LIBRARY AND DOCUMENTATION CENTRE

FrCH NEWSLETTER

Jan. - Feb. 1995 Vol. IX, No. 1

THE SICKNESS IN INDIA'S PUBLIC HEALTH SERVICES

Debabar Bannerjee

Signs and Symptoms

Protecting people against epidemics is one of the primary duties of any civilized government. Indeed, the constitution of India has visualised something much more than mere protection against epidemics as a duty of the government. In its Directive Principles for State Policy, it requires the government to provide comprehensive health and nutrition services to the whole population of the country. But the recent plague epidemic has shown that our government is incapable of discharging even its primary duty of protecting the citizens against epidemics.

The plague has indeed turned into an 'epidemic of epidemics', scourging the country for more than twenty-five years now. Apart from that, almost every year, the country has been swept with epidemics of cholera (euphemistically termed as 'gastro-enteritis'). Barely three months before the outbreak of plague in India, there were reports of massive outbreaks of cholera in Bihar, Uttar Pradesh, West Bengal, Jammu & Kashmir Valley and the North-Eastern Region, claiming thousands of lives. But it received little attention by the media and the government because it affected the downtrodden sections and did not cause much alarm internationally. This is an important indicator for the diagnosis of the sickness affecting India's public health system. Incidentally, because of this sickness, the information regarding government health policy and action is grossly deficient. This could well be a blessing to the government, because it enables the latter to play down the seriousness of the problems. Supervision of information, misinformation and manipulation of information are some of the instruments actively used by the government to cover up its failure in performing its primary duties.

Besides cholera, there have been frequent reports of outbreak of the epidemics of encephalitis and meningococcal-meningitis in different parts of the country. The dreaded disease of Kala Azar, after devastating large populations of the Eastern states of India, had virtually disappeared by the end of 1950. However, it re-emerged in the Northern districts of Bihar in the early 1970's and later spread to some adjacent districts of West Bengal. It is still raging virtually uncontrolled but there was little curiosity within the research establishment as to why it disappeared and why it re-emerged in North Bihar. Dispite all the enthusiasm shown by the research establishment to the Essential National Health Research Organisation, even the need to conduct interdisciplinary operational research to deal with Kala Azar as a public health problem was not realised.

The recent outbreak of epidemics of malaria in Western Rajasthan and the North Eastern Region dramatically showed that even in the watered down programme of malaria containment (after abandoning eradication), there are serious problems of deficient surveys. Hence, spread of the falciperum type parasite with resistance to chloroquin and insecticides.

Analysis of Recent Plague Epidemic

An analysis of the recent outbreak of plague exposes the sickness prevailing in the public health system. The glaring mishaps were:

♦ Warnings of possibility of the epidemic occurring were repeatedly ignored by the public health authorities of one of the foremost states in the country.

♦There was virtually no surveillance system to detect the early symptoms of the epidemic. There was unpardonable delay in action even after the people drew attention of the authorities to rat falls and bubonic fever.

♦ Most of the elementary steps for epidemic control were not taken, even though the many effective tools of insecticides and antibiotics have made the task so much easier.

♦ Hesitant protests by public health specialists were drowned by patently uninformed and irresponsible statements from the authorities concerned - a significant sign of the utter confusion and panic that prevails.

♦ Expectedly, there was a hysterical reaction from the 'sterilized and saniticised' affluent people abroad, leading to a serious set-back to tourism and trade. It is a cruel irony that a democratic government, which could not be goaded into action by the previous epidemics claiming thousands of lives, was awoken by an epidemic that threatened trade and tourism.

♦ Another sign of the serious flaws in the public health system of the

The author is a former Prof. of Community Medicine. JNU and a well known writer on health issues

In this Issue

♦ The Sickness in India's Public Health Services 1
Debabar Bannerjee
♦ Maping Health Resources 4
Shirish Kawadi
♦ Health Hazards 6
Srilatha Batliwala
♦ Health News 7
♦ From The Sr. Librarian's Desk 8

FOR PRIVATE CIRCULATION ONLY

country was that even more than ten weeks after the outbreak, controversy was still raging among the top microbiologists whether it was, indeed, the plague.

It may be noted that outbreaks of epidemics are symptoms of an advanced stage of sickness of the public health services. It is worse when the epidemics range virtually uncontrolled and people are left helpless. That the 'health' of public health services was not very good even before the outbreak of the 'epidemic of epidemics' can be seen from the high prevalence and incidence of diseases like tuberculosis, malaria, filarisis, maternal and childhood diseases and so on. Moreover, the fact that the country does not have reliable reports of births and deaths, not to speak of reports of compulsorily notifiable diseases, shows how deeply the malady has affected India's public health services.

Genesis of the Malady and its Diagnosis

Ironically, India has a rich heritage of public health service. Even during British rule, it had an efficient organization for epidemic control under the leadership of the officers belonging to the Indian Medical Service. A much broader vision of health services was developed in independent India in the reports of the National Health Sub-committee of The National Planning Committee (1940) and the famous Bhore Committee (1946). The first two decades after independence saw many bold initiatives in this field; these were indeed the 'golden decades' of health service development in India. The programme of Primary Health Centres (PHCs) was started in 1952 to provide integrated health services to the rural population, free of cost, as a part of the Community Development Programme. A programme was also undertaken for massive manpower development, with a social orientation of education and training in medical colleges and public health institutes. Interdisciplinary public health research was carried out to devise optional ways of dealing with the prevailing health problems. Such research in the field of tuberculosis brought about fundamental changes in the approach to the problem, not only in India, but all over the world, including the developed and underdeveloped regions. However, instead of building on this solid base, there has been a steep decline in the quality of the public health services during the following decades. The responsibility for this decline squarely lies on the political leadership. Their cynical and even contemptuous disregard for the health of the people they are supposed to be serving led to four major setbacks that contributed to the sickness of the public health service. They ignored the degeneration in the quality of key institutions for education and research in public health like the All India Institute of Hygiene and Public Health, The National Institute of Communicable Diseases and The Indian Council of Medical Research.

♦ There was a steep decline in the quality of public health specialists.

♦ Key public health positions were filled by physicians who had little expertise in public health services.

♦ Generalist administrators belonging to the IAS cadre, who are obvious misfits for taking operational and policy decisions in medical and public health fields, were allowed to dominate the public health system, by the political leadership.

Imposition of target oriented programmes on the public health organization was one consequence of such ignorance at the political level. Insistence on attainment of family planning targets during the past three decades dealt a body blow to the infrastructure of the health services. Moreover, some foreign countries and international institutions added to the erosion of these programmes in the name of 'international initiatives', for e.g. the global programmes concerning immunisation, AIDs, Polio Eradication, Diarrhoeal Disease Control Programme, Acute Respiratory Infections Programme and so forth. In line with this unpardonable neglect, there have been serious cutbacks in allocations for health as a percentage of the overall investment. The already meagre plan allocation of around 3 per cent in the First Plan plunged to less than 2 per cent in the Seventh Plan. The expenditure for health in the Union Budget declined in the 1980s from 0.08 to 0.04 per cent of GDP. As if all this was not bad enough, the 1992-93 Union Budget saw an actual slashing of 20 per cent in health investment in nominal terms. The malaria programme especially, faced a whooping cut of 40 per cent. This cut was restored in the subsequent budget, presumably at the instance of the IMF and the World Bank. The impact of union budgetary cuts on the state budgets was so devastating that many of the state budjets could barely cover the salary of the staff of their rural health services. As the states are primarily responsible for running the public health services, with substantial assistance from the centre in specified areas, they have to bear the brunt of the acts of omission and commission of the political leadership, both at the union and the state levels. This provides the clinching evidence for diagnosis of the public health services in India.

Remedial Measures

The diagosis shows the measures to be taken to remedy this sickness - a long, grinding task indeed. It is the political leaders who will have to be the pace-setters. They need to recapture the spirit of the 'golden decades' of public health administration in India. The specific measures required include:

♦ Strenthening of the key public health institutions for education, training and research by expressly seeking out bright creative scholars to form a 'critical mass'.

♦ Filling key positions in public health services with competent physicians, who can provide inspiring leadership.

♦ Integrating target oriented special programmes within the overall health services.

♦ Reducing the dominant position that the generalist officers have come to occupy in deciding upon the technical aspects of policies or at least in programme implementation, to the status they held during the 'golden age' of public health services in India. Instead, they should be handed over tasks like manpower development and hospital and medical care services.

♦ Undertake research on health systems towards using techniques of operational research and systems analysis to optimise the health service system, i.e. making more effective use of the available resources.

♦ Increase budgetary support to health services, but only after ensuring that the funds in hand are being optimally utilized.

♦ The same area of the country, which was supporting 361 million people in 1951, is now supporting a population of 900 million, most of which lives under degrading conditions in terms of housing, sanitation, water supply, nutrition and so on. These areas must also be attended to, wherever required. After all, health services are but one aspect of the overall effort needed towards improving the health of the people.

❐

MAPPING HEALTH RESOURCES

Shirish Kavadi

Health care services in India are inefficient, unequally distributed, and because of the dominance of the private sector, also unaffordable to the general population - making them virtually inaccessible to the people at large. True, for a country of India's size and population, the resources needed are phenomenal, but there is no acute shortage of health care facilities or personnel in the country. Instead, as most studies point out, the real problem lies in poor planning and unequal and improper distribution of available resources. Such improper planning may be the result of misplaced priorities as much as due to the absence of an adequate and reliable database. In India, information on human resources and infrastructure for health care services is poorly documented. The total volume of these resources is not known. Also, data available from various sources do not tally. Thus, while proper planning is imperative, it is hampered by the lack of reliable data. This problem is countenanced by researchers as well, especially those carrying out policy research and field based studies.

This article explains the attempt made by a team of researchers from FRCH to carry out a comprehensive survey of health resources/providers in Ahmednagar district - to determine the volume of health care facilities and practitioners - as a part of a larger study on health expenditure and investment. The survey was restricted to a district since the latter appeared both a suitable and a manageable administrative and territorial unit. Here, an attempt is made to delineate the approach adopted, the methodology and techniques used and the limitations of these techniques. In so describing the process, the idea is to outline an approach for mapping health resources, which could prove useful to researchers conducting studies into district level health services and related issues and related issues. A fairly accurate and reliable information on the volume of health resources and distributional pattern across social geography, sector and system would make for a better understanding of the issues involved in health care inequity.

Techniques of Data Gathering

To begin with, definite categories of health providers were identified, with a view to making them as comprehensive as possible. The health providers, as identified, covered:

♦ **Health care facilities** - dispensaries, hospitals, clinics, polyclinics, special hospitals, PHC's, sub-centres, medical stores, indigenous/folk and other non-allopathic facilities.

♦ **Practitioners** - allopathic doctors, indigenous and other non-allopathic doctors, nurses and all other paramedics from the private and public sectors in both urban and rural areas.

The discussion that follows will, however, pertain primarily to medical practitioners.

The exercise involved the listing of all health care providers in the district by tapping all known official and non-official sources. Three techniques were used for listing:

♦ **Collecting information from official and non-official sources:** Information gathered from these sources, for both health personnel and health establishments, was cross-checked, compiled and then classified. Classification was done mainly on the basis of social geography, system of medicine, qualification and sector.

♦ **Sample survey:** To check the validity of these data and specifically the sources, a sample check was conducted.

♦ **Mailed questionnaires:** The last exercise involved a postal survey. Questionnaires were mailed to all the listed practitioners and hospitals to generate information on providers within their locality.

The second and third techniques were used owing to the inadequacies of the sources used in the first.

Official Sources of Information

Official Registration with their respective Councils is a statutory requirement for all qualified medical graduates who wish to practise. The Councils are statutory bodies and it is in-turn obligatory for the Councils of all systems of medicine to maintain updated records of qualified but practising doctors. Hence, the Councils were the major source of information regarding medical practitioners in the district. The four Councils were :

♦ Maharashtra Medical Council (Allopathic)
♦ Maharashtra Board of Ayurved and Unani Systems of Medicine
♦ Board of Homeopathic and Biochemic Systems of Medicine and
♦ Maharashtra State Dental Council.

From the Council directories/registers, 1887 doctors were listed.

In addition, information on private practitioners and doctors working in public health services was recorded through the District Health Office, Civil Hospital, Medical Officers of Municipal Councils and Cantonment Hospital and the Extension Officers of Health at Panchayat Samitis. Lastly, information on the total number of health professionals was also collected from the National Information Centre, Pune.

The major sources of information on health establishments were: the ***Directory of Hospitals in India (1988)*** published by the Health Ministry, Government of India, and the lists provided by the District Health Officer, Municipal Councils and Panchayat Samitis. The office of Food and Drug Administration provided a list of medical stores and licensed drug sellers in the district.

Non-Official/Private Sources:

Information was also gathered from private sources. Maharashtra Sales and Medical Representatives Association, Ahmednagar Unit had published a directory, ***"Medical Directory Ahmednagar District"*** in 1986, for private circulation. Some pathological laboratory owners, pharmacists

The author is a researcher at FRCH and has coordinated the study, ' Health Investment and Expenditure' on which the present article is based.

and medical associations too have published directories in talukas like Shrirampur. In addition to this, membership lists of the local branches of Indian Medical Association (IMA), National Integrated Medical Associations (NIMA) and other taluka-level associations were sought. Also, the associations of medical stores and pharmacies at both the district and taluka levels were tapped along with distributors of pharmaceuticals and drugs. The latter mainly provided information on medical stores. The private and public sources (non-council) elicited the names of 1773 doctors. The overall impression was that the non-official sources and non-council lists were more reliable (though not necessarily exhaustive) since these lists contained names of doctors who were actually practising in the district.

Limitations of the sources

Since none of the Councils had updated the published directories of the registered medical graduates till 1990, the unpublished registers had to be referred to, in all these Councils. From the directories and registers, doctors having their professional addresses (if available) or residential addresses or both at Ahmednagar district, were listed. The Allopathic Council does not specify whether the addresses of doctors are residential or professional. The Ayurvedic Council registers only residential addresses. The Homeopathic and Dental Councils give both professional and residential addresses but not all doctors have registered with professional addresses even for these Councils. As a result, in the case of a majority of doctors from these four Councils, only the residential addresses are known. This makes it difficult to identify or trace doctors who have either emigrated out or immigrated into Ahmednagar district and not cared to inform the change in residence, or doctors who practice within Ahmednagar but do not reside therein. Visits to the offices of the Civil Surgeon, DHO, Panchayat Samitis and Municipal Councils also revealed that the obligatory registration of practice, especially for the nursing homes under the Bombay Nursing Home Act, is not complied with by medical practitioners, particularly so in rural areas. That the legally required registration with the local bodies is not being observed was confirmed by the Medical Officer of Ahmednagar Municipal Council who informed us that only 25 percent of the privately run health units care to register. Only the Shop and Establishment Departments of the Municipal Councils of Shrirampur, Sangamner and Kopargaon, however, had lists of registered doctors and hospitals in their respective areas. But overall, The information from these lists was neither complete nor adequate and hence not fully reliable. All other official sources gave lists that were either informally prepared for us or were prepared for some other purpose with little concern for accuracy. The exception was the Ahmednagar Municipal Council. The Health Department of this Council had an updated list of general practitioners, consultants and hospital owners in Ahmednagar city. The Chief Medical Officer has undertaken to prepare such a list almost every year. The ***"Directory of Hospitals in India"*** (government) was also found to be most inadequate especially regarding units with a small bed strength. A possible explanation for this could be that since most nursing homes do not register with Local Boards as required under the Bombay Nursing Home Act, they remain officially non-existent. The directory depends entirely on official sources. Hence, the listing of private medical establishments encountered the same problem as in the listing of medical personnel. Information on the number of beds and facilities available, types of establishments (general/special hospitals, nursing homes, dispensaries, clinics) and ownerships too was not available or was incomplete for most hospitals in these published sources. Data gathered from the sources other than the Council records was inaccurate as far as qualifications and names were concerned.

Organization and Processing of Data

Each list was entered into the computer and a database of the practitioners was constructed. Whatever information about doctors that was available - address, sex, degree, registration number, year of qualification, university etc. - under each list, was included. Subsequently, all the lists were tallied and thoroughly checked to remove errors and repetitions. A similar exercise was carried out for hospitals and nursing homes. A list of pharmacy shops was also compiled. An indication of the inadequacy and unreliability of the Council lists was seen from the fact that only 32 per cent of the 1887 doctors who had registered with the Councils were identified amongst the 1773 practitioners listed from other sources. It was also found that names of about 66 per cent of the 1773 practitioners could not be located in the Council registers with an Ahmednagar address. Cross checking was an arduous and time consuming task. After going through the whole process a single master list of medical practitioners from Ahmednagar district was compiled. All duplications were deleted from the list, giving a final total of 3059. Given the limitations of the exercise carried out, we decided to undertake a sample survey with a view to determining both, the reliability of our sources and validity of available data. The sample survey had also, as one of its objectives, the identification of non-qualified and non-conventional medical practitioners who could not be listed from the earlier mentioned sources.

The Sample Survey

The second technique involved a sample check in over 65 villages and 2 towns in 4 talukas. The sampling was based on rural-urban and regional (developed and under-developed) differentials in the distribution of health resources and on the doctor-population ratio (high, average and low). Accordingly, the towns Nagar and Shrirampur and talukas Parner and Akola were selected.

♦ Rural Sampling

Villages from the selected talukas were classified as those having high, average and low doctor-population ratios and those villages having no doctors. Sixteen villages were randomly selected in this fashion. Four villages within a 5 km. radius of every selected village were included, to form village clusters, for a doctor's area of operation extends to the adjacent villages as well. Thus village clusters rather than isolated villages became the basic units for the survey. In the first round of the survey in Parner all villages in a cluster were visited. Subsequently, in the remaining sample talukas the strategy was changed to cover only the central or PHC village within each cluster. This was so since it was felt that the medical information about the whole cluster could be gathered from the central or the PHC village itself. In cases where the centre had shifted to the PHC village, the village clusters also changed

slightly. After the Parner experience, only three village clusters in each of the remaining three talukas were surveyed. Thus instead of 16, our sample consisted of only 13 village clusters with 5 villages each, making a total of 65 out of altogether 1503 villages in the whole district.

♦ Urban Sampling

Two towns, Nagar and Shrirampur were automatically selected, being the only urban centres among the targeted talukas. These towns also fell in the categories of high and low concentration of doctors respectively among the urban areas in the district. The approach involved in the urban survey was different owing to various difficulties involving logistics and lack of adequate personnel. Physically cross-checking 836 and 184 doctors in Nagar and Shrirampur respectively was not possible unless a ward-to-ward survey was done. We decided to approach medical stores, instead. Prominent areas in Nagar and Shrirampur were marked. A centrally located medical store in each locality was identified. Ten medical stores in Nagar and 4 in Shrirampur were accordingly selected. Names of doctors in the respective locality were listed with the help of employees/owners of the medical stores.

♦ Questionnaires

Though the main objective was to seek information on medical practitioners in the locality with a view to counterchecking our list, we planned general interviews with doctors, paramedics, folk healers and with the lay community in order to establish our credentials and develop a good rapport with them, before enquiring about the health providers within their locality. The questionnaire was pre-tested through a pilot survey in Purandar taluka of Pune district. The interview schedules began with background information regarding the villages, families, occupations, amenities available in their areas, disease patterns, problems in giving and receiving medical care etc. Only towards the end did we enquire about the health personnel in that area.

Validity of Information Sources

The fact that only 72 out of the 127 listed doctors actually practised in the areas that they were expected to be practising in, exposed the inadequacy of our sources of information, in particular the Council directories. Of the remaining 55 doctors, some had shifted to other places, some had retired or expired while others could not be traced at all. In all, 42 new doctors practising in the sample areas were added to our list. Out of these 42 additional doctors, about 11 doctors came from the same district and had already been included in our inventory, but with different addresses. We could not determine whether those who had shifted or were untraceable were practising elsewhere in the same district. The actual number of doctors practising in the sample areas was thus calculated at 114 (See Table No. 1). Out of the 114 practising doctors only 33 had registered with their respective Medical Councils with their current addresses. The percentage of doctors who had shifted from their original residence (26.4%) and of those who were untraceable (12.8%) was very high. Among the Medical Councils, the Board of Homeopathy and Biochemic Systems of Medicine provided a comparatively more complete and valid list of doctors. It's information acquired from informal sources that proved to be more accurate than that rendered by various Councils and Boards.

Table No. 1
Taluka-wise break up of existing doctors in comparison with the original list.

Sample Taluka	No.of Doctors Original list	Verified list
Nagar	11	11
Akola	20	22
Parner	30	28
Shrirampur	66	53
Total	127	114

Taluka-wise assessment of the sample list

For Parner taluka, which had a low concentration of doctors, our estimation was most accurate, whereas for Shrirampur, with a high concentration, our estimation was least accurate. In both the talukas with an average concentration of doctors there were more doctors than expected. But on an average the list of practising doctors fell short of the original sample list (See Table No. 1). During the sample check the team experienced great difficulty in identifying and locating folk practitioners. Often, community members were reticent and would not talk about them; at times we were even laughed at, saying that such practices were no longer prevalent; at other times persons so identified when personally met, denied that they practiced folk medicine. Practitioners of traditional medicine (Ayurveda/Unani) were also difficult to locate, since the practise of this medicine as a hereditary or caste profession appeared to have died out. Against the background of difficulties encountered in the first two techniques, we decided to mail questionnaires to the listed doctors and ask them to provide information on the fellow practitioners in their locality or within their knowledge.

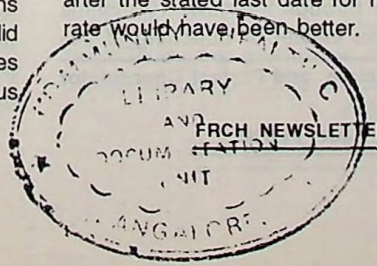
Postal Survey

The postal survey was carried out by mailing questionnaires to all the listed health providers, and to those who were identified from the incoming responses, thus attempting to cover the whole district. Besides seeking information regarding their practice and the delivery of health care in their area, the respondents were also asked to identify other practitioners in their vicinity.

Response to postal questionnaires

Out of 3059 doctors to whom the questionnaires were mailed, 460 (15%) replied to us. Eight per cent (249) of the questionnaires came back unopened because the doctors concerned had either shifted, expired, retired or were untraceable (See Table No. 2). We received 177 new names of individual doctors, not recorded elsewhere in our list. During our subsequent tours to the district a number of non-respondent doctors informed us that the questionnaires reached them only after the stated last date for replies; otherwise, the response rate would have been better.

(contd. on page 8)



HEALTH HAZARDS for Women & Unborn Children

Srilatha Batliwala

India has one of the highest infant death rates in the world, particularly for infant girls. Good health services are essential to reduce this rate, but they are not enough, suggests the report on a project in Alibag taluka, a rice cultivating area in rural Maharashtra, initiated by the FRCH in 1973. The report, undertaken in 1982, states that while village level health services can greatly improve women's and children's health status, they must be accompanied by other basic changes in order to be truly effective.

The FRCH was disturbed by the fact that despite early successes in the rural health project, a plateau of sorts was reached and from 1980 onwards, no significant changes in the health profile of the people could be achieved. Concern was greatest over the stubborn refusal of the infant mortality rate (internationally accepted as the most sensitive index of the health status of a nation or society) to move below 70 to 75 per 1000 livebirths.

The main goal of the study was to understand the nature and characteristics of all the deaths occuring in the project area in one calendar year by age, sex, subregion and cause. This enhanced understanding would then be used to improve the health services, provided in the project, wherever possible. A unique feature of this study was that it was carried out by village women and not trained investigators from the city.

Startling Facts Uncovered

The first clear trend to be detected by the study was the gender differential in pre-school mortality, with girls contributing almost two-thirds of all deaths in the 0-6 age group.

The vast bulk of preschool mortality (80 percent) occured below the age of one year; of this, over three-fourths occurred in the neonatal period, that is, up to 30 days after birth. Almost half the neonatal mortality is accounted for by pre-mature and small-for-date infants. Another 34 per cent was due to stillbirths and birth injuries, the latter including three cord strangulations, one antepartum haemorrhage, and one skull fracture when the infant was dropped at delivery.

However, the most startling finding of the study came to light when all infant deaths were plotted by month (See Table 1.), to determine any seasonal variation in the mortality pattern.

Firstly, we see that 40 per cent of all infant deaths occured in the four monsoon months of July to October. If we include May and June, when the fields are being prepared for sowing operations, and seedlings are grown in the nurseries, the figure rises to 61 per cent. This is not surprising in itself, since public health wisdom states that the environmental onslaught of the monsoon brings in its wake a host of infections and parasitic diseases which hit the young and vulnerable the hardest. It is also a time when the village access to health care is severely reduced by floods, blocked roads, and the heavy demand for labour in the fields.

However, on disaggregating the 14 deaths which occured in July-August, it was found that 50 per cent, that is, seven, were stillbirths and prematurely born infants, or both. This was intriguing, since the 10 other stillbirths and premature babies were scattered randomly through the other 10 months of the year. Why was there this cluster or bunching of this particular problem in these months? It could not even be explained by a large number of births having occurred in those months - if anything, the largest number of births occurred after this period.

Possible Explanation

The only explanation that the author has been able to find is that July and August are the height of the agricultural season in this area, with rice sowing operation in full swing. In a single crop area like Alibag, this means that every pair of hands - including those of women in advanced stages of pregnancy - is busy in the fields from dawn to dusk, either in their own fields or as labourers on others' lands. It is well known that **women alone perform the important skilled, but back-breaking job of transplanting sapplings in rice cultivation.** This means that every woman - heavily pregnant or otherwise - is squatting on her haunches for hours together. Obstetricians confirm that such physical strain and pressure on the uterus could well trigger off premature labour in the last trimester of pregnancy, not to mention increasing the chances of a stillbirth.

Premature deliveries, that too by half starved, physically debilitated women endanger not only the infant's chances of survival, but the mother's as well. It is hardly surprising, if the above explanation is correct, that so many stillbirths and premature births occured in these couple of months in the project area. This could well be the culminating expression of the social, economic, and technological neglect which the poor in general, and poor women in particular, face through out the year, throughout their lives. The fact that no maternal death occured in this or any other part of the year was either pure chance, or proof of the incredible biological strength of the female of the species - but a strength which, in our country, is clearly reaching the limits of its endurance.

Conclusion

Firstly, though the FRCH study was carefully planned, closely supervised and comprehensive, one cannot rule out the possibility that some or all of its findings were eccentric or arbitary fluctuations of that particular year or region. While they cannot be dismissed, neither can they be considered conclusive until further data is generated. This is particularly vital vis-a-vis the high incidence of stillbirths and premature births and deaths during the peak-rice cultivation season.

Secondly, if the findings presented in this article and the accompanying explanation are indeed valid, then we have located an important new occupational health hazard to pregnant women and their unborn children in rice growing areas. Our theory about this is somewhat strengthened by the fact that in parts of Tamil Nadu, folklore dictates that husbands and wives are not permitted to cohabit in the period 10 to 8 months prior to the next sowing season.

For those engaged in appropriate technology research, and who follow the dictum "start with women", the tentative findings of the study indicate the need to concentrate on developing transplanting and sowing devices which will reduce the arduousness of these tasks, particularly the need to squat while performing these activities. Above all, this information must be disseminated among the labouring women themselves, after all , it is they who have to discuss the matter and decide upon what is to be done. ❐

The author was Research Associate and Project Coordinator for the above project.

HEALTH NEWS

The World Summit for Social Development is scheduled to meet at Copenhagen in March this year. The draft of the declaration of the summit, to be signed by all heads of the state, has already been prepared at the Preparatory Committee meeting for the Summit.

The Summit has been called to exploit the opportunities for international cooperation that the end of the cold war presents in order to manage the process of globalisation so as to enhance its benefits and mitigate its negative effects and to address the 3 core issues of poverty alleviation, employment generation and social integration.

UNICEF's latest 'State of The World's Children Report' makes special mention of India, along with a number of other developing countries, for the dramatic progress it has made in protecting the health of the children and its immunisation and iodination programmes. Among the various success stories cited by the report is the progress made by India against iodine deficiency disorders (IDD); the successful implementation of the immunisation programme by the public health care system - 90 per cent of the children are getting immunised within the first year of their birth; its guinea eradication scheme and the action taken on a national scale to eliminate iron deficiency in pregnant women. It also made a mention of India's plans to eradicate polio from 11 states, with a combined population of 260 million.

The report specially singled out Kerala as a model for developing societies in the field of social progress.

However, it also said that India has not done as well in improving its sanitation and nutrition programmes while efforts to contain the incidence of diarrhoea have also not been very successful as it continues to be the main cause of child morbidity in most parts of the country.

In an attempt to decentralise family welfare programmes, the Health and Family Welfare Ministry has drawn up a plan for 4 districts in 4 states on an experimental basis.

This change in planning is meant to promote peoples' participation and an area specific approach where the diverse needs of the states, sporting different demographic data, would be catered to. The plan will be tried out in the 4 pilot districts of Medak in Andhra Pradesh, Nagpur in Maharashtra, Dausa in Rajasthan and Anna Dindigul in Tamil Nadu.

The draft is the result of a joint effort by the district -level officials, community leaders and resource persons from local institutions who were sensitised with the issues concerned through a series of workshops. The cost of implementation, to be worked out by the local-level officials and leaders, will be shared by the Central Government and the United Nations Population Fund.

A draft proposal on the National Sexual Health Education Programme was released on the last day of the third Asian Conference held in New Delhi on December'94. The draft includes a detailed curriculum targeted at young adults and those in pre-pubertal and pubertal stages of life. The aim of the programme is imparting knowledge as well as sexual conditioning wherein an individual develops a healthy attitude towards sex and sexuality.

A detailed schematic curriculum has been devised that is divided into 5 parts - human sexual development, inter-personal relationship, interactive abilities, sexual behaviour and sexual health. The first part includes study of anatomy and physiology, the sexual act and conception, pubertal changes, self awarness and gender role. The second part deals with inter-personal relationship, talks about the family unit with emphasis on husband-wife and parent-child interaction,peer group and tolerance of ethnic variations.

For the first time, 20 NGOs supported by the Ford Foundation met to pool their experiences and plan future action regarding the anti-AIDS programmes carried out by the Ford Foundation and the Tata Institute of Social Sciences, Bombay; in a three-day national workshop organised by the Cell for AIDS Research, Action and Training at TISS. The effort would be to fashion a national programme which was not run by the government but instead involve the people themselves.

The infectious disease Anthrax, a bacterial disease transmitted through domesticated animals, is threatening to take an epidemic form in 2 Tamil Nadu districts. Experts warn unless effective preventive measures were taken, the disease would take a heavy toll of human lives in the region. Already, several lives have been claimed in North Arcot and Thiruvannamalai Sambuvarayar districts in the current year. The last reported outbreak of human anthrax in this region. which is known to be an enzootic for the disease, was in 1990.

The carcasses of infected animals are the source of numerous spores that contaminate the environment, particularly the soil. From the soil, the spore may become air-borne. Some doctors believe that the spores of the bacteria are present in the region - North Arcot, Tiruvannmalaiand Chittor District - for people to have got the infection. But, they say, the cases were reported from a fairly large area making it difficult for them to detect a common source of infection.

Despite a legal ban on the sale of uniodised salt. a study conducted in Gorakhpur, Varanasi and Dehradun Districts in Uttar Pradesh found that in a number of samples the level of iodine is quite erratic while some of the samples were found to contain no iodine at all. The study was conducted by the International Council for Control of Iodine Deficiency Disorders and the Centre for Community Medicine at the All India Institute of Medical Sciences with the help of non-governmental organisations active in the 3 districts. Incidently, Uttar Pradesh has the highest incidence of iodine deficiency disorders with some areas reporting prevalence of goitre as high as 46 per cent.

Penicillin, a key bulk drug, may be removed from the negative list of imports. The move is significant as this bulk drug is critical to the country's health needs while the domestic industry caters to only 40 per cent of the demand. The rationale behind this move is to lower the cost of controlled drugs where penicillin is used as a basic input. ❐

Compiled from ***The Times Of India***

FROM THE SENIOR LIBRARIANS DESK....

Panchayati Raj : Selected References Available in FRCH Library

1. Webster, Neil, **Panchayati Raj and the Decentralisation of Development Planning in West Bengal**, Calcutta, K. P. Bagchi and Company, 1992, Pgs. 149.
2. Thakur, Devendra (Ed.), **District Planning and Panchayati Raj**, New Delhi, Deep and Deep Publications, 1991, Pgs. 472.
3. Sivanna, N., **Panchayati Raj Reforms and Rural Development**, Allahabad, Chugh Publications, 1990, Pgs. 308.
4. Singh S.S. and Misra, Suresh, **Legislative Framework of Panchayati Raj in India**, New Delhi, Intellectual Publishing House, 1993, Pgs. 299.
5. Singh S.K., **Role of Panchayat Raj in India**, New Delhi, Radha Publications, 1992, Pgs. 143.
6. Shah, B.L., **Panchayati Raj : The Role of Panchayats in Integrated Rural Development**, New Delhi, Cosmo Publications, 1990, Pgs. 198.
7. Satyanarayana, P., **Towards New Panchayati Raj : Critical Perspectives on the Reorganisation of Rural Local Government** New Delhi, Uppal publishing House, 1990, Pgs. 247.
8. Palanithurai, G., **Empowering People for Prosperity : A Study in New Panchayati Raj System**, Delhi, Kanishka Publishers Distributors, 1994, Pgs. 131.
9. Mishra, S.N., **Panchayati Raj Bureaucracy Rural Development**, New Delhi, I I. PA., 1986, Pgs. 166.
10. Mehta Ashok, Chairman, **Report of the Committee on Panchayati Raj Institutions**, New Delhi, Ministry of Agriculture and Irrigation, Government of India, 1978, Pgs. 301.
11. Mathew, George, **Panchayati Raj from Legislation to Movement**, New Delhi, Concept Publishing Company, 1994, Pgs. 156
12. Lal, G.M.M., **Rajiv Gandhi and Panchayati Raj : Democracy and Development at the Grassroots**, Delhi, Konark Publishers Pvt. Ltd, 1994, Pgs. 120.
13. Krishnan, M.G., **Panchayati Raj in India, An Analytical Study of Karnataka**, New Delhi, Mittal Publications, 1992, Pgs. 149.
14. Institute of Social Sciences, **Decentralised planning and Panchayati Raj : Proceedings of the D.T Lakdawala Memorial Symposium**, New Delhi, Concept Publishing Company, 1994, Pgs. 64.
15. Inamdar, N.B. and others, **Panchayati Raj : An Annotated Resource Guide**, New Delhi, Concept Publishing Company, 1991, Pgs. 253.
16. Datta Prabhat, **Second Generation Panchayats in India (With Special Reference to West Bengal)**, Calcutta, Calcutta Book House Pvt. Ltd., 1993, Pgs. 174.
17. Dutta, N., Village Panchayats in India : A case study of Assam, New Delhi, Mittal Publications, 1989, Pgs. 207.
18. Desai, Vasant, **Panchayati Raj : Power to the People**, Bombay, Himalaya Publishing House, 1990, pgs. 516.
19. Chand, Attar, **Panchayati Raj and Rural Development**, New Delhi, H.K. Publishers and Distributors, 1990, Pgs. 216.
20. Bhargava, B.S., **Panchayati Raj System and Political Parties**, New Delhi, Ashish Publishing House, 1979, Pgs. 536.
21. Bhadouria, B.P.S., **Decentralised Planning for Development in India**, Delhi, Commonwealth Publishers, 1988, Pgs. 375.
22. Aziz, Abdul, **Decentralised Planning : The Karnataka Experiment**, New Delhi, Sage Publications, 1993, Pgs. 148.

(contd. from page 5)

Table No. 2

A breakup of the doctors' status

Doctor's Status	No. of Doctors	% of Total
Shifted	14	(5.6%)
Retired	10	(4.0%)
Expired	9	(3.6%)
Not traceable	216	(86.7%)

Data Processing and Findings

The original list was cross-checked with lists prepared through the sample check and postal survey. All duplications were taken care of. The final list showed 3059 doctors (qualified and unqualified) located in urban and rural areas, representing all systems of medicine. Doctors from both the public and private sectors were covered. Nearly 92 per cent were from the latter sector. Around 860 health establishments including 274 hospitals (with bed strength ranging from 3 to 200 beds), PHC's, sub-centres etc. were also listed, while 565 medical stores were found to be functioning in the district.

From both the surveys, the status of 1164 doctors (294 non-existing and 870 existing) could be determined, leaving the status of 1895 (62%) doctors undecided. Out of the 870 practising doctors, an addition of 209 doctors was made to the final list, based on information gathered during the surveys. After adding and deleting from the final list as per our information, we found that the original list of 3059 doctors was overestimated by a mere 3 per cent. There is the possibility of a certain number of doctors still being inadvertently left out by us, but the number 3059 serves as a fairly reliable figure of doctors in the district.

Conclusion

An important constraint in conducting an exercise of this kind covering a large territory is that of Logistics. Such an exercise can be carried out only in a district or a smaller territorial unit. Yet, it may be said that in spite of the various limitations and constraints, the FRCH team was able to prepare a fairly reliable inventory of health providers in the district which also enabled them to better understand the distributional pattern of medical personnel across social geography, sector and system of medicine[1]. Keeping in mind the various limitations encountered by the FRCH team, other researchers can improvise upon the above described approach by improving the techniques and better dealing with local conditions. ❐

[1] ***See* Manjiri Sule, *FRCH Newsletter* (Nov-Dec'92), and S. Kavadi and M. Sule, *FRCH Newsletter* (July-Aug.'94).**

Produced by the Foundation for Research in Community Health
(Registered under the Bombay Public Trust Act),84-A, R. G. Thadani Marg, Worli, Bombay 400 018

❐

Edited by Vaijayanti Aphale
with secretarial help from Rajesh Ingle, Jayashree Puranik & Sushama Joshi.

❐

Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 590 006.

FREE ABSTRACTING

The contents of this newsletter may be abstracted without prior permission. However, we would welcome acknowledment of the source and copies of any abstractions

The Foundation for Research in Community Health

frch

NEWSLETTER

For Private Circulation Only | Vol.IX, No. 3 | May-June 1995

COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT
BANGALORE

Family Medicine

Prakash C. Rao

***'Wherever the art of medecine is loved, there also is love for humanity'* - Hippocrates.**

Family doctors constitute an important part of medical care, with most of them being private practitioners. It is said that a family doctor is concerned with the art of providing the science of primary health care. An ideal family physician provides personalised, primary, holistic and continuing health care to the people irrespective of age, sex or illness. The very personal nature of his relationship with the patient facilitates timely diagnosis and also allows him to integrate the physical, psychological and social factors in diagnosis. He undertakes continuing management of his patients who are bed-ridden with chronic, recurrent and terminal illness. The relationship of trust that exists between the family physician and the patient serves him well in his profession in knowing exactly when and how to intervene through treatment, prevention or education to promote the health of his patients.

In the West, family medicine is an established specialty in which the concerned doctors undergo specialised training. In India, family medicine as a separate discipline does not exist, in spite of the fact that quite a few graduates, willingly or unwillingly, do end up being private general practitioners. Neither the need for family medicine nor the potential of a family doctor in community health care is recognised. The family doctor is not included in any of the government health care programmes and remains a missing link in the health care of the society. With the quality of interaction between the doctor and the patient getting business-like and often exploitative, health has turned out to be a commodity bought and sold in the market.

Dr. Prakash C. Rao is a consulting family physician.

Especially in urban areas, where the family doctor faces stiff competition from hospitals, nursing homes and consultants (who contrary to their training are engaged in primary health care) as also quacks and his own colleagues, the family doctor is tempted to break down the barrier of ethics in order to achieve success and wealth.

In more than 50 per cent of the cases in family practice, patients cannot be diagnosed correctly using the conventional approach, especially where the patient shows symptoms that do not fit typically, into any known medical conditions. In such a case the three dimensional approach (physical, psychological and social) helps the family doctor in treating the patient rationally. In contrast, an overenthusiastic hospital-based approach may lead to unnecessary investigations and irrational therapy. But in actual practice, the pressure of making a quick buck forces the doctor to go for symptomatic hospital oriented 'management' of patients' problems, turning the whole concept of personalised family medical care upside down. If the diagnosis does not corroborate the existence of any major disease the doctors do not hesitate to state, 'Low B.P., General Weakness etc!' and treat the patient with unnecessary vitamins.

William Osler, the family physician, once said, "Talk to the patient and he will tell the diagnosis". Family medical practice is expected to make use of this dictum where listening often serves the purpose of diagnosis and talking that of therapy. Instead, family doctors too often rely heavily on irrational investigations and irrational prescriptions.

It is the moral responsibility of doctors to use a rational approach to diagnosis and therapy; yet, are the conditions in which a family

(contd. on page 8)

In this Issue

- **Family Medicine..... 1**
  Prakash C. Rao
- **Cultural Determinants of Diarrhoea..... 2**
  S. N. Morankar
- **Health Awarness..... 4**
  Seema Deodhar
- **Health News..... 7**
- **From the Sr. Librarian's Desk..... 8**

338
2/9/95

Cultural Determinants of Diarrhoea

This is a revised summary of **S. N. Morankar's** PHD thesis in Anthropology (Poona University) under the same title

Every disease has a scientific explanation as well as a cultural context. The latter involves a study of local concepts of health and illness among people/patients for whom these concepts are meaningful, known as EMIC, while the former refers to an epidemiological study using clinical diagnosis and employing a structured clinical view, called ETIC. Unfortunately, the dominant model for research remains the Knowledge Attitude and Practice (KAP) Survey which is heavily biased towards the ETIC framework as it provides a strong data base but is not very sensitive to users' perspectives and their actual behaviour. For instance, detailed literature reviews undertaken on the prominent aspects of diarrhoeal diseases such as breast-feeding, personal and domestic hygiene, water supply, excreta disposal, utilization of home based ORT etc., point to the need for new and innovative type of research to better understand the determinants, especially the cultural concepts, of diarrhoeal illness and appropriate use of ORT at home. (It is estimated that diarrhoea kills about five million people, mostly children, every year, of which 1.5 million deaths occur in India alone.)

Accordingly, a study was conducted at the village Supa in Baramati Taluka of Pune district to define the cultural determinants of diarrhoea, thus attempting a reorientation of research technique. The village was ideal for the study since it contained plural medical and health facilities including a primary health center (now upgraded to a rural hospital with 30 beds), six private practitioners and one medical store. Religious healers known as *Devrishis* also were part of the village health infrastructure.

The study uses both EMIC and ETIC frameworks for social analysis to study the relationship between culturally defined experience and professionally defined outcomes. A combined methodology using quantitative and qualitative techniques was employed which enhanced the practical utility of the ethnographic and epidemiological methods. The qualitative methods included in-depth interviews, group discussions and observations conducted with village leaders, government health functionaries, family members and private practitioners to document perceptions, beliefs and practices in relation to diarrhoea. All mothers (total 224) having children below the age of five years (345) were the target population of the study. To collect quantitative data, basically, two proformae were prepared. A semi-structured interview schedule (EMIC) was administered in the first proforma to determine the classification of diarrhoea, patterns of distress related to various types of diarrhoea, and the help and treatment seeking behaviour. The second proforma was an interview-cum-observation schedule which contained questions regarding the practical behaviour of the mother or family members while caring for the child during actual occurrence of diarrhoea.

S. N. Morankar is a senior researcher at FRCH

Field research was carried out from Oct. 1990 to April 1991 in two phases. Phase I was undertaken from Oct. 1990 to mid-January 1991. During this period pre-episode (prior to actual occurrence of diarrhoea) data was collected, using the structured interview schedule (EMIC) to understand the mothers' views regarding diarrhoea management. Phase II data was collected from 1st Feb. 1991 to 30th April 1991. During this period all mothers having children below the age of five years were visited twice a day at 8.00 am and 6.00 pm to observe actual behaviour and talk with the respondents. Such frequent visiting also reduced the recall time. During analysis of the data each variable was cross tabulated with components of other variables, comparing the data collected in both phases i.e. pre-episode knowledge with the actual practice of diarrhoea management during episode. To test the association among these variables, chi^2 test was used for interpretation.

Epidemiological Observations

Diarrhoea was found to occur in 81 children (23.5 %) during 89 days of the research period consisting of 36.2 per cent of the families. A strong correlation with occurrence of diarrhoea was found in the following cases :

* Children who belonged to large families (7.7 persons), who had younger siblings below five years, and whose mothers were comparatively young (22.4 years old) and engaged as housewives were more prone to diarrhoeal episodes.

* A twelve week incidence of diarrhoea was highest among children below six months, followed by 7-12 month old children. Generally, male children suffered more and had a longer duration of episode as compared to their female counterparts.

* The traditional Indian practice of maintaining a long breast-feeding period proved helpful. Data collected indicates a negative correlation between the period of breast-feeding and occurrence of diarrhoea. Compared to the average period of breast-feeding (30 months) in rural India, the village average of 18.2 months was less, either due to successive pregnancy, exhaustion of breast milk or, particularly, the influence of urbanization on the upper and middle classes. Therefore, though no significant association was found between socio-economic status of the study population and occurrence of diarrhoea, bottle feeding practices were an important cause of diarrhoea among children below five years in the upper middle class.

* More children who lived in large houses suffered from diarrhoeal episodes. Since such houses were likely to be used as godowns for storing agricultural produce, and thus not cleaned for months, the child crawling freely in the area was prone to

catch diarrhoea.

In the following cases correlation with occurrence of the illness was non-significant :

* Though diarrhoea occurred more among families using bore-well water for drinking purposes, no significant relationship was found between the water source and diarrhoea. Insufficient availability of tap water made it difficult to draw conclusions regarding this source.

* Though the place for sheltering domestic animals - cows, bullocks, goats, sheep, dogs etc. - plays a non-significant role, more children suffered from the same where animals were sheltered in the house, dogs and poultry birds were allowed to move freely in the living place as well as the kitchen and especially where animals were tied inside the house itself. These animals seem to bring in more infection as they spread the human excreta by their feet, either from the courtyards, roadsides or defecation fields.

* The distance at which the children's excreta was disposed of as also the place of adult defecation was not significantly related to the occurrence of diarrhoea. It was found that in families having their own sanitary latrine the occurrence of diarrhoea was less compared to families using public latrines or open fields.

* Fewer children who played within the house were affected with diarrhoeal episode. However, no significant association was found between the place of play and occurrence of diarrhoea.

Environmental sanitation and hygiene is one of the main routes of transmission of diarrhoeal infection. The study shows that a common view among the people was that faeces pose little danger to health. A majority of mothers (93 %) threw the stools of their children within a range of 50 feet from the living place. Due to lack of time, particularly during the morning, mothers belonging to the lower and lower middle classes often unhygenically cleaned the bottom of the child as also the defecation place in the house and threw the faeces nearby. Personal hygiene practices were determined culturally, such as hand washing and bathing. Traditionally, people are supposed to wash their hands or bathe completely after defecation, after exposure to childbirth or death and when in contact with spittle, human faeces or animal faeces. However, only two-third of the mothers used water for their child's anal cleansing and the remaining used cloth or rags. Economic compulsions allowed only one-third of the mothers to use soap to clean soiled clothes. Forty-three per cent mothers used soap to clean their hands on cleaning a child after it defecated and, usually, the left hand was used. Though culturally the left hand may be avoided in ritual salutations and in transferring gifts, it is used in handling cooking utensils, peeling fruits, serving food, drawing water, to taste food during cooking and hold tooth powder while cleansing teeth.

Considering the above findings, concentrated efforts will be necessary not only to educate the community but also for concrete action on the proper disposal of wastes, disposal of child's excreta, personal hygiene, the use of safe drinking water and other related issues.

Patterns of Distress

As illness and disease occurs, it shows symptoms, and further action is taken depending upon the severity of the symptoms as perceived by the individual patient or caretakers. Opinion of the mothers regarding severity of diarrhoea, causation of the illness, help and treatment seeking for illness both at the time of pre- and particular episode was found to be significantly related to the signs and symptoms accompanying the illness. Diarrhoea, in the village, was considered an inevitable, common, non-serious health problem that occurred frequently. When enquired, mothers spontaneously recognised four types of diarrhoea : loose/watery stool, stool with mucous, stool with blood and abnormal stool. As many as 33 types of signs and symptoms were reported by them which could be categorised into six broad categories of : dehydration, physical, behavioral, diarrhoea with fever, stool quality and uncertain. Stool quality followed by physical symptoms were major patterns of distress found to be worrying the mothers. Whereas continuous loose/watery motions were considered 'fatal' by one-fifth of the mothers, very few considered stool with mucous and blood and abnormal stool as fatal. The majority considered loose/watery motions with mucous and blood as "serious" diarrhoea. More than 90 per cent mothers considered abnormal stools as 'not serious'. Comparing peoples' perceptions, more considered diarrhoeal illness as 'not serious' during a particular episode than during pre-episode.

On the whole, it was observed that what the mothers perceived during pre-episode was not what they actually did when an episode did occur. On actual occurrence of the disease they had a comparatively casual attitude towards diarrhoea. They encountered it often and a majority took to modern medicine, seeking help of private practitioners.

Perceived Causes

Transitional phases in the normal growth and development of children e.g. teething, were reported most frequently and as the most important cause of watery/loose stool. The most important causes for stools with mucous and blood were reported as food, water, weather, growth stages in a young child and also the consequence of continuous loose/watery motions. It is believed that a mother's irregular food consumption leads to occurrence of diarrhoea with abnormal stools (green, black, white, frothy or grain type) in breast-feeding infants. Thus developmental phases and mother's irregular food consumption were considered the main culprits of diarrhoea both during pre- and particular episodes. None of the mothers spelled out the supernatural as a cause of diarrhoea, which is a welcome sign.

Perceived causes, along with signs and symptoms of the illness are important determinants of patterns of distress, help and treatment seeking and preventive measures for the disease

HEALTH AWARNESS of village Tais

-- Seema Deodhar

FRCH has undertaken a project at Parinche, a part of which consists of educating select village *tais* (female workers) in matters pertaining to the overall development of the village including health care. During the health training sessions formal questionnaires as well as informal group discussions were arranged in order to obtain the views of village *tais* on the causes of various illnesses. Such an exercise was undertaken in order to :

* Check out the impact of wider exposure to media and formal education on general health awareness - to what extent this better health awareness has been able to substitute their traditional beliefs about health matters.

* Find out what impact did the technique used (formal versus informal) in eliciting their views, have upon the final response.

Techniques

It was decided to administer questionnaires containing two to three questions at the beginning of each session, pertaining to the topic to be discussed in the session. After each session an informal group discussion would be held where the same questions would be approached indirectly. For eg. if the formal question asked was what was the cause of fever, in the group discussion the *tais* would be asked to narrate their own experiences regarding fever, what treatment they underwent to get rid of the same, what different practices were followed in their family to cure fever, where did the family usually go for treatment and why was a particular practitioner favoured over others.

Questions

The main topics covered were fever, diarrhoea, snake bites, respiratory tract infections and reproductory tract conditions. Following are some of the questions covered in a formal (F) as well as informal (I) manner :

1. What causes illness ?

(F) Infection, unclean water supply, lack of adequate sewage facility and heredity.

(I) Possession by an evil spirit, black magic, influence of the evil eye or bad luck.

2. What causes fever ?

(F) Infection, over-exertion, exposure to sun or rain water.

(I) Possession by an evil spirit, black magic, influence of the evil eye or fear..

at the time of pre-episode as well as particular episode. While majority of the mothers reported help seeking of private practitioners during pre-episode investigation, in actual fact 27 per cent of them did not go for any help as they thought that teething was a natural phenomenon and believed that diarrhoea so occurring would heal naturally. Also, several others who were uncertain regarding the cause of diarrhoea did not actually seek any medical aid. Where treatment seeking was concerned, those mothers who held food and water responsible for the illness and home remedy as its treatment during pre-episode inquiry in fact did not give any treatment, including home remedy, during actual episode. Also, mothers uncertain about the use of ORT for treatment did not seek any treatment at all during actual episode. Thus a majority of them did not go for help and treatment seeking during actual illness due to their perception regarding the causes of the disease and not because they meant to neglect their children.

Help Seeking Behaviour

Several factors act to decide upon whom to consult for treatment. Although most parents almost always try to give the best possible care to their children, standards of care vary both between and within cultures. As per this study, a majority of them preferred private physicians, due to a belief in their effective treatment, immediate recovery, easy accessibility and understanding behaviour on part of the doctors.

On occurrence of mucous and bloody type of diarrhoea, most mothers visited the primary health centre and private physicians as it requires long treatment, whereas about 60 per cent considered that abnormal type of diarrhoea could be controlled by home remedy or by regulating the mother's food consumption. Those mothers who wanted to get rid of the worsening condition of the child to be free of worry and also to utilize their time for household chores or other activities, heavily depended upon private practitioners.

A major change in help seeking was observed with respect to those mothers who fell in self-healing, self-medication and uncertain categories. Uncertain mothers during pre-episode took to self-healing during particular episode. During pre-episode mothers claimed to take maximum care to seek help for diarrhoea; however, several of them did not seek help during the actual episode. Thus, significant change in behaviour of the mothers was found during pre- and particular episode with regard to help seeking patterns.

Treatment Seeking and Feeding Practices

Physicians always complain that mothers or caretakers fail to bring children to doctors for treatment immediately, especially given the speed with which diarrhoea can kill. But the study shows that after considering and judging the stool quality, signs and symptoms and waiting period, 90 per cent mothers resorted to home remedy or referred to PHCs or private physicians within

3. Reproductory tract infections :

What causes white discharge ?

(F) Infection or indulging in sex with multiple partners.

(I) Indulging in sex with multiple partners or possession by an evil spirit.

What causes infertility ?

(F) Some fault in the reproductive system of the woman or man concerned.

(I) The influence of seven evil fairies believed to frequent any natural water source.

4. Respiratory tract infections :

What causes cough and cold ?

(F) Eating sour food or excess rice.

(I) Same response as above. Only regarding ear infections, if pus came out of the ear it indicated the rebirth of a family member and the same could be cured only by the village pir.

5. What was the treatment for a snake bite?

(F) Blood flow from the bitten part into the rest of the body had to be obstructed and the poisonous blood had to be quickly extracted.

(I) The traditional practice of going to the temple and praying to God.

6. What causes diarrhoea ?

(F) Indigestion or allergy.

(I) Indigestion, allergy or upon straying in an evil place.

Analysis

A wide discrepancy was observed between the responses to the same question when asked formally and informally. Thus the technique used for gaining information had a remarkable influence upon the answers given. This dualism was a reflection of the dual influence of traditional culture along with modern education and media exposure. Only one *tai* out of total 15 *tais* gave rational responses throughout. To conclude, though modern health awareness has increased in the village, the same does not necessarily influence actual responses or perceptions during occurrence of an illness which are more likely to be defined by traditional beliefs and practices. ❐

Seema Deodhar is a researcher at FRCH

two days of onset of diarrhoea. Most of the cases were of loose/ watery stool and fell in the 'not serious' category. This time-lag for reporting for treatment is short compared to other parts of rural Maharashtra where it takes 7-8 days of time-lag to report 'not serious' type of diarrhoea with ordinary loose yellow stool or with mucous type of diarrhoea, as reported by UNICEF.

More than 80 percent believed that only modern medicine (oral, injection, IV fluid) was effective to cure all types of diarrhoea. However, when particular episode occurred only 62 per cent sought modern medicine as treatment. Modern medicine was believed to be useful for early or immediate recovery of illness. It controls diarrhoea early (brings to normal colour and texture of stool) and the patient feels better (recovers strength, feels fresh, etc). None of the children with diarrhoea during study period were administered IV fluid.

Where the mothers had talked about going in for home remedy or ORT during pre-episode, in actual practice one-third of them did not go for treatment due to a wait-and-watch attitude towards treatment seeking in diarrhoeal episode with it getting arrested in the process itself, maybe due to continuous breast-feeding or a self-healing process. Only 2.5 per cent mothers used ORS and other 2.5 per cent used ORT since many mothers complained that the child did not drink the solution.

The UNICEF[44] study has also reported that only 11 per cent mothers utilize ORT/ORS in Maharashtra. Moreover, health providers, particularly private practitioners, considered ORS and ORT ineffective and they had prescribed antibiotics in preference to ORS/ORT. This is a very significant finding from the programme point of view, since it proves that though ORT is the mainstay of the programme it has not been propagated properly by health workers to motivate mothers to use it as home remedy for diarrhoeal management.

Regarding restrictions on food, majority of the mothers were uncertain during pre-episode inquiry. However, they did not restrict the food during particular episode as they did not want their child to become weak and further deteriorate in health. Neither selective feeding of food nor cutting down or stoppage of breast-feeding nor restriction of fluids was resorted to. Only plain water was given by majority of them. It is a welcome sign that mothers did not restrict the usual feeding and fluids and continued breast-feeding, which benefited the child by preventing dehydration. Though home-made Oral Rehydration Solution (ORS) e.g. *sarbat, sago khir,* etc. was known as a home remedy for diarrhoea, it was not very popular, as the ingredients were not readily available and mothers were reluctant to spend money and time, which was diverted to administering modern medicine instead. There is need to develope a positive attitude of mothers towards the use of ORT/ORS, with the aid of which mothers can control/manage diarrhoea at home, instead of depending on modern medicine.

The study reveals that mothers who promptly reported to a health practitioner for medical advice were relatively more

interested in their child's health in general, and were more concerned about the diarrhoeal illness episode. They perceived that diarrhoea presented a substantial threat to their child, but had confidence in the ability of physicians and medication to reduce this threat. These mothers worried about the child's health and engaged in behaviour they felt would prevent future illness. They appeared to have had more satisfactory interaction with the clinics.

Social Context

Social context is a complex phenomenon in which several variables having complex relationships are associated. One's social status plays a prominent role in utilization of health services and participation in health and development programmes. It has been reported by Foster and Anderson that : " from a cultural point of view, however, illness is quite a different thing; it is the social recognition that a person is unable to fulfill his normal roles adequately, and that something must be done about the situation. Man's diseases, a pathological concept, become socially significant only when they are identified as illness, a cultural concept and, a physiological malfunctioning that is seen to threaten the individual and his society, which causes us to seek aid."

As per the study, signs and symptoms of diarrhoea were known to all the mothers uniformly. No significant change of opinion was found regarding the causes of diarrhoea among various socio-economic classes. However, a significant change of opinion with regard to severity of the illness was found among the middle, lower middle and lower class mothers and most of them did not administer or secure any treatment during a diarrhoeal episode. This emphasizes the need to concentrate more attention on all aspects of diarrhoea in the middle, lower middle and lower classes of rural India.

Conclusion

Important steps to be taken on the basis of the study are :

1.There is need to create a positive attitude in the community and to have very effective programmes regarding ORT/ORS promotion which is the main stay of the Diarrhoeal Disease Control Programme.

2. Despite the availability of public health services in the village, majority of the mothers utilized private practitioners' services. Therefore, there is urgent need to upgrade and improve the quality of service provided by public health services. This also suggests that private practitioners can be effectively involved in the diarrhoeal control programme as people have a greater trust in them.

3. Presently, there is no mechanism to report the diarrhoeal cases treated by private practitioners to the government's Management Information System (MIS). Therefore, there is urgent need to include these cases in the MIS reporting system to have correct morbidity patterns of diarrhoeal diseases.

4. Concentrated efforts regarding all aspects of diarrhoea are needed in the middle, lower middle and lower income populations of India for effective diarrhoea management.

5. In traditional societies the existing cultural values of a longer period of breast-feeding must be imbibed/reinforced in the community for control of diarrhoea..

6. Since more diarrhoeal cases were observed in houses which had a large area, there is need to include the message in health education that the whole house should be kept clean.

7. A culture of poverty such as non-availability of enough water, casual attitude towards domestic and surrounding cleanliness and personal hygiene prevailed in the village.Though house-to-house and person-to-person health education is included in the National Diarrhoeal Control Programme the message does not actually reach every house. A culture of cleanliness could be imbibed through greater efforts in the direction of demonstration and continuous follow-up by community and village leaders, ICDS workers, youth and mahila mandals, peripheral health workers and NGOs working in the area.

The study's major contribution to current knowledge on diarrhoea management and the research methods for evaluation/ study of diarrhoea related behaviour is the discovery of significant inconsistencies between information provided by mothers about their behaviour during pre-episode as compared to actual behaviour during particular episode. The mothers' actual diarrhoea management, with respect to perceived severity, perceived causes, help seeking and treatment seeking differed from the information they provided in the pre-episode survey (i.e. one time KAP information). This shows the drawbacks of KAP surveys in diarrhoea management and points to the need for use of qualitative methods (EMIC) in health programme evaluation for the explanation and prediction of behaviour. The methodology of 'daily visit' used for assessment of diarrhoeal morbidity in the study, subsequently followed for diarrhoeal management actions, was useful to ascertain the behaviour/ perceptions of uncertain categories of persons.

Hopefully, the variables studied will enable health and paramedical professionals, including ICDS workers, to gain a better understanding of the problems that different mothers might have in help and treatment seeking. On the basis of the study findings, it could be possible to construct a relatively brief list of questions to be administered to each mother, the answers to which might aid the health worker in identifying the problem dimensions and the health worker may thus be able to tailor interventions to suit the particular needs of each individual.

Further research needs identified show that a study should be undertaken on the line of this study in different villages having/ not having various levels of public health services, to understand the utilization of health services in general and, particularly, to assess the use of ORT and home made ORS. Also, their is need to evolve a comprehensive and effective health understanding strategy in consultation with the community to determine what role the community could play in providing for an easily accessible health infrastructure within the holistic framework of a village development plan. ❐

HEALTH NEWs

Chemists and druggists all over the country are complaining that some pharmaceutical companies are selling drugs (IV) fluids directly to general practitioners and private nursing homes. The Dombivili Medical (Chemist) Association maintains that while chemists have to adhere to stringent rules laid down by the FDA, unscrupulous doctors justify stocking of medicines on emergency grounds. Reliable sources say some pharmaceutical companies allegedly bribe doctors and private nursing homes by offering them gifts. Chemists claimed that this had resulted in a 30 per cent drop in sales during the last year or two.

In spite of increase in foodgrain production over the years, it has failed to create a significant impact on the overall nutritional status of the Indian population. The department of Women and Child Development recently released a National Plan of Action on Nutrition which is meant to operationalise the National Nutrition Policy framed earlier with the specific objective of rectifying this situation. The action plan highlights priority areas and lays down specific objectives and a time-frame for achieving the goals before them. It sets out plans concerning agriculture, civil supplies, education, women and child development and health and rural development which can contribute to improvement in nutrition levels.

The country's first Occupational and Environment Medicine (OEM) clinic was inaugurated at Bombay to identify health hazards caused by the environment at one's work place (for eg. a person working in a power industry is constantly exposed to carbon tetra-chloride, a chemical which affects the liver) at an individual and industrial level; to study exposure patterns; to treat affected persons and create awareness. Since it is a new concept in India, many developed countries have offered their assistance in the matter.

The union government is planning to launch a major programme, known as the Pulse Polio Programme, in December'95 for polio eradication in the country. Some of the neighbouring countries are also being involved. Under the programme, two days of the year will be identified for immunisation of all children under the age of three all over the country. The programme will be carried out over a period of four years for which financial assistance of Rs 50 crores has been granted. Nehru Yuvak Kendra sangathans, anganwadis, state branches of the Voluntary Health Association of India and other non-governmental organisations will be actively involved in its implementation.

A special technology mission has been set up by the Centre with the specific objective of bringing down the birth rates in the four Hindi speaking states of Bihar, Uttar Pradesh, Madhya Pradesh and Rajasthan. It is to be operationalised by mid-July and would stretch over a period of six years, at the end of which officials hope to bring down the birth rate to 26 per thousand. Separate cells will be set up right from the centre up to the village level for the smooth functioning and effective monitoring of the programme which is to be actually implemented by the state government. The methodology adopted would do away with the general approach and focus on identifying specific gaps by providing resources directly at the operational level instead of routing them through the state government.

A seminar was organised in May this year by the Impact India Association to make wholesale dealers in pharmaceuticals aware of how they should stock and maintain the temperature of vaccines. In India, despite being immunised by vaccines, a great number of children suffer from vaccine preventable diseases because the potency of vaccines had been lost due to failure to store in cool temperatures (ranging from two to eight degrees centigrade).

The study, 'World Mental Health : Problems and Priorities in Low-Income Countries'prepared by 88 specialists from 30 countries draws attention to the rise in mental illness and behavioural problems in the world's poorest nations, even as advances are made against debilitating or fatal diseases. Though deterioration in mental and social health threatens more violence, ethnic conflict and destability in developing nations, these problems are often relegated to the margins of policy in some countries because of the stigma attached to the mentally ill.

Malaria is threatening to turn into epidemic proportions in Assam where officially 11 districts have been declared as malaria affected. Though officials have put the death toll at 129, the voluntary health workers fear it to be much higher. Anti-malaria drugs are reportedly in short supply as also the testing facilities are inadequate or in disrepair. Malaria has become a widespread cause of death in the entire north-east region where,unlike in other parts of the country, malaria cases are found throughout the year. The symptoms of malaria may also not be the characteristic sweating and shaking chills, making diagnosis of the disease difficult.

Dhule has been witnessing many cases of children dying or taking ill, especially in the tribal community, due to a virtual epidemic of measles breaking out in the region. Other causes of death include pneumonia, gastoenterites etc., many of which could be rooted in the chronic state of malnutrition, arising from poverty and the absence of basic infrastructural developement in the tribal areas. The Maharashtra government has formed a special coordination committee to initiate relief measures but absence of roads and scattered, tiny settlements are making speedy outreach of food and medical aid difficult. ❐

FROM THE SENIOR LIBRARIAN'S DESK . . . .

Food & Nutrition : Selected References Available in FRCH Library

1. Alpers, David H and Others, **Manual of Nutritional Therapeutics**, Boston, Little, Brown & Company, 1988, Pgs. 486.

2. Antia, F.P., **Clinical Dietetics and Nutrition**, Bombay, Oxford University Press, 1989, Pgs. 438.

3. Ballentine, Rudolph, **Diet and Nutrition : A Holistic Approach**, Pennsylavnia, The Himalayan International Institute, 1978, Pgs. 634.

4. Biswas, Margaret and Pinstrup- Andersen, Per (Ed), **Nutrition & Development**, Oxford, Oxford University Press, 1988, Pgs 190.

5. Bender, Arnold E., **Health or Hoax? : The Truth About Health Foods & Diets**, New York, Prometheus Books, 1986, Pgs 184.

6. Berg, Alan, **Malnutrition : What Can Be Done?**, London, The Johns Hopkins University Press, 1987, Pgs. 139.

7. George, Susan, **How the Other Half Dies : The Real Reason for World Hunger**, England, Penguin Books Ltd., 1978, Pgs. 352.

8. Gillespie, Stuart, **Struggle for Health**, New Delhi, Concept Publishing Company, 1993, Pgs 164.

9. Gopalan, C., **Nutrition and Health Care : Problems & Policies**, Nutrition Foundation of India, Pgs. 118.

10. Gopalan, C. and others, **Nutritive Value of Indian Foods**, Hyderabad, National Institute of Nutrition & ICMR, 1985, Pgs. 204.

11. Jackson, Tony and Eabe, Deborah, **Against the Grain : The Dilemma of Project Food Aid**, Oxford, OXFAM 1982, Pgs. 132.

12. King, Maurice and Others, **Nutrition for Developing Countries**, London, Oxford University Press, 1976, Pgs. 436.

13. Thimmayamma, B.V.S. and Others, **Use of Food Products in Supplementary Feeding Programmes in Andhra Pradesh**, Hyderabad, National Institute of Nutrition, 1987, Pgs. 76.

14. Rao, V K R V, **Food, Nutrition & Poverty in India**, New Delhi, Vikas Publishing House Pvt Ltd., 1982, Pgs. 154.

15. Edmundson, Wade C. and Others, **Diet, Disease and Development**, Delhi, Macmillan India Ltd., 1992, Pgs. 324.

16. Vijayaraghavan, K. and Others, **Identification of Simple Indicators and Development of Nutrition Surveillance Method : At the Primary Health Centre level**, New Delhi, Indian Council of Medical Research, 1989, Pgs. 96.

17. Shields, Brenda, **Nutrition During Pregency**, Allahabad, A. H. Wheeler and Co. Private limited., 1988, Pgs. 61.

18. ICMR, **Field Supplementation Trial in Pregnant Women with 60 MG, 120 MG, and 180 MG of Iron with 500 MG of Folic Acid**, New Delhi, ICMR, 1992, Pgs. 46.

19. Rao, N. P. and Others, **Nutritional Content of Community Care Services Delivered Through Health and Non-Health Channels**, Hyderabad, National Institute of Nutrition, 1988.

(Contd. from page 1)

doctor practices today, conducive to adopting such an approach? Today, the Indian market is flooded with inessential medicines and some of the banned drugs are also easily available. Some of the inessential drugs often overprescribed are :

1. Tonics 2. Some Expectorants and Cough Syrups 3. Enzymes for Digestion 4. Steroids for Debility 5. New Generation Vitalizers 6. Combination Drugs 7. Brain Tonics 8. Drugs for Liver Diseases 9. Protein Powders and Liquids 10. Gripe Water and Bonnison 11. High Concentration Vitamins 12. Multivitamins for Healthy Individuals

A family doctor should learn to restrict his treatment practices to the essential drugs list drawn up by the WHO. Also, there are many Indian journals which give a critical appraisal of the drug situation in India through which the family doctors can keep their kowledge updated, but very few family doctors in India are well-informed. At the same time continuing education and information remains a neglected area . It is necessary that the Indian government inform doctors periodically about relevant facts related to essential and rational health care. Obviously, family doctors should stick to a few time tested and safe drugs. New drugs should be prescribed only if they have a clear side effect profile, safety and proven efficiency on double blind multicentric trials. Use of a particular drug by a reputed physician is no guarantee of its safety and efficacy. Unfortunately, doctors are often seen to be making experimental guinea pigs of their patients. Over the years the patients are virtually conditioned to believe in the efficacy of injections for every illness. The current practice of recycling syringes is also unhealthy. Who else but the doctors can be held responsible for this?

To conclude, the health care of the community should primarily be the concern of the state but experience shows that the public health services have not been able to cope with the situation. Hence, committed contribution of family doctors is essential to help salvage the worsening health situation in India. Also, the health problems of our masses are related to illiteracy, poverty, ignorance, superstitious beliefs etc. - in many instances not expensive medicines but correct advise is all that is needed to cure the illness and a family doctor is ideal for dealing with such situations. The government has to recognise this large and useful group of health care providers and induct them into the health service infrastructure. One way of doing this would be to make doctors compulsorily serve in rural areas for some period of time (especially since the government spends such a huge sum on training doctors). Such an integration of the private and public sectors in health care services, if well coordinated, would surely take us closer to our goal of 'Health for All'. ❐

FREE ABSTRACTING

The contents of this newsletter may be abstracted without prior permission. However we would welcome acknowledgement of the source and copies of any abstractions.

Edited by Vaijayanti Aphale, with secretarial assistance from Rajam John & Rajesh Ingle and produced by the Foundation for Research in Community Health, 3-4 Trimiti-B, Anand Park, Aundh, Pune - 07. Registered under the Bombay Public Trust Act, Printed at Omega Offset, Belgaum - 06

COMMUNITY HEALTH CELL LIBRARY AND DOCUMENTATION CENTRE BANGALORE

The Foundation for Research in Community Health

frch

NEWSLETTER

For Private Circulation Only | Vol.IX, No. 5 | Sept. - Oct. 1995

Aspirin : The Wonder Drug

Dr. Ashok Vaidya & Dr. Noshir Antia

Introduction

Three years from now, Aspirin or acetylsalicylic acid will be celebrating its continuous service to mankind as a pain-reliever for over a century. Every year, more than 40,000 metric tons of aspirin is used world-wide for making tablets. Given the rate of obsolescence of drugs today, that aspirin has managed to stay in the limelight for so long and gain new indications is an achievement in itself, deserving a detailed analysis of its strengths and weaknesses, its uses and abuses and its cost-effectiveness in health care. The fact that aspirin is a derivative of a plant chemical makes it even more interesting in view of the resurgence of global interest in herbal remedies.

Individuals vary in their 'pain-threshold'; one person may lightly bear a wound being sutured without any anaesthesia, whereas another may be in pain for hours from a small cut to the finger. The physiology of pain, the underlying neural pathways and behavioural mechanisms, and chemical transmitters of pain like kinins, substance-P and prostaglandins have been studied in both, animals and man. Morphine-like endogenous substances relieving pain - endorphins and encephalins - have been identified and synthesized. Nevertheless pain remains of much scientific interest for many laboratories and more so in health care.

History and Chemistry

The first reference to aspirin dates back to the time of Hippocrates (460-377 B.C.) who mentioned the pain-relieving effects of the juice of the bark of the willow tree (Salix alba vulgaris). In the mid-eighteenth century, Reverend Edmund Stone in England wrote "An account of the success of the bark of the willow in the cure of agues", to the President of the Royal Society. It became so popular that it was feared that the tree may become extinct, hence, stripping the bark of the willow tree was made a punishable crime. Probably this is the first plant-protecting environmental legislation in history. (We could do with some such legislations in India, today.)

A bitter glycoside called salicin, the active portion in the willow bark, was discovered by Leroux in 1827. In 1838, Piria made salicylic acid from salicin. In 1853, Charles Frederic Gerardt, for the first time, produced an impure form of the acetyl derivative of salicylic acid. Hermann Kolbe and Lautemann in 1860 achieved synthesis of salicylic acid from phenol. Buss, in 1875, used sodium salicylate as an antipyretic and for rheumatic fever. Felix Hoffmann from the Bayer company synthetically produced pure acetylsalicylic acid which was introduced in medicine by Dreser in 1899. Aspirin was actually a brand name given by Bayer to acetylsalicylic acid but its popularity since, has turned it into a generic name.

Chemically, scientific is salicylic acid acetate. The crystals are needle-like and odourless, but in moist air aspirin is gradually hydrolyzed into salicylic and acetic acids and acquires the odour of acetic acid (vinegar), loosing its effectiveness.

Indications for Aspirin

The list of indications for aspirin is quite formidable and evergrowing. This is obvious if one

* A. Vaidya : Hon. Jt. Director , The Bhavan's SPARC & Research Consultant, FMR.

* Dr. Antia : Director, FMR & Director, FRCH

In this Issue

♦ Aspirin : The Wonder Drug.....1
Dr. Vaidya & Dr. Antia
♦ Health Care Reform.....3
G. J. Annas
♦ Prevention Costlier than Cure ?.....6
Dr. R. V. Bampel
♦ Health News.....7
♦ From the Sr. Librarian's Desk.....8

was to consider how often pain and inflation occur in diverse diseases and infections and how thrombosis is a common basis for stroke, coronary attacks, embolism etc. Following is an illustrative list of the indications for aspirin which have emerged over the years (Table 1.).

Table 1.

Indications for Aspirin

* Anti-pyretic (when fever is delirious)
* Analgesia (headache, arthritis, dysmenorrhoea, neuralgia, injuries, dental pain)
* Acute rheumatic fever
* Rheumatoid arthritis
* Coronary artery disease
* Transient ischemic attacks (minor strokes)
* Post-operative or varicose vein thrombosis
* Pre-eclampsia and eclampsia
* Renal colic
* Retinal micro angiopathy
* Closure of patent ductus arteriosus
* Enhancement of immunity

Formulations and Dosages of ASA

Aspirin is a white powder, poorly soluble in water and available in the form of tablets ranging from 65 to 650 mg (the common tablets weigh from 325 to 450 mg), capsules (300 mg) or as suppositories. If a patient has taken the tablet with very little liquid, i.e. less than quarter of a litre, there is a risk that the tablet will disintegrate too slowly and insufficiently. Micronized aspirin and effervescent tablets have been developed for countering these problems of slower and decreased absorption and more gastrointestinal irritation.

It is desirable to start taking aspirin in low dosages and assess the relief obtained. Most of the patients obtain relief from pain within 4 to 6 hours, on taking a dose of 650 mg - this quantity of aspirin has little or no anti-inflammatory effect. Aspirin should always be taken after eating something. For rheumatoid arthritis or where relief from inflammation is desired, only 0.9 gm tablets of aspirin, four times a day, is the recommended initial dose, to be increased as and when required. There is hence, a difference between the dose of analgesia for an headache and that for relieving inflammation. The antipyretic dose ranges from 325 mg to 1 gm orally every 3 to 4 hours, in adults.

The correct dosage of aspirin for prevention of myocardial infarction, stroke, or transient ischemic attacks, ranges between 325 to 1300 mg, daily. An extensive study carried out by many investigators showed a decrease in the risk of cardiac infarction by 47% if 325 mg of aspirin is taken every alternate day. The recent trend is to use even lower (75-150 mg) doses of aspirin daily, for prevention of transient ischemic attacks.

How Aspirin Works

Though relief from pain or inflammation on taking aspirin is a common experience, yet how this was actually brought about was not understood for many decades. The mystery was finally deciphered by Sir John Vane when it was found that aspirin inhibited the synthesis of prostaglandins by acetylating and inactivating the synthetic enzyme cyclooxygenase. Aspirin stimulates the secretion of interleukin 2 and gammainterferon from the body's own immune cells (monocytes). Immunostimulatory effects are likely to be of help in viral infections and autoimmune diseases.

Side-Effects of ASA

The most common side-effect of aspirin is gastric irritation leading to heart-burn, nausea, epigastric pain and bleeding in some cases. It is said that with a full dosage of aspirin, almost 70% of patients will bleed 5 ml of blood through their gastric mucosa each day. Those who have peptic ulcers or acid-peptic diseases do not take kindly to aspirin. But this effect can be mitigated by concomitantly giving histamine-2 receptor blockers or acid secretion blockers to reduce gastric acidity. About 2% of patients are sensitive to aspirin and may develop skin allergy or bronchial asthma. Only rarely, in younger children, a peculiar syndrome of mitochondrial dysfunction - Reye's syndrome - can occur which may be fatal. Hence aspirin is not permitted for use in children.

Aspirin has multiple drug-interactions and care should be taken in patients receiving anti-coagulants and other medications for chronic diseases. Only with large dosages, salicylism-tinnitus (ringing in the ears) and acidosis may occur. Therefore, the usual, short-term therapy is considered safer. Many new non-steroidal anti-inflammatory drugs (NSAIDs) are claimed to have advantages over aspirin in terms of efficacy (on the basis of dose required), but as far as the safety profile is concerned, the advantages claimed are marginal and debated even among experts.

Cost-effectiveness of Aspirin

Aspirin is one of the lowest-priced drug. The price of Aspirin can be further brought down if proper packaging of the drug powder with calcium carbonate is evolved which can resist humidity and decomposition of aspirin. Many of the other NSAIDs

(*Continued on pg. 5*)

Changing our Metaphors

Health Care Reform

The following article by ***G. J. Annas*** *has been abstracted from the16th March'95 issue of* ***The New England Journal of Medicine.*** *Though the specific reference in the original article is to the American health care system, we have generalised it since the basic argument is applicable to all economies on the path of modernisation.*

A democracy is founded on the proposition that we are all endowed by our creator with certain inalienable rights, especially the rights tolife,liberty and the pursuit of happiness. Any government sponsored health care plan must take into account these inalienable rights. Unfortunately, side-by-side also exist the extreme and distorted manifestations of democracy, as reflected in the wasteful, technologically driven, individualistic, and death-denying culture found in our urban localities. Every health care plan, government-sponsored or not, must also take these post-modern characteristics into account. How is it even possible to think seriously about reforming a health care system that reflects these primal and pervasive values and characteristics? The first necessary step - which will require us to look deeper than money and means, to goals and ends - is to devise a new metaphor to frame our discussions of public policy and to help us develop a new conception or metaphor of health care. Metaphors, which entice us to understand and experience "one kind of thing in terms of another...play a central role in the construction of social and political reality". We have tried the military metaphor and the market metaphor; both narrow our field of vision, and neither can take us where we need to go.

The Military Metaphor

The military metaphor has had a pervasive influence on both the practice and the financing of medicine. Medicine is a battle against death. Diseases attack the body, and physicians intervene. We are almost constantly engaged in wars on various diseases, such as cancer and AIDS. (*In India its also Tuberculosis, Malaria etc.*). Physicians, who are mostly specialists backed by allied health professionals and trained to be aggressive, fight these invading diseases with weapons designed to knock them out. Physicians give orders in the trenches and on the front lines, using their armamentaria in search of breakthroughs. Treatments are conventional or heroic, and the brave patients soldier on. We engage in triage in the emergency department, invasive procedures in the operating the alter, and even defensive medicine when a legal enemy is suspected.

The military metaphor leads us to over-mobilize and to think of medicine in terms that have beccme dysfunctional. For eg, this perspective encourages us to ignore costs and prompts hospitals and physicians to engage in medical arms races in the belief that all problems can be solved with more sophisticated technology. The military metaphor also leads us to accept as inevitable organizations that are hierarchical and dominated by men. It suggests that viewing the patient's body as a battlefield is appropriate, as are short-term, single-minded tactical goals. Military thinking concentrates on the physical, sees control as central, and encourages the expenditure of massive resources to achieve dominance.

As pervasive as the military metaphor is in medicine, the metaphor itself has been so sanitized that it is virtually unrelated to the reality of war. We have not, for example, used the metaphor to assert that medicine, like war, should be financed and controlled only by the government. The metaphor has also become mythic. As a historian of war, John Keegan, correctly argues, modern warfare has become so horrible that "it is scarecly possible anywhere in the world today to raise a body of reasoned support for the opinion that war is a justifiable activity".

The Market Metaphor

The market metaphor has already transformed the way we think about fundamental relations in medical care but is just as dysfunctional as the military metaphor. In the language of the market, for example, health plans and hospitals market products to consumers, who purchase them on the basis of price. Medical care is a business that necessarily involves marketing through advertising and competition among suppliers who are primarily motivated by profit. Health care becomes managed care. Mergers and acquisitions become core activities. Chains are developed, vertical integration is pursued, and antitrust worries proliferate. Consumer choice becomes the central theme of the market metaphor. In the language of insurance, consumers become "covered lives" (or even "money-generating biological structures"). Economists become health-financing gurus. The role of physicians is radically altered as they are instructed by managers that they can no longer be patient advocates (but instead must advocate for the entire group of covered lives in the health plan). The goal of medicine becomes a healthy bottom line instead of a healthy population.

The market metaphor leads us to think about medicine in already familiar ways : emphasis is placed on efficiency, profit maximization, customer satisfaction, the ability to pay, planning, entrepreneurship, and competitive models. The ideology of medicine is displaced by the ideology of the market place. Trust

is replaced by caveat emptor. There is not place for the poor and uninsured in the metaphor of the market. Business ethics supplant medical ethics as the practice of medicine becomes corporate. Nonprofit medical organizations tend to be corrupted by adopting the values of their for-profit competitors. A management degree becomes at least as important as a medical degree. Public institutions, which by definition cannot compete in the for-profit arena, risk demise, second-class status, or simply privatization.

Like the military metaphor, the market metaphor is also a myth. Patients, as consumers, are to make decisions, but these decisions are now relegated to corporate entities. The market metaphor conceals the inherent imperfections of the market and ignores the public nature of many aspects of medicine. This perspective also ignores the inability of the market to distribute goods and services whose supply and demand are unrelated to price. The metaphor pretends that there is such a thing as a free market in health insurance plans and that purchasers can and should be content with their choices when unexpected injuries or illnesses strike them or their family members. The reality is that markets are highly regulated, major industries enjoy large public subsidies, industrial organizations tend toward oligopoly, and strong laws that protect consumers and offer them recourse through product-liability suits have become essential to prevent profits from being too ruthlessly pursued. (Another reason why the market metaphor is not valid to health care is, because, unlike the conventional assumption in market economics of absolute knowledge on part of the consumer, high technology completely distances the average consumer from knowledge of medicine. This gives the doctor near complete power over the patients body and mind; the consumer is no longer "king" but more of an experimental guinea pig and\or a money making machine. - editor)

The Ecologic Metaphor

It seems reasonable to conclude that if the government is ever to make meaningful progress in reforming our system for financing and delivering medical care, a new way must be found to think about health itself. This will require at least a new metaphoric framework that permits us to reenvision and thus to reconstruct the American medical care system. The leading candidate for a new metaphor is ecology.

Ecologists use words such as "integrity," "balance," "natural," "limited (resources)," "quality (of life)," "diversity," "renewable," "sustainable," "responsibility (for future generations)," "community," and "conservation." If applied to health care, the concepts embedded in these words and others common to the ecology movement could have a profound influence on the way the debate about reform is conducted and on plans for change that are seen as reasonable. The ecologic metaphor could, for example, help us confront and accept limits (both on expectations about the length of our lives and on the expenditure of resources we think reasonable to increase longevity), value nature, and emphasize the quality of life. This metaphor could lead us to worry about our grandchildren and thus to plan for the long term, to favour sustainable technology over technology we cannot afford to provide to all who could benefit from it, to emphasize prevention and public health measures, and to debate the merits of rationing.

Use of the ecologic metaphor is not unprecedented is medicine. Two physician writers, for example, have used it extensively. Lewis Thomas often invoked this metaphor in his essays in the Journal, and his idea that the earth itself could best be thought of as a "single cell" became the title for his first collection of essays, The Lives of a Cell. Using this metaphor helped him to develop many of his important insights into modern medicine, including his concept of a "halfway technology," his argument that death should not be seen as the enemy, and his suggestion that in viewing humans as part of the environment, we could see ourselves from a new perspective, as highly specialized "handymen" for the earth.

The other leading physician spokesperson for an ecologic view of medicine is Van Rensselaer Potter, who in coining the term "bioethics" in 1971 meant it to apply not to just to medical ethics (its contemporary application) but to a blend of biologic knowledge and human values that would take special account of environmental values. In his words, "Today we need biologists who respect the fragile web of life and who can broaden their knowledge to include the nature of man and his relation to the biological and physical worlds."

Drawing on the attempts of the "deep ecologists" to ask more fundamental questions than their "shallow" environmental counterparts (who concentrate on the abatement of pollution and recycling), psychiatrist Willard Gaylin suggested that what was needed was a "wide-open far-ranging public debate about the deeper issues of health care - our attitudes toward life and death, the goals of medicine, the meaning of health, suffering versus survival, who shall live and who shall die (and who shall decide)." Without addressing these deeper questions, Gaylin rightly argues, we can never solve our health care crisis.

The ecologic metaphor also naturally leads us to considerations of population health. This perspective shifts the emphasis from individual risk factors, for example, "toward the social structures and processes within which ill-health originates, and which will often be more amenable to modification." Use of the ecologic metaphor encourages us to look upstream to see what is causing the illnesses and injuries downstream. This is a reference to another metaphor, about villagers who devised complex methods to save people from drowning, instead of looking upstream to see who was pushing them in. The ecologic

perspective puts more emphasis on prevention and public health interventions and less on wasteful interventions at the end of life.

Control and Community

The predominance of the military and market metaphors in our thinking about medicine has reinforced the quest for control that seems to define both modern medicine and post-modern politics. Medicine's accomplishments have been astonishing at both borders of life. Medical technology has, for example, eliminated the necessity to engage in sexual intercourse to procreate and has thereby radically altered the meaning of parenthood in ways we have yet to confront socially. At life's other border, we continue our effort to banish death and, if unsuccessful, to assert control in the name of freedom to end life itself.

Unlike the military and market metaphors, which only reinforce our counterproductive post-modern characteristics of wastefulness, obsession with technology, fear of death, and individualism, the ecologic metaphor can help us confront them. Applied to medicine, the ecologic metaphor can encourage an alternative vision of resource conservation, sustainable technology, acceptance of death as natural and necessary, responsibility for others, and at least some degree of community. It can also help move us from standards of medical practice determined by the law, an integral part of the market, to standards that provide a greater role for ethics and ethical behaviour in the practice of medicine.

Conclusion

The challenge remains to create a health care system that provides affordable, high-quality care for all, and we will not face, let alone meet, this challenge if we continue to rely on visions of health care mediated by the military and market metaphors. Language has a powerful effect on how we think and is infectious; as William S. Burroughs has aptly put it, "Language is a virus". We need a new vision of health care, and the ecologic metaphor provides one that can directly address the major problems with our current culture, as well as the deeper issues in health care. ❐

(*Continued from pg. 2*)

cost significantly higher. Paracetamol, though a good and economical analgesic, does not have much anti-inflammatory effect. Multiple formulations are available which are unduly expensive and their sustained release makes matters worse. Table 2. compares the prices of aspirin and other NSAIDS in the Indian market. It can easily be seen that the price differential is sizeable and many drugs are beyond the purchasing power of most Indians.

Table 2

Price of Aspirin and other NSAIDS

Drug	Price per Ten Units (in Rs.)	Drug	Price per Ten Units (in Rs.)
Aspirin	1.00	Voveran - E.C.	7.50
Naproxin	27.90	Diclorann E.C.	11.40
Crocin	3.25	Indomenthacin	5.93
Metacin	3.25	Dolonex	42.30
Cataflan	8.85	Naproxin	27.90
Paracetamol	2.50	Brufen (200 mg)	4.00

Aspirin is available both as generic tablets and as brands and multiple combinations and modified formulations. Table 3. lists some of these available in the market.

Table 3

Aspirin Formulations, Combinations & Price

Brand	Constituents	Comments	Price per 10 Units (in Rs)
DAPRISAL	Aspirin 325 mg Destropro poxyphene 100 mg	Habit forming ?	7.40
DISPRIN	Aspirin 325 mg Ca (CO3)2 105 mg Citric acid 35 mg	Rational Combination	2.00
MICROPIRIN	Aspirin 350 mg Caffeine 20 mg	APC without 'p' (phenacetin)	1.25
ASA - 50	Enteric control aspirin 50 mg	Low dose for TIA. CHD	7.00

T^5A = Transient ischemic attacks
MI = Myocardial infarcttion
CHD = Coronary heart attack

Conclusion

Aspirin is a relatively safe drug for short-term use in acute pain or inflammation. However, in case of long-term intake, large dosages may lead to stomach upsets and occasionally, bleeding in some patients. As a preventive measure for transient ischemic attacks and coronary artery disease, smaller dosages are relatively safer. ❐

Prevention Costlier than Cure?

Dr. R. V. Banpel

It is a well accepted notion in public health that prevention is better than cure. But is this true in its strict sense? Given the existing situation in most developing countries, the actual implementation of preventive strategies would require a rehauling of the socio-political environment. Moreover, the balance between curative and preventive health service is very delicate - the health of the people is determined by how this balance is maintained by the government. Though primary health care is provided by all governments, ultimately, the extent to which the services provided, both curative and preventive, are realistic and relevant, will determine the success or failure of the health infrastructure of the government. Thus the issue is not merely financial but also political, exacting a high cost overall.

Small wonder then that an observation of primary health care development since its inception in most developing countries shows that both governmental as well as non-governmental agencies have continued to build service-based delivery systems, rather than try to tackle down the complex problems of political, social and environmental issues that ultimately determine public health. Most governments prefer to invest in the solid manifestations of health care - clinics and curative health - as these are acceptable signs for the people that the government is doing something for them!

The main obstacles in the implementation of preventive health care strategy are :

- Lack of allocation of time to work through the issues in interaction with the people in a fully participatory way;
- Lack of relevant training of service personnel;
- Lack of inter-sectoral management.

The persistence of such obstacles is a clear indication of the lack of political interest at the local, national as well as international levels in taking a comprehensive view of public health care. To take the case of our own country, while the state feels that the centre is being too dictatorial, at the local level accusations are levelled at PHC doctors and ANMs from sub-centres for neglecting their work.

The doctors at the PHCs justify their attitude by saying, "We are trained as doctors and not as social workers, how can the government expect us to go to the people with folded hands and request them to accept family planning methods ?" This clearly speaks of the failure of the social medicine departments in our medical colleges, in creating social awareness among young doctors.

On the other hand, ANMs at the sub-centres complain that they are always bullied and pressurised by panchayat members, youth leaders, doctors and bureaucrats. Moreover, in the existing bureaucratic system, a lot of their time is taken up in paper work. In all this, real work suffers to a great extent.

The nature of the system prevents true involvement of the health workers in their work. It is not a fault of the workers though. They get no support in developing meaningful or relevant programmes locally, as the planners are afraid that such a step would subvert the system imposed by them!

Talk to the people and they have their own story to tell. A typical experience of those on field work is that the people are always complaining about the shortage of doctors at PHCs, irregularity of doctors and nurses etc. According to the people, barring a few exceptions, none of them are well conversant with their work, for eg. if a sterilisation operation is undertaken, they do not have the capacity to deal with any post-operative complications. The '*Sarkar*' too does not seem to be bothered about the plight of the people. If you ask the people what they want, they readily demand a good hospital, competent doctors and free medicines.

Legislative enforcement in health, as found in the U.K. at the turn of the century, is not possible in the poor countries since such enforcement, in effect, involves high costs overall, as has already been elaborated at the beginning of the article. Given all the above conditions, prevention actually becomes costlier than cure.

How does one escape from this vicious circle? Though our discussion has dwelled upon why preventive health care can be very costly, it has not calculated the actual cost of prevention. Actually their can be no definite answer as the cost can be as high as one pleases. But what we can concentrate upon is how the available resources can best be utilised. Since service based systems have a severe limitation in that they are unable to achieve an integrated approach because of "vertical demands" (top-down approach) made by donors and governments, the solution lies in adopting flexible responses to local situations in an approachable manner, in cooperation with the local community. Much can be done with the services and resources available at our disposal if only we try and be more realistic of our goals and work together as a team. Peoples health in peoples hands is the only true answer. ❐

Dr. Banpel is a Primary Health Consultant at SOSVA

HEALTH NEWs

The centre has decided to sanction 460 new Integrated Child Development Schemes (ICDS) with a view to improving the nutritional and health status of vulnerable groups. The new blocks would be identified on the basis of criteria of backwardness in different parts of the country. So far, 3908 ICDS projects have been sanctioned in the country, of which 3342 are fully operational.

If the prevailing trend in Kerala of preference for breast-feed over baby-food is sustained, Kerala may soon become the nation's first 'baby-friendly' state. In terms of actual measures, it would mean that all hospitals with minimum 250 deliveries a year will pledge to make all efforts to encourage breast-feeding, shun tinned-food and bottle-feeding and encourage immunisation. Ernakulam city in Kerala has already been declared the first baby-friendly urban centre in the country.

The 1995 Human Development Report has placed India 134th among 174 countries, as per a ranking based on the human development index (HDI), thus relegating it to the "low human development category". The HDI is based on several parameters like longetivity, educational attainment and basic purchasing power. Other countries in the south Asian region also placed in the low human development category are : Paksitan (128th), Myanmar (132nd), Bangladesh (146th), Nepal (151st) and Bhutan (160th).

An inexpensive tuberculosis test has been developed by a team of scientists led by Pramod Khandekar at the National Institute of Immunology. The test can detect tuberculosis in a person within 24 hours and costs just Rs 60 per patient. (Presently, it takes up to two months to carry out different tests to detect TB.) The mechanical equipment fabricated to conduct the test costs around Rs 7 lakhs and any trained technician should be able to operate it. Nearly 200 samples could be tested with the equipment daily. The test is based on amplification of micro-bacteria TB-DNA technique called polymer chain reaction.

Bombay was rocked by a 'bloody' scandal in which the Indian Red Cross blood bank was allegedly found guilty of selling HIV-infected blood to hospitals. The Food and Drug Administration (FDA), in consultation with the Drug Controller of India (DCI), immediately directed the Indian Red Cross Society to shut down its blood bank until further orders and cancelled its license as well. Incidiently, a recent finding contained by a report prepared by the School of Tropical Medicine revealed that a fourth of the HIV-infected patients in West Bengal are blood donors, causing considerable alarm in the state.

The government has issued the Bio-medical Wastes (management and handling) Rules, 1995 notification under the Environment Protection Act for proper disinfection, treatment and disposal of bio-medical wastes from hospitals, research and development organisations, laboratories and slaughter houses. Presently, the indiscriminate disposal of the waste so generated is becoming a potential source of health risk to the human population. One of the important features of these rules is the prohibition on the import and export of such wastes. In order to track these wastes - bi-annual reports, maintenance of records and annual returns concerning such wastes has been made mandatory.

The first hospital and rehabilitation centre for AIDS patients is to be set up at Gadab in Raigad district of Maharashtra, 88 kms from Bombay. Besides admitting patients who require acute and chronic care the hospital will also look after orphaned children of AIDS victims and HIV-infected sex workers. The plan for starting such a centre has been initiated by the Indian Health Organisation, an NGO involved in checking the spread of AIDS since 1985.

India's first herbal health care kit for therapeutical use has been prepared by theTropical Botanic Garden and Research Institute (TBGRI) of Kerala. Drugs made of herbs in the form of granule, capsule and ointment are to be packed and marketed by a Madras-based unit under the technology transfer mission. Termed the "common man's mobile dispensary," the kit contains remedies for cough, fever, diarrhoea, gas trouble, eye disorders, constipation, colic, uterine bleeding, appetite, general stamina, sprain, burns, head and earache. The clinical safety of the drugs was established by toxological studies as per the WHO guidelines-1991. The kit is a product of the two-year-long joint efforts of the scientists in ethno-medicine, ayurveda, phytochemistry, pharmacology and pharmacy.

A micro-study of the family planning programme was conducted in 24 villages of Roopnagar district in Punjab by the Population Research Centre attached to the Centre for Research in Rural Development. It is part of the operational research in spacing methods conducted separately by 18 PRCs located throughout the country. The findings reveal that the family programme in Punjab has suffered seriously because of lack of knowledge of the side-effects, selection of methods not guided by health status and absence of effective management of the side-effects of the popular methods of contraception.

A new health awareness programme is being launched among school-going children by the Delhi government, considering the fact that the roots of heart ailments and many other diseases concerning the lungs and stomach begin in the school years itself. Educational as well as medical experts are being incorporated into the programme. Central to the programme is the organisation of a 'health mela' which will spread awareness on matters such as personal hygiene among the capital's school children. ❐

FROM THE SENIOR LIBRARIAN'S DESK....

Working Women : Selected References Available in FRCH Library

Banerjee, Nirmal, **Women Workers in the Unorganized Sector : The Calcutta Experience**, 1985, Sangam Books Pvt. Ltd., Hyderabad, Pgs. 150

Black, Clementina (Ed.), **Married Women's Work**, 1983, Virago Press Ltd., London. Pgs. 290

Chandola, L. M., **Women in the Unorganized Sector**, 1985, Radiant Publishers, New Delhi, Pgs. 109

Chandra, S.K. & Lakshmiswaramma, **Working Women and Instant Care : Problems of Breast Feeding and Instant Weaning Faced by Women Working in the Organized and Unorganized Sectors**, 1991, Mittal Publications, New Delhi, Pages 102

Devasia, Leelamma & Devasia, V.V. (Ed.), **Women in India**, 1990, Indian Social Institute, New Delhi, Pgs. 193

Everett, Jana and Savara, Mira, **Women and Organisations in the Informal Sector**, 1994, Himalaya Publishing House, Bombay, Pgs. 180

Gill, Tess & Whitty, Larry, **Women's Rights in the Workplace**, 1983, Penguin Books, England, Pgs. 438

Ministry of Labour, GOI, **Socio-economic Conditions of Women Workers in Manufacture of Chemicals and Chemical Products and Food Product Industries**, 1986, Labour Bureau, Ministry of Labour, GOI, New Delhi, Pgs. 65

Hirway, Indira, **Denial of Maternity Benefits to Women Workers : A Study of the Factory Sector in Gujarat**, 1986, Oxford and IBH Publishing Co. Pvt. Ltd., New Delhi, Pgs. 151

SI, **Tribal Domestic Worker at the Crossroads : A Search for Alternatives**, 1993, Indian Social Institute, New Delhi, Pgs. 71

Mazumdar, Vina (Ed.), **Women Workers in India : Studies in Employment and Status**, 1990, Chanakya Publications, Delhi Pgs. 304

Mitra, Asok (Etc. All), **Status of Women : Household and Non-household Economic Activity**, 1979, Allied Publishers Pvt. Ltd., Bombay, Pgs. 78

Mitra, Asok, **Status of Women : Literacy and Employment**, 1979, Allied Publishers Pvt. Ltd., Bombay, Pgs. 74

OECD, **Integration of Women into the Economy**, 1985, OECD Paris, Pgs.183

Rose, Kalima, **Where Women Are Leaders : The SEWA Movement in India**, 1992, Vistar Publications, New Delhi, Pgs. 286

Sen, Sunil, **Working Women and Popular Movements in Bengal : From the Gandhi Era to the Present Day**, 1985, K. P. Bagchi & Co., Calcutta, Pgs. 128

Shah, K. T. (Ed.), **Womens Role in Planned Economy**, 1947, Vora & Co. Publishers Ltd., Bombay, Pgs. 265

Sinha, G. P. and Ranade, S.N., **Women Construction Workers : Reports of Two Surveys**, 1975, Allied Publishers, Bombay, Pgs. 76

Tellis Nayak, J. B., **Education and Income Generation for Women : Non-formal Approaches**, 1982, Indian Social Institute, New Delhi, Pgs. 79

Vohra, Gautam, **Women in Bihar : A Study of their Role in Tasar Silk Production**, 1988, Vikas Publishing House Pvt. Ltd., New Delhi, Pgs. 206

State of Rural Health Complexes in Bangladesh

*A news item from **'Dhaka'**, it has been reproduced here since the conditions are akin to those of the Indian rural health comlexes.*

Though a relatively poor country, Bangladesh appears to have developed a network of health care facilities. Hospitals in cities apart, physical facilities have been built up in rural areas both at thana and union levels. These facilities have been termed as health complexes and equipment of different types have also been installed in some of them. They have been made operational at least in theory with the posting of doctors, nurses and other technicians.

In reality though, not many of these health complexes have been made operational. Many of them are yet to render effective service to patients. This is because doctors and other technicians have not either been posted in such complexes or even if posted, such personnel are not available in their stations. Some of the doctors and technicians have remained in the cities, despite their posting in rural areas.Of course, the absentee medical professionals of rural health complexes have arguments of their own. They justify their behaviour on groundsof family obligations or professional interests; higher remuneration and fees in city-based clinics and laboratories ; better opportunities in cities for pursuing studies in institutions of higher learning etc.

Such arguments, however, do not stand the test of legality and morality for in either case, a patient seeking emergency treatment or medical advice is automatically denied service. Such denial of service to the people cannot be condoned on any account, since the patients and their family members as citizens and taxpayers indirectly bear the cost of development of health complexes. Those in charge of the management of such complexes and doctors, nurses and technicians appointed there are paid for their services from these taxes. The people at large also indirectly bear the cost of education of doctors, nurses and technicians in addition to the expenses made by parents and guardians of such professionals. It therefore becomes a moral duty of all concerned to be available at their workplace and render such service as needed by patients coming from far and near.

Strict disciplinary measures should be taken by appropriate authorities against all absentees in rural health complexes. Also, positive measures like providing family accommodations and schooling of children of professionals in such complexes need to be initiated in order to encourage them to work in rural areas.

The capital costs of the existing health complexes are quite pronounced and no one would like to see these not utilized properly. As these facilities are geared to attaining improved health of the people at large, efforts have to be made to optimize their utilization. The goal of serving the rural people should be upheld.

❐

FREE ABSTRACTING

The contents of this Newsletter may be abstracted without prior permission. However, we would welcome aknowledgement of the source and copies of any abstractions.

Edited by Vaijayanti Aphale with secretarial assistance from Swati Tore. Produced by the Foundation for Research in Community Health, 2-3, Trimiti B Appts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 6.

The Foundation for Research in Community Health

frch

NEWSLETTER

For Private Circulation Only | Vol.IX, No. 6 | Nov.-Dec. 1995

COMMUNITY HEALTH CELL LIBRARY AND DOCUMENTATION UNIT

An Introduction

Training for Health

Dr. N. H. Antia

The term 'Health Education', despite being so called, fails to address either health or education. Like similar other programmes it has degenerated into another techno-managerial exercise designed to help achieve the 'targets' of vertical programmes like Family Planning, Immunization, Malaria Eradication, Tuberculosis Control and AIDS Control. The failure to achieve even these limited targets after several decades of such effort indicates that there is some basic flaw in the approach itself, a fact corroborated by the health statistics of our country as compared not only to China but even to that of our own state of Kerala.

A Happy New Year to all our readers

The holistic concept of health has evaded the medical profession trained almost entirely in curative medecine imported from the West. And yet, it is common knowledge that health involves most aspects of life such as nutrition, education, water, sanitation, housing and environment. This understanding of health as taught by Ayurveda and Yoga is a part of the health culture of our people. Training for health at every level whether it be the health professionals, paramedicals, school children or the community and its health workers must be such as to enforce and support that which is fortunately a part of the health culture of our people and is now sought to be eroded by the unfortunate materialistic culture and values of the West. A culture, alien to our own, increasingly moulded by market forces, which aims to promote an unhealthy mental and physical style. It has converted health into illness and illness into another lucrative business or industry.

A major objective of training for health must therefore be not only to promote our traditional values of health but also to counter the unhealthy life styles being promoted by the new globalised market forces. Even in illness care the training must be oriented towards encouraging self help to the extent possible and creating awarness of the dangers of overmedication promoted so vociferously by the health industry. Quality of medical care must not be equated with its cost because good health and medical care is cheap while bad health care has no upper limit. Over 70% of all problems of health and illness care can be best undertaken by the people themselves if they have access to proper information and support from their own trained community health workers.

The role of the professionals is to teach, encourage and support the people and community for the relatively complicated problems that require greater skills and facilities. An important aspect of training for health must concern itself with demistifying the present overprofessionalised approach and return health and its care to the people where it truly belongs. ❐

Dr. N.H. Antia, Director and Trustee of FMR & FRCH, has done commendable work in plastic surgery, leprosy and community health. Major committees he has served on include the Planning Commission Health Committee, GOI.

In this Issue

- Training for Health 1
  Dr. N.H. Antia
- Health Education : Limits and Strengths 2
  Dr. Ramesh Awasthi
- Selection and Training 3
  Dr. R. V. Banpel
- Women in Health Training 5
  Aarti Kelkar
- Participatory Approach to Training 7
  Seema Deodhar
- Teaching the Teachers' Teachers 8
  Subhash Saudagar
- The Participatory Trainer 10
  Vaishali Vaidya
- Health News 11
- From the Sr. Librarian's Desk 12

Health Education : Limits and Strengths

Dr. Ramesh Awasthi

The famous Alma-Ata Declaration on Primary Health Care recognised that the role of information and education is not restricted to merely bringing about 'desirable' changes in people's health behaviour. It is now accepted that health education has a wider function of working with the people, so that they can effectively take charge of their own health concerns and be able to demand decent health services from the state, irrespective of people's capacity to pay.

Yet, most health education efforts are largely restricted to top-down instructional endeavours with a few audio-visual shows aimed at achieving people's acceptance of the programme, so that the planners of the programme are able to achieve their targets. Due to this narrow approach, people have often been made targets of health messages chiefly related to family planning, and now to AIDS; the programmes being largely decided through availability of aid from bilateral foreign funding agencies.

Health behavior of a community is shaped by a large number of interlinked determinants. Physical realities of life, socio-economic conditions and totality of knowledge and experiences of many generations, i.e. 'health culture', are important factors which influence health behaviour of the people. Therefore, it is not rational to expect that mere communication of 'proper health information' (howsoever scientific it might be) to the people will change their behaviour. Availability (or lack of it) of resources is also a major impediment to realisation of good health, in spite of good health education services.

Health education, like any other endeavor, has to be a two-way communication process. There is no ground to be arrogant about our ' scientific' information and to have disrespect for the experiential knowledge base of the people. It would do us some good to remember that the people we are planning to 'teach' have survived, with considerable skill, through untold adverse conditions.

If 'Health for All' has to become a holistic concept, then health education should not only develop consciousness about health care activities, but should also aim at creating critical consciousness among the people for improvement in all aspects of life. The role of health education, therefore, is to initiate a positive process of change towards betterment in health of all the people, especially of those who are today, deprived and vulnerable.

An action research study was undertaken by the FRCH to study and understand this process, with the objective of strengthening health education services. The emphasis was to be on getting people to demand services from the public health system by putting collective pressure on the functionaries. The study was carried out in three PHC areas covering 47 villages (about 90,000 population) of Baramati and Purandar talukas of Pune district in Maharashtra.

In the area covered by the Supa PHC in Baramati taluka, the project activities were carried out through the existing government health functionaries. This would help to realise the replicablity of our work and methodology. While in teh Malshiras PHC in Purandar taluka, we worked through intensive interaction with the local people. The Parinche PHC area, also in Purandar taluka, was studied only as a control area. As the Malshiras area was to be the field of intense interaction with the people, the research team stayed in Malshiras village for the five years of the project.

For many reasons we did not have a doctor on our team. To get a doctor to take health education without providing services in a region that is so starved of medical facilities would have been insensitive to people's reality. Secondly, our intention of increasing people's demands on the public health services would have failed, as our doctor-oriented project would have to, in all ethical consideration, provide medical intervention in the face of emergencies, or on demand from the people. Thirdly, health education would have got identified with the doctor, and people would have found it hard to believe that non-medicos could impart such knowledge effectively and in a demystified manner. The role of local educators would have been sidelined, and the myth that 'health = doctor' would have got further strengthened.

Even as we were conducting health education activities in the two areas of intervention, we were aware that health education, on its own merit, cannot change the reality of people's lives. In a limited way, health education has been used, by government and non-government agencies to increase the coverage of their programmes, and to increase "people's participation". If the education is given in an understandable and sensitive fashion,

(Continued on pg. 4)

Dr. Ramesh Awasthi is a trustee and senior scientist of FRCH and coordinates the Parinche, Grameen Bank, Public Information and Village library projects of FRCH

Community Health Workers

Training and Selection

Dr. R. V. Banpel

"In the context of development, community participation refers to an active process whereby beneficiaries influence the direction and execution of development projects rather than merely receive a share of project benefits" ***--- Samule Paul.***

1. Two hundred and seventy-eight women die everyday in Bharat during pregnancy and childbirth.

2. Only 30 per cent children have been fully immunised against six infectious diseases.

3. Sixty per cent newly married women do not plan to resort to any form of family planning.

These are some of the dismaying statistics given by the National Family Health Survey 92-93 carried out by the International Institute of Health Sciences, Bombay. This, when we are just two years away from the golden jubilee of our independence.

Inspite of spending crores of rupees on health care, we are still unable to provide basic health care facilities to the majority of our population. Even the thousands of medical graduates that we churn out every year have been unable to change the situation. Where have we gone wrong?

The main fault seems to lie in our health care system which follows a centralised, top-down approach. The conventional approach of training community health workers has met with little success since it disregards the vital principal of decentralisation. The only workable alternative would be a national level training programme that incorporates training of village level workers not only in the field of health but in various sectors related to health care like veterinary health and formal/non-formal education. The training programme could be divided into the following components :

* Pre-selection and community participation
* Final selection
* Base Line Survey and actual training
* Service component and referral service
* Follow-up

Dr. R.V. Banpel, presently a Community Health Consultant at SOSVA, was associated with the Parinche Project of FRCH as a senior researcher.

Pre-selection and Community Participation

Before the final selection of the health workers the philosophy of the NGO, its objectives, participation required from the community should be clearly defined and explained to the people. This can be done by holding village level meetings involving the community and people from all walks of life viz., local leaders, mahila mandals, youth clubs, other organisations working in the area and also government officials. The role of community workers should be clearly delineated and the community should be involved in all the programmes right from the start.

Final Selection

Final selection of community workers should be fair and open to all. Priority should be given to women workers.

Actual Training (Classroom and Field)

This should be designed to suit the needs of the local community with emphasis on local problems of sanitation, drinking water, common communicable diseases and their simple treatment/prevention. A Baseline Survey carried out by the workers themselves would form an important part of initial training. This will have two advantages :

(a) Community will come to know the community workers and vica versa.

b) Community Worker will know not only what she has to do but also why she has to do so

Presently, most of the health training is done by doctors. The latter though very informative, may not be able to communicate with the grassroots level workers. Hence if training were to include substantial inputs from ANM's, trained nurses and school teachers it would prove to be more effective.

Service Component and Referral Service (Including Basic Pathology)

Service Component should start operating gradually as it has

two distinct advantages :

a) It gives confidence to the worker that she can treat on her own.

b) It allows the worker to develop a rapport with local components and her utility is appreciated by the community, which should help in the sustanability of the programmes.

Follow up

Training is a continuous process. So effective follow up of all three aspects viz., training, service and referrals is essential to decide the success or failure of the training programme.

To sum up, the age old policy of "I take care of you" should change drastically, to "I take care of myself". ❐

(Continued from pg. 2)

without insulting local beliefs, its impact on utilisation of services is almost dramatic.

Health education, one may say, can create an impact if one is 'filling the gaps' in the information available to people. That is to say, when a particular service is available, but people are unaware of its benefits, then one may impart the relevant information and expect to find a change. What happens then, if people have no access to the 'services' mentioned above? Is health education then irrelevant, or should the information about the very absence of services be given to people ? Is health education a means to increase utilisation of existing services or is it something more than that ? The dilemma is undoubtedly that of an ethical and political nature.

Over and over again, our educators faced dead ends, when they noticed the 'futility' of their efforts. When pregnant women were advised to eat greens, they said that there was not enough clean drinking water, leave alone fresh leafy vegetables (we worked in an area of severe drought). When a TB patient was convinced of compliance in treatment and came to the PHC, drugs and/ or doctors were not always available. Private doctors continued to pump saline intra-venously, in spite of our patient being' educated' in the rational therapy for diarrhoea, and young mothers who finally brought their babies for immunisation, were perpetually ragged for sterilisation by the ANMs. Was our intervention really meaningful ?

All our workers (including we ourselves) were pleasantly surprised to see that our KAP surveys had actually shown an impact in the project area. Peoples' responses to diarrhoea, to TB, to ante-natal care and to immunisation had markedly changed in the area of active intervention, as compared to those in the control area. Government workers in both the areas of intervention were opening up with their difficulties and were making some effort, at least, to get ahead. Even in dire situations, it was apparent that people had appreciated the effort that the educators had put in. Perhaps it was because the educatiors were part of their own community, a fact that facilitated better interaction, and that the education was demand based and was told in a demystified fashion, taking into account local beliefs and practices.

It was clear then, that health education without providing services was also having an impact on people's minds. Perhaps, it was this very fact that created the impact. People were told about their rights at the health centre, and how to question health workers who were negligent. The myth that public services are free was disputed; people as payers of indirect taxes had infact paid in advance to the state so as to receive optimum services, in health and in other sectors. People were told of their right to see case papers, and to ask the private doctor details of treatment and diagnosis.

When people, especially women tried to act upon the advice of our educators, they were often unsuccessful, and sometimes they even got into trouble for their efforts. The case of the PHC doctor who was allegedly molesting women is a case in point. He threatened to 'dismiss' the Community Health Guide, and also threatened to disclose the names of women who had approached him for abortions. Yet all those who put up a fight felt more empowered through their experiences. Somehow there was a difference this time, you realised that you were not wrong, but that you had been wronged. It was a case of health education with a little difference.

Perhaps women would also learn to apply the same formula and realise that not eating greens is different from not having any greens to eat, or that an interrupted supply of drugs in TB meant that the health services were issuing a death warrant to the patient. Similarly, the fact that a doctor is no God, and that she or he has to be occasionally questioned.

Tracing a full circle, we come to the argument that if health education is necessary to increase people's utilisation of available services, it is doubly necessary when services are not available. Withdrawing one because the other is absent would amount to doubling the injustice done to the people.

During our intervention for two years, we tried also to 'fill the gaps' in the collective consciousness of people about their lack of access to health services, hoping that the questioning would extend to the causes of drought or of wife-beating. Because after all, health is a state of physical, emotional and ecological harmony; a condition that is not possible to achieve unless equality, freedom and social justice exist for all people. ❐

The human element

Women in Health Training

Aarti Kelkar

"In order to awaken the people, it is the woman who has to be awakened. Once she is on the move, the household moves" ***.....Jawaharlal Nehru.***

Involvement of the grassroots level in development is a relatively new concept. Till recently, all programmes at development failed mainly due to the fact that aid was provided externally. People who provided aid did not have, or failed to generate, faith in the minds of the local people nor could they go to the roots of the problems the villagers faced as they were culturally alienated from the people. They came as total aliens providing help to the villagers, for a temporory period of time, to be withdrawn on exhaustion of resources. The organisations failed to motivate self-respect, involvement, a sense of justice and responsibility among the people, making them dependent upon the organisations. Thus all these efforts at development though good, failed to produce long term effects.

On the other hand centralised development schemes of the government including public health care failed to reach the people because of a gap between the providers and the beneficiaries, lack of social awareness, absence of political empowerment of the people, political exploitation and social domination by the rich and higher castes in the village set up.

Keeping this in mind involvement of the members or people from the community itself was proposed, as they would be easily accepted by the local people, well acquainted with the problems at the village level and have a natural affinity for the people from their community. This can be done at the village level through the panchayats, thus preventing health from being the monopoly of administrators, bureaucrats and politicians.

Thirty per cent reservation of women in the panchayats is a very important step in this direction. A woman is an important development agent as she plays a fundamental role in the orientation of her family. Increasing her awareness will increase the awarness of the family and simultaneously improve her status in the community.

With this aim in mind the Parinche project has been undertaken, involving an integrated approach for development. This includes the tai training programme wherein competent women eager to work have been selected by the community, and are expected to function as 'development workers' for their community. We deliberately address these women respectfully as `tais' which also conveys the closeness associated with a family member.

Seventeen tais have been selected who are being given training in various areas like health education wherein measures of prevention of diseases and epidemics, early detection and primary help, motivation of people to approach doctors when needed have been encouraged. The other areas are public information, village library and grameen bank which intend to create social awareness among the people. This research is experimental in nature wherein after being trained the tais are expected to use this information for the benefit of the community.

The uniqueness in the principles and proceedings of the training sessions make them very different from the usual formal educational pattern. The training process is not just a mechanical task of equipping the women with technical skills but a highly educative and enlightening process for the participants. While the community at large will benefit, the tais themselves are gaining a lot and are undergoing a virtual metamorphosis in their personality and attitudes. Interactive communication is encouraged where all contribute their views at an equal level and the end product of the discussions is a combination of technical information enriched by local knowledge, beliefs and practices. Not only medical aspects but the associated social, cultural and psychological aspects of every problem are analysed. This allows the women to relate every instance from the sessions with their personal experiences which makes every problem more realistic and approachable thus, preventing it from being handled at the technical level alone. For instance, through the tais we realised that poor sanitary practices common among the village women, like reusing damp menstrual clothes thrown carelessly in the cattleshed or not cleaning the body properly while taking a bath, arise from the isolation practices and taboos associated with menstruation and the lack of privacy and inferiority and shame associated with their bodies.

One more positive aspect of our training is that during the sessions valuable information regarding the various problems of women which have remained hidden till now can be identified which unfurl the different aspects of how women 'suffer in silence' and also bear with the atrocities committed towards them in the society.

Aarti Kelkar is trained in health sciences and is presently doing documentation for the Parinche project at FRCH.

It is clear that the training sessions have not remained a formal training programme but a place to express themselves and to share their joys and sorrows, stresses and anxieties, thus, encouraging a feeling of mutual help, goodwill, encouragement and hope to attain the common goal together. The aim behind this is that only when this ideology is practised and internalised at a personal level can it be applied at the community level. The tais find the training sessions undertaken a very good outlet from their daily tensions. There were a few instances where some of the tais were seen crying, expressing their sorrows while other tais sympathetically listened to their problems. In one of the health sessions when the transport problem of the tais was raised one of the tais retorted "Why do you (the trainer) not make arrangements for our stay here during the training sessions so that we could get some relief from the usual family pressures?"

Another tai recalled that when she had been over to her mother's place and was asked to rest she told her mother that it was wrong for her to rest at the expense of her sister-in-law who was made to work the whole day. This instance gives an idea as to how the tais are slowly changing.

The tais have also started questioning, on a rational basis, a few existing norms in the society. They now reason that if menstrual blood was bad, why had God arranged for this same blood to nourish the child in times of pregnancy? Their analysis also extends to various aspects related to the society. While talking about social hierarchy one of the women reflected that the traditional Indian game of Dahi Handi, to be played on Gokul Ashtami, symbolised the exploitative social structure, wherein those at the top of the social pyramid trampled upon those at the bottom and appropriated all the resources for themselves. Why should the common person support such a structure?

One more important operational aspect of the project is that the women are asked to collect case studies and information on cases related to different problems from the village itself. The main aim is to motivate people to take their own decisions, analyse problems at their own level and build the concept of 'self help' in their minds. The women are encouraged to formulate their own questions which has met with a good response. In connection with this the tais informed us that they would never approach people with pen and papers as it would offend the people and invite their suspicion. Thus the tais have realised the importance of developing trust and faith among the people.

More Effort Needed

While the tais have certainly aquired a more posiitve outlook, there are areas where a better orientation is required. For instance, it was felt during the demonstration of their presentation skills that the tais tended to use all technical words and theoretical information. They were exactly imitating words used during the sessions. There appears a need to encourage the tais to use their own means of communication which should be cultivated right from the early stages.

There is another aspect which needs to be considered. Many of the women are becoming aware of the changes taking place around them, but fail to take effective action. For instance, Ms. X knows that it is wrong of her husband to drink and hit her but, remains silent. This means, there is a gap between the knowledge and actual practice of the people. Utilising the understanding aquired in actual practice remains one of the major challenges of the project. Only if the tais can affect change at the personal level first, would they be able to persuade others to do so.

It is becoming clear that just as we have started evaluating and deriving information from the women, the women have also started evaluatiing and examining us. One interesting example can be given here from the Khelwadi session wherein Raju was telling the women that it was wrong to peel vegetable skins while preparing vegetables. During lunch, one of the tais immediately pointed out that vegetable skins in Raju's tiffin had been peeled off, which was wrong. The process of training is not a one way process, hence, whatever be our responses during the training sessions will be reflected in the training of junior tais by the senior tais.

Also, to what extent can we absolve ourselves of the personal problems that these tais have to face only because they have been bold enough to attend these training sessions ? We have to be extremely sensitive to these events which relate to the everyday lives of the tais. The human element cannot be ignored.The tais face various problems at the family, the community, the economic level etc. and sheer inconviniences like lack of adequate transport. Some tais have to wallk huge distances due to lack of *pucca* roads especially during the monsoons. One of tais had to face her in-laws' ire because she needed to give up a day's work in the fields earning her Rs 30 for attending the training sessions which just earned her Rs 20 daily. Any saving done by the tais from this allowance is not welcome by the in-laws and some even have doubts whether the tais are disclosing their true income at home. Many of the tais have to face a negative reaction from the community which does not hesitate to critiicise their initiative as a wastage of time or as atempts to play God. If these women are widows or have been separated from their husbands the matter becomes worse.

(Continued on pg. 9)

Participatory Approach to Training

Seema Deodhar

Health is not an isolated concept but is determined by the surrounding socio-economic and political milieu and in turn affects the same. The 73rd amendment to the constitution seeks to introduce decentralisation in our political process. It is imperative that community health workers whether in the public or private sector, mould themselves to function in this decentralised system. Also, as in other fields, even in health care, the top-down approach has failed to give the results desired. If our declaration of Health for All by 2000 AD is to become a reality, primary health care has to be easily accessible, a task impossible to achieve in a vast country like ours unless its functioning is adequately decentralised.

Thus any complete training programme for community health workers must seek to upgrade not just the medical skills of the trainees but also train them to function in the new decentralised setup. It is this philosophy that underlies our participatory approach to health training. In essence, participation becomes both a basic value underlying this method of training as well as an instrumental requirement whereby trainees learn through participation. The training sessions become a mini-decentralised setup where the trainees get to experience the participatory approach which they can then extrapolate to the larger local situation. The trainees necessarily come from the grassroots level and every aspect of training including content, location and duration of training is determined by trainees participation. In fact even the mode of training was decided by the trainees themselves who said they preferred the participatory informal approach as a long time had elapsed since they had been to school and they would now find it too tedious to sit through formal lectures stretching for two to three hours. To make it truly participatory, during the sessions we divide the tais into small groups of four or five so that the training is not dominated by a few outspoken tais.

Course Content

It is true that the strictly medical inputs may get diluted as compared to the course content of the formal educational institutions. Also the skills learnt may not be perfected since a critical, supervisory authority is missing. But in real-life situations it is the overall compatibility of the health providers, of which pure medical skills form just a part, that determine their optimal usage to the community. That is the reason why ANMs, though equipped with medical skills are unable to function properly since they are not trained to work in grassroots level surroundings which have complex political and socio-economic aspects.

Collective discussion and interaction are central to the participatory approach. People can only understand their situations by learning from their own and each others experiences. They do not feel that some knowledge alien to them is being thrust upon them. In the session, knowledge about fever was imparted not by giving boring structured lessons but by making each tai relate her personal or close relative's experience about illness, its causes and remedies. This leads to cumulative knowledge and thus the technical support required for training is minimised. The trainer only has to help them rationalise the situation. This allows the trainees to relate their health problems to the existing socio-economic conditions. For eg. after our training session on diarrhoea, they do not relate the disease only to microbes but can identify that it usually happens to deprived people as they are unable to get adequate and clean water supply. Such basic understanding of how or why a problem exists is essential to undertaking effective action to eliminate it.

As no person really acts as the 'expert' or 'teacher' it ensures that the trainer is not seen as know-all but more as a co-traveller on the path of joint exploration. The trainer has to acknowledge their inputs especially where it comes to knowledge of the local situation. While this helps to broaden the perspective of the trainer, it makes the trainees feel involved as their own contribution is accepted. At Parinche it has also given the tais the confidence to apply this knowledge to solve their particular problems and in the process make interesting innovations. For example, one tais's cow was suffering from diarrhoea and wouldn't be cured even after being treated by a vet. The tai who had attended a training session on diarrhoea innovatively administered the medicine meant for curing diarrhoea in humans to her cow in a much larger dosage and it did give relief to her cow.

Analysis and action are strengthened through debate and discussion which is very much a part of participatory training. Disagreements and conflict are not to be feared; they are part of the process and must be dealt with openly by all those involved so that important issues do not become personalised as bad feelings and individual problems. When it was realised that one of the tais tended to over-prescribe, the tais made a collective analysis of the whole situation and decided that the tai should administer medicine only after consulting the other tais till she got used to prescribing rationally. Of course the tai was to be provided with drugs which she could administer on the spot in cases of emergency. This method of putting a check on undesirable practice

(Continued on pg. 9)

Seema Deodhar, who has teaching experience in ANM training schools, is currently working at FRCH as editor of the ANMs journal AYUSHI, and simultaneously conducts health training sessions of the Parinche tais.

COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT

Training the Teachers' Teachers

Subhash Saudagar

School age child health education and teachers training is one of the projects currently being implemented by the FRCH in the four districts of Nashik, Ahmednagar, Pune and Solapur.

Since almost all the primary school teachers are trained at the DEd. colleges, all students from these colleges in all the four districts were incorporated in this study. Lecturers in the colleges were given health education training so that this would be passed on by them to the trainee (student) teachers in their colleges. One of the main aims of SACHETT is to create the right kind of attitude towards health education among student teachers.

Health education has recently been incorporated in the DEd syllabus. It is basically looked upon as a scoring subject by students with the result that it was studied only from the examination point of view. Moreover, the syllbus was not at all practical and far removed from reality. Health education was limited to academic knowledge and lecturers were unaware of how to incorporate other elements in it.

Keeping this in mind the training of lecturers in health education was taken up. The purpose of such training was to provide for more time to discuss the issues at length and to develop the right kind of attitude. A seven day training period was planned, split up into three phases of two + two + three days.

In the first workshop the topics discussed were the doubts regarding health education, the role of the teacher and health education in schools. The importance of dialogue and discussion in health education was stressed with an entire session devoted to 'dialogue in health education'. This session helped to a large extent in dispelling the doubts of the teachers. It was concluded that the lecture system was redundant in the teaching of health education.

Since the basic method of training in our project is that of open discussion, the lecturers were convinced of the advantages of this method of teaching. We regarded this as the first successful step of our training.

The next training workshop discussed the preparation of the lesson beforehand, use of educational tools and guidance of how to impart health education through various practical methods.

The lecturers realised that the background of the students being taught had to be taken into consideration and the knowledge being imparted to them linked to familiar things in their milieu. The need to have lively sessions in order to sustain the interest of the students was also recognised. The need to develop a scientific positive attitude and proper knowledge of the subject instead of needlessly stressing technicalities was also discussed. Since our entire training session was done through open discussion the lecturers could experience this training method first hand. This participation helped in developing the right attitude to health education and developing a social temperament. Since there was no insistence on learning the lesson, lecturers used various techniques such as discussions, role-play, songs, dance, poetry, story telling as their teaching methods. The enthusiasm of the students in this kind of session was noteworthy.

Not only was care taken to keep the experience and age of the lecturer in mind during the training sessions, but efforts were also taken not to hurt the 'ego' of the teachers. This attitude helped in sustaining the interest of the lecturers throughout the training period organised by us.

Presently our book '*Javoo Arogycha Gava*' is being taught in DEd. colleges. The lecturers are now using discussion methods and practical demonstrations while teaching. We have observed these lessons and are satisfied that health education is no longer mere book knowledge but something which affects everyday life. In fact today it would be correct to say that there has been a change in attitude about health education in a majority of DEd colleges and due importance is now being given to the subject.

Health education as a subject has also now gained importance in schools. Trainee teachers are keen to take up health related social issues. Many students have already taken up projects in annual camps and at the quarterly camp. In those DEd colleges where service training centres exist, lecturers are making a beginning by taking a couple of lectures per day beyond the traditional framework of teaching. Some lecturers, whenever they get the opportunity, have been presenting their views about health education at various public meetings or through newspaper articles.

Subhash Saudagar, an experienced communicator, has teaching experience of nearly 26 years. He is presently working as researcher on the project SACHETT of FRCH.

After listening to broadcasts of the educational series 'Javoo Arogyacha Gava' over Aakashwani, lecturers have been enthusiastically sending in their responses. the listeners/ lecturers are asking for more participation from the social health research officers, and wait with anticipation for the officer to pay a visit to their school. Several of the teachers participating in this project feel that their status has been enhanced due to it.

The cooperation received for the project is commendable. Many schools are enthusiastic about enrolling more students in this project in the following educational year.

Lecturers are now convinced that the need for the right kind of health education in society can be fulfilled by the teachers themselves.

It is our belief that the new conciousness in health education is the impact of our training in health. ❐

(Continued from pg. 6)

At times, while speaking to the tais, it was felt that they had started anticipating the responces we expected of them and started responding accordingly. It is time we stopped looking upon them as mere respondents and broaden their roles from being respondants to those of information givers and that too in their own way.

Most of all, the tais constantly need to be made aware of the fact that whatever information is given to them has to be utilised for the good of the community and not to be kept to themselves.

Conclusion

The training is also turning out to be a jouney of self-evaluation at the personal and process level. It does not follow a pre-determined closed pattern but is oriented according to the reactions and needs of the community.

The training sessions encourage interactive communication, helping the tais to understand and analyse the intricate and deeper dimensions of the problems and equiping them with the capacity to deal with these problems.

Thus the programme is elevated from being a mere transfer of skills to a continuous process of learning, internalising and development of the decision making capacity of the tais leading to the empowerment of women. ❐

(Continued from pg. 7)

certainly is very effective without being offensive.

Our sessions are conducted in an informal atmosphere with lots of games, songs, role-plays etc. Besides making the sessions interesting they create a situation in which the tais feel comfortable and free to speak, feel interested in gaining knowledge and help to build a sense of trust, support, solidarity and confidence. The openness and free discussion also develop a questioning attitude among the tais. Once when a tai had been to a hospital and found the doctor administering an injection to a two year old child for simple fever, she pointed out to him that a tablet of crocin would have been as effective and there was no need for such an expensive injection. In another incidence, when one of the tais's daughter was suffering from anemia and the doctor was inclined to give her blood transfusion the tai suggested that her daughter should first be put on a course of iron tablets for at least two months and even after that if there was no improvement in her condition, she could be given blood transfusion. This kind of confidence and rationality is rarely found even among those who pass out from formal health training institutes.

Our informal method of communication has created a great impression on the minds of the trainees. On conducting a session on prolapsed uterus we were keen that the tais should actually interact with women in their community who were suffering from the above condition and gather first hand information. We devised a formal questionnaire for the purpose of the survey and then pointed out that such formal questions might fail to get the right and correct information out of the women. The tais promptly replied that they were not naive enough to ask formal questions to the women but would be using the questionnaire only as a guideline for eliciting information. The actual interaction would take the form of informal discussions where the women would be asked to relate their own experiences as per the method of interaction that was followed in our training sessions. This proves that the tais have come realise the value of communication techniques which should differ according to the surroundings and status of the respondents, for optimal results. Of course it remains to be seen how well the tais can gather information and analyse it.

Our experiment in participatory training is not without its flaws and whether the tais attending our training session will prove more useful than the existing health providers is to be seen. But where we have already succeeded is in introducing the participatory approach in our training right from the selection of the trainees which was done by the village people themselves to conducting the actual training. We hope to extend this approach right to the evaluation of our trainees and the selection of junior tais for continuing the training process. Also it is important that the training retain its participatory element , that is, even after the completion of our training programme, the tais continue to interact with each other share and update their knowledge on the basis of their actual experiences.❐

Experiences at Khelwadis

The Participatory Trainer

Vaishali Vaidya

The Heseroc project for non-formal education in health, sanitation and environment in 27 bastis in and around Parinche seeks to extend education through the tais to children who are either out of school or irregular in attendance. We run Khelwadis (non-formal educative sessions) for children which are now managed by the tais, the latter trained at participatory workshops run by us. Our objective is that by the time the project is over, the tais are able to manage these Khelwadis on their own and also train junior tais who will further spread non-formal education.

Such an objective required a specific orientation of our training sessions as well as the functioning of our Khelwadis. Before conducting our workshops we explained to the tais the project work and how they could help us in the project. We then asked them about their expectations and their needs, their aspirations and their perceptions. Our workshops were oriented keeping in mind this information.

The workshops were entirely participatory in nature. While discussing the contents of education we discussed about various modes of transferring knowledge and skills to children. Simple stories, skits, role-plays, folk songs, stimulation exercises, pictures, flip-charts created in the workshops - all have given a new confidence to the tais and a new incentive for children to learn.

As regards the content, major topics about food, air, water, diseases related to these and their prevention, measures related to environment protection and sanitation have been covered so far. At no stage however was the training medicalised neither was it loaded with information, since the aim was to equip the tais with knowledge and skills which could be easily transferred to children. The tais were given detailed notes in order to help them to remember, reflect upon and practise what was taught.

These tais now conduct Khelwadis at their respective villages. Not only are these Khelwadis being run efficiently, the tais have introduced various innovative means of communication including inexpensive teaching aids. For instance the tais have taken to writing messages on Blackboards at public places like S.T. stands so as to get the message across to the parents.

We have recently started a newsletter called *'Savali'*, which serves as a platform for tais to share their experience of teaching and learning and to express and exchange information with each other. We do not edit or 'refine' the material received for *Savali* so as to retain the true grassroots level expression. The response so far has been quiet encouraging.

While the running of Khelwadis is being decentralised, simultaneously even the conducting of workshops for tais is being handed over to the FRCH staff recruited from Parinche, i.e. the entire training is being localised. The local staff is encouraged to look after the entire training sessions right from planning the agenda for the training to conducting the actual workshops.

This experience of participatory training at three levels : participation of children in Khelwadis, of tais in training sessions and of local people in conducting the training workshops for tais has been very educative to us as trainers and we have gained immensely from interaction with our tais. We have also realised how important it is for the participatory trainer to have the right orientation in non-formal participatory education. In such an approach the trainer has to play the role of co-educator and encourage a give and take among the participants rather than acting as a know-all, dictating to the community workers what is to be done. The educator must have the willingness to deepen her/his knowledge of the local situation by constant observation, listening, questioning, discussion and analysis. When possible, she/he should live, eat and work with the local people which is the best way to increase one's understanding about the local situation and to develop a good rapport with the participants. The trainer should be able to analyse the local problems in-depth including their national, international ramifications.

It is preferable to use not just the local dialect but even local expressions as it brings all the participants closer and helps to develop a sense of trust and oneness and also allows the trainees to be more articulate.

Also it is very important to know whom you are working with. While training for the rural population (in this case the Khelwadi children) needs to be comprehensive and liberating, for the community workers (the Khelwadi tais and our local staff) it should be specific and sensitising.

(Continued on pg.11)

Vaishali Vaidya is trained in education and has teaching experience for 20 years. She is presently coordinating the HESEROC programme undertaken by FRCH.

HEALTH NEWs

In a unanimous verdict a three-judge Bench of the Supreme Court rejected a batch of writ petitions filed by private hospitals and doctors seeking a declaration that the provisions of the Consumer Protection Act, 1986 were not applicable to alleged deficiency in medical service. The Court upheld the judgement of the National Consumer Commission of April 1992 holding that the activity of providing medical assistance for payment carried out by hospitals and members of the medical profession falls within the scope of the expression "service" as defined in Section 2(1)(O) of the Act and that in the event of any deficiency in the performance of such service the aggrieved party can invoke the remedies provided under the Act by filing a complaint before the consumer forum. The fact that medical practitioners are subject to the disciplinary control of the Medical Council of India or State Medical Councils would not exclude the services rendered by them from the ambit of the Act. The Court held that service rendered free of charge or for a token payment would not come under the ambit of the act.

Despite the operation of the National Malaria Control Programme by the centre, the disease continued to strike many districts in India in the states of the North-East, Assam, Bihar, Bengal and Maharashtra. These occurrences expose a weakened health system, alienated from the common people, ill-informed on current medical treatment and inadequately supported by infrastructure or manpower trained in a comprehensive public health approach.

A three-day conference of the Central Council of Health and family welfare (the apex advisory body to the Union ministry of health and family welfare) was held in the capital from 11th October'95. Inaugurating the conference, the Union minister for Health and Family Welfare, Mr. A. R. Antulay said that strenthening the primary care delivery system was the key to the success of the goal of Health for All by 2000 A.D. Achieving the goal would require the committed involvement of the entire society, the industry, the non-resident Indians and the panchayats. The government would provide private and non-governmental institutions with funds for building hospitals and other facilities provided they earmarked 30 per cent of the beds in their hospitals for the poor. The important role of alternative systems of medicine like Unani, Siddhi and others in low-cost health care for the poor was also stressed. The importance of health insurance in providing access to health care for all was emphasised. The government proposed to set up more regional testing laboratories to ensure quality control of drugs of alternative systems. The resolutions passed on the concluding day of the conference included :

* Graduates of alternative systems of medicine to receive same facilities as doctors of modern medicine.
* Compulsory service for medical graduates to reach health care to rural areas.
* Creation of a separate foundation at central level for promoting health activities and development of a mechanisim to facilitate inter-ministerial co-ordination for better health care.
* A separate national programme for preventive diseases and promotional health in which alternative medicine systems are found effective should be formulated. The council stressed upon the urgent need for an oral health policy and recommended strenthening of the disease surveillance mechanism at all levels of administration and implementation of hospital emergency contingency plan for management of mass casualities and crisis situations and epidemics.
* Tuberculosis, which claims 1,300 lives everyday is to be made a notifiable disease.
* The role of panchayats was identified as a crucial factor in ensuring health care to the people. The panchayats were called upon to associate themselves with the 'panchayat swasthya seva scheme' .

A UNICEF report, 'The Progress of Indian States' released on 13th November'95 reveals that India has nearly 75 million malnourished children - the largest number in the world. The report brings out the wide disparities in the achievement levels of various states in child-care programmes. For instance while Kerala's infant mortality rate is 13 in 1000, Orissa's is 110. ❐

(Continued from pg. 10)

The trained community workers appreciate if we follow up our training and actually see the achievement of the workers. For instance our tais like it if we visit their Khelwadis periodically, not to supervise but to observe the progress of the students and credit the tais for the genuine work they have put in it.

Most important, the trainer has to carry this attitude outside the four walls of the training place and generally empathise with the local people and their needs and beliefs.

Considering our rich experience of training at different levels, we hope to bring out a comprehensive manual for trainers towards the end of the project. ❐

FROM THE SENIOR LIBRARIAN'S DESK....

Poverty : Selected References Available in FRCH Library

1) Aziz, Abdul, **Poverty Alleviation in India : Policies and Programmes**, 1994, Ashish Publishing House, New Delhi, Pgs. 173.

2) C.D.S, **Poverty, Unemployment and Development Policy : A Case Study of Selected Issues with Reference to Kerala**, 1977, Orient Longman Ltd., New Delhi, Pgs. 235.

3) Dandekar, V.M. and Rath, Nilkantha, **Poverty in India**, 1971, Indian School of Political Economy, Pune, Pgs. 159.

4) Dogra, Bharat, **Poverty Development and Poverty : India 1947-84**, 1984, Bharat Dogra, New Delhi, Pgs. 327.

5) Eswaran, M. and Kotwal, Ashok, **Why Poverty Persists in India**, 1994, Oxford University Press, New Delhi, Pgs. 130.

6) Ghosh, Samarjit, **The Turn : From Poverty to Prosperity**, 1986, Best Books,, Calcutta, Pgs. 140.

7) Government of India, **Papers Presented at the National Seminar on Poverty Alleviation**, 1988, Ministry of Programme Implementation, Government of India, New Delhi.

8) Haq, Mahbub Ul, **The Poverty Curtain : Choices for the Third World**, 1976, Oxford University Press, Delhi, Pgs. 247.

9) Hayter, Teresa, **The Creation of World Poverty**, 1982, Select Book Service Syndicate, New Delhi, Pgs. 128.

10) Harriss, B., Guhan, S. and Cassen, R.H., **Poverty in India : Research and policy**, 1992, Oxford University Press, Bombay, Pgs. 465.

11) Krishnaswamy, K.S. (Ed.), **Poverty and Income Distribution**, 1990, Oxford University Press, Bombay, Pgs. 420.

12) Kurien, C.T., **Poverty Planning and Social Transformation**, 1978, Allied Publishers Pvt. Ltd., Bombay, Pgs. 174.

13) Myrdal, Gunnar, **The Challenge of World Poverty : A World Anti-poverty Program in Outline**, 1971, Vintage Books, New York, Pgs. 530.

14) Nambiar, A.C.K., **Rural Poverty : Problems and Prospects**, 1992, Ashish Publishing House, New Delhi, Pgs. 134.

15) Naoroji, Dadabhai; **Poverty and Un-British Rule in India**, 1990, Low Price Publications, Delhi, Pgs. 597.

16) Ranadive, Kanta, **Political Economy of Poverty**, 1990, Orient Longman Ltd., Hyderabad, Pgs. 72.

17) Rohini Nayyar, **Rural Poverty in India : An Analysis of Inter-state Differences**, 1991, Oxford University Press, Bombay, Pgs. 297.

18) Sen, Amartya, **Poverty and Famines : An Essay on Entitlement Deprivation**, 1981, Oxford University Press, Delhi, Pgs. 257.

19) Singh, S. P., **Poverty, Food and Nutrition in India**, 1991, Chugh Publications, Allahabad, Pgs. 543.

20) Sinha, Madhuri,, **Poverty Planning and Social Transformation : Towards Alternative Development Strategy**, 1993, Deep and Deep Publications, New Delhi, Pgs. 121.

21) Thomas, H, **A Picture of Poverty**, 1979, Oxfam, Oxford, Pgs. 117.

Index : Newsletter Articles 1995

January-February, 1995

1) **The Sickness in India's Public Health Services** - Debabar Banerjee.

2) **Maping Health Resources** - Shirish Kavadi.

3) **Health Hazards** - Srilatha Batliwala.

4) **Panchayati Raj** : Selected references from the FRCH library.

March-April, 1995

1) **Community Involvement in Mental Health Care** - Dr. R.L. Kapur.

2) **The Health Status of Women in India** - Srilatha Batliwala.

3) **Child Abuse and Welfare** : Selected references from the FRCH library.

May-June, 1995

1) **Family Medicine** - Dr. Prakash C. Rao.

2) **Cultural Determinants of Diarrhoea** - Dr. S.N. Morankar.

3) **Health Awareness** - Seema Deodhar.

4) **Food & Nutrition** : Selected references from the FRCH library.

July-August, 1995

1) **Leading Issues in Medical Ethics** - Dr. Anant Phadke

2) **Private Nursing Schools** - Seema Deodhar

3) **Health Care in HIV/AIDS** - IMA, Pune & Health Plus.

4) **Trials and Errors** - Women & Health Cell of MFC.

5) **Medical Ethics** : Selected references from FRCH library.

September-October, 1995

1) **Aspirin : The Wonder Drug** - Dr. Ashok Vaidya & Dr. N.H. Antia

2) **Health Care Reform** - G. J. Annas

3) **Prevention Costlier than Cure ?** - Dr. R.V. Banpel.

4) **Working Women** : Selected references from the FRCH library.

November-December 1995

1) **Training for Health** - Dr. N.H. Antia.

2) **Health Education : Limits and Strengths** - Dr. Ramesh Awasthi.

3) **Selection and Training** - Dr. R. V. Banpel.

4) **Women in Health Training** - Aarti Kelkar.

5) **Participatory Approach to Training** - Seema Deodhar.

6) **Training the Teacher's Teachers** - Subhash Saudagar.

7) **The Participatory Trainer** - Vaishali Vaidya.

8) **Poverty** : Selected references from the FRCH library.

FREE ABSTRACTING

The contents of this Newsletter may be abstracted without prior permission. However, we would appreciate aknowledgement of the source and copies of any abstractions.

Edited by Vaijayanti Aphale with assistance from Sushma Joshi, Rajesh Ingle and Shubha Gadkari. Produced by the Foundation for Research in Community Health, 2-3, Trimiti B Appts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 6.