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Panchayati Raj, Women and Primary Health Care

In this pamphlet prepared by ***Vaijayanti Aphale*** *for the Foundation for Research in Community Health it is explained how the primary health care needs of a village community are best served by women under the Panchayati form of Government*

Primary health care means the exposition of the real meaning of health to the community, health education and induction of health culture utilising the resources available within the community. Only 10% of primary health care has a curative part. The rationale of health care is to reach the health input to the doorstep of the people against the prevailing situation where the ailing people come to the deliverer of treatment and beg or purchase their health. The health input includes provision of reasonably clear water, sanitation facilities, transport, immunisation and sample remedies like ORT etc. along with health awareness. It is common knowledge that these activities are generally managed by women, making them the basic health care providers in the family. Also, the bulk of the health problems at the village level are related to women and children. Thus, to improve the health culture of a people it is necessary to bring health awareness to the community in general and to women in particular. The community must be made aware about the infrastructure created for them including information about the units, personnel and their respective functions. It is necessary to gather indigenous knowledge on health already existing within the community and accommodate it in the framework of health care delivery. The effective implementation of primary health care is preconditioned by the assessment of morbidity rate and pattern along with the analysis of demographic and epidemiological scenario of the locality. Health care needs to be integrated with a movement for social justice and economic upliftment of the target section of the population. For example, family welfare programmes need to be integrated with women's liberation and enhancement of female literacy. All this can never be possible without community participation. Hence, the role of Panchayat becomes vital in planning for and delivering effective primary health care to the people.

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Powers of the Panchayat

The 73rd and 74th amendments to the Constitution have delegated 29 subjects to be taken care of at the village level under the Panchayat Act, due to which, the following health related functions will come under the purview of the Panchayat:

* Preparing the draft development plan and performing the civic functions of village local government (the mandatory functions listed in Panchayat Acts).

* Performing the coordinating functions regarding preparation and implementation of development schemes by Village Panchayats. Making recommendations to the State or District Governments in the interest of village development.

* Management and proper use of water for various functions. Implementation of drinking water schemes involving supply to individual households as well as to other areas.

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Preparation, maintenance and management of drinking water sources at the village level.

* Poverty Alleviation Programmes.

* Welfare of the weaker sections including implementation of programmes for economic and social development.

* Education including primary and secondary education, technical training and vocational education as well as adult and non-formal education.

* Women and child development including management of maternity and child care centres, monitoring of Integrated Child Development Programme (ICDP), implementation of preschool children's feeding programme, enlisting local contribution for mid-day meals in primary schools and elimination of child labour and violence against women and children.

* Family Planning measures.

* Above all, control of the public health care services from the Gram Panchayat up to the taluka level including 1) establishment and management of local dispensaries, primary health centres and sub-centres and even district hospitals if it comes under the Panchayat area, 2) managing public health activities like control over communicable diseases, immunisation and vaccination services, health education, environmental hygiene etc., 3) campaign against use of narcotic and psychological drugs, alcoholic drinks and tobacco.

As part of health care management it is the duty of the Panchayat to:

i) Link primary health care with regionalised services at the national level.

ii) Undertake community orientation of education and training of health workers - socialisation of community health workers can best be undertaken at the village level.

iii) Take care of logistics in the form of drugs, equipment, other supplies, transport etc.

iv) Undertake supervision - provide technical support guidance and encouragement to workers at health centres and at the village level. Report lapses of governmental health care to the proper authorities.

v) Entail participation of the community with government efforts.

vi) Arrange discussions on public health problems with the health caretakers of the village health sub-centres within the Panchayat area and assign appropriate tasks to the members.

vii) Assist in conserving the health centres of the Gram Panchayat and help the health workers in their work.

viii) The Panchayat members should consult other Samities and Zilla Parishads to seek their cooperation and submit their progress reports to the latter.

Community Participation

To tackle the village health problems, along with utilising the help of village level health functionaries like CH, GS, local health workers, multipurpose health workers and social health workers, the Panchayat should entail community participation in the following areas through liasoning with various groups within the community and canvassing among the people:

Medical Care:

Community members may be encouraged to make maximum use of self-care procedures through continued use of various home remedial measures. Services of locally available practitioners of various systems of medicine should be used as a supplement. Another supplementary community resource can be created by providing training to community selected primary health workers, who are specifically drawn from among the weaker sections, especially women, who can make available home remedies as well as remedies from the indigenous and western systems for meeting the medical care needs. Services of full-time health auxiliaries may be used only to tackle more complicated cases needing specialised skills.

Maternal and Child Health:

Here too the key workers should come from the community itself - the family members assisting in child birth and child rearing and the traditional birth attendants. The birth attendant or any other member selected from the community can be trained as a primary health worker to work with the members of the community to improve the work that is already being carried out there and to provide assistance when called for. They, in turn, can be backed-up by a full-time auxiliary health worker and a primary health managerial physician and other referral services. Panchayat members must ensure that a disposable delivery kit is used by traditional birth attendants/family members.

Malnutrition can be tackled by increasing community efforts for production of crops, vegetables, eggs, fish and fruits and ensure their equitable distribution. A record of village food trade should be maintained and effort should be made to increase local production with special attention to fruits. The community should be encouraged to help the community health workers in monitoring the nutritional quality of the people's diet. Mothers can be trained to monitor the weight gain of their children, so that the health workers can provide nutritional supplements as required.

In problems like severe diarrhoea the community health workers can help the mothers to undertake oral rehydration themselves. ORS packets can be kept in sufficient amounts for distribution at Grampanchayats.

Control of Communicable Diseases:

Even within the existing framework of vertical programmes for communicable diseases, primary health workers and other community level personnel can take over many of the duties carried on by specialised medical personnel. Surveillance of malaria and smallpox, treatment of cases of leprosy, filaria and trachoma, spraying of houses with insecticides and water management including vector control, are some of the duties that can be taken over by the community. Demystification of diagnosis and treatment of many communicable diseases like tuberculosis will increase community participation in controlling the diseases. The Panchayat should compile epidemiological information of the village community with its cooperation.

Family Planning:

Linkage of fertility regulation programme with rural development programme will have a significant influence on population figures - education of women, increasing their social status, increasing age of marriage, curbing the dowry system, opening up employment opportunities for them and their participation in community activities ensuring greater social justice and fall in the maternal and child mortality and morbidity in particular are likely to materially change the level of motivation for a small family norm in the community. Even use of proper contraceptives can be better managed at that level. Gram Panchayat can help the people by registering the birth and death incidents primarily, to avoid inconvenience due to late registration. The Panchayat should canvass the need for such registration among the community so that each and every birth and death incidence reaches the Gram Panchayat.

Environmental Sanitation:

Community involvement in environmental sanitation programmes through efforts of community health workers and interdisciplinary research efforts to develop technologies that are appropriate to the specific conditions in different rural communities will contribute significantly in increasing the cost-effectiveness of the programme. Supply of drinking water including provision and maintenance of tube wells and dug wells is the responsibility of the Gram Panchayat. A community pond can be dug by the Panchayat under the Jawahar Rojgar Yojana. Local organisations exist The Zilla Parishad can be contacted for information regarding local organisations which impart training in cost-effective construction of latrines. The Indira Housing project also provides help in this regard. The Panchayat can simultaneously monitor construction of biogas plants connected to latrines.

Women's Participation

As the majority of the health problems affect women and children and as women are the main health care providers in the family, it is especially necessary to entail women's participation in inculcating a positive health culture. For this the Panchayat and local health workers should liaison with various women's groups at community level like Mahila Mandals and Micro-credit organisations to spread health awareness and increase community participation. This will ensure their access to services. Training of women for health provision will also increase access as well as provide part-time jobs to many women at village level. It will allow the women to actively associate with programmes at various levels and set priorities among the programmes. As they themselves will also be the main users of these services it will lead to desired generation and utilisation of services. Utilising the services of local women should also be expected to create a more cooperative and respectable attitude towards the female government health providers like ANMs working in the village and attention to be paid to the problems they face in carrying out their tasks. Many NGOs have already successfully tried out this approach of training local women to undertake basic health care of the community. This has established that an affordable, accessible and effective health care system is within the reach of the entire population provided people understand their own health needs and plan and implement their own programmes.

Financing under Panchayat Raj

It should be ensured that along with various responsibilities, corresponding finances are raised at the village level through the following means:

i) A greater share in the existing budget and greater powers to generate finances at the village level through leving of taxes, collecting land revenue etc. Besides, creation of permanent remunerative assets like shops, fish ponds, nurseries etc. will help to increase non-tax revenue. Villagers have also suggested innovative schemes like all households being provided equal amount of water and the poor families being allowed to sell water to the rich farmers for agricultural purposes. The money collected by these households could be utilised for their health care.

ii) Local health workers could also resort to differential pricing - the poor being charged less and the rich being charged more. Since the health workers would be familiar with the socioeconomic status of the villagers this scheme would be relatively easy to implement. Identification of poor could be based on factors like their agricultural status - whether they own land or work as farm labourers on other fields, their purchase and consumption of foods etc.

iii) A system could be worked out wherein the local health workers are paid by the Village Health Committee either

through Panchayat funds or with funds collected from the villagers as per their income levels, explicitly for the purpose.

iv) Another method of financing could be cooperative health insurance wherein a village cooperative is formed which insures its members against illness and simultaneously provides health services through local health providers. The insurance could cover those illnesses that are most likely to occur at the village level unlike regular insurance which deals only with catastrophes. Also, detection of genuine cases will be relatively easy as the villagers themselves would run the cooperative and it would be a comparatively small unit.

Panchayati Raj for Better Health Care

To conclude, the main features of health care through Panchayati Raj are:

Physical accessibility:

Since it will be managed by the community itself it can be physically accessible to the whole community and without wastage of precious time, especially in emergency cases. Special arrangements can be made like use of handset radios to facilitate communication for those living in inaccessible areas.

Cost-effectiveness:

Health care will be made cost-effective by using the available records to cater to the basic health care needs of the majority than the exotic needs of a few. Also, care will be taken to incorporate home-based remedies and indigenous health providers wherever possible so that existing resources are optimised. For instance, judicious use could he made of existing resources like training of midwives for conducting deliveries, utilising herbs locally available etc. The village community, with its own specifically trained community health and paramedical workers would be able to cater to over 80% of the health and illness problems which affect people at the village level. Only a rational combination of drugs will be utilised so that expenditure on unnecessary or dangerous drugs is avoided making it not only cost-effective but safer.

The Kerala experience demonstrates that the essential elements of genuine human development can be achieved without squandering enormous amounts of natural resources. With less than 10% of the per capita resource availability compared to the developed countries, Kerala has managed to achieve high levels of human quality of life by making a more judicious use of human labour and by developing a new non-consumerist ethics. In contrast, the U.S.A., after spending over a trillion dollars a year on `health', finds that 15% of its population, representing 40 million individuals, has no access to any meaningful form of medical or health care.

Demystification of knowledge:

Health will be provided not by overspecialised, indifferent health providers from the cities but by trained local people themselves who will be given basic knowledge and medicines and who will be accountable to the village committee. The health providers will also be responsible for spreading health education and awareness in the village and training more local people. Since they would already be familiar with the local situation people would trust them and they will be able to provide health more effectively. The role of the medical profession and paramedics would be redefined as supportive to, and not appropriative of, that of the people. As far as possible the health providers would be women as women and children comprise 70% of the population and 90% of the health problems affect them. Also, women undertake the majority of functions involving the family and local community hence, involving women should automatically improve the welfare of the whole family and even the community.

Accountability and Responsibility:

Since the Panchayat members are elected by the community itself they will be accountable to the people and also the beneficiaries of any development in their village and hence, better motivated to work for the development of their own village. The Panchayat being a relatively small unit, the members would be more accessible to the community and in tune with local health and related problems. Even the local health providers, since they will be accountable to the village health committee or any committee formed exclusively for the purpose, are not likely to monopolise the knowledge they get or overcharge for their treatment.

Holistic Health Care:

The history of industrialised nations shows that their overall health situation improved not due to innovations in medical care but due to general improvement in hygiene and nutrition and overall development. Health care at the village level can easily be combined with other public services to make it more lasting and part of the overall development effort. The major pillars of health such as nutrition, education, water supply, sanitation and environment can be assured by the people only through their own political and social action. Health care initiatives can be combined with other activites like education, micro-credit and employment through use of local resources.

Judicious Utilisation of Existing Services:

Health under Panchayati Raj provides not only a viable alternative to the existing health care systems but would also

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Women and TB

The research team of the FRCH project "Socio-cultural Aspects of Tuberculosis Among Women - Implications for Delivery of Services" comprising of ***Dr. S.N. Morankar, Dr. N.S. Suryavanshi, O.N. Patil, A.M. Kudale & D.C. Deshmukh*** *traces the methodological problems in field-based research on gender differentials in Tuberculosis and offers some practical solutions*

Introduction

Despite decades of research and effective treatment strategies being available, the problem of tuberculosis remains unsolved, taking its toll on society even today. The Government of India is rehauling its National Tuberculosis Programme in an effort to ensure the cure of TB patients by providing the most effective medicines and by direct monitoring of treatment follow-up of patients. However, as with other such projects, successful implementation of this programme would require community involvement for which it is mandatory to study the disease in its socio-cultural aspect.

While much has been written about the influence of socio-economic and cultural factors on compliance with tuberculosis treatment, there is hardly any research done on gender differentials in tuberculosis and its control. Hence, FRCH has undertaken a study on the gender specific problems of help-seeking behaviour of women TB patients, simultaneously providing them with useful information to help improve their access and adherence to treatment.

TB Takes its Toll

* Approximately one third of the world's population is infected with Mycobacterium Tuberculosis.
* Tuberculosis kills over one million women each year.
* About 80% of deaths due to tuberculosis occur in the age group of 5-49 yrs. - the most productive years of life.
* The risk and prevalence of tuberculosis infection are similar in males and females until adolescence, after which, they become higher in males.
* Tuberculosis is as prevalent in the rural areas as it is in the urban concentrations.

Methodology

The study methodology includes conducting interviews of TB patients and non-affected people with the Exploratory Model Interview Catalogue (EMIC)* method, which is the first time such a method is used in data collection in studying TB.

The purpose of using EMIC in the present study is to identify patterns of distress, perceived causes and the preferences as well as past history of help seeking and treatment. A section of the EMIC will be focussing on social stigma attached to the disease, which has an important effect on TB-related illness behaviour, to produce a stigma scale.

Selection of Patients and Interview Strategy

Initially, the following strategy for selection of patients and their interviews was decided upon:

i) Clinic based patients : 80 rural clinic-based patients (40 male and 40 female) who have been registered for treatment 4-6 weeks prior to the date of interview at the District TB Centre, Pune were each to be interviewed by one male and one female investigator.

ii) Community based patients: Mapping of all patients diagnosed as suffering from TB 3-4 months before the start of data collection or currently on treatment in the Parinche Valley, Pune District (FRCH's action-research area consisting of 20,000 population) would be done by contacting all available formal and informal sources. The patients would be interviewed by an FRCH researcher working at Parinche. Information about these patients would be collected by community based women known as "tais" as per specific guidelines provided to them by FRCH staff. Tais would prepare case studies of the patients and do a follow-up of their treatment behaviour for six months. This would also allow us to study the advantages/ disadvantages of involving community based female workers in a research process.

iii) Non-affected persons : Non-affected persons would be selected from 20 villages picked out from a list of villages from where come the patients registered at the DTC. These 20 villages are within a radius of 50-60 kms from Pune city, for the purpose of logistics and convenience of data collection.

iv) Health care providers : All health care providers in the same 20 villages would be identified through discussions with key informants from the villages and interviewed with the help of a semi-structured interview schedule. This would include all providers identified and visited by villagers including traditional and folk healers for health and medical care.

v) It is proposed to conduct a focus group discussion (FGD) in the evening after completing the interviews in each of the 20 villages. In each village emphasis would be laid on participation by a different socio-economic or gender strata in the FGD so that all stratas would be covered. The Sarpanch or members of the Mahila mandal were to be contacted to help gather the kind of people we wanted for the discussion. It has been our experience so far, that besides the target group many others take part in the discussion and it is quite difficult to stop them from interfering in the proceedings.

Village Health Ethnographic Study

To understand the community's perceptions about health it was decided to conduct a detailed study emphasising health and related aspects of the village concentrating on stigma related diseases such as TB, leprosy, HIV/AIDS etc. with a focus on gender differentials. This study was to be conducted by a village based local women researcher. This is an attempt at developing methodology for collecting health information using qualitative research methods with the help of a village based local woman as an investigator by giving her appropriate inputs.

Altering the Methodology

During pretesting we faced certain difficulties regarding our methodology hence, after due discussion with members of our research advisory committee, certain changes have been made in selection criteria of patients as follows:

Clinic based patients: As Directly Observed Therapy (DOTS) has been implemented in the whole of Pune district, we had to take patients who came under DOTS treatment. Not a single rural woman patient who attended the clinic at DTC and who fulfilled our criteria could be interviewed by us. The explanations given by medical staff at the DTC and as understood by the researchers are:

* Even if a woman came to the DTC she is always accompanied by her husband, brother, mother-in-law etc. and hence, is unable to talk on these sensitive issues in their presence.
* She is in a hurry to go back home.
* Most of the patients, female as well as male, are transferred to the nearest PHC for further treatment.

Hence, the criteria for interviewing patients was changed and it was decided to visit rural hospitals and PHCs in rural areas of radius 50-60 kms from Pune to cover the target.

Moreover, it was observed during pretesting that females feel more comfortable with and talk more openly to female researchers. So instead of one male and one female researcher it was decided that female researchers would interview female patients and male researchers, male patients. The same strategy was followed in interviewing non-affected persons. The qualitative information gathered in the interview is immediately coded by the interrater method. The code is mutually decided upon by the researchers.

Initially, we had planned to conduct FGDs in the evening when all the women would be at home and had some time to spare for us but it was suggested by village women and others in the community to conduct FGDs in the morning on a weekly market day. The reasons given were: firstly, it being the market day nobody would go for work and hence, everybody would be available for group discussions and secondly, in the evening most of the men folk in the community came home absolutely drunk making it difficult for women to come for group discussions. Incidentally, the problem of alcoholism was prominent in 2 of the 4 villages where FGDs were conducted.

After due discussion it was decided that as it would be very hectic for the community based patient if s/he was visited by FRCH researchers and again by tais for in-depth study and follow up, instead, only tais would visit the patient and take in-depth information form patients. When it was observed that tais give more information orally than in writing, as writing seems to be a constraint for them, we decided that the one of the FRCH researcher would write whatever relevant information the tais had gathered about the patients. The data collected through this method has been purely qualitative to date and will be analysed by the computer package popularly used for qualitative data `Text Base Beta'.

These were a few methodological problems faced by the researchers in the present study and the necessary modifications made to our strategy. We hope our experience will benefit other researchers carrying out similar work.

Note : * EMIC: The Explanatory Model Interview Catalogue is a highly appropriate method for acquiring information about social and cultural determinants of illness, help seeking, treatment adherance and other aspects of illness behaviour. Though rather lengthy and exacting, it is able to simultaneously collect qualitative as well as quantitative information in depth about any particular illness.

EMIC has been developed in studies of tropical diseases and mental health in India and used in Africa, East Asia, Europe and North America. It has already been used for operational research studies of leprosy, onchoceriasis and childhood diarrhoea. ❑

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ensure proper utilisation of the existing public and private health systems through health education, awareness of individual rights, more economic resources to help them buy better services, timely referrals to public/private providers by the village health workers in complicated cases etc.

Empowerment of the People - Bottom-up Approach:

It has been realised that no development initiative including basic health care can succeed unless people's participation in the scheme is ensured. The 73rd amendment to the constitution now offers people an opportunity to initiate and plan schemes for their own development. The 33% reservation provided to women and schedule castes in Panchayats should ensure the participation of the weaker sections of the society in the political process and give them socio-economic empowerment. ❑

The ANM Speaks

Seema Deodhar gives an account of the feedback given by Auxiliary Nurse Midwives (ANMs) on "Aayushi" a journal for ANMs published in Hindi and Marathi by the Foundation for Research in Community Health

The Foundation for Research in Community Health had undertaken a project 'Training Support for Rural ANMs in the States of Madhya Pradesh and Maharashtra' to provide the ANMs in the states of Maharashtra and Madhya Pradesh with information regarding technical, administrative and social problems on a regular basis. For this, a monthly journal 'Ayushi' was published and distributed to ANMs.

The publication included two sections: i) One section provided ANMs with technical information related to common disease conditions, contraceptives, women's and children's health problems and how to manage them, public health issues, health care delivery, home remedies and so on. The language was simple and illustrated with line diagrams, photographs etc. ii) The other section dealt with real life case studies of ANMs, short stories on women's lives and their predicament in the present society, commentaries on social issues, letters from ANMs and other health workers etc.

A total of 37 issues containing 352 articles were published. Following is the distribution of articles according to their themes (Many articles have covered all the three aspects and hence have to be included under more than one theme):

Themes	No. of Articles	% of total
Social	303	86.00
Technical	143	40.62
Administration	103	29.26

In our attempt to distribute Ayushi to all the ANMs from both the states we had to face two major kinds of hurdles:

1) * Inefficient Postal service in rural areas.

* Irregular visits by ANMs to their sub-centres.

* Lack of initiative by the PHC Staff to disseminate the journals which were reaching them; we usually recovered journals from the Pharmacist's cupboards or from Medical Officer's tables.

2) * Generally, the daily work schedule of ANMs does not leave much time for reading.

* The ANMs are high school passouts with additional 18 months of course training. Most of them are first generation educated women in the family and thus have not really developed the reading habit.

Hence, our feedback is restricted to only those ANMs who read Ayushi and whom we came in contact with personally or through letters and/or questionnaires.

Impact Assessment

Four methods were employed to assess the impact:

1. Informal feedback obtained through ANMs' response to letters and articles and response of the PHC and non-PHC staff.

2. Personal contact through Field Surveys conducted by FRCH Staff.

3. Feedback from ANMs through questionnaires mailed to them or distributed in workshops.

4. Discussions and specific exercises in workshops conducted in the four socio-economic regions of Maharashtra.

Response from ANMs

The total number of ANMs contacted was 2678 of which 2017 ANMs responded. There was no overlapping of samples covered through each method.

1. Analysis of letters - 1002 ANMs out of 11500 ANMs (8.66% of the total) responded to our publication through letters from the four socio-economic regions of Maharashtra. This could be considered as a reasonably good response as compared to the average response to such exercises which is 2-21/2 %. On later enquiry many ANMs said that they did not respond as they were mentally not prepared to give their opinions/experiences in writing.

Of the 1002 ANMs who wrote letters to FRCH, 97.1% appreciated Aayushi; 2.2% did not like Aayushi; 90% found it useful and 60% were ready to pay subscription. The articles

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and poems sent by ANMs were regarding their work, problems and interesting experiences.

ANMs from the Vidarbha region of Maharashtra gave the most enthusiastic response as many of the ANMs therein reside at the Sub-Centres and read Ayushi more regularly. Only 6.6% of ANMs specifically demanded back issues, though on personal enquiry, many more said that they would be interested in reading them. 20 ANMs wrote to us pointing out our mistakes, or what they did not like, as follows.

1 A cover photograph depicting a wrong method of injection administration by an ANM. Actually, the method that we showed was ideal, it is the ANMs who held a popularly wrong notion.

2. The dose of TB medication mentioned in an article was wrong. It was actually a printing mistake and we apologised for it.

3. A few accused us of concocting the experiences of some ANMs narrated to us which we had published.

Many ANMs wrote letters in praise of Ayushi. They said they found the matter relevant and found useful tips which helped them improve their rapport with the women during home visits. Even other PHC staff was interested in receiving Ayushi separately. The column 'Bolake Patra' or open letters to the editor was an opportunity for the ANMs to express their feelings and state their problems. In this, the ANMs wrote back showing their appreciation for other columns like write-ups by David Werner, songs on the last page, informative essays about children, women and poems. The response through letters proves that Aayushi has indeed made an impact on various categories of paramedical staff.

2. ***Visits to PHCs and Sub-Centres*** - Of the 449 PHCs and SCs visited by us, 433 were in Maharashtra and 16 in Madhya Pradesh. The number of ANMs contacted were 551 and 31, respectively. As per their response 27.19% did not read Aayushi; 65.69% read Aayushi; 65.69% preserved the issues after reading; 61.08% found Aayushi useful; 58.15% were willing to subscribe and 7.00% did not respond.

Methodology Used in Selection of PHCs and Sub-Centres:

First, we selected a few districts from both the states through random sampling. Thereon, we attempted to cover the entire district by starting from the most backward/tribal area PHC in the district and then spreading out to as many adjoining PHCs/SCs as possible. All those ANMs present at the time of our visit were then interviewed by us.

The opinion of ANMs was sought on the following points

1. Did ANMs receive Aayushi regularly ?
2. If yes, did they read it ?
3. If yes, did they find the language easy to follow?
4. What subjects would they have preferred to be incorporated in the forthcoming issues of Aayushi ?
5. Probable reasons, if any, for non-receipt of Aayushi by ANMs.

It was found that if the issues were mailed to PHCs, they were rarely distributed to the ANMs. Neither were the ANMs allowed to take the issues home where they could be read at length. Sometimes the other staff from the PHC would keep the issues for their own reading, which though indicating the wider appeal of Ayushi, did deprive the ANMs of the issues. Thus, if the issues were mailed directly to ANMs they had better chances of receiving them. However, most of those ANMs who did not reside in Sub-Centres, were ignorant about Aayushi being meant exclusively for them and hence, had not read the issues mailed to them. Quite a few sub-centres have no building of their own. Hence, chances of ANMs receiving Aayushi at these Sub-Centres were remote. In such cases, either the issues were returned to FRCH or delivered to Gram Panchayats, private medical practitioners or even to banks!

ANMs in Nasik district positively affirmed that 'Aayushi' as a magazine fared better than 'Arogya Patrika' and 'Centre' - two health publications published by the Government, as Aayushi was more informative and more useful to field workers. When asked about the content of future issues of Aayushi, the ANMs requested that subjects like AIDS, Cancer, Family planning, TB, Leprosy, Malaria etc. be included. They also wanted the journal to contain more illustrations and sketches.

We were also told that often the contents were read out publicly in Mahila Mandals, workshops, training sessions, ANMs' monthly meetings etc. In fact, a large number of PHC staff, especially in Maharashtra, confirmed that Aayushi was used during training courses for ANMs. The Medical Officers and Training Officers used Aayushi along with the Government Training manuals to facilitate training.

In some PHCs in Vidarbha Aayushi issues were bound and preserved. Some MOs and DHOs felt that it was equally useful to doctors. All of them insisted that they be individually mailed a copy rather than through Sub-Centres as not to miss any issue of Aayushi. They had voluntarily compiled a list with names and addresses of those wanting Aayushi. Some

ANMs said they even lent it to their neighbours who found it very interesting.

ANMs working in tribal or Adivasi areas claimed that due to time constraints they could not devote enough time to Aayushi but insisted that it be continued. They were keen that the journal deal at length with the problems faced by them in their work.

Majority of the ANMs were willing to pay subscription from their own pockets, but they differed on the amount to be paid. Two options were suggested by them 1) as much as Arogya Patrika, 2) between Rs. 20 to Rs. 50 per month.

ANMs from Marathwada informed us that they were willing to pay even above Rs. 50 rather than see it discontinued. A large number of ANMs felt that if they could spend much more on luxuries they could easily afford a subscription between Rs. 50 - Rs. 100 per month. Unfortunately, in Western Maharashtra, Aayushi was not received as enthusiastically as elsewhere.

3. Questionnaires - To gauge the impact of Aayushi a questionnaire was prepared and after field testing, was mailed to ANMs along with the issues.

Only 120 out of total 11,500 ANMs returned the questionnaire. The questionnaire was repeatedly printed in three consecutive issues of Aayushi to reach all ANMs at least once. The response to the questionnaire was 1% which is at the lower end of the average response of 1-2% received for such exercises by popular publications.

The explanation given by ANMs for this low response during our personal interaction with them was :

* Questionnaires were a new concept to a lot of ANMs.

* Some of them were scared of repercussions by the authorities later on.

* Some thought the questionnaire running to two pages was too lengthy and tedious to be filled in.

After our personal interactions with them through workshops we received 244 completed questionnaires making a total of 384. Our analysis is based on these 384 questionnaires.

The impact of Aayushi as reflected through the 384 responses to our mailed questionnaires is: 92% read Aayushi; 69% find Aayushi useful; 92% preserve the issues of Aayushi and 72% are willing to subscribe to it.

4. ***Workshops*** - Four workshops were held in Pune (Western Maharashtra), Gadchiroli (Vidarbha), Raigadh (Konkan) and Latur (Marathwada) each. In each region 40 ANMs were invited for the workshops.

The response of the 229 participating ANMs was : 93.44% read Aayushi; 6.5% did not read Aayushi; 100% have changed their perspective; 87.33% found Aayushi useful and 92% paid subscription for it.

The ANMs made the following suggestions regarding the Publication:

* Language - The language should be as simple as possible; heavy academic language and superlatives should be avoided; the dialogue form was easier to understand and more appealing.

* Content - The content should be straightforward - irony is not easily understood; stories with tragic ends were not appreciated, a positive outlook was preferred; the subject matter should be relevant to their own life experiences. The poems included should be women-oriented and based on grassroot activities - poems on personal emotions or human relations were not understood.

* Text Layout - a sentence should not extend beyond fourteen words; a paragraph should generally contain only 150 to 170 words; an article should not contain more than 1800 to 2000 words; a three column layout per page was easier on the eye and the font should not be too artistic.

* Pictures -

i) Line diagrams were preferred over figures.

ii) Urban stereo types were not appreciated.

iii) Figures represented in a definite background were easily contextualized and hence better understood.

iv) Pictures that were too abstract or symbolic were difficult to comprehend.

v) Human figures represented in straight lines/square forms were not appreciated.

Conclusion

1. A journal like 'Aayushi' is necessary for ANMs.

2. The journal, if it is to be effective, should be based on personal interaction and rapport with ANMs through workshops.

3. The length of the journal should not exceed 12 pages since ANMs are short of time.

4. Aayushi has proved to be successful among those for whom it was meant. However, it is difficult to collect the necessary amount of subscriptions from the ANMs to keep such a magazine going. ❑

सम्यक् स्वास्थ्य उपलब्ध कैसे होगा?

डॉ. भूषण पटवर्धन द्वारा लिखा गया यह लेख, एफ.आर.सी.एच द्वारा प्रकाशित पत्रिका 'आयुषी' के जानवरी 1995 के अंक में प्रकाशित हुआ था

विगत कुछ वर्षों में एलोपॅथी, यानी आज सर्वाधिक प्रचलित एवं लोकप्रिय चिकित्सा प्रणाली के विरुध्द जनमत तैयार हो रहा है। आधुनिक कृत्रिम औषधि द्रव्यों का बड़े पैमाने पर होने वाला दुरुपयोग तथा उससे उत्पन्न भयानक दुष्परिणाम इसके लिए जिम्मेदार हैं। दरअसल जिसे हम आधुनिक चिकित्सा विज्ञान के रूप में जानते हैं, वह तार्किक दृष्टि से प्रमाणित विज्ञान नहीं है, वरन् वह परंपरागत अनुभवसिध्द चिकित्सा प्रणाली पर आधारित विकसित विज्ञान है। इतिहास देखें तो हम पाते हैं कि सिर्फ विगत १०० वर्षों में ही एलोपॅथी सारे संसार में एक प्रमुख चिकित्सा प्रणाली के रूप में मान्यता प्राप्त कर चुकी है। किंतु अब सारे संसार में जनमत इसके विरोध में जाने का रास्ता पकड़ चुका है।

उन्नीसवीं सदी के मध्य तक किसी एक बीमारी के लिए विशिष्ट औषधोपचार, (जैसे सिरदर्द या बुखार के लिए एस्प्रीन का प्रयोग) देने वाले चिकित्सक नीम हकीम समझे जाते थे । जबकि आज जड़ीबूटी से उपचार करने वालों को नीम हकीम कहने का फैशन चल पड़ा है। सौ साल पूर्व एलोपॅथी को अवैज्ञानिक, गैर जिम्मेदाराना कह कर निम्नस्तर की चिकित्सा प्रणाली समझा जाता था। एलोपॅथी द्वारा प्रयोगशाला में अनुसंधान की गई कल्पना को मूर्खता मान दुर्लक्षित रखा जाता था। आज यही सब आयुर्वेद, एक्युपंक्चर, प्राकृतिक चिकित्सा, इत्यादि परंपरागत चिकित्सा प्रणालियों के बारे में हो रहा है।

जिस युरोप-अमरिका में एलोपॅथी एक सर्वोच्च चिकित्सा प्रणाली के रूप में विकसित हुई, वहीं पर अब सुपर स्पेशलायज़ेशन की बेहद अधिकता से उकता कर लोग फिर से परंपरागत चिकित्सा प्रणाली की ओर झुकने लगे हैं। लोगों को अब सिर्फ 'बीमारी से मुक्ति नहीं वरन् 'संपूर्ण स्वास्थ्य' चाहिए। बीमारी ठीक करना और स्वास्थ्य प्राप्त करना, इन दोनों बातों में जो सूक्ष्म फ़र्क है, वह अब सामान्य मनुष्य भी समझने लगा है। अब लोगों के विचारों में आ रहे बदलाव के अनुरूप रहना हो, तो आधुनिक तथा परंपरागत दोनों प्रकार की चिकित्सा प्रणाली में कालानुरूप बदलाव लाए जाने की आवश्यकता है। इन दोनों प्रणालियों के मध्य प्रतीत होती विभाजन रेखा मिटा कर 'स्वास्थ्य' को सर्वोपरी मानते हुए एकीकृत रूप से स्वास्थ्य रक्षा का ध्येय सामने रखना होगा। कोई भी पूर्वग्रह न रखते हुए पूरक पध्दति से परस्पर विकास करने की प्रक्रिया शुरू करने की आज आवश्यकता है।

विश्व स्वास्थ्य संगठन के निदेशक द्वारा किया गया अधिकृत निवेदन इस संदर्भ में अत्यन्त महत्वपूर्ण है। वे कहते हैं, "संसार भर के अधिकांश मेडीकल कॉलेज, जो सर्व साधारण जनता के स्वास्थ्य रक्षा की जिम्मेदारी ले पाने में सक्षम हों। ऐसे डॉक्टर तैयार नहीं कर पा रहे हैं। अपितु वर्तमान चिकित्सा प्रणाली, आँखे बंद रख कर बीमारी तथा उसे ठीक करने के लिए विभिन्न प्रकार की युक्तियाँ करने तक सीमित रह गई है। कमरतोड़ महंगे दामों वाली दवाओं की संख्या में तेजी से हो रही वृध्दि तथा सर्वसाधारण व्यक्ति की क्षमता से बाहर के निदान विषयक नाना यंत्र-सामग्री, इस चिकित्सा विज्ञान को गरीबों से दूर ले जा रहे हैं। "

आधुनिक चिकित्सा प्रणाली तथा उससे संबध्द दवाओं के निर्माता, परीक्षा (जाँच) प्रणाली तथा निदान यंत्र सामग्री निर्माता मिलकर संपूर्ण स्वास्थ्य की कल्पना की राह में रोड़े बन रहे दिख पड़ते हैं। पुरानी बीमारियों पर काबू पाया नहीं कि नई-नई बीमारियां सिर उठाए तैय्यार। पहले खसरा/चेचक तथा गलघोटू, प्लेग वगैरह थे तो आज हृदयरोग, मधुमेह, कॅन्सर तथा एड्स जैसी बीमारी नींद हराम कर रही हैं।

दुनिया भर के मेडीकल कॉलेजों में विद्यार्थी उच्च रक्तचाप के लिए जिम्मेदार कारण के रूप में 'रक्त वाहिनियों में अथवा यकृत का कार्यों मे रुकावट ' को महत्त्व देते (पढ़ाए जाते) हैं। किंतु ऐसा न होने के लिए क्या किया जाए यह प्रभावशाली ढंग से नहीं सीख पाते हैं। बल्कि बढ़े हुए रक्तचाप पर किन किन औषधियों से नियंत्रण पाया या सकता है, इसी पर जोर दिया जाता है। जिन कारणों से ये विकार उत्पन्न होते हैं वे तथा उन पर कैसे उपचार किया जाए इस मुद्दे को गौण समझा जाता है। आज अकेले अमरिका में लगभग पंद्रह फीसदी लोग उच्च रक्तचाप से ग्रस्त हैं। रक्तचाप, हृदयरोग, संधिरोग, कॅन्सर जैसी बीमारियाँ धीरे-धीरे बढ़ने वाली तथा जल्दी से पकड़ में आने वाली नहीं है। फिर उनका संबंध, मनुष्य का आहार-विहार, जीवन स्तर तथा परिसर वातावरण से काफ़ी निकट का होता है। और इसीलिए उन्हें टाला भी जा सकता है। ऐसी अनेक बीमारियों के लिए एलोपॅथी निश्चय ही कमजोर साबित होती है। वह उन पर संपूर्ण विजय प्राप्त करने में अक्षम प्रतीत होती है।

एलोपॅथी सिर्फ बीमारी को ही लक्ष्य मान्य कर सीमित दृष्टिकोण से चलने वाली होने की वजह से, आज रोग उपचार ही स्वास्थ्य के लिए मूलमंत्र समझा जा रहा है। सभी अधिकांशतः बीमार हैं और उपचार द्वारा उन्हे ठीक करने की प्रक्रिया के द्वारा ही स्वास्थ्य प्राप्त होता है, ऐसी धारणा होती है। उक्त सीमा की वजह से स्वास्थ्य का सही अर्थ समझना और उसका प्रचार, प्रसार होना मुश्किल हो गया है। आधुनिक चिकित्सा प्रणाली तथा उसका अवलंबन करने वाले डॉक्टर को स्वास्थ्य का सही अर्थ बता पाना कठिन होता है।

इस पृष्ठभूमि पर सर्व समावेशक औषधोपचार यानी 'होलिस्टिक मेडीसिन' की परिकल्पना के लिए सर्वत्र उत्सुकता दिख पड़ना कोई आश्चर्यजनक बात नहीं। इस परिकल्पना में स्वास्थ्य प्राप्ति के लिए, उपलब्ध सभी चिकित्सा प्रणालियों को एक दूसरे का पर्याय या प्रतियोगी न मानते हुए एक दूसरे के लिए 'पूरक' के रूप में उपयोग किया जाना अपेक्षित है। इस परिकल्पना की शुरूआत प्रथमतः अमरिका में ही हुई तथा इसके पीछे मुख्य कारण यह था कि सुपर स्पेशलायजेशन के अति प्रयोग से जनता उकता गई । चिकित्सा विशेषज्ञ भी निराश हुए और उसी के फलस्वरूप एलोपॅथीक डॉक्टर तथा अन्य परंपरागत चिकित्सा प्रणाली का उपयोग करने वाले विशेषज्ञ इकट्ठे हो कर सिर्फ 'रूग्ण हित' ध्यान में रख 'स्वास्थ्य' को अंतिम लक्ष्य मानकर 'संपूर्ण स्वास्थ्य सेवा' की ओर झुके। इस में अत्यंत महत्वपूर्ण भाग है एलोपॅथीक डॉक्टरों का प्रमुख रूप से सहभागी होना। इसी के साथ मानसोपचार, सामूहिक सम्मोहन विज्ञान,

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लेखक, स्कूल ऑफ हेल्थ साईन्सेस, पुणे विश्वविद्यालय के निर्देशक हैं तथा विश्वविद्यालय के एक्ज़ीक्यूटिव कमेटी के सदस्य भी हैं।

लैंगिक मार्गदर्शन, बीमार के जीवन में आए उतार-चढ़ावों का विश्लेषण तथा साथ ही साथ आवश्यकतानुरूप पौष्टिक (संतुलित) आहार का प्रसार, रोग निवारक आहार प्रणाली, योग व अन्य ध्यान-धारणा तथा व्यायाम विधियों का अवलंबन, वनौषधि द्वारा उपचार, होमिओपॅथी, आयुर्वेद जैसी औषधोपचार प्रणाली के साथ जो भी प्रणाली 'पूरक' रूप में उपयुक्त दिख पड़े, उन सब का प्रयोग करना, इत्यादि एकीकृत रूप से चलाया गया कार्यक्रम का ही दूसरा नाम 'पूरक औषधोपचार विज्ञान' अथवा 'कॉम्प्लीमेंटरी मेडीसिन' है । इसमें 'बीमारी' का विचार करना भी महत्वपूर्ण माना गया है ।

उक्त परिकल्पना के लिए सर्व साधारण जनता में तो उत्सुकता है ही, इसके अलावा इसके महत्व को एलोपॅथीक डॉक्टर भी पहचानने लगे हैं, यह संतोष की बात है । एलोपॅथी को ॲक्युपंक्चर या आयुर्वेद की जानकारी न होना कोई दोष देने योग्य बात नहीं है, किंतु बीमार के अंतिम हित की दृष्टि से 'निरर्थक स्वाभिमान' परे रख, खुले मन से अन्य प्रणालियों का अवलंबन करना आवश्यक प्रतीत होता है। एक अध्ययन ने साबित कर दिया है कि अकेले एक इंग्लैण्ड के लगभग दो हजार से अधिक डॉक्टर कॉम्प्लीमेंटरी मेडीसिन यानि पूरक औषधोपचार का प्रयोग करते हैं । ब्रिटिश मेडीकल जर्नल नामक विश्व प्रसिध्द वैद्यकीय पत्रिका में प्रकाशित रिपोर्ट के अनुसार लगभग ८० प्रतिशत डॉक्टर, अन्य पूरक औषधोपचार प्रणाली जैसे आयुर्वेद, ॲक्युपंक्चर, होमिओपॅथी, वनौषधि इत्यादि की जानकारी प्राप्त करने के इच्छुक हैं।

अनेकों साल हम पश्चिम का अंधानुकरण करने में ही धन्यता मानते चले आए हैं । इंग्लैण्ड-अमरिका से जो कुछ आया वह सब अच्छा, यही धारणा सर्वत्र दिख पड़ती है । कुछ लोग तो उक्त आगांतुक बातें हमारे पुराणों में पहले से ही मौजूद हैं, ऐसा कहने से भी नहीं चूकते ! परंतु फिर भी होलिस्टिक मेडीसिन, कॉम्प्लिमेंटरी मेडीसिन यानी पूरक औषधोपचार की परिकल्पना की जड़ें आयुर्वेद में निसंदेह रूप से हैं । यथार्थतः इस संदर्भ में भारतीयों द्वारा विश्व स्तर पर नेतृत्व किया जाना चाहिए था, किंतु जब यह परिकल्पना पुनः विदेशों की ओर से आई है, हम उस पर गंभीरतापूर्वक विचार करने लगे हैं ।

अभी भी हम विश्व में इस परिकल्पना के प्रसार के लिए नेतृत्व कर सकते हैं। इसके लिए हमें प्रथमतः अपने ही देश में पूरक औषधोपचार प्रणाली का सर्वांगीणपूर्ण अध्ययन कर कुछ ठोस नीति निर्धारित करना आवश्यक है। इसी के एक भाग के रूप में सभी को आज विश्व में प्रचलित विभिन्न औषधोपचार प्रणालियों की जानकारी कर लेना जरूरी है। इसके पश्चात ही प्रत्येक व्यक्ति अपनी अपनी बुध्दिमत्ता तथा आवश्यकतानुरूप निर्णय लेने में सक्षम हो सकेगा।

संसार में किसी भी विज्ञान का ज्ञान परिपूर्ण नहीं है, इस पर सभी विचारक विशेषज्ञ सहमत हैं। इसी प्रकार कोई भी चिकित्सा प्रणाली परिपूर्ण नहीं मानी जा सकती। प्रत्येक शास्त्र (विज्ञान) की जैसी अपनी विशेषताएं हैं, वैसी ही सीमाएँ भी हैं। इसीलिए स्वास्थ्य के संदर्भ में विचार करते समय वह अंतर्विद्याशाखा दृष्टि से किया जाए तो अधिक यथार्थवादी तथा परिपूर्णता की ओर जाने वाला हो सकता है, ऐसा विशेषज्ञों को विश्वास है। चिकित्सा शास्त्र की दृष्टि से देखें तो फिलहाल विश्व में कुछ चार चिकित्सा प्रणालीयाँ प्रमुखरूप से प्रचलित हैं। इन सब में एलोपॅथी सर्वाधिक लोकप्रिय है। दूसरी प्रणाली है भारतीय चिकित्सा प्रणाली। इसमें आयुर्वेद, युनानी, सिध्द आदि समाविष्ट हैं। सुदूर पूर्व की ओर चीनी, जापानी, कोरीयायी, तिब्बती औषधोपचार लोकप्रिय हैं। चौथी प्रणाली के अंतर्गत परंपरागत औषधोपचार आता है। इसमें प्रत्येक संस्कृति की अपनी-अपनी विशेषतायुक्त पध्दति, जिसमें आदिवासी प्रणाली से ले कर ग्रीक सुमेरियन जैसी प्राचीन संस्कृति की चिकित्सा प्रणालीयों का समावेश होता है। इन चारों प्रणालियों में कई तरह के औषधोपचार सम्मिलीत हैं।

'अ' से ही शुरूआत करे तो ॲक्युपंक्चर-जिसमें ॲक्युप्रेशर, शियात्सु, इलेक्ट्रो ॲक्युपंक्चर जैसी शरीर के विशिष्ट दबाव-बिंदुओं पर सुई अथवा अन्य प्रकार के उपकरणों का प्रयोग किया जाता है। ॲथोपोर्सोफिकल प्रणाली में मानव एवं प्रकृति के बीच संबधों पर आधारित संगीतोपचार, मंत्रोपचार आदि का समावेश होता है। विद्युत उपचार में डायथर्मी, मैग्नेट थैरपी, इन्फ्रारेड, आदि आते हैं। होमिओपॅथी में अतिसूक्ष्म प्रमाण में दी जाने वाली दवाईयाँ तथा वारा क्षार उपचार हैं। जलौपचार में पानी, मिट्टी, स्नान आदि का प्रयोग किया जाता है। प्राकृतिक उपचार में मनुष्य की प्राकृतिक सुप्त शक्ति को उत्तेजित कर, रोग उपचार अथवा प्रतिबंधात्मक उपचार उपलब्ध कराए जाते हैं। इस में उपवास, शरीरशुध्दि, आहारनियंत्रण आदि का प्रयोग किया जाता है। मॅन्युपलेटिव्ह थेरैपी के अंतर्गत कायरोप्रॉक्टिक, ऑस्टिओपॅथी, वोन सेटिंग, मसाज वगैरह का समावेश है। मानसोपचार प्रणाली में स्वयंसूचना, सम्मोहन, ध्यान, बायो फीडबॅक आते हैं। संवेदन उपचार में गंधोपचार, रंगोपचार, ध्वनीउपचार हैं तो दूसरी ओर घरेलू उपचार, वनौषधि उपचार, ओजोन थेरैपी, प्रार्थना, योगोपचार इत्यादि के साथ-साथ रोगनिदान के लिए आँखों की पुतलियों की जाँच (आयरीऑलॉजी), कीर्लीयन फोटोग्राफी जैसी प्रणालियों का भी इस्तेमाल होता है। मोटे तौर पर विश्व में प्रचलित चिकित्सा प्रणालियों की संख्या लगभग पचहत्तर के आसपास है। इसके अतिरिक्त कई छोटी-मोटी उपचार पध्दतियाँ भी दिख पड़ती हैं। इन सभी की अपनी कुछ विशेषताएं हैं। कुछ-कुछ बिमारियों में इनमें से कई पध्दतियों का बहुत अच्छा उपयोग होता देखा गया है। फिर भी उन सभी की अपनी सीमाएँ भी हैं।

इन सभी पध्दतियों का समुचित उपयोग कर हम अपनी स्वास्थ्य रक्षा अधिक प्रभावी रूप से कर सकते हैं। कब तथा किस हद तक कौन सी प्रणाली प्रयुक्त हो, यह चिकित्सक द्वारा तय किया जाना चाहिए। पूरक औषधोपचार प्रणाली में आधुनिक चिकित्सा केंद्रीय प्रणाली है, इसका भी ध्यान रखा जाना जरूरी है। आधुनिक डॉक्टर को मानव शरीर की, उस में स्थित विभिन्न शरीर रचना तथा शरीर क्रिया की योग्य जानकारी होती है, अतः ऐसे विशेषज्ञ की देखरेख में किए गए उपचार सर्वथा ख़तरे से परे होते हैं।

संक्षेप में कहा जाए तो स्वास्थ्य एक ऐसा मुद्दा है जिसके लिए सभी के द्वारा प्रयत्न किया जाना आवश्यक है। गोली लेते ही जैसे कोई बीमारी ठीक होती है, वैसी 'स्वास्थ्य' दिला सकने योग्य कोई गोली या दवा उपलब्ध नहीं है, इसका सदैव ध्यान रखें। स्वास्थ्य प्राप्ती के लिए उक्त प्रक्रिया में खुद भी शामिल होना महत्वपूर्ण बात है। ऐसा होने पर ही 'पूरक औषधोपचार, प्रणाली' को अधिक यश प्राप्त हो सकेगा तथा स्वास्थ्य लाभ प्राप्त होगा।

अंततः एक महत्वपूर्ण मुद्दा यह है कि अधिकांश पूरक औषधोपचार, कानून द्वारा नियंत्रित न होने की वजह से इन उपचार प्रणालियों से कई अज्ञानी तथा दिखावटी चिकित्सक भी बड़ी संख्या में जुड़े हैं। कोई भी असाध्य बीमारी ठीक कर देने की गप्पें हाँकने वालों की भी कमी नहीं है। इसीलिए प्रत्येक व्यक्ति को इससे संबध्द प्राथमिक जानकारी होना भी जरूरी हो जाता है। ❑

अनुवाद : डॉ. सुशील टिकले

Invasive Devices Increase Risk of Infection

This information has been supplied by ***Stephanie Swafford*** *in the 24 May 1997 issue of BMJ*

A patient is seven times more likely to acquire an infection in hospital if an invasive device is used, according to a report from the Public Health Laboratory Service.

Invasive devices such as urinary catheters or intravenous lines are used increasingly often and the report found wide variation between hospitals in the use of such devices and in the incidence of infection.

Data for the report Hospital Acquired Infection were collected from 19 hospitals in England and Wales which were clinically audited for infection control activity. Results of the three year study showed over 2000 hospitals acquired infections in over 80,000 admissions, giving a rate of nearly three infections for every 100 admissions. Rates of infection for intensive care unit, where invasive devices are used more frequently, were nearly 20 for every 100 admissions.

There is a great disparity among hospitals in the use of invasive procedures. For example, the percentage of women undergoing gyneacological procedures who have a catheter inserted varies from 20% to 72% depending on the hospital.

"Clearly such devices should be used with restraint", said Professor Alon Glynn, study leader and former director of the Public Health Laboratory Service's central public health laboratory. □

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