh	Village Health Workers trained by Mobile Clinic Doctors and paid by by Community

S.No	Name	Address	Features
8.	Comprehensive Rural Health Project Jamkhed. (Dr R.S. Arole Director)	District Ahmednagar. Maharashtra	

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