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NEWSLETTER

For Private Circulation Only | Vol. X, No.1 | Jan. - Feb. 1996

Personality Development Programme

One of the main objectives of a project undertaken by FRCH at Dahisar (a slum settlement in Bombay) was to train women from within the slum community as health workers. ***Usha Kumari Kumbla*** *overviews a personality development workshop conducted for these health workers.*

Though the first batch of women health workers had completed their training and were set to function as health workers in their community, they had hardly had any exposure to their work environment and were not too confident about managing their role as health functionaries. Also, they would now have to manage their job responsibilities along with their household work which called for a great deal of time management. Given this background, we invited *Avehi*, an organisation which imparts such workshops, to conduct a personality development programme for both the trained and trainee health workers.

The programme was held for the whole day on Sunday the 5th March, 1995 followed by two half-day sessions on subsequent Thursdays. Altogether, 10 women attended the session from both the previous and present batches.

The main objectives of the workshop were :

1. To create awarness and help them to accept their own uniqueness and that of others including their strengths and limitations.

2. To bring clarification to their role as health workers.

3. To develop assertiveness in them and teach them communication skills.

The first full-day session was held in the open atmosphere of Borivli National Park. The reason for choosing such a venue was to enable the participants to get away from household distractions and to make the experience pleasurable.

The resource person for the day was Ms. Aruna Tavde and she focussed the session on self awareness, role clarity, identifying barriers in personality development and ways to overcome them.

When the participants were asked what they expected from the session their answers were vague like : "Someone from outside is to give us some direction"; "To develop ourselves"; "To get to know ourseleves better" etc.

To clear their misconceptions, firstly, through an exercise they were given to understand that the direction has to come from within and for this one needed to explore from within. The participants were asked to sit quiet for five minutes and listen to the various sounds around them and then share their reflections with the group. The participants reported that they heard birds singing, leaves rustling, footsteps of people, vehicles moving etc. The first lesson on self exploration was that, just as we kept our eyes open and yet failed to notice so many things around us, we failed to know ourselves really well. Therefore, as a first step we needed to take a closer look at our own selves.

The subsequent excersise continued the self exploration process. Participants were asked to close their eyes for five minutes and think of the most pleasant experience they

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had had, relive it, then go around alone, touch the things they came across in nature and later share the experience with the group. While some of them wandered around as though they were in their own familiar surroundings, others were busy exploring things in nature as though they were noticing them for the first time.

While some of them were exploring a tree, the facilitator encouraged them to climb it if they wanted to. To the amazement of the onlookers, four of them did climb the tree. Later when they shared their experience, the facilitator explained to them that the act of climbing the tree implied their readiness to take the risk to explore themselves, and only if we took risks could we gain. She continued that many a time, women, tied down as they are with marriage, motherhood and household responsibilities, felt as though their life was like a tree being cut while branching out. The participants were reassured that even though the branches were cut, the root was intact and one still had the capacity to branch out again !

As the women shared their experiences, a map was drawn to denote their world as seen by them. As this was being done, women got to know their world and how they relate to it. Initially, the women were hesitant to share their experience as they felt their feelings were too private to be made public. But once the process of sharing began, they realised that they had much in common and could in fact gain from others experiences. In the process they also got to realise their own potential, hidden talents etc. For instance, one participant shared her experience in a most poetical way, revealing a poet hidden in her.

In the next exercise, participants were divided into two groups and were asked to enact their experience during the earlier exploration exercise. While one group presented itself as a shade giving tree, the other acted as a temple for the faithful. When the first group did their presentation, the second group got some new ideas and improvised their presentation accordingly. When asked to share their experience, they said :

- "We learnt to listen to others, bring together each others ideas and prepare a theme."

- "We realised we could not do everything alone. We needed to give and take."

The post lunch session started with an exercise to build self confidence and shed inhibitions. Participants were blind folded and were asked to move around for 15 minutes with facilitators.

When they were observed without their knowledge, their spirit and enthusiasm was overwhelming. While some participants strolled as far as they could go, some climbed the tree without any assistance, to the amazement of the picnickers around ! This is what they had to say about their experience :

- "I felt that I could do something in spite of the limitations and obstacles."

- "I learnt to trust others (facilitators) who cautioned us against falling or knocking."

- "I felt a surge of self confidence when I climbed the tree blind folded."

- "I think we need to have a goal and respect for what we are doing, then we can do it better."

In the next session, the group was divided into three sub groups and each group was asked to present one of the roles that they carried out in their daily life. The first group enacted the role of a housewife - the daily drudgery, the demanding husband and children, and yet how she found time to attend the weekly classes on health education. The theme that emerged was that it was the woman's responsibility to run the house; she had no alternative but to adjust !

The second group presented the dual role a woman plays - that of a wife and of a daughter-in-law. How she had to put up with her in-laws harassment and indifference from her husband and neighbours. The message they conveyed was that in spite of doing so much, a woman was still considered a nobody !

The third group enacted the role of the woman as a health worker. They conveyed that it was a tough job. If they genuienly wanted to bring about change, they had to work hard. People don't easily understand the importance of health, they had to be visited and talked to again and again, only then could the message be got across.

Through the role plays, women were taught to think loudly clarifying and compartmentalising the different roles they played in their daily life. It was also an opportunity for the women to quantify the effort they put in to run the family which rarely got noticed. They realised their worth in their family and also as health workers.

The day's session ended with a game, after which two groups were formed. Each group was asked to prepare a slogan and chant it aloud. The slogan prepared by the first group was :

Hum Milke Rahenge
Hum Milke Chalenge
Koi Bhi Ho Toofan
Hum kabhi Na Darenge

The slogan prepared by the second group was :

Hum Auroton Ka Nara Hai
Sara Desh Hamara Hai
Ghar Se Nikal ke Aye Hai
Khushiya Yanha Manayenge
Naye Phool Khilayenge
Duniya Ko Dikhayenge

Even though the day started with a vague note, by the end of the day it was obvious that the participants had surely taken a step ahead towards self awareness and role clarity while building self confidence and shedding some of their inhibitions. The result can best be elucidated through the replies given by some of the participants when asked what they felt about the day's experience :

- "I totally forgot about my home and responsibilities and realised that I have the capacity to do something more."

- "I realised my potential."

- "I can do anything."

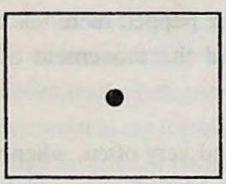
- "I liked it. I never thought I could climb a tree at this age."

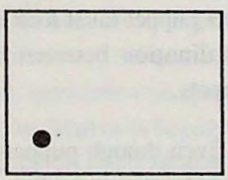
- "I feel happy to know that I have some potential."

- "How much I would have missed, had I stayed at home"

The second session was held on 5th March at the Community Office by Dr. Uma Pocha, Director of *Avehi*. Before starting the session, she recapitulated the previous session and explained its relevance to the theme of her session - health communication.

To begin with, she displayed two charts - each showing a red dot stuck on a white surface in black background. In one chart the red dot was in the center and in the second chart it was on the left hand side bottom.





The facilitator asked the participants a few questions like description of the charts and what they meant to them. Based on their answers, she interpreted that :

- different people see and interpret the same thing differently

- we tend to have a fixed notion about a man-woman relationship. All man-woman relationships need not be sexual. They could be father-daughter, mother-son, brother-sister relationships etc.

- some issues were considered taboo like talking about sex, sex organs, sexual relationships etc. We have to learn to view and talk about them objectively.

- since everyone thinks and interprets differently, other viewpoints can also be correct. We need to listen and respect others views.

In the next communication exercise, participants were grouped into couples and each couple was numbered one and two respectively. All participants numbered one were asked to speak (anything) to those numbered two while the latter were asked to listen quietly. The same exercise was repeated vice versa. Through this exercise, the facilitator explained that to be effective, communication had to be both ways. One way communication could not elicit a good response. We must allow others to speak and equally listen to others when they are speaking. Generally we find it easier to talk than to listen. Therefore, one must cultivate the habit of listening.

Many a time, the kind of response we received depended on the way we communicated. For eg. if a woman wanted her husband to support her role as a health worker, much depended on how she would put it across to him. With the help of a dialogue demonstration the facilitator showed that if you were timid, the other person tended to take you lightly and brushed off your proposal. So if the worker put across her viewpoint assertively and confidently, she was more likely to get her husband's respect and a positive reply. The same principle would apply when she would work as a health worker.

Further, she talked about how we could use audio-visual aids to effectively convey the message we wanted to. Since what we saw and listened to created a more lasting impression, what was demonstrated in the form of diagrams, charts, role plays etc. played an important role. Also, it was necessary to be aware of the way we talked and the tone we used. Some times we needed to step into the other persons shoes and try to think about what was going on in her/his mind. For eg. when the facilitator realised that the participants harboured some myths regarding family planning (FP), she went on to clear these myths with the help of diagrams of both male and female anatomy and the process of FP operation. She said that we needed to encourage men to go for FP because it was much easier and less complicated. She initiated a dialogue to demonstrate how to convince a couple to go for a small family in spite of initial resistance.

Dr. Pocha stressed that while using flash cards as a medium, instead of explaining what was shown and written, we must

encourage participation from the people and build a story based on it and then fill in the information whenever needed. The story could be different with different audiences as long as the information remained the same.

Some very interesting questions were raised during the discussion following the above demonstration:

- " When a female undergoes FP operation, the egg does not get released into the fallopian tube. Then where does that egg go?"

- " How does the woman get her periods after undergoing an FP operation?"

- " How do some women get pregnant even after undergoing an FP operation?".

- " Which operation was better - Durbeenwala (Laproscopic) or conventional?"

All their questions were satisfactorily answered by the resource person.

Dr. Pocha concluded the session by giving them the following set of clues with the help of which health education could be conveyed more effectively (She called it the first *barakhadi*) :

- What do I want to convey ?

- To Whom ?

- Where (place) ?

- How ?

- When ?

Dr. Pocha's session was immensely enjoyed by the participants because she herself was full of vitality and had the ability to extract the best from her participants.

The third and final session was on preparation of low cost teaching material. The resource person for the day was Mr. Kate Babu and Ms. Taramati accompanied by Dr. Uma Pocha.

Mr. Babu began the session by saying that teaching aids, if used effectively, could convey the message better than simply talking to the group. We could use waste material to prepare attractive teaching aids without any extra cost. Besides, according to him, we did not need to go for elaborate material. If we are imaginative and alert, we could even initiate discussion with the help of a dot drawn on a plain paper.

Mr. Babu demonstrated to the participants some of the teaching aids like charts, flash cards, models, puppets etc. which were prepared from waste material like old files, shoe boxes, rags etc. When accompanied with dialogue or songs, these teaching aids can become effective media of communication. He said that one need not be an expert to prepare teaching aids, but we must be clear about the message we wish to convey. After this session the group was divided into four subgroups. Each group was asked to choose a theme and present it with the aid of any one media demonstrated to them.

The first group presented a poster on 'Clean Environment and its effect on Health'. One representative of the team explained the matter depicted on the chart. The second group talked about balanced diet with the help of a set of flash cards. The third group prepared a role play conveyed through puppets, family planning being its theme. The fourth group performed a role play on malaria.

Each group presentation was followed by a critical evaluation from other participants and the facilitator which helped the next group to perform better. From the above exercise, the participants were able to learn that :

- It is important to talk with confidence. When someone asks questions we must not loose our confidence.

- We must not use concepts which the lay person finds difficult to understand, for eg. 'protein'. Instead we must use day-to-day words which are easily understood.

- Building rapport with the audience helps to convey the message better.

- We must look at the direction of the audience while talking or performing role plays.

- While using puppets : the voice must be loud and clear; puppets must be seen clearly; when one puppet is talking the other puppet must look at the talking puppet; there has to be coordination between dialogue and the movement of the puppets.

Even though puppets are not used very often, when used properly, they can be a powerful media of communication. The resource team demonstrated the use of puppets on the theme 'garbage management' which was appreciated by the participants.

The practical experience in making and handling teaching aids immensely helped the participants in building confidence. In fact the participants wanted to learn how to make puppets. Because of time constraints this could not be done. However, it was decided that the group would meet again on a later date

(Continued on pg. 7)

The Right Approach to Teaching

Environmental Education

Shriniwas Indapurkar

Environmental education is gaining increasing importance in our formal education system. The constituents of the environmental system, their relation to and differences with the human species etc. are now being taught to us right from the beginning.

Unfortunately, like most other subjects, environment too has been reduced to being just another part of the school syllabus to be taught from the examination point of view. Its teaching has become an indoor exercise with no special attempts to relate what is being taught in class to the actual environmental surroundings and the problems arising therein. For instance, if the children are being told that it is preferable to drink boiled water, the teacher should enquire whether the children actually follow the practice in their homes, and if not why ? Whether it is feasible for everybody to boil water ? etc. Answering such questions makes the children think over the problems and relate them to their day-to-day lives and thus get a clear conception about them.

It is important that the teachers develop a dialogue between themselves and the students rather than allow it to remain a one way exercise where the teacher talks and the student receives the information passively. The student should feel free to discuss the issue with the teacher and clear any doubts s/he may have on the subject. Obviously, environment is a subject to be taught outdoors where the children's knowledge expands through their own observation. Books should be used only for reference.

In our conventional education system, only those students do well in examinations who are able to answer the questions in a predetermined set pattern. In effect, questions concerning the environment are too subjective and qualitative to be judged according to this set pattern. Instead, the children should be made to see both sides of the problems and discuss and write upon them, spontaneously. This is how they get to learn more.

To take our own experience, while the rain cycle was being taught to the students, we gave the usual explanation of how water vapour goes up in the air to form clouds and subsequently rains down on earth on coming in contact with cold air. On being questioned the students quickly gave us all the formal answers. But when we delved deeper and encouraged the students to feel free to clear all their doubts we were questioned on related issues like why were the clouds shaped as they were ? Why does the sky otherwise look blue, and in the evening take on various hues ? Clearing these doubts led to a spontaneous give and take of additional information, giving an added dimension to our educational sessions.

Environmental education becomes more effective the more informally and innovatively it is taught as it helps to establish a good rapport between the students and the teachers. In one of the schools where I was teaching, the students would run their own wall magazine, '*Dhashta Pushta* (Hale and Hearty)' in which the students would pour out their thoughts, their experiences etc. The magazine also included special features for the children like crossword puzzles. Overall, it proved to be a very effective communication and education media for the children.

The subject can be made more effective and interesting by encouraging the students to draw, go for picnics, plant saplings etc. as elaborated below :

Picnics : It is not necessary to arrange conventional picnics to far off places that cost too much. Picnics can be arranged in the vicinity where the children are encouraged to observe their own surroundings including plants, animals, nearby historical places, statues of great leaders put up in the various squares, the vehicles passing by etc. Similarly, a visit can be arranged to a nearby vegetable market where the students are made to observe the various vegetables, their nutritious value etc. These picnics are educative without being too expensive.

Songs and stories : The more complicated portions of the syllabus can be made easier by converting the same into short stories, and questioning the children upon these stories. In fact the children themselves come up with their own stories and songs full of vivid imagination which simultaneously gives them a good feeling of having done something creative.

Supporting activities : It is necessary to conduct various supporting activities to enhance environmental knowledge.

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Ironically, the teachers seem to have only one target - that of completing the portion for examintations, from which they hardly get any time off for allied activities. But the children can be made to do simple activities like growing certain plants at home and observing various stages of their growth; observing the amount and type of garbage collected in their homes within a period; identifying bio-degradable and other garbage and their proportion to each other etc. These activities have the advantage that they do not require direct day-to-day supervision by the teachers.

Live models : Usually, the conventional charts, torso etc. are used to teach about the various human organs. Instead, it would be more effective if one of the students is made to stand in front of the class and the various parts of the body are pointed out on the student. Similarly, while talking about teeth the students can be made to observe and count each others teeth.

Experiments like filtering muddy water can easily be conducted in the classroom by the teacher or better still by the students themselves. Instead of simply talking about pasteurisation, the students can be taken to a nearby dairy and shown the actual process of pasteurisation.

Posters/charts : Children have a natural liking and flare for drawing. This can be used to advantage by getting the children to make various posters on environment and exhibiting them so that it encourages the students' talent as well as allows them to gain a deeper insight into environmental issues. This increases the participation of the children in the whole learning process.

Various other audio-visual mediums like puppets, charts etc. too can be used effectively keeping the local culture and local needs in mind. Ultimately, it is up to the teacher to ensure maximum participation of the students by making the subject lively through effective communication and a deeper understanding of their mental framework. ❐

FREE ABSTRACTING

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(पृष्ठ ८ से आगे)

से घर वापिस आई तो उसे पता चला कि ग्रामसेवक ने विना पैसे लिए प्रमाणपत्र घर पहुँचा दिया था । इस उदाहरण से जानकारी होने का फायदा कैसे होता है यह दिखाई देता है ।

जानकारी हो तो हममें हिम्मत आती है और हम सामने वाले व्यक्ति से विना घवराए वात कर सकते हैं । इसका अनुभव हमारी एक ताई को हुआ। उस ताई के गाँव की ग्रामपंचायत को नालियाँ वनाने के लिए पैसा आया। गटर वनाने का निश्चय हुआ। यह गटर उस ताई के घर के सामने से निकलवाना था । उसके घर के पास रास्ता होने के कारण गटर ठीक से वन नहीं रहा था । तव वह ताई ने खुद ही अपनी नौ इंच जमीन गटर के लिए देने का निश्चय किया । उसने इजाजत दे दी । उसके वाद तुरन्त उसे किसी काम के लिए दूसरे गाँव जाना पडा । गाँव से वापिस आने पर उसे पता चला कि ग्रामपचायत न ९ इच स वह्त ज्यादा जगह पर खदाइ की ह, मतलव जितनी जगह की इजाजत दी थी उसस कहीं अधिक जगह उन्हान इस्तमाल की थी।

यह पता चलने पर इस वहन ने फौरन ग्रामपंचायत को काम रोकने के लिए कहा। इस काम के पीछे गाँव के किसी अमीर आदमी का हाथ था यह पता चला। काम रूक गया यह पता घलने पर उस आदमी ने वह ताई को धमाकेयाँ देना शुरू किया। ताई ने ध्यान नहीं दिया तो गाँव में पुलिस लाकर उस पर दवाव डालने की कोशिश की ।

पुलिस आने पर वहन ने विना घवराए पुलिस से वात की । पुलिस ने कहा कि तुम्हें कैद करेंगे तो ताई ने उत्तर दिया कि "चलो अभी कैद करो"। ताई की हिम्मत देखकर पुलिस जैसे आई थी वैसे ही वापिस चली गई। पुलिस को लाकर भी कोई फायदा नहीं हुआ।

इसके वाद केंद्र में चर्चा करते हुए ताई ने कहा कि मुझे डर लगा ही नहीं। अपना पक्ष कानूनन सही होने से ऐसे दवाव से क्यों घवराया जाये और अपने केंद्र में पुलिस के वारे में जानकारी दी थी इसलिए पुलिस से अव डर नहीं लगता। एक वार सव पता चल गया तो वोलने और सामना करने की हिम्मत आ जाती है।

इन एक दो उदाहरणों से जानकारी का फावदा अवश्य होता है यह पंता चलता है। कई वार ऐसे भी पता चलता है कि इन परचों का उपयोग लोग आवश्यकता के अनुसार करते हैं। उदाहरणत के तौर पर - तलाठी से कोई काम पडा तो तलाठी के वारे में जो पर्चा निकलता है उसे पढ लिया गया ऐसी भी जानकारी मिली है।

इस प्रकार गाँव की जानकारी का प्रयोग संस्थाएँ अपने सीमित कार्यक्षेत्र तक ही करती है। जन-जागृति के लिए ज्यादा-से-ज्यादा लोगों तक यह जानकाही पहुँचनी चाहिए। जानकारी देने से सारा समाज वदल जायेगा ऐसी आशा करना अवास्तविक है। इसके लिए देश के अलग-अलग भागों में वहाँ के स्थानीय प्रश्नों पर लोगों का इकठ्ठा होना आवश्यक है। इसलिए जानकारी देना उन्नति की पहली सीढ़ी है। इससे आगे जाने की भी आवश्यकता है। पर इस सीढी को हम छोड़ नही सकते, यह भी ध्यान में रखना चाहिए।

हिन्दी अनुवाद : गुरविंदर कौर सोधी ❐

FROM THE SENIOR LIBRARIAN'S DESK....

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(Continued from pg. 4)

and actually practice making puppets.The resource person stressed that to make the sessions really worthwhile, what was learnt during the brief period had to be brought into practice while participants actually undertook health education in the community.

The workshop was concluded with a formal evaluation of all the three sessions during which the participants spoke about what they gained during the session and what they felt about the methodology used.

For all the participants it was their first such experience and they enjoyed it a lot. They specially liked Dr. Uma Pocha's session as it gave them a lot of opportunity to express themselves.

While the training session in itself was a unique and helpful experience, we plan to increase its effectiveness in the following manner :

1. To incorporate the methodology and communication skills taught during the workshop in the practice sessions in health education classes and later, in the community.

2. To prepare low cost teaching aids to be used for health education.

3. To share the knowledge and experience with those women who could not attend the workshop. ❐

जानकारी : उन्नति की पहली सीढ़ी

वृंदा वझे

जव्हार मोखाडा के आदिवासी वच्चे निकृष्ट अन्न के कारण मृत्यु को प्राप्त हुए । वास्तव में वच्चों को उतना निकृष्ट भोजन मिलता है मतलव इतनी गरीवी है कि वच्चों को काफी मात्रा में खाना भी नही मिल सकता। इस इलाके की जाँच पड़ताल करने के लिए जो लोग गए थे उन्होंने पाया कि अन्दर के पिछड़े भागों में छोटी-छोटी आवश्यक सुविधाएँ भी नहीं पहुँची है। लोगों के पास जीने के लिए कोई साधन नहीं है। खेतों में मजदूरी करके थोडा वेतन भी नहीं मिलता। भूक लगती है, इच्छा भी होती है लेकिन न अनाज है न साफ पानी।

इस उदाहरण से जाहिर होता है कि स्वास्थ्य यह सिर्फ विमारी से ही संवंधित नहीं होता है। जव हम रोग के शारीरिक कारणों के अलावा सोचते है तव पता चलता है कि सामाजिक, राजकीय, आर्थिक आदि सभी वातों का परिणाम स्वास्थ्य पर होता है। लेकिन यही धारणा सव जगह दिखाई देती है कि विमारी हुई तो दवाई दे दी तो काम हो गया। ज्यादा से ज्यादा सफाई पर भाषण देना, दवाई वाँटना या पोस्टर्स लगाकर जागृती पैदा कर देना। सरकारी, अर्ध सरकारी, वैसे ही स्वयं सेवी संस्था में भी ऐसे विचार करने वाली संस्थाएँ ज्यादा मिलती है। विचार पूर्णतया गलत नहीं है लेकिन वहुत ही ऊपरी विचार है। स्वास्थ्य संवंधी दूसरे प्रकार का विचार होता है यह दिखाई नहीं देता। दवाई देकर सिर्फ विमारी ठीक होती है विमारी का कारण नहीं।

स्वतंत्रता मिलने के इतने सालों में पिछड़ी जाति, आदिवासी और कमजोर वर्ग तथा आर्थिक रीति से दुर्वल लोगों के लिए वहुत सी योजनाएँ वनी और वे केवल कागज पर रह गईं । असल में जिनके लिए ये योजनाएँ वनाई गईं उन तक वे पहुँची हों ऐसा दिखाई नहीं देता । इसलिए उनकी हालत में अधिक फर्क नहीं दिखता । देश में गरीव और अमीर का फाँसला वढ़ता जाता है । मुठ्ठी भर अमीर, थोड़े से मध्य वर्गीय और वहुत से गरीव ऐसा असमान विभाजन दिखने में आता है। यह असमानता सिर्फ आर्थिक क्षेत्र में ही नहीं वल्कि राजकीय, सामाजिक क्षेत्र में भी दिखाई देती है। इसलिए मुठ्ठी भर अमीर लोग देश के अधिकतर कारोवार चलाते हुए दिखते है। यही कारण है कि खुद के स्वार्थ का ही विचार मुख्यत: होता है। विल्कुल छोटे गाँवों के भागों से लेकर देश की हद तक सभी जगह यही दृश्य दिखाई देता है। ऐसी परिस्थिति निर्माण होने के कई कारण हैं और उसमें मुख्य है किसी वात का ज्ञान न होना। योजनाएँ, कायदे, उन्नति के नए प्रयोग, शोध आदि की जानकारी आम लोगों तक पहुँचती ही नहीं। योजनाओं की जानकारी इन लोगों तक पहुँचती ही नहीं तो ये लोग इसका फायदा कैसे लेंगे। अगर लोगों तक जानकारी पहुँची तो लोग अपने हक्क के लिए लड़ सकेंगे।

जानकारी ही उन्नति की पहली सीढ़ी है। इसी विचार से एफ.आर.सी.एच. ने जानकारी केंद्र शुरू किया। जानकारी केंद्र में गाँव की समस्याओं से संवंधित विषय पर जानकारी इकठ्ठी की जाती है। गाँव में काम करने वालों की मदत से आसान मराठी भाषा में परचा तैयार किया जाता है। यह परचा छापने से पहले गाँव के कार्यकर्ता गाँव के अलग-अलग लोगों को यह परचा पढकर सुनाते हैं। इस पर उनकी प्रतिक्रिया ली जाती है। कुछ शव्द मुश्किल हो या कुछ भाग कठिन लगा तो जिस प्रकार के सुझाव हो उस प्रकार से परचे में वदलाव किया जाता है और उसके वाद ही विवरण छापा जाता है । इसमें भिन्न-भिन्न सरकारी योजना, कायदे, सिंचाई आदि के विषय में जानकारी, गाँव की सरकारी संस्था (सोसायटी, ग्रामीण स्वास्थ्य केंद्र इ.) गाँव की सीमा में काम करने वाले सरकारी अधिकारी - उदाहरण के लिए तलाठी, ग्रामसेवक के काम, ऐसे अनेक विषयों पर जानकारी दी जाती है । परचा छप जानेपर गाँव में सभा वुलाकर उस विषयपर चर्चा की जाती है। परचा पढकर सुनाया जाता है, फिर कार्यकर्ताओं या भिन्न-भिन्न स्वयं सेवी संस्थाओं द्वारा यह परचे वाँटे जाते है। कभी डाक द्वारा कुछ लोगों को परचे भेजे जाते है। उदाहरण के लिए वनाई गई योजना में (I.R.D. P.) ये परचे निकाले फिर गरीवी रेखा के निचले स्तर के लोगों की सूची वनाई और उसके अनुसार परचे भेजे।

परचे निकाले वाँटे यह सही है लेकिन लोगों को उसका फायदा होता है या नहीं यह प्रश्न रहता ही है । इस वारे में हमें अलग-अलग अनुभव मिलते ह।

तलाठी के काम के संदर्भ में परचे के आधार पर एक संगठन कार्यालय पर जलूस लेकर गया और इस वात की माँग की कि हर लेखपाल दफ्तर में, किस काम में कितने पैसे लगते हैं या नहीं लगते इसकी सूचना लिखें।

महाराष्ट्र के पुणे जिले में परिंचे नाम के गांव में एफ.आर.सी.एच. का केंद्र चल रहा है । इसमें स्वास्थ्य के साथ-साथ गाँव की जानकारी, वाचनालय, खेती आदि जैसे उन्नति के विषयों पर भी जानकारी दी जाती है । यहाँ प्रशिक्षण के लिए आने वाली कुछ स्त्रियों के अनुभव आगे दिए जा रहे हैं :

गाँव के प्रशिक्षण सत्र में ग्राम-सेवक (ग्रामपंचायत का सेक्रेट्री) के विषय पर जानकारी दी गई । उसमें ग्रामसेवक कौन-कौन से प्रमाणपत्र दे सकते है इस विषय पर चर्चा हुई । इसमें ही जन्म-प्रमाणपत्र देने के लिए पैसें नहीं लगते, इसका महत्त्व क्या है, इस विषय पर भी चर्चा हुई ।

यह जानकारी मिलने पर हमारे ट्रेनिंग के वर्ग में से एक ताई (स्वयंसेविका) ने अपने वेटे का जन्म-प्रमाणपत्र निकालने का निश्चय किया। उसने ग्रामसेवक के पास अर्जी भेजी। ग्रामसेवक ने प्रमाणपत्र देने के लिए पैसे माँगे । ताई ने पैसे देने से इन्कार कर दिया और वलपूर्वक कहा कि कायदे से वे इस काम के लिए पैसे नहीं ले सकते थे। ग्रामसेवक ने कहा कि फिर उन्हें प्रमाणपत्र नहीं मिलेगा । फिर भी वह ताई पीछे नहीं हटी । दूसरे दिन जव ताई ट्रेनिंग

(शेष पृष्ठ ६ पर)

ग्रामीण स्तर पर, महिलाओं के लिए एफ.आर.सी.एच. के द्वारा दिये जानेवाले प्रशिक्षण में वृंदा वझे लोकसूचनात्मक प्रशिक्षण देने का कार्य करती है।

Edited by Vaijayanti Aphale with assistance from Nagesh Mirajkar. Produced by the Foundation for Research in Community Health, 3-4, Trimiti B Apts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 6.

FRD 9/8/96 Duplicate

The Foundation for Research in Community Health

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NEWSLETTER

For Private Circulation Only | Vol. X, No.2 | March - April 1996

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Cooperative Financing for Health Care in Rural India

Compiled from the paper presented under the above title by ***William C. Hsiao and Priti Dave Sen*** *of the Harvard School of Health, Cambridge at the international seminar on* ***Health Insurance in India*** *held at Bangalore from 20-22 September 1995.*

Community-based cooperative health care schemes have existed for decades and today, cooperative financing/ organisation of basic health care has sprouted in many low income nations. This article explains the basic concept of cooperative health care (CHC) and compares it to other forms of health care delivery.

Cooperative Health Care

To some extent health care is a merit good and recognising this the community takes collective action to mobilize the cooperation of all its members to finance, organise and manage health care. This is the basis of cooperative health care. The generic form of cooperative financing/organisation of health care has three distinct features. First, the funds come from three channels : households, the government and local industries (tripartite financing). Second, there is an integration of financing and delivery of basic health services. And third, the financing and delivery are organised and managed by the local community (community based and community managed system). Thus cooperative health care incorporates two major principles : community cooperation and self-reliance.

What is the rational for organising CHC when there are already government and private health services being provided in the country ?

Public sector provision is under funded, sometimes inaccessible and often of poor quality. Moreover, the services provided by government providers are not free. Often, government clinics and hospitals have a shortage of drugs and patients have to purchase drugs from private chemists and also pay unofficial fees to government providers. In fact, patients' out of pocket payments for government services (Rs. 125) are quiet close to those in the private sector (Rs. 164).

Where private sector health services are concerned, many Indian villages do not have qualified private providers because of insufficient demand or because market forces failed to generate the supply due to information barriers and other market failures. Consequently, patients often consult local unqualified practitioners or, alternatively, have to travel long distances to obtain health care from qualified practitioners. Even where private services are easily available, many a time, the sheer cost of the treatment renders them beyond the reach of the average consumer.

Health financing experts often point to health insurance as the answer to the above problems, but CHC takes care of providing health services in an even better manner than traditional health insurance due to the following differences :

1) CHC mobilises tripartite financing and funds both basic and catastrophic health services. Thus, unlike in conventional health insurance which insures only for catastrophic

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expenses, cooperative financing allows consumers to budget in advance for the services they expect to use, regardless of whether the cost of the service is large or small. The services covered by CHC are selected based on their cost effectiveness and people's willingness to pay.

2) CHC does away with trilateral relationships, brought into play by insurance health plans, by combining together financing, risk-pooling and service delivery thereby keeping intact the vital bilateral relationship between patient and provider organisation.

3) The fee-for-service payment method or the method of reimbursing the patient for expenses incurred, both followed under an insurance scheme, induces practitioners, clinics and hospitals to provide greater quantities of services and prescribe more drugs than is really necessary. Cooperative financing does away with this problem by paying practitioners (such as health workers, midwives, physicians) on a capitation or salary basis. More sophisticated practice could add a bonus to the capitation or salary based on performance.

4) CHC and insurance plans differ on organisation and management of communities. Firstly, CHC is organised and managed by the communities themselves. Secondly, CHC organises together the preventive, primary and tertiary services and coordinates them. The services of medical specialists are also organised and coordinated and made available to patients when they are needed.

In contrast, traditional insurance plans do not manage the actual provision of health care, thus prevention, primary care and tertiary services are often fragmented and there is no coordination among specialists when they render services to the same patient.

Potential Gains From CHC

CHC differs from other cooperatives such as milk, agricultural etc. because illness is uncertain and thus the need for health care and the payoff from CHC for households is uncertain. Hence, there have to be enough potential personal gains from CHC to bring people together for collective action.

In order to analyse what potential gains may be produced, we have constructed a hypothetical health cooperative and estimated the cost of providing a comprehensive package of basic primary health care services.

Hypothetical Model

A village may not have sufficient number of residents required for profitable risk pooling, consequently, adjacent communities may have to be grouped together to form a health cooperative but each community would have representatives on the Board of the centre to direct and supervise its affairs. This board would be accountable back to the community members and the government.

We have assumed that our hypothetical cooperative covers 15 villages with a population of 1000 in each village. Their is provision for one primary health centre for this total population of 15,000. The primary health centre would be staffed by one doctor, one mid-wife, one clinical nurse, one primary care practitioner, one pharmacist and one assistant.

In addition, a sub-centre is established in each village and staffed by one full-time equivalent primary care practitioner - a retrained and certified ancillary health worker who is competent to deliver preventive services, perform basic diagnosis and curative services for the 8-10 most common diseases with the medical competence to give appropriate injections and drugs, and also treat minor wounds. The sub-centre has a stock of generic drugs specified in an essential drug list. This worker will be retrained to perform the designated functions and will be supervised and monitored by the medical professionals staffing the primary health centre.

In exchange for an advance payment, CHC promises to organise and provide health services and drugs when the consumer needs them. CHC provides preventive services, immunisation, health promotion, family planning, maternal and child health and outpatient services to all its members, including drugs for which copayment is levied. Patients have the choice of obtaining free health services at the health posts and primary health centres or from private practitioners. In the latter case the health centre will reimburse the patient for 50 percent of her/his costs.

Health workers and practitioners are salaried by the coperative. Tertiary care is provided at the regional centres. The cooperative refers patients to these centres and pays a packaged fee for these services or contracts for tertiary care on a capitation-payment basis.

From the hypothetical model we can conclude that cooperative financing of health care may offer at least four types of gains to the Indian rural population :

Access : The new organisation comprises one sub-centre per 1000 population and a primary health centre for 15000 population which compares favourably to one sub-centre per 5000 population and one primary health centre for 30,000 population under the existing government programme. Thus households can reduce their travel time and costs[1] since the sub-centre is located in each village.

Quality : The qualifications of providers will be improved

through the cooperative at each village as the primary care workers staffing the sub-centres will be retrained to perform the designated functions and will be supervised and monitored by the medical professionals staffing the primary health centre.

The cooperative members would be entitled to use either the community-managed primary health centre or a recognised private provider with partial reimbursement. Such an introduction of competition by giving the patient a choice of providers will induce the health providers to be responsive to the patient's needs and to improve the technical quality of services.

Economic gains : The cooperatives can form associations to buy drugs and supplies through international tender and distribute drugs through regional centres. Thus costs would be reduced because of economies of scale in group practice and because of absence of monopolistic pricing.

As mentioned earlier, the payment system for medical professionals under CHC will reduce over-prescribing of drugs. In addition, essential drug lists can be established to assure the most cost-effective use of drugs.

Also, CHC can serve to rationalise health service utilisation by developing referral linkages with other providers in both government and private sector so that patients do not go directly for higher level facilities for relatively simple ailments.

Such a rational use of health services and drugs will ensure significant cost savings.

Another significant gain would be the reduction in poverty that is generated by indebtedness due to high medical expenditures[2].

Feasibility of CHC in India

Fortunately, India has a long history of local self government or Panchayati Raj. Since the 73rd amendment to the Constitution these Panchayati Raj institutions have been rendered even more powerful with 29 subjects including health delegated under the purview of local governments. These local organisations could prove to be a convenient vehicle for organising and financing health care for the community.

Moreover, some studies have estimated that the health care of about five percent of the Indian population is already being served by NGOs. These NGOs have already demonstrated considerable innovativeness with cooperative financing approaches. For example, there are successful rural NGOs - Sewagram, Raigarh Ambikapur Health Association, Voluntary Health Services - that collect prepayment from households and organise primary care and some inpatient coverages to these households. The success of these NGOs in financing and delivering health care show that the NGOs could be another vehicle for India to develop a wider spread of CHC.

Though the Government has no direct role to play in CHC it can support this health care system in the following manner :

* Legitimize the CHC approach - official encouragement as given to other cooperatives will certainly help the rapid development of CHC in India.

* Government of international donors can facilitate the development of CHC by providing some of the initial capital equipment.

* Government can develop human resources needed by offering training courses for supplying qualified managerial, financial and health personnel.

* Government can make appropriate regulations to assure the financial solvency of the cooperatives, prevention of fraud and monitor the quality and availability of health services.

Of course, field studies are needed to assess whether CHCs are viable and can produce more benefits than other alternative ways of financing and organizing health care of its rural population and to examine the existence and operations of the panchayats, and evaluate the potential savings that can be generated through an Indian model of CHC. If initial viability of the CHC programmes in India is established, then demonstration projects can be developed to test the organisational form and management that would be most suitable for India.

Editor's Note : In a study on household health expenditure conducted in Jalgaon, Maharashtra (1987) and Morena & Sagar, Madhya Pradesh (1990-91) by FRCH it was concluded that :

1. Monthly per capita health expenditure was Rs 16. 02 for rural areas and Rs. 14.25 for urban areas of which rural transport took the major share of Rs 9.12 and urban only Rs. 5.30.

2. During the reference period of the study (3 mths), loans were taken for treatment of 1.3% of the illness episodes amounting to a phenomenal Rs. 1,233.25 per case. ❐

Jaoo Arogyacha Gava

The Government of Maharashtra has selected the set of four books titled "*Jaoo Arogyacha Gava* " published by FRCH for distribution to over 700 schools all over Maharashtra under the "Operation Blackboard" scheme which provides for, among other things, free distribution of textbooks to government schools in Maharashtra.

This set of books was brought out as a part of the School Health Education Project implemented by FRCH to facilitate teaching basic concepts of health to school children. The books have been selected mainly for their reader-friendly presentation and use of simple language accompanied by attractive illustrations. That the health concepts have been interwoven with the day-to-day lives of the children makes the books highly appealing.

How Universal Coverage Makes Cost Control Easier

The Relation Between Universal Health Insurance and Cost Control

Edited version of an article under the above title written by ***Mark Goldberg, Theodore Marmor and Joseph White*** *that featured in the 16th March'95 issue of The New England journal of Medicine.*

If a nation does not commit itself to controlling the costs of medical care, then those costs will rise there quickly (as they have, in the United States). Frequently, the blame for these spiralling costs is put on private health insurance which gives rise to third-party payment with all its abuses, as elaborated in the subsequent paragraphs. Medical costs could be curtailed by abolishing health insurance. But that would reduce available medical care substantially for all but the wealthy and devastate any medical care system based on private insurance. If third-party payment is to be the norm, then the experience of many countries shows that coverage of all citizens can be combined with slower growth in costs by resorting to universal health insurance.

Because they provide medical care for everyone, not just subgroups of patients, universal systems are able to develop ways of managing the capacity of the health care system as a whole where system-wide bargaining and rule making substitute for individual price bargaining. In coherent programmes of universal health insurance there is no need for much of the apparatus with which individual insurers seek and select customers. Providers and payers engage in one round of wholesale price negotiations rather than multiple rounds of retail bargaining. For eg. a standard fee schedule prevents patients from committing their insurer to pay whatever a provider charges. If there are any rules about the type or volume of treatment, providers confront only one set of such rules. Since all payment follows the same (or similar) rules, savings that result from changing those rules are spread over the entire system. All these differences from the practice of private insurance reduce administrative costs both for insurers and for providers, thus, reducing overhead costs.

In some countries there are funds that market their coverage to citizens who believe they get better service by paying more, and their funds pay providers more than the standard rates to provide that service. But in universal systems, providers cannot play payers off against one another, threatening each that unless it pays more the service to its members will decline relative to the service received by people with different insurers. For eg. hospitals cannot compete by adding cardiac surgery units, and lithotripters are not likely to be found in different hospitals in the same city, each being used only two days a week.

As compared to the alternatives, cost-control methods used in universal health insurance systems also have many advantages for providers of care. More of the health funds go to the care givers, and less to their own administrative staffs or to outside managers and consultants. Also, universal systems are able to structure negotiations with the medical profession in ways that make cost controls more effective and more evidently fair. They allow an evolution toward stable machinery for joint decision making, in which the medical profession has a stake in decisions it helps to make about, for eg, relative values for fees.

No one should imagine that any effective method of cost control is loved by all providers. No system is immune to arguments that the wrong costs are being controlled. But the universal systems, because they deal with the system as a whole, are able to involve providers in cost control in a way that forces attention to equity among providers. Physicians and hospitals are paid in predictable ways for the services they provide. There are few if any worries about charity care (save for illegal aliens, in some cases). Universal coverage means that doctors know they will be paid for the work they do.

Consequences of Separating Coverage and Cost Control

To be sure, the uninsured in developed countries like the USA with private health insurance receive some services : just fewer of them, and later. Also, if cost controls were imposed without universality, providers would be expected to reduce their levels of "free" care; experience in California supports that expectation. The uninsured - and nearly a quarter of the population will be uninsured at some point during a given year- would then be worse off than before. As most voters are covered by the same payment rules under universal coverage, there is political pressure to ensure that these rules are compatible with good care - in contrast to what happens in the United States, where the majority has no stake in how *Medicaid* payment rates affect the quality of care. Instead,

Resolution on Social Security for the Unorganised Sector by the National Centre for Labour (NCL) - *An apex body of the labour organisations in the unorganised sector*

The Universal Declaration of Human Rights and the Covenant of Social, Economic and Cultural rights, to which India is a signatory, have declared social security as a basic human right. Yet, the unorganised sectors which constitute 92 per cent of the workforce in India, remain uncovered by any social security provisions such as ESI, Maternity Benefit or Provident Fund.

The unorganised sector workers earn incomes which are often not enough to keep them above the poverty line. They have to pay medical expenses out of these meagre incomes. In addition, since they have no security of work, they loose even those earnings when they fall ill. In cases of accidents or death of the main earner, the family is often reduced to destitution. The unorganised workers have to work even when they are old and disabled as there is no old age pension or provident fund. Women often work till the last days of pregnancy and start again a few days after child birth as there is no maternity benefit.

There are various schemes, governmental and non governmental, which do provide a limited coverage to the workers. These include the Beedi Workers Welfare Fund, Life Insurance Coverage for Agricultural Labourers, Maternity Benefit Schemes in various States, etc. However, these schemes cover only a small percentage of workers and their scope is very limited, but they do point the way to the type of coverage required by the unorganised sector and can be used as a basis for more comprehensive coverage.

The founding convention of the NCL therefore calls for:

* All member organisations to try and develop social security programs for their members and link them to similar programmes already existing.

* The national and state governments to set up tripartite social security funds which would provide a comprehensive social security cover to workers.

* Employers, farmers, traders and other sections of society which benefit from the labour of the unorganised sector, to contribute adequate funds for social security for these workers.

flimsy social security nets are created for the poor in the United States which are more in the nature of a safety valve. A universal system faces political pressures to ensure quality as well as control costs.

The Adequacy of Supply

Even under universal coverage effective care could be limited by shortages of physicians and facilities in rural and urban areas, or by an uneven distribution of medical specialists. Opponents to universal coverage also claim that cost controls with universality would lower the quality of medical care by creating waiting lists for some procedures. But the question here is whether a different financing system can produce similar services for as less costs. If we take the case of USA which has private health insurance and Canada which practices universal health insurance, both otherwise following similar medical practices, no one can build a convincing case that Canada has health care that is inferior overall to that in the United States, never mind that any American advantage would be worth the price tag ($250 billion in 1993). Canada has comparable life expectancies even for the very old (and, of course, the American elderly have national health insurance). A wide range of studies of specific applications show comparable performance - lower levels of elective surgery must be balanced against better access to other treatment. Further more, if there is agreement among American health policy analysts on any issue, it is that the United States has serious oversupplies of many services, especially surgery. In some cases, such as cardiac surgery, oversupply threatens the quality of care. It is possible to provide much the same services at lower cost with better capacity controls.

Conclusions

Many forms of regulation can be used to control costs but there is no system that controls costs through pure "competing plans". Competition and regulation are not mutually exclusive. Instead of seeking universal coverage as a threat to the quality of care, a coherent system should be viewed as a change for strategic action to get both the level and the distribution of capacity right. As an alternative to fee-for-service practice, good health maintenance organizations can provide lower cost sharing, better coordinated treatment, and, if their enrollment grows, a strong indication of inadequacies in the fee-for-service world. If patients prefer health maintenance organizations, they should grow. Combinations of regulated fee-for-service practice and voluntary health maintenance organizations can be evolved as per convenience. In general, the issue of the relative incomes

(Contd. on pg. 7)

COMMUNITY HEALTH CELL LIBRARY AND DOCUMENTATION UNIT BANGALORE

The Coverage of Compulsory Health Insurance

Extracted from the paper presented under the above title by ***Brian Abel-Smith*** *of the London School of Economics at the international seminar on* ***Health Insurance in India*** *held at Bangalore from 20-22 September 1995.*

Compulsory schemes generally start with employees in the formal sector and their dependents because contributions can readily be collected through employers. They can expand to cover the self-employed and those on social security benefits, pensions or social assistance are brought into the scheme, often, with tax subsidy.

Developed countries

In OECD countries, which have the most mature systems the trend has been towards universal coverage under national health insurance as shown in Table 1, below.

Table 1 : The Trend Towards Universal Rights to Health Care in OECD Countries

1938 New Zealand	1978 Italy
1948 United Kingdom	1979 Portugal
1960 Denmark	1983 Greece
1960 Japan	1984 Australia (finally)
1962 Sweden	1994 Switzerland
1969 Canada	1999 Turkey (planned)
1974 Iceland (explicitly)	

The countries without universal coverage are Austria, Belgium, France, Luxembourg with 99 percent coverage, Germany with 92 percent, the Netherlands and Turkey with about 50 percent. But the Netherlands provides universal coverage for long term care, community care and drugs. Turkey is currently planning compulsory coverage of the aged and disabled (about 15 percent of the population) and of certain groups of the poor (10 percent of the population). Ireland does not fit into this model as all can use the publicly financed inpatient care but only the poorer sections of the population can use the government contracted primary care services.

Developing Countries

Central America : Nearly all the Caribbean countries attempt universal coverage but the provision is entirely paid for by taxation. In Latin America, there is universal coverage in Cuba and Nicaragua. There is theoretically 80-90 percent coverage in Brazil, though the services are far from being equally available everywhere. In Costa Rica 86 percent or 2.8 million people are insured including 49 percent of dependents, but the indigent population is insured by the state - about 15 percent of the population is covered without having to pay contributions. In Chile all are covered except those with high incomes who are not working. In the remaining Central American countries, the scheme covers either all salaried employees or the main groups among them. In 13 Latin American countries, provision is made for the self-employed - compulsorily in four countries and voluntarily in nine. And in 12 countries domestic servants are covered but compulsorily in only nine. Dependents are covered in all these countries except the Domenician republic, Guatemala, Peru, Haiti and Ecuador. The first three do, however, cover wives for maternity and infants.

Asia : Apart from Japan, only Korea and Hongkong have universal coverage with Taiwan planning it. The Korean scheme which started in 1977 achieved universal coverage in 1989. There are some 400 insurance societies in three categories - civil servants plus private school employees, industrial workers and community-based schemes for rural workers and the urban self-employed. In India and the Philippines the schemes cover all or most of those with salaries, at least in larger companies, but the latter scheme only finances hospital care. In China the government covers civil servants and students from universities and colleges: 30 million persons are covered under this scheme. Those working in state and collective enterprises are insured by each enterprise's welfare fund. This scheme covers 140 million people and 60 million dependents. But dependents pay half the cost of services. There are cooperative medical services in rural areas - funds are collected from farmers and local government. The current scheme covers around 100 million. In Thailand the civil servants scheme covers about five million workers in establishments with 10 or more employees. In neither case are dependents covered. Indonesia covers nine percent of the population - mainly civil servants and the armed forces. Vietnam covers civil servants including those retired, private sector employees and

(Contd. on pg 7)

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persons under special social protection.

Africa : Egypt covers government employees, private sector employees, pensioners (who must apply to be eligible), widows and all pre-university students numbering around 14.5 million. Only in Alexandria are family members covered and they must apply to join the scheme. In all, 23.3 million are insured out of 56.4 million population in 1993. In Algeria and Tunisia, all those employeed in the formal sector and their dependents are covered. Compulsory health insurance is least developed in sub-saharan Africa. Only in Kenya is there a scheme with considerable coverage : the National Hospital Insurance covers about 11.4 percent of the population (2.1 million employees and their families). In the Cameroon, 60 percent of the formal workforce are covered by their dependents. The scheme in Mali covers only 60,000 members, serves about 250,000 persons and finances less than two percent of the cost of health services. Government employees and their families are covered in Burundi and in Ethiopia : they obtain health care from government facilities at half the cost.

Thus in developing countries with less than universal coverage, those that are insured tend to be better off economically than those who are not covered. The insured include typically the civil servants and employees in private or state enterprises. Usually excluded in the early phases of health insurance development are the farmers and other self-employed in the rural areas, whose incomes are likely to be lower on average, though in some of these countries like Thailand and Indonesia, voluntary community based schemes have been promoted to cover these groups. ❐

(Contd. from pg. 5)

of providers should be left, as much as possible, to the providers themselves, as should issues related to the allocation of care among patients while issues of capacity require more collective decision making.

To conclude, the combination of diminishing coverage and spiraling costs is not some law of nature. It is a disease inculcated by the prevailing fragmented, partial insurance systems and worsened by political failure. It can be cured with effective implementation of universal systems with their advantages of more efficient methods of cost control, some compensating benefits for providers, and better political support for controlling costs. ❐

स्वास्थ्य का वित्तीय प्रबंध

डॉ. एन. एच. आंटिया

भारत, स्वास्थ्य पर, अपने सकल घरेलू उत्पाद (जी.डी.पी.) का ६ प्रतिशत या २५,००० करोड़ रुपयों से भी ज्यादा खर्च करता है। यह लगभग प्रति व्यक्ति २७५ रुपये सालाना के बराबर है जो कि जरूरतमंद देशों में स्वास्थ्य पर किए जा रहे खर्च में सबसे अधिक है। इस खर्च का तीन चौथाई हिस्सा प्राइवेट क्षेत्र पर होता है। चीन, स्वास्थ्य पर अपने सकल घरेलू उत्पाद (जी.डी.पी.) का केवल ३.५ प्रतिशत ही खर्च करता है, जिसमें से केवल एक तिहाई हिस्सा ही प्राइवेट क्षेत्र पर होता है, फिर भी भारत की शिशु-मृत्यु दर, जो कि ६० प्रति हजार है, की तुलना में चीन में शिशु-मृत्यु दर केवल ३८ प्रति हजार ही है। स्वास्थ्य पर ३०० रुपये प्रति व्यक्ति सालाना खर्च करके केरल में शिशु-मृत्यु दर केवल १७ प्रति हजार है, जबकि अमरीका जैसे विकसित देश में, जहाँ प्रति व्यक्ति ४०,००० रुपये सालाना खर्च होता है, विशेष कर प्राइवेट क्षेत्र पर, शिशु-मृत्यु दर १० प्रति हजार है। इन सब उदाहरणों से साफ जाहिर होता है कि स्वास्थ्य पर किए गए कुल खर्च की राशि नहीं, बल्कि खर्च करने का ढंग अधिक महत्वपूर्ण ह।

भारत की कई गैर-सरकारी संस्थाओं के अध्ययन यह बताते हैं कि सरकारी कार्यवाही और मुनाफा कमाने के मकसद के बिना, प्रति व्यक्ति केवल १०० रुपये खर्च करके भी, सबके लिए बुनियादी स्वास्थ्य प्रभावी ढंग से प्राप्त किया जा सकता है। इसमें से ६० रुपये ग्रामीण स्तर पर खर्च होने चाहिए, जहाँ पर कुल स्वास्थ्य समस्याओं की ७० से ८० प्रतिशत समस्याएं लोगों द्वारा स्वयँ ही सुलझायी जा सकती है। यह काम वे अपने क्षेत्र के, विशेष रुप से प्रशिक्षित स्वास्थ्य कार्यकर्ताओं और पैरामेडिकल कर्मचारियों की मदद से और बाद में प्राथमिक स्वास्थ्य केन्द्रों के समर्थन से कर सकेंगे। वर्तमान में, स्वास्थ्य के सरकारी क्षेत्र में किए जा रहे ६५ रूपयों के खर्च में से, केवल ३० रुपये ही ग्रामीण क्षेत्रों को मिलते हैं, जबकि शहरी क्षेत्रों में हमारी २५ प्रतिशत जनसंख्या की स्वास्थ्य जरूरतों को पूरा करने के लिए प्रति व्यक्ति लगभग १०० रुपयों का खर्च किया जाता है। इसमें से काफी कुछ खर्च विशेषज्ञों की सेवाएं देने वाले बड़े अस्पतालों और मेडिकल कालेजों में मेडिकल शिक्षा और शोध पर होता है। फिर भी मुनाफा कमाने वाले प्राइवेट क्षेत्र पर प्रति व्यक्ति २०० रुपयों से भी अधिक खर्च किया जाता है जो कि केवल शहरी क्षेत्रों तक ही सीमित है।

डा. एन. एच. एन्टिया, निदेशक व ट्रस्टी, एफ.एम.आर, एफ आर.सी.एच. ने प्लास्टिक सर्जरी, कुष्टरोग व सामुदायिक स्वास्थ्य के क्षेत्र में सराहनीय कार्य किये है। प्रमुख कमेटियाँ जिन से सम्बद्ध होकर उन्होने कार्य किये, उनमें भारत सरकार की योजना आयोग स्वास्थ्य कमेटी भी शामिल है।

आई सी.एस.एस.आर/आई सी.एम.आर. की रिपोर्ट ने यह संकेत दिया था कि करीब ९८ प्रतिशत प्रतिबंधात्मक, प्रोत्साहक और उपचारीय स्वास्थ्य समस्याओं का १ लाख की जनसंख्या या जिले के स्तर पर सुचारू रूप से समाधान हो सकता है। इस तरह से, विशेषज्ञ शहरी केन्द्रों के लिए केवल कुछ समस्याएँ ही बची रह जाएँगी। यह एक अधिक मानवीय और कम लागत पर बेहतर नतीजे देने वाली सेवा है जो पंचायती राज के लिए अति उपयुक्त है। पिछले तेरह सालों का अनुभव यह दर्शाता है कि ग्रामीण और शहरी दोनों ही आबादी को, सरकारी क्षेत्र में प्रति व्यक्ति करीब १०० रुपये खर्च कर के एक प्रभावी विकेन्द्रित सामुदायिक स्वास्थ्य देखरेख प्रणाली उपलब्ध कराई जा सकती है, जो कि वर्तमान में हो रहे प्रति व्यक्ति २५० रूपयों के खर्च से बहुत कम है। अमरीका द्वारा स्वास्थ्य सेवाओं पर अपने सकल घरेलू उत्पाद (जीडीपी) का १३ प्रतिशत खर्च करने की तुलना में, पश्चिमी यूरोप के पूँजीवादी देश अपने घरेलू उत्पाद का केवल ६ प्रतिशत ही खर्च करके, वह भी मुख्यतया सरकारी क्षेत्र पर, अपने लोगों को कहीं बेहतर स्वास्थ्य सेवाएँ उपलब्ध कराते हैं। पूँजी-वादी देशों में भी लोगों का यही मानना है कि स्वास्थ्य की देखरेख केवल सशक्त प्राइवेट क्षेत्र के हाथों में नहीं छोड़ी जा सकती है। एक बेहतर सरकारी स्वास्थ्य क्षेत्र ही, प्राइवेट क्षेत्र को ठीक तरह से नियंत्रित कर के सही दिशा दिखला सकता है।

यह सभी कुछ यह दर्शाता है कि बेहतर स्वास्थ्य देखरेख कहीं अधिक सस्ती होती है जबकि गलत तरीकों से की जा रही स्वास्थ्य देखरेख में खर्च की कोई सीमा नहीं है। भारत में, एक अनुपयुक्त मॉडल को लागू करने की वजह से, भोरे कमेटी की रिपोर्ट को अपनाने के बाद भी, स्वास्थ्य देखरेख के खर्च में अत्यधिक वृद्धि हुई है। अतः हमें इस दिशा में एक नई और अलग सोच की जरूरत है। ❐

*(हिन्दी अनुवाद : **मीता श्रीवास्तव**)*

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Edited by Vaijayanti Aphale with assistance from Nagesh Mirajkar. Produced by the Foundation for Research in Community Health, 3&4, Trimiti B Apts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 6.

HRD
18/10/96.



The Foundation for Research in Community Health

NEWSLETTER

For Private Circulation Only | Vol. X, No.3 | May-June 1996

The Rockefeller Foundation in India

Establishing Modern Medical Centres

Nikit Dravid and Vaijayanti Aphale overview the contribution of the Rockefeller Foundation to medical research in India on the basis of information collected in the course of an ongoing FRCH project analysing the role of this Foundation in the development of public health and medical research in India.

The Rockefeller Foundation was established in 1913 with a deep concern over the then-existing state of health care the world over, as it considered 'good health' to be a primary ingredient in what its charter called the 'well being' of the people. Considering the prevalence of endemic disease at that time it was a logical conclusion. Its representatives explored conditions in many countries and joined with the local authorities to battle against malaria, hookworm, yellow fever, influenza, tuberculosis and yaws. Simultaneously, research funds were provided to medical schools, departments and individual investigators to help build up the basic knowledge upon which effective and efficient medical care must rest.

Till 1920, the British colonial medical facilities in India had a distinct racial and urban bias. Separate provisions were made on employment and racial grounds, though in some places non-official Europeans might be allowed access to hospitals designed for civil servants. With the entry of the Rockefeller foundation in 1920, for the first time a rural health care expansion began in India. The Foundation started preventive health programmes in the Madras Presidency in collaboration with the government and gradually extended its support for such activities in Mysore, Travancore, United Provinces and New Delhi. The focus of their activities was on developing health unit organisations in rural and semi-rural areas.

Simultaneously, through the years the Rockefeller Foundation made a series of long term grants for the development of medical education in India. The Foundation was particularly interested in experiments which could lead to the incorporation of the elements of rural medicine into the traditional medical curriculum.

One effective plan by which this was done was through the creation of community health centers which could function in the curriculum as teaching units, much as do conventional teaching hospitals and outpatient departments. To overcome the practical difficulty of isolation of such centres and make their functioning effective they were provided with quarters where students and staff could live for the assigned period and with space and equipment for a modern medical college in a teaching situation. Chief among the health institutes and rural community centres funded by the Foundation are :

All India School of Hygiene and Public Health, Calcutta

During 1927 and 1928 an extensive survey was made of medical institutions and conditions in medical education throughout India. There was a great need for higher training of personnel for more responsible positions connected with teaching hygiene and administration of public health in India.

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Towards this end, the local authorities proposed to develop an All India School of Hygiene and Public Health using the Calcutta School of Tropical Medicine and Hygiene as a foundation. The Rockefeller Foundation provided financial aid both for the establishment of the All India School of Hygiene and Public Health (AIIHPH), Calcutta and for public health education in the AIIHPH. The institute was established in 1932.

To serve the institute as an experimental unit in public health practices and provide a training ground for students in rural hygiene, the Singur Health Unit was established by an agreement between the Government of India, the Government of Bengal and the AIIHPH. The studies were to be undertaken in both urban and rural areas in an attempt to determine sources of infection and relative importance of various agencies of transmission. These studies were an expansion of the work of the All India Institute Public Health Experiment Station, to which the International Health Division of the Foundation gave support from 1943 to March 1945.

Virus Research Centre, Poona

The Virus Research Centre in Poona, now known as the National Institute of Virology, was set up in April 1952 by the Indian Council of Medical Research, the Government of Bombay and the Rockefeller Foundation for the study of the arthropod-borne virus disease of man and domestic animals in India.

It was the over-all function of the centre to define the distribution of arthropod-borne virus diseases in the various regions of India, to collect and identify new viruses, to study their natural history emphasising those agents which were important for public health and to advise the government on appropriate control measures. As part of the Foundation's programme of virus research, three Foundation staff members were assigned to this research centre.

All India Institute of Medical Sciences (AIIMS)

The Government of India, in October 1943, appointed a "Health Survey and Development Committee" (commonly known as the Bhore Committee) to make a survey of the existing facilities in India pertaining to public health and medical care, and to recommend lines of improvement and development for the future. As per the recommendations of the Committee the All India Institute of Medical Sciences (AIIMS) was established with the following objectives:

* To develop a pattern of teaching in undergraduate and post-graduate medical education in all its branches so as to demonstrate a high standard of medical education to all medical colleges and other allied institutions in India;
* To bring together in one place educational facilities of the highest order for the training of personnel in all important branches of health activity; and
* To attain self-sufficiency in postgraduate medical education.

In September 1956, AIIMS first opened its doors to a class of 41 men and nine women medical students. Since then, AIIMs has emerged as India's chief center for medical education and for training teachers of medicine.

The Foundation has been able to play a minor, though important, role in the development of this institute. Fellowships were awarded to three of the staff. Since 1957 six travel grants enabled members of the faculty and administrators to visit medical centers in the United States, Europe, and Japan. A total of $ 300,000 were appropriated for the purchase and shipment of teaching and research equipment. Early in 1960, the Board of Trustees designated some $ 500,000 to be used to meet the foreign exchange requirements for the construction of the hospital clinic complex. Further, a grant of $200,000 was made for equipment for the institute's clinical departments, bringing to more than $ 1,000,000 (million) the total of Foundation aid given since 1958.

Dr. Lucien A.Gregg, the Rockefeller Foundation's senior medical representative in India, was one of the advisors for constructing a teaching hospital to support clinical programmes of the institute in both education and research. Through most of the year, two Foundation staff members were connected with AIIMs in New Delhi, one as a consultant on general development and the other as an adviser for the teaching center in rural medicine at the community health unit in the Kurali village outside New Delhi.

For the Sarojini Nagar health center in Delhi, Foundation funds and a matching amount from the state provided the costs of constructing and equipping, in three subcenters, rural clinics each with about four beds, a hostel for about ten interns, and quarters for medical and paramedical staff. The Department of Social and Preventive Medicine, which administers the rural medicine training plan, expected that when the students lived in the villages the value of their experience would be greatly increased.

Indian Cancer Research Centre, ICMR

The Rockefeller Foundation had appropriated $ 23,800 to the Indian Cancer Research Centre, ICMR (Bombay), an important medical research centre in India toward equipment and operating expenses of a laboratory of studies on human variation. This grant was available for three years.

The Indian Cancer Research Centre had included research in neuropathology in its programme since 1948. Because of

(Contd. on pg. 7)

The International Challenge of Tuberculosis

A Seminar

Sanjay Juvekar, one of the participants, reports on the above seminar organised by the London School of Hygiene and Tropical Medicine at London from 6-14th February 1996

As part of its aim to encourage cultural and scientific exchange between Britain and other countries the British Council had sponsored a seminar "The International Challenge of Tuberculosis" to enable senior specialists, academicians and professionals to learn about recent developments in the field of tuberculosis. The seminar took a global view of tuberculosis including the new challenges of the epidemic of HIV and multidrug resistance in tuberculosis. It was well attended by professionals from African, Asian and European countries. The following topics were covered in detail :

* The challenge - global picture of tuberculosis
* TB control strategies
* Economic and anthropological aspects of TB
* Recent advances and new technology

The Challenge - Global Picture of Tuberculosis

It is well known that tuberculosis leads to approximately 2.5 million deaths every year, the majority of these being in low income countries. It is estimated that about eight million new cases of tuberculosis develop annually. Half or more of the cases in high income countries occur among the elderly while in low income countries, young adults are affected the most. Though a rule of thumb says that only one in ten infected individuals will usually develop tuberculosis, risk factors such as simultaneous infection of Human Immunodeficiency Virus (HIV) and Mycobacterium Tuberculosis is sure to distort this rule because the lifetime risk of such a dually infected individual exceeds even 30 per cent. Unless resourses are made increasingly available to combat tuberculosis, it will always remain a threat not only to low income but also to the so called developed high income countries.

Dynamics of tuberculosis in a community can be well understood from three componants of epidemiologic research, namely :

* Identification of the risk factors for occurence of a particular event;
* Descriptive epidemiology stating the magnitude of the problem;
* Predictive epidemiology attempting to delineate the likely course of the epidemic based on past observations using modelling techniques (This is necessary because the risk of exposure to *tubercle baclli* is an abstract phenomenon that cannot be quantified statistically).

Tuberculosis Control Strategies

Achieving high patient adherence in diverse urban and rural settings, and structural and managerial characteristics of health service organisation associated with successful tuberculosis control were the main points of discussion. The consensus reached was that the occurrence of tuberculosis can be reduced by reducing transmission of the disease, reducing susceptibility to infection and disease, prevention of progression from known or presumed infection to disease and by treatment of active cases of tuberculosis with priority given to infectious cases and prophylactic treatment.

Another major issue discussed was the integrated approach and multidisciplinary orientation to TB control with the need to incorporating doctors and social scientists and the private and voluntary sectors in management of TB; combining the TB programmes with the AIDS control programme etc. One cannot deny that control programmes for any disease will benefit from a thorough understanding of the broader social context in which they are operating. For this the people's perceptions of symptoms, diagnosis and treatment of TB are to be known. The way people interpret, classify and act upon symptoms of a disease is culture bound and societally affected and hence the need for an anthropological look at tuberculosis control. Some of the clinicians also felt that there is a need to develop a suitable model to assess the patient's perceptions for facilitating its use in fields other than anthropology.

Some experts pointed to the directly observed therapy or DOTS (short course) as a need to achieve all the above. Infact, the World Health Organisation has already successfully implemented the DOTS concept in the form of intermittent supervised chemotherapy to TB patients in some places to increase compliance and ensure that drugs are consumed by the patients. Under this practice, a patient has to consume anti TB drugs at least thrice a week in front of a health worker at the clinic. Practical problems in implementation of DOTS were pointed out by some experts, especially, the problem of

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implementation of DOTS in the remote interior areas of African and South East Asian countries. It was also pointed out that as emphasis is laid on behavioural change in AIDS control and on completion of treatment in TB control, there is always a difficulty in combining these two programmes. But this was counter argued by others who felt that TB too is not a disease that can be tackled by doctors alone but had a social dimension and hence could be well combined with the AIDS control programme. Many of the representatives from high income countries stressed on an international policy to allow only chest physicians to treat tuberculosis but keeping in mind the cultural and health sector diversity in different countries, it was universally accepted that such a policy could not be implemented everywhere.

Economic and Anthropological Aspects of Tuberculosis

One important hurdle to developing a global TB programme is politico-economic as in a majority of the countries the political will to implement the health policy decisions is lacking. Instead, it would be easier to concentrate on other avenues of tuberculosis control like developing user friendly and affordable technology as far as drugs and diagnostic facilities are concerned. Another crucial need is to find out a test for diagnosing whether a TB patient has been completely cured. This will enable one to confirm and define 'cure' scientifically.

Recent Advances and New Technology

New molecular biology methodologies are currently being developed for diagnostics and epidemiological studies of tuberculosis. Most important of these are the use of polymerase chain reactions (PCR) in diagnosis, rapid methods for antibiotic susceptibility testing and DNA fingerprinting for typing of M. Tuberculosis. A need was felt for scientists, social scientists, clinicians and administrators to understand each others role so as to strengthen the multidimensional approach to TB control. The use of combination therapy in place of monotherapy was suggested to curtail the emergence of drug resistance and modern methods of improving compliance were searched for. As far as drugs are concerned, it was learnt that in addition to the 1st line drugs, many second line drugs were being tried like Rifa diene, Rifa pentiene, roxithromycin, amikacin etc. Yet aother trend in the West is that of chemoprophilaxis as preventive therapy. It was said that if not the whole population, at least specific groups could be identified in low income countries for preventive therapy. Specific groups like Bidi workers, people working in mines, stone quarries, cement factories and cotton mills have to be the target populations for preventive therapy.

Some Observations and Impressions

One cannot deny that there exist vast differences between more industrialised western countries and comparatively less industrialised eastern countries. These differences are evident in economic, political, educational and social development Moreover, because of cultural differences, the whole concept of health is different in various parts of the world thereby influencing the health management practices in different countries. Tuberculosis management is no exception to this.

From the presentation and discussions at this seminar too it can be said that no single strategy to control TB can work worldwide. For instance, some of the European countries are trying prophylactic treatment on the high risk population but in a country like India this high risk population itself is massive in number. Furthermore, when a country is unable to treat already diagnosed cases how would it be possible for that country to think of giving prophylactic treatment ?

New York and Hongkong trials tell the success story of DOTS. This has largely influenced the World Health Organisations strategies resulting in implementation of DOTS by WHO on a global arena. The question arises whether DOTS can be successfully implemented in remote interior rural and hilly terrain regions of India. Is it possible to give supervised though intermittent therapy in these totally inaccessible areas ? The answer is obviously no, especially as many such places are inacceasible particularly so during the mansoons. The case holds true for the majority of south-east Asian and African countries as well.

The use of second line drugs as anti-tuberculosis treatment is also not possible for all countries as firstly it is very costly and secondly diagnosis of these cases is not feasible. Rise in drug resistant cases and the spurt in HIV infected tuberculosis cases has made the problem even more complex. Socio-cultural factors responsible for tuberculosis control cannot be ignored - the *tubercle bacilli* will make its presence felt in the patient's system, causing him/her to feel unwell; medical technology, drugs and newer diagnostic measures will assist doctors to diagnose and cure the disease; yet, will they make the patient take medicines regularly ? Even if the patient knows that he has to take medicines regularly according to the doctor's suggestions, he at times, cannot comply due to economic and social reasons. Thus, if at all there is a need for global control of tuberculosis there have to be different strategies for different countries while simultaneously retaining as many similarities as possible. For this, more research has to be undertaken in different parts of the world in order to understand people's knowledge about illnesses, attitudes towards health and their practices for getting cured. ❐

Local Belief Systems and Practices

How They Affect Health Behaviour of Rural Women During Pregnancy

The information in this article has been obtained during the course of health training sessions of village tais conducted by ***Seema Deodhar*** *at Parinche, as part of the Parinche project of FRCH. The information has been documented by* ***Aarti Kelkar****, some of it cross checked by interviewing women from the village and by information obtained from the baseline survey.*

Health and disease, though scientifically understood as biological in nature are related to the people's belief systems. Thus, the health culture and behaviour of the people is determined by their concepts about health, disease, their classification of normal and abnormal and their bodily experiences along with their social, cultural and religious understanding of any phenomenon.

This was made evident as we documented the various beliefs and practices followed at the local level by the Parinche women during and after pregnancy along with their personal experiences. The concepts reported include the signs of pregnancy, their methods of identifying the sex of the foetus, the stage of its development, the correct food, behaviour etc, during pregnancy to give birth to a normal child, various taboos regarding pregnancy, health and so on.

Knowledge of Anatomy

The village women believe the uterus to be situated below the stomach inside the urinary bladder. This belief leads them to conclude that as the size of the foetus increases it puts greater pressure on the bladder leading to an increase in the frequency of urination during pregnancy. This particular information has been cross checked by interviewing other women from the village.

Signs of Pregnancy and Fetal Development

The popular signs of pregnancy as given by the women are : nausea, vomiting, giddiness, loss of appetite, sleepiness, a burning sensation in the chest, heaviness of breasts, muscle pain in the legs, cramps in the stomach. One also develops peculiar obsessions like eating mud, ash or tamarinds; putting on false moustaches (!) etc.

The women identified that conception takes place on the 4th and 5th day of menstruation. It is also believed that the development of the head of the foetus takes place in the 5th month while it can be identified as a living entity in the 7th month.

Sex, Appearance and Nature of Foetus/Child

The foetus conceived on a full moon day is usually a girl while on Amavasya a boy. A male foetus rotates on the left side while the female foetus rotates on the right and shows more movement than the male. A women feels more hungry in case of a male foetus.

Regarding the appearance of the child, it is believed that if the pregnant women has greater intake of either milk, water or coconut water the child will be fair. If she has paan the child's lips will be red. If she has a large quantity of coconut the child will be born with lots of hair on the head. One shouldn't open the mouth too wide during pregnancy as the childs lips will become too thick. During pregnancy one is not supposed to sit cross legged. Rather, the legs should always be gathered close so that the pressure would give the foetus a compact shape. If a pregnant women walks over the leg of another women the child will resemble the latter.

A diet of rice and fish curry will make the child fickle while if a pregnant women cuts vegetables during an eclipse the child will be bad. The women also reported that after delivery, a male foetus is washed with cold water while a female with hot water to make the latter more tolerant.

Desired Food Intake

During pregnancy, a woman is not allowed to eat foods believed to generate heat in the body like raw papayas, bananas etc. as they are thought to cause an abortion. A pregnant women has to eat less as eating in excess will lead to an increase in the size of the foetus causing difficulties during delivery. It is believed that a pregnant women will suffer from night blindness if she crosses papaya seeds or egg shells on saturdays and normal vision would be restored only after delivery. The treatment includes :

* Eating bhakri (Bread made of jowar/bajara) at the doorstep of some houses on saturday
* Eating chana on the doorstep
* Eating gram and jaggery boiled in a mud utensil
* Eating green leaves and carrots for 21 days

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If a pregnant women has too many tamarinds, custard apples, raw rice, areca, pepper ash, tea with jaggery there will be discharge of white substance. If she eats during an eclipse her child will be diseased and if she roasts anything on the pan the child will have inflammation on its skin.

The general traditional diet of a pregnant women contains a lot of coconut, jaggery, *sunthavda* (dry ginger), *khaskhas* (poppy seeds), milk and *halim* (cress). Also, the practice of *dohal jevan* (a feast given in honour of a women during pregnancy) ensures that the women gets a lot of food rich in vitamins, carbohydrates, iron etc.

During lactation, a women has to eat less, slowly and have mostly liquid food otherwise it is believed that the infant will suffer from diarrhoea. Also, stool softeners are included in the diet so as to reduce incidence of piles which is quiet common after delivery. Colostrum is not given to the child. For the first two days the child is given sugar water or honey. The women reported that nowadays, though colostrum is not given in the case of the first child many women give it in case of second due to the problem of breast engorgement. This practice shows how people learn from their personal experiences.

Other Beliefs

There is a strict taboo on sex once it is known that the woman has conceived. An interesting example could be given here. There is a condition called vernix caseosa, where the foetus is covered with a white covering. Such type of babies are believed to be born due to sexual relations after conception. The woman is strongly ridiculed in such cases.

Pregnant women and new born babies are not allowed to be weighed; also, abdomens of pregnant women cannot be inspected as it is considered to be one of the means of casting the evil eye.

Health Care During and After Delivery

No pregnancy checkup is done. The first delivery is usually done at the mother's place. Generally, home deliveries are preferred by the women as :

* It is not possible to reach the hospital in time due to transport problems.
* Women prefere the deliveries to be done in sitting position while in hospitals the supine position is maintained.
* The women reported that they felt comfortable among women they knew and the atmosphere at home was congenial. In the hospital, they felt isolated. Also the women did not like it if the deliveries were conducted by male doctors. The women informed that deliveries were performed by any woman or an untrained dai in the village.

To increase contractions a women is given "vermicelli" water during her delivery. For a few days after delivery a pad dipped in brandy and tumeric or in castor oil is applied to the abdomen of the women which helps to contract tissues and thus arrest uterus prolapse and also prevents infections.

The umbilical cord known as "vaar" has to be removed otherwise it is believed to travel upto the "kaliz (heart)" of the woman and kill her. The abdomen of the woman is pressed to remove the cord which comes out in the form of a red mass. The cord is usually cut with a blade and never thrown in the open as it is believed that it might be used as a medium for black magic or casting an evil eye thus, affecting the newborn. The umbilical cord is hence buried in the backyard

There is a common belief in the village that blood restored in the uterus during pregnancy is converted into the foetus which is thus considered impure. Hence, the mother and child are isolated for a few days following childbirth.

In case of breast engorgement, rice paste is applied to the breasts which exerts pressure due to slight pulling effect on drying or hot and cold water is poured alternately on the breasts facilitating dilation of the ducts. Both these methods help to assist in the free flow of milk. In fact, there are women in the villages who provide treatment for breast engorgement.

Conclusion

The question which arises here is what is the significance of documenting these beliefs and practices at the village level.

Most of the health programmes fail to take into consideration the cultural background of the people, leading to a communication gap between the providers and the beneficiaries. Instead there are more chances of rational health care practices being accepted by the people if the providers take into account the existing local beliefs and practices and mould their treatment to the latter.

It is true that many beliefs, especially those regarding the influence of the evil eye and identification of sex and appearance of the foetus, are very illogical and some practices like not allowing the new born child and its mother to be weighed, at times even harmful. These beliefs and practices need to be discarded for the health of the mother and the child. But other traditional practices regarding the type of food given and the position during delivery have a perfectly scientific basis and are in accordance with modern theories on maternity and infant care. For eg. *sunthavda* and *khaskhas* contain lactogenics, *haliv* and jaggery contain iron, milk and *nachani* contain calcium etc. Also green vegetables and carrots given to cure blindness contain A Vitamins - and modern medicine tells us that vitamin deficiency is one of the main causes of

blindness. Practices like conducting the first delivery at the maternal home and isolating the mother and child a few days following delivery give much needed rest to the pregnant women. The practice of conducting delivery in the sitting position helps the mother and child as the gravitational force facilitates delivery while the modern practice of conducting delivery in the supine position facilitates only the conductor of the delivery. These examples show the wisdom in following the "integrated approach" by encouraging utilisation of the positive traditional health practices along with modern health care and simultaneously discarding the harmful practices through health education of the community women ❐

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the excellent opportunities for neurological investigation available at the centre, plans had been made to expand the neuropathology unit by adding neurophysiological and biochemical studies. To help the Indian Cancer Research Centre expand its neurological research programme the Rockefeller Foundation made a grant of $88,200, for use over a three year period, to the Indian Council of Medical Research.

Other Institutions

In 1956 the Rockefeller Foundation made grants totalling nearly $1,000,000 to aid the general development of three medical colleges in India, and to support teaching and research in preventive medicine at a fourth Indian medical college. The four colleges - the Christian Medical Colleges in Vellore and in Ludhiana, King George's Medical College in Lucknow and the Seth Gordhandas Sunderdas Medical College in Bombay- represent private, provincial and muncipal institutions, and geographically are located near major centres of population in southern, northern and western India.

Conclusion

As is evident from the preceding paragraphs, the intervention of the Rockefeller Foundation is historically very important for development of health care services and health policy in India, especially for rural areas.

True, the philanthropy of the Foundation had a base in tax planning and in the irritatingly superior attitude of the white man's burden.

Also, ultimately, the Rockefeller Foundation too is a product of the Western capitalist system responsible for invading the world with expensive, irrelevant, and often dangerous medical and public health systems. Along with this system goes a medical world view which allows or facilitates the commercially rewarding, discrete technological fix or 'campaign' mind set to guide all legitimate efforts for control of population, malaria or whatever rather than an integrated holistic view which sees and acts upon the health of the people as dependent upon their role in the control and distribution of resources. The accent is on high medical technology with complete disregard for indigenous medicine and neglect of the basic elements of public health - adequate nutrition, pure water for drinking, safe handling of human and animal wastes, adequate clothing etc. Further, in India the Rockefeller Foundation was partial to research of hookworm and malaria rather than the more endemic cholera and even territorially the support for health centres was unduly concentrated in south India.

But limited as are the Foundation's funds, this type of investment suggests a high return in better health over the longer run; it responds to many urgent requests to the Foundation for assistance in lifting the quality of health training, and it has usually stimulated a much stronger financial effort from others on behalf of the institutions concerned. The Foundation's experiments in the incorporation of the elements of rural medicine into the traditional medical curriculum, its work in controlling epidemics of malaria and hookworm and its financial and intellectual inputs in the establishment of modern medical centers represents a tremendous investment for India. ❐

New FRCH Publications

1. Health Research Studies in India : A Review and Annotated Bibliography
2nd ed. 1996, 185, Rs. 225

Brought out in two volumes, this book reviews a countrywide study, undertaken at the instance of the Ministry of Health and Family Welfare, to answer the questions often posed about health research in India like who conducts it, its extent and type, its relevance to the present health problems etc.

2. NGO's in Rural Health Care
Dr. Amar Jesani., Manisha Gupte, Ravi Duggal., 2nd rev. ed. 1996, 125, Rs. 110

This study, involving 45 important NGO's, gives an insight into the role and functions of the different types of NGOs in Maharashtra, whose major focus is on the field of health. It aims at critically evaluating the intervention of NGOs in rural health care, especially those using alternative models of primary health care.

3. Women in Health Care : Auxiliary Nurse Midwives
Aditi Iyer, Amar Jesani, 1995, 157, Rs. 130

This study of Auxiliary Nurse Midwives (ANMs) was conducted between 1990 and 1992. It considers the complex network of roles that they play as health workers, wage earners, wives and mothers and provides an understanding of the nature and spheres of subordination and empowerment in their lives. ❐

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स्वास्थ्य सेवाओं का ढ़ाँचा

डॉ. एन. एच. आंटिया

देश में स्वतंत्रता के बाद, निजी व सरकारी दोनों क्षेत्रों में, स्वास्थ्य सेवाओं के ढाँचे में बहुत विस्तार हुआ है। दुर्भाग्यवश, इस विस्तार का स्वरूप व वितरण, आम जनता की आवश्यकताओं को ध्यान में रखकर नहीं हुआ। आजकल एक ओर, समृद्ध लोगों के लिए शहरों में आधुनिक अस्पताल व नर्सिंग होम की सेवाएँ उपलब्ध कराता हुआ, मुनाफा कमाने वाला निजी क्षेत्र है, जिसमें चिकित्सा के क्षेत्र के तीन चौथाई स्वास्थ्य कार्यकर्ता काम कर रहे हैं। जबकि दूसरी ओर, गरीबों के लिए अनेक छोटे-छोटे दवाखाने और नर्सिंग होम हैं, जिनमें साफ-सफाई तक पर कोई ध्यान नहीं दिया जाता है। फिर भी सरकारी क्षेत्र द्वारा, इलाज के लिए ४,११,८०० बिस्तरों की तुलना में, निजी क्षेत्र द्वारा केवल २,०६,८०० बिस्तर ही उपलब्ध कराए जाते हैं। इस प्रकार की सेवाओं का स्वरूप व विस्तार चिकित्सा की असली जरूरतों को ध्यान में रखने की बजाय, बाज़ारी व्यावसायिक शक्तियों द्वारा तय होता है। इस व्यवस्था में शहरों में तो समृद्ध लोगों को जरूरत से ज्यादा दवाएँ दी जाती हैं, परन्तु गाँवों में स्थित प्राथमिक स्वास्थ्य केन्द्रों में, जरूरत से भी बहुत कम व निम्न स्तर की दवाएँ ही पहुँच पाती हैं।

सरकारी क्षेत्र की सुविधाएँ, अधिकतर शहरी क्षेत्रों में और अक्सर आधुनिक सेवाओं वाले बड़े-बड़े अस्पतालों में ही केन्द्रित होती हैं, जैसे कि सरकारी मेडिकल कालेजों से जुड़े १०६ अस्पतालों में। ये सुविधाएँ, उन लोगों को इलाज की सेवाएँ उपलब्ध कराती हैं, जो कि निजी क्षेत्र की महँगी सेवाओं का उपयोग करने में सक्षम नहीं हैं। समाज में, नियोजित रूप से न होने की वजह से, इन सुविधाओं पर बहुत अधिक दबाव पड़ रहा है। समुदाय में विभिन्न स्तरों पर चिकित्सा सुविधाएँ उपलब्ध न होने और समुदाय में जटिल बीमारियों के लिये; उपलब्ध करायी जाने वाली, विशेषज्ञों और अति-विशेषज्ञों की सुविधाओं के महँगा होने के कारण, इन मेडिकल कालेजों में सामान्य बीमारियों वाले रोगियों की भीड़ लग जाती है, खास कर बाह्य रोगियों को जाँचने की उचित व्यवस्था न होने और स्वास्थ्य की ऐसी समस्याओं, जिनमें चिकित्सा और आपरेशन की मूलभूत सेवाओं की जरूरत होती है, के उपचार के लिये सामुदायिक अस्पतालो के न होने के कारण, जिससे मेडिकल कालेजों की सुविधाओं पर बहुत अधिक दबाव पड़ता है।

सातवीं पंचवर्षीय योजना में ग्रामीण स्वास्थ्य सेवाओं के ढाँचे में बहुत वृद्धि हुई है और अब प्रत्येक ३०,००० की जनसंख्या पर एक प्राथमिक स्वास्थ्य केन्द्र, प्रत्येक ५,००० की जनसंख्या पर एक सब-सेंटर और प्रत्येक १,००० की जनसंख्या पर एक सामुदायिक कार्यकर्ता उपलब्ध है। परंतु ये उपलब्धियाँ, भोरे कमेटी द्वारा सुझाये गये स्तर तक नहीं पहुँची हैं। यही नहीं नौकरशाही की अकुशलता, लक्ष्यों की प्राप्ति के लिए दबाव, संचार माध्यमों और परिवहन की कमी, कमजोर नेतृत्व व उत्तरदायित्व और सामुदायिक नियंत्रण के अभाव में, इन बढ़ी हुई सुविधाओं का उपयोग भी बहुत कम मात्रा में हुआ है। किन-किन स्थानों पर स्वास्थ्य सुविधाएं उपलब्ध करानी हैं, इसका फैसला भी, स्वास्थ्य की जरूरता की वजाय, अधिकतर, स्थानीय राजनीति का ध्यान मे रखकर किया जाता हैं। इसीलिये इनका उपयोग कम मात्रा में होता है और इनका रख-रखाव भी ठीक से नहीं किया जाता हैं। इसके साथ-साथ, इन सुविधाओं पर किये जाने वाले खर्च का ८५ प्रतिशत कर्मचारी वर्ग पर किये जाने के कारण, दवाईयों, अन्य सुविधाओ, रख-रखाव व परिवहन के लिये बहुत कम ही बचता है।

यदि शहरों के बड़े-बड़े अस्पतालों द्वारा उपलब्ध कराई जा रही स्वास्थ्य सेवाओं को, सामुदायिक स्वास्थ्य देखरेख की प्रणाली में भी उपलब्ध करा दिया जाय, जैसा कि आई सी एस एस आर/ आई सी एम आर की १९८१ की रिपोर्ट में भी सुझाव दिया गया है, तो सरकारी क्षेत्र की सीमित निधी, सुविधाओं व संसाधनों का, शहरी व ग्रामीण दोनों समुदायों में कहीं बेहतर उपयोग किया जा सकता है। इसके द्वारा सामुदायिक अस्पतालों में, सामुदायिक कार्यकर्ताओं की सेवाएँ व विभिन्न स्तरों पर विशिष्ट व अति-विशिष्ट सुविधाएँ भी प्राप्त हो सकेंगी। □

(हिन्दी अनुवाद : मीता श्रीवास्तव)

डॉ. एन. एच. आंटिया, निदेशक व ट्रस्टी, एफ.एम.आर.व एफ.आर.सी.एच. ने प्लास्टिक सर्जरी, कुष्ठरोग व सामुदायिक स्वास्थ्य के क्षेत्र में सराहनीय कार्य किये है। प्रमुख कमेटियाँ जिन से सम्बद्ध होकर उन्होने कार्य किये, उनमें भारत सरकार की योजना आयोग स्वास्थ्य कमेटी भी शामिल है।

FREE ABSTRACTING

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Edited by Vaijayanti Aphale with assistance from Rajesh Ingle. Produced by the Foundation for Research in Community Health, 3&4, Trimiti B Apts. 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

Vol. X, No.4 July-August 1996

HRD 4/2/96

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Decentralised Drug Management in African Countries

Bamaco Initiative

Dr. S. N. Morankar

The structural adjustment programmes implemented during the 1970s and 1980s in the African and Caribbean countries, though meant to bring about economic recovery in the long term, required drastic reductions in the social services (education, health etc.) budgets during the transition period.

Such reductions in health budgets had serious effects on the functioning of the health system, especially where drug policy was based on the use of expensive non-essential drugs. For eg. in 1985, for some of the countries, the drug expenditures represented 50% of the resources allotted to health, for all the wrong reasons. These drugs were procured under their commercial names, supplies were not always well managed and prescription practices were often anarchistic. Therefore, in spite of such a large percentage of the budget being allotted to drugs, in many countries where these drugs were supposed to be provided to the patients free of charge, drugs were rarely available. The system had become progressively more paralysed, due to the lack of drugs, material and personnel.

Unable to have access to quality medicine at an affordable price through the health centres, the population resorted to supplying itself through private pharmacies or local markets. In private pharmacies, however, drugs were sold at very high prices relative to the people's purchasing power. At the local markets, all types of drugs of varying degrees of quality were sold, but without any control what-so-ever. The poorer segments of the population were experiencing increasing difficulty in satisfying their basic needs. Moreover, these out-of-pocket expenditures were not being re-invested to improve the health system.

This led to an unfortunate situation of weakened purchasing power due to worsening socio-economic conditions on the one hand and reductions in government health budgets for functioning costs and drugs on the other.

This unfavourable situation called for a recrientation of primary health policies and for making the health care system more effective, less expensive and more sustainable over the long term. Thus a series of policy reforms, collectively known as the Bamako Initiative, were formulated in response to the rapid deterioration of public health systems in developing countries during the structural adjustment period.

The Bamako Initiative aims at ensuring access to affordable essential health services for the majority of the population, while containing costs. It also aims at restoring consumer confidence in the public health system by improving the quality of services and delegating greater decision-making

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power - the financing of health care including salaries of the health staff, the procurement and disbursement of drugs etc. is undertaken at the community level itself. In addition it seeks to create better health by promoting behavioural change at the household level.

It has made a major contribution to health systems development, pioneering decentralisation and active community participation. By late 1994, the initiative had been implemented in 33 countries of which 28 were in Sub-Saharan Africa, the others being Cambodia, Myanmar, Peru, Vietnam and Yemen. Preparatory action is underway in several countries in Africa, South East Asia, Eastern Europe and Russia.

This initiative involves four key strategic elements :

1. The revitalisation and extension of peripheral health care delivery systems;

2. A strong advocacy in favour of use of essential generic drugs in order to ensure access to quality drugs at affordable prices;

3. The sharing of recurrent costs through community financing. The aim is to improve and extend services by generating sufficient income to cover some local operating costs such as the essential drug supply, salaries of some support staff, incentives for health workers and investment in community health activities. Community financing is based on user fees, prepayment for services, local taxes and various income generating activities. In addition, communities can help pay for health care costs by contributing labour or making direct financial contribution.

4. Community control which involves community responsibility for the management of local health services. Funds generated by community financing do not revert to the central treasury or health ministry but remain in the community and are controlled by it through a locally elected health committee. This is seen as a manifestation of a community's full partnership in the decision-making process and as a way of ensuring that the poor become better organised and more vocal in demanding health services.

In this part of the article we shall concentrate on the drug procurement and supply management practices evolved and practised as part of the initiative.

Logistical Support : Drug Supply and Distribution

Regarding drugs the Bamako Initiative aims at ensuring a regular supply of essential drugs to the health centres which will help reduce functioning costs, ensure quality of treatments, restore the people's confidence in the health system and respond to its demand for curative care.

The importance of the health problem (disease priority) is measured by its frequency according to epidemiological data, its severity and repercussions on the people's socio-economic activities.

Feasibility of including the disease in the priority list is judged on the basis of the problem's vulnerability to an intervention (in this case decentralisation) by the community, the financial viability of implementing the intervention and the degree to which the community would be likely to accept the intervention.

Each country following the Bamoko Initiative has estabilised a central drug procuring unit where after an international tendering procedure, the least expensive supplier is chosen, a supply system and drug management established, and training carried out to assure their rational use. Care is taken to see that these drugs are procured under their generic names to avoid duplication of drugs purchased and also to avoid the extra costs associated with brand names. Thus, using essential drugs under their generic names can significantly improve the cost-effectiveness of treatments. The working groups (groups elected by the community to implement the health care initiative at the community level) then establish an essential drug list of specific number of drugs corresponding to the treatment of the priority diseases. A limited number of drugs are chosen, based on their cost-effectiveness and their response to priority needs as well as perceived needs. And quantities are ordered calculating the requirement using epidemiological data on drug consumption on the basis of one illness episode per person per year.

In the community health budget, which is created in order of priority of items and services essential in health care, drugs and information tools feature first on the list. In fact around 75% of the budget is appropriated by drugs alone. A proportion of revenue corresponding to the value of drugs and information tools consumed, is blocked in a bank account and constitutes a reserve fund, for as long as UNICEF continues to support these drug and information tool costs. For eg. in Benin, three prepacked kits, every containing 40 essential drugs, are provided to each community health centre by the UNICEF, each kit having a purchase value of US $ 1200. The revenue realised from the sale of these kits is then put in a bank which constitutes the reserve fund.

Drug Donations

Four types of drug donations exist and distributions are made according to their usage :

1. Drugs received as emergency assistance in the case of natural disasters - they are not sold.

2. Drugs in the national essential drug list that are received as a gift or a special short or long term assistance - they are registered on the stock forms and sold. In addition to facilitating programme management in the start-up phase, the sale of these donated drugs generally generates sufficient revenue to create a reserve fund and to finance certain local functioning costs.

3. Drugs not included in the national essential drug list - the director of pharmacies must make a decision concerning their utilisation in line with the final procedures.

4. Drugs used for special programmes (tuberculosis and leprosy, contraceptives etc.) - the central purchasing unit negotiates with the supplying organisation on how to proceed.

Drug Prescription

Flow charts are used by the health workers, which are decision trees to decide upon which therapy to apply or whether to refer a patient. Decision trees standardise guidelines to assure quality care and avoid inappropriate and potentially dangerous treatments. For the health system as a whole, flow charts help reduce costs by limiting over-prescription and facilitate the management of drugs and equipment. They provide nurses with concrete guidelines and for the health systems, they ensure optimal use of available resources.

National and provincial directorates are provided pick-up vans to be used for : delivery of material, cold-chain, injection and sterilisation material, pre-packed kits of essential drugs, forms, files, registers, vaccines etc.

Drug Management and Supervision

The presence of drugs and money in the health centres necessitates rigorous management and control, exercised by the users, the community, and the health system supervisors. Such careful management is applied to both the daily health care activities and the administrative task in the health centre.

The community is required to ensure a minimum number of storage safety measures before availing of the donation of essential drugs. These include measures for protection from the environment like a waterproof roof, a location protected against floods, sufficient ventilation etc. and measures against thefts like burglar bars in the windows, solid doors with two locks, one for the president of the managing committee and other for the health centre nurse.

When the stocks arrive the drugs are handed over to the president of the management committee and the nurse in charge of the centre. Together, they make a complete inventory and register the drug quantities on the stock forms. The drugs are stocked in the secure rooms prepared for this purpose by the community. These drugs constitute the main stock. Periodically, generally monthly, the president of the committee and the nurse in charge of the health centre take small stocks kept in a closed cupboard in the treatment room which are available for daily use.

Monthly Supervision

Based on three randomly selected drugs, the supervisor totals the quantity of each drug prescribed according to the drugs and revenue register. He then checks whether the theoretical stock of these three drugs in the main stock according to the stock forms, corresponds to the quantity found during the supervisor's inventory. Finally, using the same method, he calculates theoretical quantity for the 'daily use' stock from the drugs and revenue register and compares it to an inventory he takes of this 'daily use' stock in the health centre. If these checks reveal an important difference, the medical officer will carry out a complete inventory of these stocks.

Monthly Supervision of Flow-chart Use

Two methods of supervision are used : direct and indirect. The direct method is based on observations of the health staff at work. This method focuses on history taking, choice of flow chart, decisions taken, drugs prescribed and their quantities, and the advise given.

The indirect method is based on the analysis of the registers to verify whether reasons for consultations are registered in the form of complaints, whether the drugs and dosages recorded are in line with the flow charts, and whether referrals to higher levels were justified. Supervisors from the district, provincial and national level verify drug management and storage conditions during their routine visits and during the semestrial monitoring sessions.

(To be continued in the next issue) ❑

Drug Policies of India and Bangladesh : A Comparison

A rational drug policy addresses the issue of prevention of, withdrawl of and protection against irrational and hazardous drugs and simultaneously, provision for easy availability of essential and life-saving drugs. Frequently, the blame for India's inability to address these issues in health care management is laid by policy makers and implementers on India's third world status. The most effective way of countering this argument would be to compare India's drug policy to that of Bangladesh - a poorer and less powerful cousin within the subcontinent.

Essence of Drug Policy

Bangladesh : The 1982 National Drug Policy of Bangladesh was seen as an integral part of the National Health Policy - applicable for the modern as well as the traditional sector and for the public as well as the private sector. The objective of the National Drug Policy was to rationalise procurement, production, quality control, distribution and drug pricing and bring it under a single legislative and administrative control.

India : Does the proposed New Drug Policy procure larger profits for the industry or is there really a good deal in the offing for the common man? While the drug policy of Bangladesh is directly consumer friendly the Indian drug policy will benefit the common man only if greater concessions to the pharmaceutical industry can promote larger domestic production and thereby increase availability and reduce costs in the long run.

Hazardous/Irrational Drugs

Bangladesh : Sixteen Criteria were evolved to categorise irrational and hazardous drugs to be withdrawn from the market. The drugs to be banned were divided into three categories according to their harmfulness and impotency namely schedule one, two and three respectively. Accordingly, the drug control ordinance was implemented on 12th June 1982, effectively putting into law the Expert Committee's recommendations, although prolonging the time allowed for implementation of the three schedules to six, nine and eighteen months respectively. Also, there is prescription control of toxic poisonous and habit forming drugs.

India : In our country loopholes between jurisdiction and lack of accountability in drug policy matters between centre, state, Chemicals Ministry, Health Ministry and Commerce Ministry have never allowed rationalisation of drug policy and seen repeated attempts sabotaged. In the absense of a clear cut policy to ensure and channelise drug production in a certain direction, what will prevent a major share of production from being diverted to non-essential areas? In fact MNCs are worst offenders when it comes to production of irrational and hazardous drugs and non-production of essential drugs - the small scale sector produces more bulk drugs than MNCs.

Essential Drug List

Bangladesh : * A basic essential drug list of 150 drugs established with 100 specialised drugs in the supplementary list.

* 150 drugs for tertiary care
* 45 drugs for primary care
* 12 drugs for village health workers

India : No national essential drug list. Attempts have been made by states eg. Delhi State, Tamil Nadu to formulate essential drug list, but these are only for the public sector health institutions. Since 80% of the drug usage is in the private sector, the formulation and implementation of an essential drug list concept, unless it is for the private as well as public sector, has limited usage.

To make matters worse, unlike in the earlier policies, essentiality of drugs as a criteria for price control is proposed to be completely done away with in the ensuing drug policy.

National Drug Formulary

Bangladesh : Preparation and publication of a National Drug Formulary

India : Last national drug formulary was prepared in 1979. Neither the 1986 nor the 1994 New Drug Policies ensured its revision.

Use of Generic Names

Bangladesh : Compulsory printing of generic names with or without brand names for 45 primary care drugs.

India : No such provision.

Price Control

Bangladesh : Prices reduced by increasing local production of drugs and by other practices like not condsidering luxury packaging charges while fixing prices etc. Also there is a control of labeling and advertising which along with reducing confusion of the consumers also helps to reduce prices.

India : Steep increase in prices expected if New Drug Policy is implemented under which any drug whose national turnover is not more than Rs. 4 crore, would be free from price control.Thus only 50% of drugs will come under price control

as compared to previous 70%. A decision is expected to be made to allow 100% MAPE (Maximum allowable manufacturing expenses) on even the 73 drugs coming under price control. This and the introduction of the GATT patent regime in the coming years is expected to lead to further widespread increase in prices as the US experience tells us that competition does not work in the market for drugs and prices keep on spiralling.

Ceiling prices are purported to be fixed for the commonly marketed standard pack-sizes of price-controlled formulations and even small scale units will have to follow the stipulated prices.

Generic drugs are also to come under the discipline of controlled pricing system.

Tax and duty concessions are expected to encourage research and development. Indigenously developed drugs will not be subject to price control.

Multinationals

Bangladesh : Regulation of technology transfer and licensing agreements with foreign collaborators.

TNC's prevented from manufacturing simple products like common analgesics, vitamins, antiacids.

India : Hathi Commitee report of 1975 had detailed the sins of the foreign sector in the drug industry. Yet in the ensuing drug policy the government is expected to allow foreign equity up to 51% for all bulk drugs, their intermediaries and formulations.

Number of items reserved for the public sector undertakings to be reduced according to whether the capacity is adequate to meet the country's demand.

Product patents are to be eliminated and use of process patents to be limited.

Good Manufacturing Practices

Bangladesh : Enforcement of good manufacturing practices and adequate quality control - greater vigilance and easier testing procedures.

Establishment of registered retail pharmacies, under the supervision of qualified pharmacists, at every government hospital. Restriction of ownership of retail pharmacies to professional pharmacists only.

Drug Administration strenthened by training all thana health administrators to act as drug inspectors.

India : Proposal to set up a National Drug Control Lab and a National Drug Authority (NDA)which is expected to eliminate industry's difficulty in dealing with different government departments like health and chemicals, and reinforce the inspectorate system to monitor the quality of drugs in the market..

Alternative Medicine

Bangladesh : Revised 1940 Drugs Act to include a registration system for Ayurvedic, Unani and Homeopathic medecines.

India : Proposal to set up a separate department for Ayurvedic, Unani, Homeopathic and Siddi systems of medicine under the New Drug Policy.

Drug Legislation

Bangladesh : Establishment of special drug courts and heavy penalties.

Introduction of medical audit and registration of all health workers

Abolition of Private Practice for all teachers in government medical colleges and post graduate institutes and doctors upto the level of junior consultants.

Introduction of various other legislative and administrative measure.

India : In India it is the constitutional duty of the State to Raise the Level of Nutrition and the Standard of Living and to Improve Public Health. The state shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties amd in particular, the state shall endeavour to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and of drugs which are injurious to health.

The drugs and cosmetics act, 1940 and 1982, are the main drug legislations that are supposed to provide some form of control over the manufacture and sale of drugs. Under these legislations the Drug Controller of India has the powers to prohibit manufacture of drugs which are not in public interest. Also the Central Government has the power to prohibit manufacture, sale etc. of drugs and cosmetics in public interest - without prejudice to any other provision contained in this chapter if the central government is satisfied, that the use of any drugs or cosmetics is likely to involve any risk to human beings or animals, or that any drugs does not have the therapeutic value claimed, or purported to be claimed for it of contained ingredients and in such quantity for which there is no therapeutic justification and that in the public interest it is necessary or expedient so to do then the government may, by notification in the official gazette prohibit the manufacture, sale and distribution of such drugs or cosmetic. Whoever himself or by any other person on his behalf manufactures or sells or distributes any drug or cosmetics in contravention of the provisions of any notification issued under section 26A, shall be punishable for a prison sentence and/or a fine.

In a landmark judgement, the, Consumer Protection Act has been widened to cover health services.

(Contd. on pg. 8)

औषधियों की आपूर्ति और उनका इस्तेमाल: बाहुल्यता के मध्य गरीबी

डा. अनन्त फड़के

भारत में प्रत्येक वर्ष लगभग 7,000 करोड़ रूपयों के मूल्य की दवाएँ इस्तेमाल होती हैं, फिर भी दवाओं की वहुत बड़ी कमी लगातार वनी हुई है, विशेषकर सार्वजनिक क्षेत्र में। यह भी माना गया है कि इस्तेमाल की जा रही दवाओं में से एक वहुत बड़ा हिस्सा ऐसी दवाओं का है जो अविवेकपूर्ण सम्मिश्रण की हैं और जिनका इस्तेमाल भी गलत ढंग से होता है। इन सभी तथ्यों की, एफआरसीएच द्वारा महाराष्ट्र के एक औसत जिले में, दवाओं की आपूर्ति और इस्तेमाल को देखने हेतु किये गये अध्ययन द्वारा भी पुष्टि की गई है।

विकास के सामाजिक-आर्थिक सूचकों को आधार मानते हुए (सीएमआई अनुसूची), दवाओं की आपूर्ति और सार्वजनिक स्वास्थ्य सुविधाओं के वाह्य-रोगी विभाग में रोगियों की उपस्थिति के अध्ययन के लिये, सातारा जिले को प्रातिनिधिक जिले के रूप में चुना गया। इस अध्ययन के लिये, जिले के तालुकों को विकसित, औसत और सूखा ग्रस्त क्षेत्रों में विभाजित किया गया।

दवाओं की कुल आपूर्ति

अध्ययन के प्रथम भाग का उद्देश्य था, सार्वजनिक और निजी क्षेत्रों में दवाओं की आपूर्ति के स्वरूप व उनके कुल मूल्य तथा सार्वजनिक क्षेत्र में दवाओं की कमी के विषय में अध्ययन करना।

प्रत्येक क्षेत्र से तीन पी एच सी, एक ग्रामीण अस्पताल, एक कुटीर अस्पताल और एक जिला सिविल अस्पताल (कुल नौ) को प्रातिनिधिक नमूने के रूप में चुना गया। इस नमूने से प्राप्त निष्कर्ष को यदि जिले के स्तर तक वढ़ाकर देखा जाय, तो इससे हमें सभी प्रकार की दवाओं (कुष्ठरोग, गर्भ निरोधक व टीकाकरण कार्यक्रमों के अन्तर्गत आने वाले टीकों को छोड़कर) के मूल्य का पता चलता है। वर्ष 1991-92 में सार्वजनिक क्षेत्र में कुल आपूर्ति रू. 56,22,862.80 अर्थात लगभग 56 लाख रूपयों की थी; जवकि वर्ष 1991-92 में, निजी क्षेत्र के लिये हमारे पास न्यूनतम अनुमान 21.28 करोड़ रूपयों के हैं - (प्रति व्यक्ति 87 रूपये)।

आपूर्ति की गई दवाओं के प्रकार

नौ पीएचसी में से प्रत्येक को औसतन 42 प्रजातीय दवाओं (26-50 प्रकार की), 171 सूत्र या फार्मूलों और सम्मिश्रित दवाओं, गोलियों, सिरप, इन्जेक्शनों की, विभिन्न खुराकों के रूप में, आपूर्ति की गई। इसके समतुल्य तीन ग्रामीण अस्पतालों के औसत आँकड़े थे -189 सूत्र और 35 प्रजातीय दवाएँ। कुटीर व सिविल अस्पतालों को क्रमशः 129 और 151 प्रजातीय दवाएँ, वहुत से सूत्रों या फार्मूलों की आपूर्ति की गई।

उपलब्धता की निरंतरता

ऊपर दिये गये आँकड़े, एक वर्ष के दौरान उपलब्ध कराई गई दवाओं की कुल संख्या मात्र ही दर्शाते हैं। दवाओं की दिन-प्रतिदिन उपलब्धता के विषय में अध्ययन करना भी अति आवश्यक है। यह पाया गया कि उन नौ पीएचसी में, 149 सूत्रों में से केवल 14 ही ऐसे सूत्र थे (9.4%), जो वर्ष के आधे से अधिक दिनों में उपलब्ध थे। तीन ग्रामीण अस्पतालों में, 158 सूत्रों में से केवल 46 सूत्र (39%) ही, वर्ष के आधे से अधिक दिनों में उपलब्ध थे। अतः पीएचसी और ग्रामीण अस्पतालों में, इन अनिवार्य दवाओं की भी एक वहुत भारी कमी लगातार वनी रहती है।

यह स्पष्ट है कि सातारा जिले में सार्वजनिक स्वास्थ्य सुविधाओं के लिये दवाओं की आपूर्ति, निजी क्षेत्र को दवाओं की आपूर्ति के तीन प्रतिशत से भी कम है। पी एच सी और ग्रामीण अस्पतालों में आमतौर पर जरूरत की दवाओं की भी लगातार भारी कमी रहती है।

औषधियों का इस्तेमाल

अध्ययन का द्वितीय चरण, सातारा जिले में औषधियों के इस्तेमाल के विभिन्न पहलुओं पर केन्द्रित था।

इस अध्ययन के 35 घटकों के लिये क्रियाविधि, विशेष उद्देश्यों के अनुसार तैयार की गई। इन उद्देश्यों और उनके क्रमानुसार परिणामों के विषय में नीचे दिया गया है।

नुस्खों का औचित्य

अध्ययन के एक हिस्से के रूप में, सार्वजनिक और निजी क्षेत्र के डाक्टरों के नुस्खों की, उनके द्वारा लिखी दवाओं की युक्तता को आँकने और गैर-ज़रूरी, अविवेकपूर्ण, खतरनाक दवाओं और गैर-ज़रूरी इन्जेक्शनों के इस्तेमाल के प्रसार को देखने हेतु विश्लेषण किया गया। नुस्खों के इन पहलुओं और डाक्टरों की शिक्षा के स्तर और संवध्द सामाजिक-आर्थिक कारकों के वीच भी सम्वन्ध स्थापित करने का प्रयास किया गया।

परिणाम : प्रत्यक प्रकार के डाक्टरों में विश्लषण के उदार दिशानिदशा के वावजूद विवेकपूर्ण नुस्खों का अनुपात कम था और अविवेकपूर्ण नुस्खों का अनुपात अधिक था और आश्चर्यजनक वात यह देखी गई कि विवेकपूर्ण

लेखक चिकित्सीय और सामाजिक क्षेत्र के एक सक्रिय कार्यकर्ता हैं तथा वे एफ.आर.सी.एच. द्वारा संचालित उपरोक्त अध्ययन के मुख्य अन्वेषी थे।

नुस्खों का अनुपात और प्रति नुस्खा औसत अंक, डाक्टरों की शैक्षिक योग्यताओं के साथ बढ़ते हैं।

सभी प्रकार के डाक्टरों के नुस्खों का एक बहुत बड़ा अनुपात ऐसे नुस्खों का था जिसमें अविवेकपूर्ण गैरज़रूरी/ खतरनाक दवाएँ और गैरज़रूरी इंजेक्शन या तीन से अधिक दवाएँ लिखी गई थी।

निजी क्षेत्र के नुस्खों की अपेक्षा, सार्वजनिक क्षेत्र के नुस्खे अधिक विवेकपूर्ण हैं। हालाँकि, सार्वजनिक क्षेत्र में अविवेकपूर्ण इन्जेक्शनों का अनुपात निजी क्षेत्र की अपेक्षा कुछ अधिक पाया गया।

नुस्खे लिखने के व्यवहार को प्रभावित करने वाले घटक

इस अन्वेषी अभ्यास में हमने विवेकपूर्ण चिकित्सीय जरूरतों को छोड़कर कुछ ऐसे कारकों का अध्ययन किया, जो सातारा जिले में डाक्टरों द्वारा लिखे जाने वाले नुस्खों के व्यवहार को प्रभावित करते हैं, जैसे, डाक्टरों को निरन्तर चिकित्सीय शिक्षा (सीएमई) का स्तर, दवाओं की कम्पनियों की विपणन नीतियाँ, डाक्टरों के मध्य प्रतिस्पर्धा का स्वरूप व प्रसार, दवाओं की उपलब्धता, मरीजों की सामाजिक-आर्थिक स्थिति, इत्यादि।

परिणाम : यह बात ध्यान देने योग्य है कि निजी क्षेत्र में सी एम ई लगभग पूर्णतया व्यक्तिगत डाक्टरों की इच्छा पर निर्भर है और यह देखा गया कि केवल 12.6 प्रतिशत डाक्टरों ने ही, दवाई कम्पनियों द्वारा प्रकाशित आवधिक पत्रिकाओं के साथ-साथ, चिकित्सा से सम्बन्धित किसी अन्य पत्रिका को पूर्व क्रम किया।

डाक्टरों के लिये, दवाई कम्पनियों द्वारा छापी गई जानकारियों, (जैसे, पैम्फलैट और आवधिक पत्रिकाओं) के माध्यम से किया गया प्रचार और दवाई कम्पनियों के प्रतिनिधि ही, 'निरन्तर चिकित्सीय शिक्षा' के सबसे महत्वपूर्ण स्रोत हैं। हालाँकि इस प्रकार का साहित्य, प्रचार करने वाला और इसीलिये सम्बन्धित कम्पनियों के प्रति में पक्षपातपूर्ण होता है, फिर भी इसे 68.1 प्रतिशत से अधिक निजी क्षेत्र और 50 प्रतिशत से अधिक सार्वजनिक क्षेत्र के डाक्टरों द्वारा शिक्षा के स्रोत के रूप में मान्यता दी जाती है।

दवाओं के मूल्यों ने भी नुस्खों के स्वरूप को महत्वपूर्ण रूप में प्रभावित किया। दवाओं के बढ़ते हुए मूल्यों के कारण, डाक्टरों द्वारा दवाएँ देने का तरीका भी बदल गया है। हालाँकि एक महँगी दवा को नुस्खे में लिखना, डाक्टर का ऊँचा स्तर दर्शाता है, फिर भी ऐसा पाया गया कि डाक्टर इसके लिये सावधान रहते है कि नुस्खे में लिखी गई दवाओं का मूल्य रोगियों की आर्थिक क्षमता के भीतर ही रहे, क्योंकि अधिक मूल्य की दवाएं लिखने पर गरीब रोगियों के सामने मुश्किल पैदा हो सकती है।

दवाओं के बढ़ते हुए मूल्यों की वजह से डाक्टरों के सामने महँगी दवाएँ देने के साथ-साथ अपनी फीस भी लेने में कठिनाइयाँ आती थीं। इसलिये कई डाक्टर स्वयं कम दवाएँ देते थे और नुस्खे में अधिक दवाएँ लिखते थे।

पीएचसी में दवाओं की कम आपूर्ति के कारण चिकित्सा अधिकारियों को बाहर बाज़ार से दवाएँ खरीदने के नुस्खे देने के लिये बाध्य होना पड़ता था। हालाँकि, चिकित्सा अधिकारी ऐसे नुस्खे लिखने से पहले रोगियों का सामाजिक व आर्थिक स्तर भी देखते थे और 'बाहर' की दवाओं के नुस्खे 'महत्वपूर्ण' रोगियों, आदि के लिये ही लिखते थे।

डाक्टरों की बढ़ती हुई भीड़ की वजह से, निजी क्षेत्र के डाक्टर, रोगियों को अपनी ओर खींचने और अपने पास बनाए रखने के तरह-तरह के उपाय खोजते थे, इसकी वजह से भी नुस्खे लिखने के तरीकों में बदलाव आया। गैर-जरूरी इन्जेक्शनों और दवाओं को कूट भेषज के रूप में देने, अधिक मँहगी दवाओं के नुस्खे लिखने, जिससे कि रोगियों की यह धारणा, कि दवा जितनी अधिक मँहगी होगी, उतनी ही अधिक प्रभावी, को संतुष्ट किया जा सके, आदि सभी ऐसी ही नीतियाँ हैं जिनसे कि रोगियों को अपने ही पास बनाए रखा जा सके।

पीएचसी की नर्सों का सामान्य दवाओं के विषय में ज्ञान

इस अध्ययन से यह ज्ञात करने का प्रयास भी किया गया कि पी एच सी की नर्सें, रोगियों के लिये जिन दवाओं का सामान्य रूप से प्रयोग करती हैं, उनके विषय में उनके ज्ञान का क्या स्तर है और इस प्रकार परोक्ष रूप से इन नर्सों द्वारा दवाओं के इस्तेमाल का अध्ययन करने का प्रयास किया गया। अध्ययन से ज्ञात हुआ कि पी एच सी में काम करने वाली नर्सों को, उनके द्वारा इस्तेमाल की जाने वाली दवाओं, विशेषकर उन दवाओं के इस्तेमाल के दौरान ली जाने वाली सावधानियों के विषय में निरन्तर चिकित्सीय शिक्षा (सीएमई) देते रहने की आवश्यकता है।

दुकानों पर (ओटीसी) दवाओं की अवैध बिक्री

सातारा में, एक औषधि विक्रेता द्वारा एक दिन में, केवल नुस्खे के आधार पर बेची जाने वाली दवाओं को, बिना नुस्खे के सीधे बेचे जाने (ओ टी सी) के तरीकों और मात्रा के अध्ययन से ज्ञात हुआ कि सभी प्रकार की दवाएँ, बिना किसी नुस्खे के, बिक्री के लिये उपलब्ध थीं। उस दुकान पर, एक दिन में, ओ टी सी बिक्री रू. 497.99 की थी, जो कि दवाओं की कुल बिक्री, रू. 4,436/- का 11.23 प्रतिशत थी।

अनियमित नुस्खों के कारण आर्थिक अपव्यय

इस अध्ययन द्वारा, सार्वजनिक व निजी क्षेत्र में, डाक्टरों द्वारा अविवेकपूर्ण दवाओं के इस्तेमाल से होने वाले अपव्यय का भी अनुमान लगाया गया। यह देखा गया कि इन अविवेकपूर्ण नुस्खों के कारण, दवाओं पर किये जाने वाले खर्च का 63.6 प्रतिशत खर्च व्यर्थ में किया जाता है. निजी क्षेत्र में इसका अनुपात (55.4 प्रतिशत) से कहीं अधिक है। भारत में रूग्णता

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की दर के उपलब्ध अनुमानों के आधार पर, समुदाय में और सातारा जिले के पीएचएफ के बाह्य रोगी विभाग (ओ पी डी) की 1991-92 की उपस्थिति के अनुसार, यह अपव्यय, निजी व सार्वजनिक क्षेत्र में प्रति दिन, प्रति नुस्खा, क्रमशः रू. 4.76 व रू. 2.08 था। यदि इस सातारा जिल की परी जनसख्या (1991) क लिय अनमानित किया जाय ता यह अपव्यय रू. 17.70 कराड़ का हाता ह।

सार्वजनिक स्वास्थ्य सुविधाओं में बाहर की दवाओं के नुस्खों का अनुपात

जो रोगी, इलाज के लिये सार्वजनिक स्वास्थ्य सुविधाओं (पीएचएफ) का उपयोग करते हैं, उन्हें अपनी बीमारियों के इलाज हेतु आवश्यक सभी दवाएँ पीएचएफ से मुफ्त मिलनी चाहिये। परन्तु यह एक आम शिकायत है आर अध्ययन क दारान हमन भी दखा कि पीएचएफ क डाक्टर रागिया का, कछ दवाआ क 'बाहरी नस्ख' दकर, उन्ह बाज़ार स खरीदन का कहत ह। हमन, एस नस्खा की वजह स, रागिया द्वारा किय जान वाल खच का भी अनमान लगाया।

परिणाम : सातारा जिले में, 1993 के जाड़े में, एक दिन में, सार्वजनिक स्वास्थ्य सुविधाओं के अनियमित रूप से चुने गये 145 बाह्य रोगी विभाग (ओपीडी) में आये रोगियों के लिये, ऐसे बाहर की दवाओं के, नुस्खों में खर्च का औसत 82 पैसे प्रति रोगी रहा। (यह बात ध्यान देने योग्य है कि इन 145 रोगियों में से, बहुत से रोगियों को कोई भी बाहर की दवाओं का नुस्खा नहीं दिया गया था)।

छोटे व बड़े शहरों में भी, उपलब्ध दवाओं के मूल्य के अनुपात में, रोगियों द्वारा बाहर से खरीदी दवाओं का मूल्य, शून्य से 221.5 प्रतिशत के बीच था, औसत रू. 7.97 का था, जो कि सभी केन्द्रों (शहरी व ग्रामीण) के लिये प्राप्त इन्हीं आँकड़ों से कहीं अधिक था।

अतः सातारा जिले में, पी एच एफ में, बाहर की दवाओं के नुस्खों का कुल अनुपात बहुत अधिक तो नहीं परन्तु काफ़ी है। रोगियों द्वारा खरीदी जाने वाली दवाओं का वर्तमान औसत 15 प्रतिशत है, जो कि अधिक तो नहीं परन्तु अवांछनीय है और इसे शून्य होना चाहिये।

उद्देश्य

प्राथमिक स्वास्थ्य केन्द्र के बाह्य रोगी विभाग (पीएचसी-ओपीडी) में रूग्णता के पैटर्न का अध्ययन करना और दवाओं की औसत आवश्यकता और पी एच सी के दवाओं के बजट का, इस आधार पर अनुमान लगाना कि पी एच सी-ओ पी डी में आने वाले प्रत्येक रोगी का पर्याप्त और विवेकपूर्ण रूप से इलाज हो।

परिणाम : अध्ययन के अन्तर्गत आने वाले छह पीएचसी के ओपीडी के स्तर की उपचारीय/लक्षणों के आधार पर देखरेख के लिये दवाओं की आवश्यकता, औसतन प्रति पी एच सी रू. 67418/- और प्रति रोगी रू. 11.68 की थी (इसमें टी.बी. और कुष्ठ रोग के रोगी शामिल नहीं हैं)। इन छह पीएचसी की उपचारीय और लक्षणों के आधार पर देखरेख के लिये दवाओं की आपूर्ति, जिसे कि इस अध्ययन के पहले भाग में ही ज्ञात किया गया था, प्रति पीएचसी रू. 37,134/- की थी। अतः प्रति पीएचसी रू. 30,280/- की कमी थी, जो कि वर्ष 1991-92 में प्रति पीएचसी, रू. 3,63,000 के वार्षिक आवर्ती खर्च का 8.34 प्रतिशत है। अतः यदि पीएचसी के आवर्ती वार्षिक खर्च को पीएचसी में दवाओं की आपूर्ति बढ़ाने के लिये केवल 8.34 प्रतिशत बढ़ा दिया जाय और यदि दवाओं की समस्त आपूर्ति का विवेकपूर्ण रूप से इस्तेमाल किया जाय, तो पीएचसी - ओपीडी में आने वाले सभी रोगियों का इलाज पर्याप्त रूप से किया जा सकता है।

निष्कर्ष

सातारा जिले में कुल दवाओं की न्यूनतम आपूर्ति, निजी और सार्वजनिक क्षेत्र में क्रमशः रू. 21.28 करोड़ और रू. 0.56 करोड़ की थी। यह आपूर्ति सातारा जिले की दवाओं की सम्पूर्ण आवश्यकता को पूरा करने के लिये पर्याप्त से भी अधिक है। अतः आज सातारा जिले की दवाओं की आवश्यकताएँ, संसाधनों की कमी से नहीं, बल्कि अविवेकपूर्ण इस्तेमाल से उनके अपव्यय के कारण पूरी नहीं हो पाती हैं। ❑

*(हिन्दी अनुवाद : **मीता श्रीवास्तव**)*

(Contd. from pg. 5)

Conclusion

In the above comparisions the drug policy of Bangladesh comes across as a bold initiative taken to make the policy more consumer friendly even at the cost of the profits of pharmaceutical MNCs. India, which is blindly opening its economy to all multinationals should take some lessons from Bangladesh and resist any attempts to be coerced into sacrificing the interests of its own citizens. The policy should be formulated only after discussions at various levels with professional bodies, health groups, rational drug groups, consumer groups and voluntary and people's organisations so that any unhealthy imbalance profiting only a certain section of the people is avoided.

Compiled from the IIHMR press clippings and the publication 'Banned and Bannable Drugs' published by Voluntary Health Association of India. ❑

FREE ABSTRACTING

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The views expressed in the articles are those of the authors and not necessarily those of FRCH

Edited by Vaijayanti Aphale with assistance from Rajesh Ingle. Produced by the Foundation for Research in Community Health, 3 &4, Trimiti B Apts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Omega Offset, Maratha Colony, Tilakwadi, Belgaum - 6.

IB 5/5/97

The Foundation for Research in Community Health

frch

NEWSLETTER

Vol. X, No.5 Sept.- Oct. 1996

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Decentralised Health Care Management in African Countries

Bamako Initiative

Dr. S. N. Morankar

In the first part of this article published in the July-Aug.'96 issue of FRCH Newsletter, the drug procurement and supply management practices under the Bamako Initiative were highlighted. This concluding part discusses the community financing and management practices evolved therein.

Along with access to quality drugs and health care delivery systems, the key strategic elements of the Bamako Initiative are community financing, supervision and training, and management and information systems.

Community Financing

Three basic alternatives exist for community financing : 1) A fixed consultation price (regardless of the type of treatment); 2) Direct payment for drugs (at prices proportional to their real costs); and 3) Pre-payment schemes where periodic contributions are made, independent of whether one uses the health services or not.

Both Benin and Guinea have chosen a community financing system which combines the first and second alternative - a price paid for the complete treatment. This price is set as a function of the actual costs of drugs provided for treatment. However in certain vital treatments, prices are standardised. Every health problem has a single corresponding price, even if several alternative treatments exist.

Dr. S.N. Morankar has done his PhD in Anthropology and is a researcher on the TB project carried out by FRCH

Because the revenue is directly proportional to drug costs, such a system reduces the risk of bankruptcy; with a fixed consultation payment or pre-payment, over-prescription can lead to financial problems. Cost variability at the health centre level is mainly due to variability in the quantities of drugs used.

In contrast to a pre-payment system, the pricing system used in Benin and Guinea has the advantage that revenue increases as health service utilisation increases though, if utilization is low, there is a risk that the fixed operating costs might not be recovered. Since the price covers the complete treatment it encourages patients to finish their treatment, in contrast to a system where they pay for each drug.

Ethically however, this system, like payment of drugs or a fixed consultation price, places the financial burden on the sick. Moreover, unlike the fixed consultation price, this system could cause difficulties in payment for patients suffering from severe illnesses requiring expensive treatments. To redress this anomaly a system of internal subsidies has been instituted.

The pricing system in Benin involves the identification of those costs that have to be recovered from community financing system revenue namely, a) essential drug costs, b) total fixed costs, c) village health workers' remuneration and, d) personnel incentives. Assuming an effective payment rate of 75% of expected or theoretical revenue, the treatment price should be about three times

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the drug costs of that treatment.

To mitigate the inequity caused by putting the burden of payment on the sick, the pricing system has been adjusted in accordance with the seriousness of the illness. Chronic diseases with prolonged treatment, such as tuberculosis, leprosy etc. are treated free of charge as these programmes are assisted by external aid organisations. Moreover, revenue generated from curative care finances the cost of preventive activities.

Budgeting :

In Benin each health centre has created a managing committee consisting of community representatives and health staff. The committee prepares budgets at the end of the financial year of the total revenue collected in that year minus the authorised expenditures to cover petty operating costs.

Benin has created seven main budget items to be allocated resources in order of priority : a) Drugs and information tools, b) Petrol for the cold-chain and sterilization, c) Petrol for the vehicles, d) Office supplies, e) Incentive payment for health staff, f) Repairs of vehicles and refrigerators, and g) Other investments.

Once these mandatory items have been included in the budget, the management committee and the health centre staff can decide how to use the remaining funds. A proportion of revenue, corresponding to the value of drugs and information tools consumed, is blocked in a bank account and constitutes a reserve fund, for as long as UNICEF continues to support these drug and information tool costs.

Training and Supervision

Training :

* Technical Training : A single technical training session focused on three key areas : EPI techniques, cold chain maintenance and management, and flow charts. In flow chart training, the nurses themselves developed their own flow charts, supervised by physicians and assisted by clinical specialists.

* Training of management committees : Resolving the health problems in the community requires that the various parties in the committee have skills in several domains : drug management, management of financial resources, supervision, monitoring of coverage, social mobilization etc.

Management Committees consist of three to five members including the physician or nurse in charge of the health centre and at least two representatives selected by the community itself. Committee members participate in programme management, especially in the monitoring and supervision, during which ongoing training for committee members is provided by the facilitators. District medical officers and staff from other related sectors are appointed as facilitators for the management committees' training.

Supervision :

Supervision, a very important aspect of the programme, aims to change health staff behaviour, to ensure good service quality, and to reinforce training. The programmes adopt systems of formative supervision which focus on improving health skills, instead of negative sanctions.

Supervision teams spend one day in each health centre, where they examine the quality of curative care (checking the extent to which the flow charts are being followed), the quality of MCH activities, and the soundness of the drug & financial management. The supervision is carried out through direct observation of health staff at work, and by record analysis. The supervisors try to avoid any direct intervention in the activities of the health staff; they are present during the consultations without influencing the health worker, and only intervene when asked by the health worker or when their silence would permit harm to be done to a patient. The supervisor then gives his assessment of the activities he observed. He congratulates the health staff for positive results and opens up a dialogue on corrective action. The supervisor/medical officer also carries out monthly supervision of prices and treatments and of drug prescriptions by random checks of relevant files. Monthly supervision of financial management too is monitored similarly.

As a result of this approach a team spirit has developed between supervisors and health staff. In fact the health staff have often requested more frequent supervision visits. Also, health staff skills have improved and a number of weaknesses in the system have been identified. Supervision appears to have contributed to sensitizing health staff about the problems stemming from indiscriminate over prescription : although it could increase revenue, it jeopardizes the quality of care.

Management and Information System

The Bamako initiative has contributed significantly to developing managerial and organizational skills at all levels. Bi-annual health centre monitoring and micro-planning systems, in place in Benin, Cameroon, Guinea, Glainea-Bissau, Mali, Nigeria and Senegal, enable health centres to monitor coverage, identify problems and determine solutions twice yearly. District health staff and communities, through their health committees, are involved in the process. In Kenya, a community-based monitoring system, known as the "Chalk and Board" system, is managed by community health workers who collect data, compile it and record it each month on a chalkboard displayed at the community pharmacy. The

information is discussed by the community and serves as the basis for planning health activities.

Any information registered at a given level of the system has to be used directly at that level by health staff responsible for its collation. Only information essential for one of the following purposes is retained : a) The provision of direct health services (e.g. MCH, treatment); b) Local management of resources and activities (e.g. drugs & financial management scheduling of outreach sessions);c) Supervision of quality of care and management; d) Monitoring of coverage, drug use and cost recovery. This way the information recorded is minimised and repetitions are avoided.

Information sources :

The key information sources are maternal cards and child health cards, curative care registers, treatment booklets, stock forms, drug and revenue registers, account books etc.

These various information sources serve several purposes like direct service activities, management, supervision and monitoring. Such integrated use of information ensures coherence in the Bamako Initiative-PHC information and management system. It provides several levels of control while avoiding multiple recording of the same information.

Logistical Support

Besides monitoring of drug supplies, which has already been covered in the previous article, transport is one of the main elements of logistical support. Under the Bamako Initiative national and provincial/regional directorates are provided pick-up vans to be used for various purposes like delivery of material like vaccines, pre-packed kits of essential drugs, etc.; supervision and monitoring in the periphery and for starting community health care centre activities and vaccination campaigns.

Some Reflections on the Bamako Initiative

In the areas where the Bamako Initiative has been implemented, it has contributed to making low-cost, quality drugs accessible to the majority of the population. Community managed health services have been able to generate sufficient resources to cover total essential drug costs and some small local expenses. For eg. in Mauritania, patients living in villages where the Bamako Initiative has been adopted spend on an average the equivalent of US $ 12 per capita annually (including costs of transportation), compared with US $ 21 in villages without the initiative.

Yet, in depth evaluation of the Initiative conducted by the London School of Hygiene and tropical medicine in 1991 revealed the following areas in need of attention :

* While the Bamako Initiative has made progress in ensuring the availability of low-cost drugs, many other determinants of the quality of care like correct case management, communication between patients and health workers and attendence of health workers have yet to improve.
* In the area of drug use, better ways must be found to train providers in appropriate prescription practices to ensure that they respond to their training rather than to other incentives, including financial ones, that may encourage over-prescription or the inappropriate use of drugs.
* So far, most efforts have been directed towards community involvement in the financing and administration of basic health services - community based preventive care has yet to be addressed. Improvement in the public accountability of health services and elected bodies is also needed, and users's sense of ownership of health programmes and their supporting institutions must be developed. A major challenge is presented by women, who, up to now, have played only a limited role in the implementation of Bamako Initiative strategy - their active participation is crucial to ensuring its effectiveness , and sustainability.
* Efforts to decentralize health care management must go hand in hand with the strengthening of managerial capacity at all levels and a reallocation of resources in favour of peripheral services.
* Local capacity to purchase high quality drugs at reasonable prices remains weak and the use of generic drugs still encounters resistance. Urgent action concerning cost-effective drug procurement and distribution systems is necessary.

From its inception equity has been at the centre of the controversy surrounding the Bamako Initiative. While it has been shown that even poor households are often willing to pay moderate fees for services of reasonable quality, policies and strategies for reaching the poorest of the poor still await. In many countries, fees of patients who cannot afford to pay for health care are waived off, but clearer guidelines concerning the use of waiver and exemptions are needed. Local health committees must be involved in the planning and application of fee waiver mechanisms.

A major obstacle to improving the efficiency of health care delivery is the crisis in health personnel : health workers go for long periods without pay, their salaries do not keep pace with inflation and they often go without in-service training, support and supervision.

Besides redressing the above problems, two conditions

(Contd. on pg. 5)

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From Community Participation to Community Action

Parinche Project in the Light of Bamako Initiative

Dr. R. V. Banpel

FRCH is presently involved in imparting participatory training to *tais* (local women) at Parinche, a village in the Saswad taluka of Maharashtra, on a wide range of subjects such as health, non-formal education, public information, village libraries, veterinary care, repair of hand-pumps and economic activities.

When we talk of community participation emphasis is on participation of the community in the programme/ activity centrally planned by the intervening agency (NGO, Government etc.). Though of a greater value than existing vertical programmes, participatory programmes like the Bamako Initiative infuse community participation more to ensure the success of the essentally vertically planned programmes and to obtain funding from international funders and/or from the beneficiaries themselves.

At Parinche we seek to go one step further where it is our organisation (FRCH) that participates in the activities/ programmes of the community and not the other way round. The community takes the initiative in deciding exactly what inputs it wants from us and how it is going to utilise them. Within the community our emphasis is on interacting with women as we feel they are better suited to carry out the task. Eventually we expect the community to be completely independent with the community evaluation of the work of the *tais* through village committees formed by the community.

Content of Training

The various broad areas (which have a high ratio of inter-connectivity) to be covered in the training are :

* Health - human and veterinary
* Environment - kitchen gardens, water, sanitation etc.
* Telemedicine and Grameen Bank
* Civic affairs - political and judiciary system
* Cultural activities - local culture with modern rational inputs
* Communication skills and participatory research methods - participatory management, evaluation, survey etc.

Provision of information to the community about the various government schemes meant for them, the financial provision for village development, the subjects under the jurisdiction of local self government, rights and duties of the people under Panchayati Raj etc. becomes an important input in the community action process. This information is expected to increase vigilance of the people and thus accountability of the government officials leading to proper channelisation and utilisation of resources meant for the village level hand-in-hand with resources generated locally.

Community Financing

The Bamako Initiative has experimented with the following alternatives of community financing : a) Fixed consultation price; b) Direct payment of drugs; c) Pre-payment scheme. Though each of these alternatives has its own advantages a common flaw is that the very poor are left out in such a system.

At Parinche the population has been grouped into units of 1500 which is to be catered to by one full time and three part time tais. Their payment is made on the basis of opportunity cost i.e. each *tai* should recover at least the amount that she would have earned from some alternative work like for eg. farm labour wages. Services rendered viz. drugs, immunisation, village libraries etc. will be charged extra depending upon the actual cost.

Economies of scale:

As per the pricing system in Benin and Guinea, revenue increases as the health service utilisation increases with the danger that low utilisation will lead to non-recovery of even the fixed operating costs. But since the infrastructure at Parinche is to be used for many activites as mentioned above, even if one particular service like health is not utilised enough, revenue earned from overall utilisation of all activities should generally manage to cover the fixed costs.

At present FRCH is taking on the responsibility of helping the community for providing the finances but eventually the financial burden will have to be borne by the community itself through any method it finds convenient and in the interests of the whole community. In our various community level meetings, mahila mandal meetings, *tais*' training sessions, the following suggestions from the community have come up for financing the above activities :

* Provision of funds from Panchayats
* Contribution from collections on various occasions at the village level like annual fairs, Ganapati festivals etc.
* Direct house-to-house collection of money on an ability to pay basis.

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* Contribution from milk and other cooperatives
* Surplus income from activities such as 'Grameen Bank'.

Supervision

As mentioned earlier, the logic of community action would hold true only if eventually the tais learn to function independently and are accountable only to the community of which they are a part and they are to serve. Such a process of community self-management would be activated by forming a village committee consisting of elected women members of the Panchayat, mahila mandal members, local school teachers (women) and senior female citizens from the community. This list is subject to change according to their availabilitya and the desire of the community. The members of the community will be selected after consulting the people in the Gram Sabha. The important functions of the Village Committee are :

* Monitoring the activities of *tais*
* Purchasing and pricing of drugs
* Fixing charges for community services like immunisation of cattle, village library etc.
* Deciding upon variation in charges for different beneficiaries according to ability to pay.

Openness is the key word in community self-management. The village committee will periodically hold meetings with the community to inform them about the various activities undertaken by the *tais*. The community will be encouraged to give a continuous feedback on the work of the *tais* which will act as an effective tool of participatory evaluation of the work of *tais*.

Conclusion

Looking at the Parinche project in the light of the Bamako Initiative the following improvisation in our approach is evident :

* Parinche project does not look at health alone
* It is a women oriented programme
* It is primarily a social experiment
* It has a possible long-term high-intensity coverage
* and last but not the least, it is a process of mutual learning.

(*With inputs from* ***Seema Deodhar***) ❑

(**Contd. from pg. 3**)

are indispensable to the success of the Bamako Initiative : maintenance of the population's purchasing power and continued payment of salaries of health workers at sufficient levels. This needs a stable political situation with sound socio-economic development aims, particularly sub-saharan African countries. Without these two conditions, the fragile balance between the household's ability to pay for their health and cost recovery of the health system will be broken. This, in turn, could lead to a further erosion of purchasing power, failure of community financing programmes, the downfall of the health system, and a drop in the level of health protection. If these conditions are met, the health system's reorganization in lines with the Bamako Initiative principles will be able to contribute to the alleviation of some of the health risks and to a reduction of infant and maternal mortality, even in the context of an economic crisis.

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A 'Burning' Issue

Hospital Waste Management

Shriniwas Indapurkar

Every city in India is dotted with private and public hospitals, which treat hoards of patients daily. Neither any of the hospital staff, nor the endless stream of patients they cater to, seem to give a thought to the waste generated in the course of their treatment, oblivious to what a health hazard this waste may become. Hospital waste is potentially dangerous, even fatal at times. Yet, unlike other aspects of the working of hospitals like the integrity and efficiency of doctors, the (un)hygenic conditions in the hospitals etc. which come under public scrutiny, the vital issue of disposal of hospital waste seems to be ignored by most.

Why Hazardous?

Almost every operation undertaken in an hospital involves the use of cotton and/or bandage to wipe and dress wounds. This used cotton gauge or bandage inevitably finds its way into the hospital garbage carrying with it hordes of germs and infected tissue. Same is the case with used operation gloves, syringes, surgeons knives, scissors etc.

Allopathy believes in operating upon and if necessary removing any organ within the body that does not function properly. These diseased unwanted organs also form a part of hospital garbage.

Hospitals are frequented by people with various diseases. The body excretions of such patients whether saliva, blood or excreta are infected with germs. If left untreated and exposed these germs enter the atmosphere infecting other patients and hospital staff.

Pathology laboratories contain samples of stools, urine, blood etc. which are often infected and also germs and/ or viruses cultured in the laboratories in the course of various experiments. The chemicals used in such experiments as well as the infected tissue samples etc. are disposed off into the garbage from where the germs spread elsewhere. Contaminated plastic ware used in the laboratories is similarly discarded into the garbage bins.

Unless all such hospital waste is sterilised and detoxicated, prior to disposal, it could be instrumental in spreading infection and even starting many epidemics.

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Waste Treatment

Few hospitals bother to treat such infected waste and dispose it in a manner as to render it harmless. Otherwise, a large part of the total hospital waste finds its way untreated into the municipality bins. There has even been a case of dissected organs being found near bins placed in residential areas.

In India and other developing countries many scavengers collect useful reusable material like knives, plastic containers tubes etc. This garbage helps them to earn about Rs.10 to Rs.12 per kg. The syringes sold therein maybe reused, often without properly sterilising them, making a mockery of the stress upon using disposable ware for preventing cross infection. In Delhi, it was found that the cotton used in hospitals was bought from the scavengers at wholesale rates by those making quilts and mattresses. Thus, while on the one hand hospitals cure patients of diseases, on the other hand they are also conducive to spreading them.

Incinerators

According to the Supreme Court order of 2nd March'96, all hospitals containing more than 50 beds have to provide for incineration (burning) of hospital waste. The Environment Ministry has also dictated that all hospitals having 30 beds or a turnover of 1000 patients per month have to make the above provision. But all these laws remain on paper and to date only a few large hospitals follow this practice. For example, in a study conducted in Delhi, where the rate of errant hospitals including large ones is very high, it was found that only 20% of the hospitals have a provision for treating their waste. In some hospitals including a few from Pune, the waste is burned in the open. Moreover, in many hospitals which provide incinerators the temperature therein can be increased only to 400°C or 500°C when in effect, for burning the waste adequately a minimum temperature of 1200°C is required.

Such practices of burning the waste in the open or at temperatures much below the required level lead to the escape of toxic gases into the atmosphere and increase the atmospheric pollution posing a grave danger to the nearby residents. A voluntary organisation 'Srushti' which had conducted a survey of hospitals in Delhi reports that burning the waste, especially if done in an improper manner, was not going to put an end to the problem as it merely changes the physical or chemical

composition of the waste. The toxins are released into the atmosphere in fluid forms which pose an even greater danger to the health of the people.

In a similar study conducted in Denmark it was concluded that while the total hospital waste would amount to one percent of the total municipality garbage, the same waste when converted into toxic gases like dioxin forms a staggering 30% of the total atmosphere. Other heavy gases like Cadmium are also emitted in the process. This shows that burning the waste cannot be an answer to the problem and alternative less harmless techniques have to be evolved for disposing off the waste.

Developing countries like India have passed laws for incineration of hospital waste. But for complete incineration to take place a certain minimum quantity of waste is required, a condition which many small hospitals are unable to fullfill as only a small quantity of waste is generated at any particular time. Incineration of such inadequate quantity of waste prevents the waste from being burned fully and generates many toxic by-products.

When the waste is burned down to ash which is carelessly thrown into public bins or even out in the open it again adds to atmospheric pollution. Unfortunately, there are no proper guidelines for the disposal of such ash either at the national or the international level.

Who Bears the Brunt?

As explained earlier, hospital waste carries various germs with it which can spread many diseases among the people. The gravest danger is posed to scavengers, many of whom are small children, who handle the waste to separate out reusable material.

Many stray or pet animals are found to frequent the garbage bins in search of food. These animals can also get infected due to the various germs contained in the garbage. Moreover, they can get cuts with the infected needles and knives carelessly thrown into the garbage which also fester with germs which are spread to other areas where the animals roam about. If the animals are adopted by any family then that family is directly exposed to the germs carried by them from the garbage.

The garbage clearance system of the municipality is very haphazard. Overflowing public bins are kept exposed in residential areas for days which allows the germs to multiply and spread and infect the surrounding residents.

Hospital Waste Management

Today, hospitals in India are aping the Western model of disposing off waste by burning it in incinerators. But in the West itself the realisation is spreading that burning waste does not offer a solution to disposing it. Only the form and chemical composition of the toxic substances change, often for the worst.

A better alternative would be to train the hospital staff to take precautions in generating a minimum amount of waste in the first place. This way, the problem is tackled at the source itself. Whatever waste is then generated should be managed in a proper manner.

According to 'Srushti' the first step in waste management would be to sort out all the garbage into various categories like :

* Garbage directly reusable by the hospital like syringes, knives etc.
* Other recyclable garbage
* Garbage that should be incinerated
* Garbage that should be treated in some other manner to render it harmless.

It is important that all the reusable material from the garbage be adequately sterilised before usage. While reusing the material helps to tackle the problem of waste disposal it also reduces the cost of medical care. For eg. reusing the cathodes involved in heart surgeries significantly reduces the cost of the surgery. In dialysis too the same case holds true.

Thus, generating minimum possible waste, recycling the reusable garbage and detoxicating the remaining waste with appropriate methods is the key to hospital waste management.

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(*English Translation : **Vaijayanti Aphale***) ❑

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सार्वजनिक क्षेत्र

डॉ. एन.एच.आन्टिया

आज़ादी के समय, भारत के गाँवों मे रहने वाली ९२ प्रतिशत जनसंख्या को प्रतिबंधात्मक, प्रोत्साहक व इलाज की अन्य मूल सेवाएँ प्रदान करने के लिए, सार्वजनिक क्षेत्र की कल्पना की गई थी। गरीबी की वजह से इन लोगों में, निजी क्षेत्र द्वारा उपलब्ध सुविधाओं का लाभ उठाने की क्षमता नहीं थी। सार्वजनिक क्षेत्र की कल्पना, भोरे कमेटी द्वारा दी गई अवधारणा,'सभी के लिए बुनियादी स्वास्थ्य देखभाल' पर आधारित थी। इस अवधारणा के अनुसार, जन-आधारित, विकेन्द्रित प्रणाली का उपयोग, स्वास्थ्य की एक इकाई के रूप में किया जाना था। प्रत्येक २०,००० की आबादी पर एक प्राथमिक स्वास्थ्य केन्द्र व ७५ बिस्तरों वाले अस्पताल की स्थापना का भी प्रावधान था। भोरे कमेटी द्वारा दी गई अवधारणा की एकमात्र असफलता यह थी कि उसमें, बिना देशी पद्धतियों का प्रयोग किये व अपने लोगों की स्वास्थ्य संस्कृति पर उचित ध्यान दिए, स्वास्थ्य को चिकित्सा व्यवसाय पर अत्यधिक निर्भर दिखाया गया था। बड़े व कृषि-प्रधान देशों के लिए, जिनके पास सीमित आर्थिक संसाधन होते हैं, विश्व स्वास्थ्य संगठन ने अलमा आटा में सन् १९७८ में और आई. सी. एस. एस. आर./ आई.सी.एम.आर. कमेटी ने सन् १९८१ में, स्वास्थ्य के इसी दृष्टिकोण को दोहराया था। इस मॉडल की प्रभावशीलता को, न सिर्फ चीन व श्रीलंका ने, वल्कि अपने देश में, केरल और कई गैर-सरकारी संगठनों ने भी प्रदर्शित किया है। यद्यपि चीन, स्वास्थ्य पर अपने सकल घरेलू उत्पाद (जीडीपी) का केवल ३.५ प्रतिशत ही खर्च करता है, (इस ३.५ प्रतिशत में, २.१ प्रतिशत सार्वजनिक क्षेत्र व १.४ प्रतिशत निजी क्षेत्र पर खर्च होता है), पर उस देश में शिशु-मृत्यु दर प्रति हजार जीवित जन्मों पर केवल ३६ है, दूसरी ओर भारत में, स्वास्थ्य पर सकल घरेलू उत्पाद के ६ प्रतिशत खर्च होने के वाद भी, शिशु-मृत्यु दर प्रति हजार जीवित जन्मों पर ८७ है, जो कि वहुत अधिक और चिंताजनक है (इस ६ प्रतिशत में, केवल १.३ प्रतिशत सार्वजनिक क्षेत्र पर जवकि ४.७ प्रतिशत निजी क्षेत्र पर होता है)।

दुर्भाग्यवश, सार्वजनिक क्षेत्र के लिए, स्वास्थ्य की देखरेख के इस बुनियादी दृष्टिकोण पर निजी क्षेत्र पूरी तरह से हावी हो गया है। साथ ही इसे, राष्ट्रीय लक्ष्यों को प्राप्त करने के लिए, ऊपर से थोपे गए कार्यक्रमों का प्रयोग करने वाले, एक अत्यधिक केन्द्रीकृत व नौकरशाही प्रक्रिया में वदल दिया गया है। इन सभी का फैसला, दिल्ली में, अक्सर अंतर्राष्ट्रीय संगठनों और संस्थाओं के आदेशों पर होता है। स्वास्थ्य के इस दृष्टिकोण ने आम जनता को, प्राथमिक स्वास्थ्य केन्द्रों से दूर कर दिया है। विना लोगों की भागीदारी के, लक्ष्यों की प्राप्ति के लिए ऊपर से थोपे गए कार्यक्रम, जैसे परिवार नियोजन भी उचित परिणाम प्राप्त करने में असफल रहे हैं। इसलिए लोग, कठिनाइयों के समय, निजी क्षेत्र से इलाज कराने पर मजवूर हो जाते हैं और जाने-अनजाने इस मुनाफा कमाने वाले निजी क्षेत्र को वढ़ावा भी देते हैं। शहर के मेडिकल कालेजों से बीमारी के इलाज के लिए, विशेषज्ञों का प्रशिक्षण प्राप्त किए हुए डाक्टर, प्राथमिक स्वास्थ्य केन्द्रों में प्रवंधक चिकित्सक का कार्यभार संभालने के लिए, न तो प्रशिक्षित हैं और न ही प्रेरित। दूसरी ओर अपनी संस्कृति से अलग हो जाने की वजह से ऐसे डाक्टर, प्राथमिक स्वास्थ्य केन्द्रों में काम कर रहे कर्मचारियों को आवश्यक नेतृत्व देने में भी असफल रहे हैं। साथ ही, अक्सर, अवैध रूप से निजी डाक्टरी व्यवसाय करके, उन्होने अपने गलत उदाहरण से, कर्मचारियों को निराश भी किया है।

शहरों में, जहाँ अव हमारी जनसंख्या के २५ प्रतिशत लोग रहते हैं, सार्वजनिक क्षेत्र की सेवाएँ, राज्यसरकार, महापालिका या दोनों के द्वारा उपलब्ध करायी जाती हैं। शहरों में तेजी से वढ़ती हुई आवादी की वजह से, पानी, साफ-सफाई व अन्य सरकारी सेवाओं पर अत्यधिक दवाव पड़ रहा है और ये सभी सेवाएँ, जितनी भी उपलब्ध हो पाती हैं, झोपड़पट्टियों में रहने वाले लोगों की तुलना में, धनी लोगों तक अधिक पहुँचती हैं। शहरों में, सार्वजनिक क्षेत्र पर होने वाला खर्च, अधिकतर बीमारियों के इलाज के लिए सुविधाएँ जुटाने पर होता है। यह खर्च, अपर्याप्त कर्मचारियों और असमुचित सुविधाओं वाले हेल्थ पोस्ट, महापालिका के दवाखानों या डिस्पेन्सरियों और मेडिकल कालेजों से जुड़े हुए, आधुनिक सुवाधाएँ देने वाले वड़े-वड़े अस्पतालों पर होता है। इन सुविधाओं का उपयोग, शहर व गाँवों में रहने वाले गरीबों द्वारा किया तो जाता है, पर ये लोग, वहाँ रोगों कै इलाज कराने की आखरी कोशिश करने, अक्सर रोगों की विगड़ी हुई अवस्था में जाते हैं। स्वास्थ्य सेवाओं के एक अच्छे ढाँचे के अभाव में, इन मँहगी और विशेषज्ञों के इलाज को उपलब्ध कराने वाली संस्थाओं का, स्थानीय निवासी, ऐसी बीमारियों के लिए इस्तेमाल करते हैं, जिनका कि एक साधारण चिकित्सक द्वारा ही इलाज किया जा सकता है। ऐसा देखा गया है कि साधारण चिकित्सक अव धीरे-धीरे लुप्त होते जा रहे हैं।

सार्वजनिक क्षेत्र, अपनी तमाम कमियों के बावजूद, उन व्यक्तियों को, कुछ हद तक, स्वास्थ्य देखभाल उपलब्ध कराने में सक्षम है, जिनकी या तो निजी स्वास्थ्य सेवाओं तक पहुँच नही हैं या जिन्हें निजी क्षेत्र से स्वास्थ्य देखरेख कराने पर मजवूरी में खर्च करना पड़ता है। अतः सार्वजनिक क्षेत्र को, देश में लागू नई आर्थिक नीतियों के द्वारा मजबूत बनाने की आवश्यकता है, न कि कमजोर करने की।

(हिन्दी अनुवाद : मीता श्रीवास्तव) ❑

डा. एन. एच. आन्टिया, निदेशक व ट्रस्टी, एफ़एम.आर. व एफ़.आर.सी.एच. ने प्लास्टिक सर्जरी, कुष्टरोग व सामुदायिक स्वास्थ्य के क्षेत्र में सराहनीय कार्य किये है। प्रमुख कमेटियाँ जिन से सम्वद्ध होकर उन्होने कार्य किये, उनमें भारत सरकार की योजना आयोग स्वास्थ्य कमेटी भी शामिल है।

Edited by Vaijayanti Aphale with assistance from J.S. Puranik. Produced by the Foundation for Research in Community Health, 3&4, Trimiti B Apts, 85 Anand Park, Aundh, Pune - 7. Registered under the Bombay Public Trust Act. Printed at Abhyankar's TypeServe, 9 Brahma Siddhi, Prabhadevi, Mumbai -400025.

The Foundation for Research in Community Health

frch

NEWSLETTER

Vol. X, No.6 Nov. - Dec. 1996

Inter-linkages Between Socio-economic Factors and Access to Health Care

Maternal and Child Health - I

Anuradha Gupte

The health status of the people is increasingly being considered in a holistic sense as an integral part of their socio-cultural and economic background. Various studies have ascertained the linkage between the deprivation of opportunities for decent living and poor health. Deprivation does not merely refer to external and systemic factors like unhygienic conditions, pollution, lack of adequate health delivery systems, lack of adequate nutrition etc. but also the individual's capacity to take advantage of these externalities. This capacity is determined by resource constraints like income levels as well as socio-cultural constraints such as education and general awareness levels, freedom to take decisions etc. Thus the deprived would generally include the poor, the socially backward classes and women.

It is important to note that these socio-cultural and resource constraints are inter-linked in a manner such that the absence of one factor in many cases reduces the impact of the others. This is especially true in the case of women who even when economically well off, are usually incapacitated in socio-cultural terms to take maximum advantage of existing benefits in all fields including health. Since in early stages at least, the child is dependent upon the mother, the socio-economic background of the women automatically becomes an important variable in determining the child's access to health care in quantitative and qualitative terms. Thus inter-linkages between various factors affecting health are strongly present and can be easily demonstrated in maternal and child health (MCH).

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Economic Status and MCH

The poor often experience a higher morbidity and risk for early deaths than the rest of the population. ***In the global perspective, poverty is the most important determinant of poor health.*** It has been estimated that more than 75 per cent of differences in health between countries are associated with differences in income. Studies show that the so called tropical diseases are rather diseases of poverty and non-communicable diseases are diseases of limited rather than excess affluence. In this context, equity oriented economic growth becomes essential.

It has been observed that poverty entails poor health not merely due to lack of economic resources but the negative impact of other non-medical factors like food availability, awareness levels, environment, sanitation, quality of drinking water available and gaps in the application of knowledge available that are generally associated with poverty.

For instance, milk cooperatives have been used worldwide as a mechanism for raising the socio-economic status of families involved in the dairy business. The impact of this phenomenon was studied in the Delhi milk market. Evaluation studies by F.A.O.[1], U.N[2].,and W.F.P[3]. show that milk

consumption in this region has in fact declined. This is because milk cooperatives increase milk demand increasing milk prices. Hence, producers prefer selling all the milk and substituting it with cheaper calorie rich foods. Also, inter- community milk exchanges decline and families who continue to remain non-producers have to pay more for milk /milk products.

Where sale of milk to co-operatives replaces milk processing activities at home such as conversion to "ghee" and home consumption, female employment and nutrition in fact declines.

In such cases, *whether sufficient milk is retained for infants, expectant and nursing mothers, would depend on whether awareness levels of women have improved. Observations prove that cash incomes are not always spent in the most desirable way and that sex biases in nutrition do not immediately disappear.*

In Guatemala, the association between malnutrition and infectious disease for the rural population was studied. It was observed that improvement in nutritional status was not associated with improvement in health indicators like infant mortality rates and incidence of low birth weights. The study concluded that *improved economic conditions positively affect nutrition but do not appear to modify health in the absence of educational and health activities that are integrated into community development programmes.* With reference to access to food and nutritional outcomes, factors like lack of access to resources, inadequate education and intra household food allocation patterns favouring boys and adult males have been pointed out as significant factors.

Family Planning and MCH

It is often stated that female and child mortality and nutritional status of the child is likely to improve when there are fewer siblings. Family planning can reduce the total number of pregnancies, thereby decreasing a woman's lifetime risk of dying in childbirth, and it can reduce the number of deaths due to high risk pregnancies. Although, family planning does not make any difference to obstetric risks, it makes an enormous difference to the number of maternal deaths. ***If women have half as many babies, there will be half as many deaths related to pregnancy even without any improvement in obstetric services.*** In addition, by preventing unplanned and unwanted pregnancies, family planning can help decrease the number of women who risk their lives seeking unsafe abortion. Lower birth rates are also associated with increased child survival. Whatever the explanation for this phenomenon, where child health is concerned, several studies have shown that ***greater acceptance of family planning alone by poor populations has not necessarily resulted in striking improvements in child health and better nutritional status for their children.*** Therefore, it is obvious that fertility programmes cannot be a proxy for programmes for direct improvement of socioeconomic and nutritional status. India's health and nutrition drives are far from complete; therefore, it is not surprising that the family planning programmes have not had the desired impact. ***Much greater emphasis must be put on the mother, on improvement of her physical state, her economic state, her health and nutrition, and her education.***

Dynamics of Socio-economic Status (SES) and Maternal Health

SES	INTERMEDIATE FACTORS	OUTCOMES
Income, Education	Health and reproductive behaviour	Pregnancy, Complications, Maternal mortality
Access to food	Health status	
Status of women	Access to health services	
	Unknown factors	

If SES is to affect maternal mortality, it must be shown to have an effect on at least one of the intermediate factors, and this chain extended to one of the three outcomes. The three outcomes are sequential i.e. one cannot die a maternal death without first being pregnant. The three basic questions regarding influence of any factor are :

Will it affect the incidence of pregnancy ?
Will it affect the incidence of complications amongst pregnant women ?
Will it affect the outcome of obstetric complications ?

Anything that reduces fertility will reduce maternal deaths. Direct obstetric deaths may occur due to pregnancy complications, delivery complications and post-partum complications including abortions. Indirect obstetric deaths are those due to existing medical conditions, made worse by pregnancy or delivery, and include malaria, hepatitis, anaemia and rheumatic heart disease. In the developing world 25 per cent of obstetric deaths are of this type. The specific medical causes vary with the socio-economic development rather than with geographic or genetic factors.

(Contd. on page 7)

Socio-Cultural Aspects

Reproductive Health Problems of Rural Women

Seema Deodhar

FRCH is implementing a project at Parinche, the main focus of which is on training of competent local women (tais) in health and related aspects to function as 'development workers' with a focus on basic (primary) health care at the village level.

During our interaction with the women in the training sessions we got an important insight into the health problems of the rural women and the various factors inhibiting their ability to address these problems.

Initially, the women were reluctant to openly discuss specifically gynecological problems. To get them talking we began with discussions on general health issues and women's role in the society and secondary social status - a subject which generated much interest in the group. Through our discussions it was revealed that the rural women blame their low social status on their perceived limitations of the female body showing their acceptance of the logic of biological reductionism. This gave us the opportunity to take the discussion further by dymystifying the woman's body which was perceived in such negative terms. Through innovative means we got out their opinions about various natural phenomenon regarding the women's body. For eg. when asked about the menstrual cycle we were surprised to learn that they regarded menstrual blood to be spoiled blood flowing from the intestines. The fact that only women undergo this experience had further degraded the female body in their eyes. Through diagrams, demonstrations on a female child, domesticated animals etc. we explained to them the proper science behind the various processes in the female body and cleared many of their misconceptions. Thereafter, discussions concerning women's sexuality and reproductive health became free and open.

It was clear through our discussions that the medical problems of the rural women are in many cases a manifestation of their social status and the conditions they live in. These socio-economic conditions are not taken into consideration by health providers leading to an insensitive attitude during treatment. Victim blaming is common when in fact the providers needed to at least understand if not address the deeper issues concerning their medical problems.

Women complaining of vaginal discharge are easily castigated for not maintaining proper hygiene discounting the fact that in areas of water scarcity women often have to carry water for household use over a distance of 2 km or more. This leads to rationing of water for all puroposes, especially bathing. Also, there are no private bathing facilities in most dwellings, thus out of modesty the women cannot disrobe before taking a bath. Moreover, there are cultural inhibitions about touching the genitals which prevents them from cleaning these parts.

The notion of menstrual hygiene too is complicated in the context of social taboo on menstruating women. We found out that all the female members of a family use the same set of rags as sanitary napkins. Since the rags are considered as extremely polluting they are kept buried under a stone in the cattle shed under unhygienic conditions. It is obvious that using such clothing will lead to repeated vaginal infections.

Given this background, it is clear that mere symptomatic treatment is not going to be enough as the complications will persist and become chronic if the basic social conditions remain unchanged.

Another important example of social conditions having medical repercussions is the various cases of prolapsed uterus. It is shocking to realise how widely prevalent this condition is among rural women even at a very young age. One of the main reasons for this is marriage and subsequently first pregnancy at a tender age coupled with hard physical labour. Quite often the loads of firewood, water and food grains carried by them weigh more than their own body weight. Women of remote hilly hamlets in drought prone areas are the worst affected. The women are made to work approximately from six years of age with the load increasing proportionally with age. The women are not spared from this job even in pregnancy or post partum. After delivery they are forced to return to hard physical labour within 15 days if the child is a female and within a month if it is a male. Some of the traditional delivery practices like too much pressure being applied on the abdomen of the partiurating

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women by the birth attendant add to the problem. The other predisposing factor for this condition is nutritional deficiency.

The side effects of uterus prolapse are offensive smell, heavy vaginal discharge and painful scratches on the uterus. These side effects often led to rejection of the women by their husbands. Many women with prolapsed uterus are sent back to their maternal homes.

An example of a chain reaction of inter-linked problems which lead to the victimisation of such women can be described in the following case history. One of the rural women with prolapsed uterus experienced great pain during sexual intercourse. To avoid sex she pretended to be possessed by divine spirits and periodically went into a 'spiritual trance'. During this phase she would advise her husband to keep her body 'pure' for the Goddesse's entry. The husband respected this 'divine injunction' and alternatively used this as an excuse to enter into a second marriage. Now the 'possessed women' is sent back to her mother's place. Even though such strategies are initially consciously developed by women, after a point the women become psycho-somatic and hysterical. Even if medical intervention is sought few medical providers will link her mental stage to her physical state of prolapsed uterus.

Sex itself becomes an issue of suppression and occasionally, torture for the women. During our discussions with the women it was revealed that their husbands insisted on intercourse within few days of delivery without giving enough time for their bodies to heal. No wonder dyspanuria is a commonly voiced condition among rural women. Ironically, though it is common knowledge that women have hardly any say in their sex life, women with multiple pregnancies are often scorned by health providers in words like "*Tenvha Maja Watat Hoti Aata Ka Radata* (You should have thought of the consequences before indulging yourself)".

Other health problems commonly experienced by rural women- piles, body aches and backache, hyper acidity, urinary tract infection etc. can also be traced to basic social problems

Constipation is endemic among rural women for various reasons like lack of green vegetables and fibrous food, limited water consumption and retention of stool until dark due to lack of closed latrines. This chronic constipation often leads to piles.

Body ache and backache is universally found among rural women. The nature of their labour in the fields and domestic chores including gathering of fire wood, fetching of water over large distances results in over-utilization of specifics sets of muscles in single directions. This leads to isometric imbalance causing body ache.

Osteoporosis is prevalent particularly in areas near any milk cooperative. This is because all the milk is sold by the rural families to the cooperative, since this is the only income generating source for many families in rural areas, leaving none for domestic consumption. Where as, in villages without milk co-operatives there is a chance that the women might consume some of the milk left. Clearly the law of economics has taken precedence over family nutrition.

Other nutritional deficiency diseases like anaemia and night blindness are common in the village areas. In case of pregnancy related night blindness women are recommended 21 days of carrot consumption. Fifty years ago carrots did form the staple diet in this region. However, poverty and ignorance along with a change in their traditional lifestyle due to commercialisation has led to a decrease in the nutritional value of their food intake. Though palak and other types of spinach are now cultivated along with carrots, their consumption has declined as they are produced purely for the market.

Where mental illness is concerned, the feature of all pervading patriarchy is now commonly accepted as an underlying cause of most cases of mental disturbance among women. Severe limitations on opportunities to express one's personality and great restrictions within the traditional setup leave no outlet to women undergoing stressful situations. Widespread prevalence of various types of depression indicates social factors rather than a purely genetic one to be mainly responsible for occurrence of mental illness.

To add to the problem, the availability of psychiatric aid is almost absent in most rural areas. In a particular case a psychiatrist would visit a small town situated 20 km away from the village of the mentally ill person on the 1st Monday of every month. In case that day was a public holiday, one would have to wait until the following month for medical aid.

The sheer number of suicides among young brides points to the suppression of women and limited options available to them in the conventional system. It is no surprise therefore that mental instability is widespread in Indian society at all levels. Male mental illness too is widely prevalent but usually conveniently categorised into substance abuse, wife beating and general violence.

A young school teacher was facing much mental torture from her husband and in-laws - all aspects of her appearance and behavior were criticised - chiefly due to her

family's inability to pay dowry. After her first child birth her infant son was separated from her and she was constantly subjected to insulting behaviour. After the second child birth she was made to resign from her job and then sent back to her mothers home leading to separation from both her children. Needless to say, the husband remarried and the once bright girl who was highly qualified according to village standards (SSE, DEd) with several accomplishments in drawing, rangoli, acting etc. lost every thing - her motherhood, job, family and self respect with no apparent way out.

Another case can be cited of a young girl displaying signs of adolescent stress. Her parents got her married at the tender age of thirteen. By the time she was twenty she had already mothered four children. The sheer stress of repeated motherhood and increasing duties at such a young age took a tol on her mental balance. She was propmptly thrown out of her husband's house while the children were retained with the father. She returned to her mothers' house where she was treated for her illness, but due to being over-burdened with domestic duties she relapsed back into her illness. Today, she is a women of 42, surviving in a mental hospital.

Mental problems which are easily curable at the early stages are ignored, building up to neurosis and psychosis later on. At the village level depression is not considered as a disease deserving medical attention. Women suffering from depression are often chided and berated for neglecting their duties which increases their mental tension. They are unlikely to find sympathy or proper treatment in their maternal home either. Medically, depression, if attended to promptly and regularly can be cured. Presently, in the rural society, such regular treatment and sympathetic case handling are almost absent. Therefore acute incidences become chromic and lead to incurable disorders.

Health care providers also have to be conscious ot the legal aspect of the cases they treat. Though touted as accidents, many of the physical injuries women carry are actually due to wife beating, rape etc. In such cases it becomes the health provider's duty to note down the injuries which could be crucial in getting a divorce or proving a rape etc. as the case may be.

To cite an example, a girl who was married at the age of 15 into a family selling alcohol was violently beaten up by her husband for not attending to one of their customers, though the latter was sexually harassing her. Her husband and in-laws then flung her on the firewood which pierced all over her back. She was forced to lie down in that condition for 4 to 5 hours since it was night and only the following morning was she was taken to a PHC for treatment. The PHC doctors merely removed thorns from her back and dressed her wounds. They conveniently accepted her husband's statement that she had accidently fallen on a pile of thorns though she sported other injuries and the thorns were embedded deeply into her flesh. Subsequently, she ran away to her maternal home, where she was fortunate to be accepted back. Her parents later faced difficulty in obtaining divorce for the girl. Had proper records been kept of her injuries in the case paper at the PHC, the legal problems would have been minimised.

Besides insensitive attitude of the health providers the other main reasons for women not reporting their reproductive health problems to health care providers, as told by the women are :

1. Women not recognizing such conditions as problems but as a necessary fact of being women.
2) Due to inhibitions or lack of vocabulary to describe the condition.
3) Inaccessibility of services due to PHCs being situated at long distances.
4) Subcentres are manned by ANMs who often neglect their duties for various reasons including lack of training or sensitisation to cope with these issues.
5) Private practitioners charge fees which are too exorbitant for rural women.

The various points revealed in our discussion and the particular examples sighted here make it obvious that health is not merely a medical issue. Socio-economic, legal and cultural dimensions are equally important in health care. What is needed is conscientisation of all health providers about the specific social issues surrounding the health problems especially of rural women and should become a part of their formal syllabus. Clearly, the doctor alone cannot attend unassisted to all these issues. It needs combined effort of an entire team of functionaires. Alternatively, the village women themselves need to be trained to collectively recognize and attend to their health care needs. In this context the concept of holistic health care has great relevance as it takes into account all these factors influencing health and health care. ❑

Latest FRCH Publication

Panchayati Raj Information Resource Book

1996, 156.

This is a directory of NGOs working in the field of Panchayati Raj and gives information on the address(es), contact no(s)., nature, area(s) of expertise and language(s) of communication of these organisations.

ग्रामीण महिला आर्थिक स्वावलंबन

डा. रविंद्र बानपेल

यदि गाँव के लोगों को स्वास्थ देखरेख में उपयुक्त प्रशिक्षण दिया जाय तो अधिकतर स्वास्थ समस्याओं को ग्रामीण स्तर पर स्वंय लोगों द्वारा ही सुलझाया जा सकता है। साथ ही यह भी सच है कि ग्रामीण स्तर पर स्वास्थ की प्राप्ति अन्य सामाजिक, आर्थिक व सांस्कृतिक गतिविधियों से अलग हट के नहीं हो सकती है। इस फलसफे ने एफ. आर. सी. एच. को पुणे जिले के पुरन्दर तालुका के परिंचे घाटी में एक समेकित योजना आरम्भ करने हेतु प्रोत्साहित किया। इस परियोजना की गतिविधियों में गाँव की ताईयों का स्वास्थ प्रशिक्षण, जन-सूचना, गैर औपचारिक शिक्षा, ग्रामीण वाचनालय, जल प्रवंधन और ग्रामीण महिला आर्थिक स्वावलंबन नामक ग्रामीण वैकिंग शामिल हैं।

वंगला देश के ग्रामीण बैंक आंदोलन के प्रारूप पर आधारित इस परियोजना का मुख्य उद्देश्य गाँव की महिलाओं की अल्प वचत और ऋण समूहों को संगठित करके ग्रामीण स्तर पर स्वतः निर्भर सूक्ष्म आयोजना को प्रोत्साहन देना है।

जव इस परियोजना को १ सितंवर १९९४ को, परिंचे में शुरू किया गया तो आरम्भ में लोगों ने इसका कुछ विरोध किया। ऐसा ग्रामवासियों के सहकारी वैंकों के साथ कुछ प्रतिकूल अनुभवों के कारण हुआ जिनका कि परिसमापन हो गया था तथा कुछ चिट फन्डों के पैसे इक्कट्ठा करने वाले एजेन्टों के साथ के अनुभवों के कारण भी हुआ, जो कि अत्याधिक अनियमित थे और जिनकी गतिविधियाँ भी संदेहास्पद थी।

इसलिए शुरूआत के ८ से ९ महीनों में हमने स्थानीय समुदाय के साथ अच्छे सम्वन्ध स्थापित करने पर विशेष ध्यान दिया। इसके लिये हमने गाँव के स्तर पर वहुत सी वैठकों का आयोजन किया। आज इस परियोजना में १४ गाँवों के १४० समूह (६८९ सदस्या) शामिल हैं। कुल वचत ७६,०६७ रुपयों की है तथा २३७ सदस्यों ने १,४७,५५१ रुपयों के संचयी ऋण संवितरण का लाभ उठाया है।

अव तक, ऋण कई प्रयोजनों के लिए दिये गये हैं, जैसे : १. घर की मरम्मत, २. हैंड पम्पों की मरम्मत, ३. कृषि संवधी गतिविधियों हेतु उपस्कर / यंत्र खरीदना, ४. घरेलू सामान (रेडियो, आदि) खरीदना, ५. स्वास्थ देखरेख, ६. तीर्थ यात्रा, ७. अन्य ऋणों की अदायगी. अव तक दिये गये ऋणों में से अधिकतर ऋण, उपभोग या अन्य अधिक व्याज वाले ऋणों की अदायगी हेतु दिये गए हैं।

बैंक का परिचालन

ग्रामीण महिला आर्थिक स्वावलंवन की गतिविधियों हेतु एक दिन निश्चित किया जाता है। इस दिन सारे समूह इकट्ठे होते हैं और प्रत्येक समूह व्यक्तिगत रूप से यह तय करता है कि किस सदस्य को ऋण मिलना चाहिए।

डा. वानपेल. (एम.वी.वी.एस. व एल.एल.वी.) एफ्.आर्.सी.एच्.द्वारा संचालित उपरोक्त कार्यक्रम के सह-संचालक हैं।

हर समूह में एक अध्यक्ष और एक सचिव होते हैं, जो कि ऋण की सुविधा आखिर में प्राप्त करते हैं।

वैंक के परिचालन में जिन नियमित रिकार्डों की आवश्यकता होती है, उनका लेखा-जोखा साधारण फार्म में रखा जाता है और उनका लेखा परीक्षण भी होता है।

नियम व अधिनियम

हर 'वचत समूह' में स्थानीय क्षेत्र की ६ से १० औरतें होती हैं। एक परिवार की एक ही सदस्या, समूह की सदस्या वन सकती है। एक नावालिग लड़की समूह की सदस्या वन सकती है, परन्तु वह ऋण लेने के लिए योग्य पात्र नहीं है।

हर माह प्रत्येक सदस्या को रु. ५/- की न्यूनतम वचत का योगदान देना आवश्यक है।

सदस्या अपनी वचत की रकम कभी भी निकाल सकती है। समूह के वनने के दो महीनों के उपरान्त कोई भी एक सदस्या रू. ५००/- तक का ऋण ले सकती है। यद्यपि रू. ५००/- का ऋण वहुत कम प्रतीत होता है, परन्तु इसमे समाज में महिलाओं के स्तर को ऊँचा किया है। आमतौर पर, रू. ५००/- का ऋण ज़रूरतो को पूर करने के लिये उनकी आय के अन्य स्रोतों में जुड़ता है।

यदि समूह ने एक साल की अवधि पूरी कर ली हो तो सदस्याएँ रु.१०००/- तक का ऋण लेने के लिये सक्षम हो जाती हैं। अक्टूवर १९९६ से यह अपेक्षित है, कि दो वर्षों से अधिक अवधि से कार्यरत समूह, अपने सदस्यों को सम्भवतः रू. २०००/- तक का ऋण दे सकेंगे।

ऋण पर व्याज की दर १८ प्रतिशत आर वचत पर १० प्रतिशत ह। ऋण प्राप्त करन क लिए एक साधारण फाम भरना पड़ता ह। जिसम उसी समह की किन्ही दा सदस्याआ का गारटीकता बनना पड़ता ह। यह गारटी महज़ आपचारिकता मात्र ही हाती ह क्याकि गारटीकता अकसर अनपढ़ हात ह।

ऋण की अदायगी १० किस्तों में पूरी की जा सकती है। कार्यक्रम की सफलता को इस वात से आंका जा सकता है कि अदायगी दर अव तक शत प्रतिशत रही है।

देरी की फीस निम्नलिखित कारणों के होने पर लगाई जाती है : १. देरी से वचत, २. ऋण की देरी से अदायगी, ३. व्याज की देरी से अदायगी।

परियोजना को स्व-पोषित बनाना

११० गाँवों के क्रियाकलापों में समन्वय स्थापित करने के लिये एफ.आर.सी.एच. गाँवों के स्तर पर एक एकाउन्टेट नियुक्त करता है।

भविष्य में इस परियोजना को स्व-पोषित बनाने के लिये, व्यवसाय की क्रियाविधी को इस हद तक सरल व आसान बनाना होगा कि गाँव की महिलाएँ समन्वय के कार्य को स्वयं ही कर सकने में सक्षम हों।

इस उद्देश्य को ध्यान में रखते हुए, सूक्ष्म-ऋण समूहों से सम्बन्धित जानकारियों का पुस्तिकाओं के माध्यम से विस्तृत प्रचार व प्रसार करना आवश्यक है, अतः, इस प्रकार की पुस्तिकाओं को तैयार करना चाहिये। इन्हें तैयार करते समय, इस बात का ध्यान रखना होगा कि इनका प्रारूप सरल हो व उसमें जगह-जगह पर चित्रों का भी प्रयोग हो जिससे कि वे सुरूचिपूर्ण रहें।

ऋण लेने की प्रक्रिया को सरल बनाने के लिये एफ.आर.सी.एच. को गैर सरकारी संस्थाओं के साथ सम्पर्क बनाना होगा, गोष्ठियाँ आयोजित करनी होंगी व अनुभवों का आदान प्रदान करना होगा, जिन्होंने इसी प्रकार के सूक्ष्म-ऋण समूहों को संगठित कियो है। इससे क्रियाविधि को सरल बनाने की संभावना पर भी अध्ययन सम्भव हो सकेगा।

प्रत्येक गाँव में, सूक्ष्म-ऋण समूह की हर एक बैठक का, गाँव के समुदाय के लोगों से सीधे बातचीत करने के अवसरों के रूप में इस्तेमाल किया जा सकता है। इन बैठकों में सार्वजनिक सूचनाओं, ग्रामीण वाचनालयों, स्वास्थ सम्बन्धी जानकारियों, आदि के विषयों मे बहुत सी बातें बतलाई जा सकती ह।

एफ.आर.सी.एच अब ग्रामीण महिला आर्थिक स्वावलम्बन मे एक शोध के घटक को लाने का प्रयास कर सकता हैं। इसके लिये ऋण लेने, उसके वितरण व अदायगी से सम्बन्धित सामाजिक परिस्थितियों अर्थात गाँवो के साहूकारों की तुलना में सूक्ष्म-ऋण समूह व अन्य सम्बन्धित विषयों का अध्ययन करना होगा। उदाहरण के तौर पर, यह निर्धारित करना आवश्यक होगा कि पंचायती राज प्रणाली के अन्तर्गत बचत व ऋण के संचालन में स्व-पोषित होने के लिये, गाँव में कितने लोगों का समूह ज़रूरी होगा। ❑

(हिन्दी अनुवाद : मीता श्रीवास्तव)

(Contd. from page 2)

Intermediate factors :

If SES affects maternal mortality it will do so through one of the following :

a) Health behaviour - The things that people do or don't do for their health (health behaviour), is influenced by many forces including many aspects of SES. Health behaviour includes utilization of pre-natal care services, while reproductive behaviour includes the age at which a woman gives birth, pregnancy order and birth-spacing.

b) Health status - It is directly affected by SES. For example, lack of money to buy food can result in anaemia. Health behaviour also affects health status, and poor eating habits too can cause anaemia. Poor health status may lead to some complication which may cause a maternal death.

c) Access to health services - Presence of facilities, information about these, and financial and physical accessibility. Availability of technology to prevent deaths from common obstetric complications in the form of antibiotics, caesareans, contraceptives and self-abortion procedures, constitute an important aspect of the facilities available.

d) Quality of care - Qualified personnel (physicians, nurses and trained midwives).

e) Unknown factors - These also operate and exert their influence.

If SES affects maternal mortality, an important programme option is to improve SES. If education is given, it is likely to affect health status and health behaviour. Similarly, better access to food may affect the nutrition and hence the health status of women, which would lower the risk of dying, in case there is a complication, and lower the risk of even developing a complication, ***provided there is access to medical care.***

Notes :

1. **Food and Agricultural Organisation**
2. **United Nations**
3. **World Food Programme**

(To be Contd.....) ❑

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Editor : **Vaijayanti Aphale**

Assistance : **Jayashree Puranik**

Publisher : **Foundation for Research in Community Health Mumbai/Pune**