An Integral Part of the Rural Health Services

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After surveying the scope and impact of the different health committees appointed by official bodies during the last five decades the authors feel that the concept of people's participation in the delivery of basic curative services will succeed in enhancing the acceptability of Community Health Volunteers in rural areas. The first part of this paper appeared last month.

Committee on the Basic Health Services (1966)

THIS Committee was constituted in continuation of the resolution passed in the 13th meeting of the Central Council of Health held at Bangalore to review the staffing pattern of the primary health centre complex and to recommend the minimum strength of staff of various categories required at different levels within the district capable of fully catering to the needs of the vigilance services in the maintenance phase of National Malaria Eradication Programme, Smallpox Eradication Programme, Tuberculosis, Leprosy and Trachoma Control, etc.

The Committee liked importance to be attached to an integrated approach in the entire health field. In its opinion, programmes of public health and medical care should be integrated to the maximum extent possible and also the programme within each field. It further suggested that an integrated organisation should be developed, at every stage of operation and supervision, for the entire health programme and health workers at the lower levels should increasingly become multipurpose workers.

Considering the need and importance of the involvement of local communities and other developmental agencies, it further observed that "even today it is necessary and should be considered a matter of some importance to bring in other existing governmental staff and the institutional leaders to lend a helping hand to the basic health services and this will be more necessary in future when the work-load on basic health services will increase on new items or work being entrusted to them as and when other mass programmes enter the maintenance phase. It should be possible for community development staff, school teachers, panchayat secretaries, leaders in the panchayati raj institutions, workers of mahila mandals and other people's institutions to give assistance to the basic health workers in various ways, such as, in educating the people, creating favourable public opinion, and in organisational work of various kinds". It also added that "...the possibility of this has not been actively investigated so far as should be our objective. It would indeed be a mistake to try to build up the basic health services in isolation of the rest of the administrative machinery functioning at the base level or to fail to take advantage of the people's institutions that are being actively promoted in pursuance of the objective of democratisation of the rural-community side and promoting people's participation in developmental activities."

While stressing the need of involving various institutions and the need of people's participation in the development of basic health services in the countryside, it added that the approach to attain the goal should be entirely practical. Accepting the principle that it is important in health programmes, and more so in health education, that there should be growing people's participation it cautioned that "in the circumstances of our country, such participation can only be promoted around active programmes undertaken by government or with their assistance. We should guard against creation of more demands by the people on government which later may not immediately be in a position to fulfil on account of financial and other limitations".

Committee on Multipurpose Workers under Health and Family Planning Programme (1973)

In pursuance of the recommendation of the Executive Committee of the Central Family Planning Council made at its first meeting held on September 28, 1972, the Government of India constituted a Committee to study the feasibility of having multipurpose workers in the field under Health and Family Planning Programme and to make suitable recommendations in this connection. The Committee submitted its report in September 1973 and for the first time proposed that the concept of integration of health services should be carried out from peripheral to state level.

Keeping in view the terms of reference of the Committee, the Committee has not gone into detailed planning and recommending a strategy for involving people in the delivery of basic health services. However, the fact that while formulating its recommendations, the Committee had considered it important to discuss and take into account the views expressed by people indicates that the Committee has attached considerable importance to the need of involving people in planning the reorientation of health care services in the rural areas. This became evident when it observed that "...while ascertaining the views of the community leaders about the existing health and family planning services, it was clearly brought out that the people are not happy with so many workers coming to their homes and making enquiries for individual programmes. The community leaders were of the opinion that a single worker delivering both health and family planning services would be more welcome". This with other factors promoted the Committee to recommend the development of a system for delivery of a package of health care services in the rural areas through the agency of multipurpose workers who should be assigned with the responsibility of providing basic health services to the population residing in their respective areas". Further, it added that ".....it may be appreciated that the multipurpose worker would be entrusted with carrying out integrated functions and would have greater rapport with the people in rural areas who would naturally look to him for all their needs in the field of naturally reinforcing components of health, family planning and nutrition."

Group on Medical Education and Support Manpower (1975)

At this juncture it may be pointed out that although the number of doctors in the country has increased over the successive plan periods, the alienation of doctors from the rural environment has deprived the rural communities of total medical care. As a result, inadequate progress has been made to cover the essential actions necessary to provide for basic health needs of the larger proportion of the people living in the rural areas.

Reviewing the development of health services in the country the Group observed that "we have adopted tacitly, and rather uncritically the model of health services from the industrially advanced and consumption-oriented societies of the west ... it is, therefore, a tragedy that we continue to persist with this model even when those we borrowed it from have begun to have serious misgivings about its utility and ultimate viability." It suggested that it was, therefore, desirable that we took a conscious and deliberate decision to abandon this model and strove to create, instead, a viable and economic alternative suited to our own conditions, needs and aspirations. The new model will have to place a greater emphasis on human effort (for which we have a large potential) rather than on monetary inputs (for which we have severe constraints). Health is essentially an individual responsibility in the sense that, if the individual cannot be trained to take proper care of his health, no community or state programme of health services can keep him healthy. The community responsibilities in health are even more important and in the view of the Group the social aspects of health are the weakest and they, therefore, need strengthening and the highest emphasis. The over-emphasis on provision of health services through professional staff under state control was observed by the Group to be counterproductive in Indian conditions. The modern system of medicine which employs only the fully trained persons on a professional basis is no doubt very competent from a technical point of view. But it lacks some of the emotional, psychological and social advantages.

The Group, therefore, recommended an active involvement of the community itself in providing the provisions of basic health services to the people. As a result, it suggested that the first assistance that any community needs in the form of health services should be provided within the community itself and not only through paid and trained professionals but also by part-time trained para-professional persons who operate on a self-employment basis, by imparting to them training and skills so that a large number of people from the community itself would be available for providing the elementary health and medical services which were needed by the community. These skills could be imparted to selected persons from the community who may have the necessary aptitude. The role assigned to these para-professional functionaries in the fields of promotive and preventive aspects of health and family planning were visualised as basically educational that were capable of doing immense good without any untoward implications. Regarding the apprehensions that may arise with regard to their role in curative aspects of health, the Group emphasized that this function would be limited to the use of a few specified remedies for simple, day-to-day illnesses.

This emphasis on the creation of a large band of semi-professional and part-time health workers in the community itself was proposed merely as a second-level supplementary personnel to fully-trained professionals and not as a substitute for them. While suggesting this, the objective of the Group appeared to introduce the concept of self-reliance as a specific operational characteristic of basic health services.

Community Health Volunteers' Scheme under the New Rural Health Policy

So far a review of the recommendations of various committees shows that although commu-

nity's participation was regarded to be fundamental to the extension of coverage of health services, most of the above mentioned committees with the sole exception of Health Survey and Development Committee have avoided to put forward any specific proposal to achieve this important objective. The New Rural Health Policy as announced by the Government of India in 1977 realised that unless and until the community is not involved in the delivery of health care services, no substantial gain can be achieven improving the health of our rural masses. To this end, among other steps that the New Rural Health Policy has suggested, the introduction of 'Community Health Policy Workers Scheme' can be cited as an effective way that the Government has devised to radically alter the concept of health care—through close identification with community in terms of recruitment, training and practice. The community health workers scheme can be termed as a concrete manifestation of the ideological principles of following mass line and being self-reliant.

The idea of community health Volunteers' Scheme has a long history. The Sub-Committee on National Health appointed by the National Planning Committee in the year 1938 envisaged the training of intelligent young men and women "imbued with missionary spirit" with the sole objective of carrying to the men under training the social implications of medicine as a science. The Sub-Committee stated: "We feel that the most urgent and important task that faces us is to educate our rural population in healthy living and make it possible for them to do so. The health volunteer will be from among the villagers only somewhat better trained than them. He will not appear to the villagers as a strange imposition of a strange system, but as their kith and kin who desires to help them."

In keeping with its pledge to provide better health facilities to the rural population, the Government of India launched a rural health scheme on October 2, 1977. The Community Health Volunteers Scheme proposes to enlist community's participation in accelerating the pace of diffusion of health innovation at the village level and in bringing simple medical aid within the easy reach of every villager. The scheme aims to achieve it by imparting skills in health care to the selected community members who have attitude and aptitude for such type of work.

The scheme conceives community health volunteer (CHV) as not to be a member of conventional health service staff team but as a selected representative of the community itself who by virtue of his situational factors, i.e., nearness to the people, ability to establish rapport with the people, etc., acts as an instrument in developing achievement motive among his community members so that villagers are able to direct their energy and abilities in improving their own health status.

At the operational level it is expected that a CHV would act as a link between his community and the health functionaries. The ideological dream of the current effort is the stimulation of local efforts for improving the health status of our rural population by promoting the growth of public support through CHV to mitigate the priority health problems.

The scheme provides that every village or community with a population of about 1000 should select one representative who is willing to serve the community in his spare time. To project the true nature of the scheme the process of selection of such representatives is to be undertaken and completed by the villagers themselves with the provision of necessary help, guidance and assistance, if needed, from the health workers of the area. With a view that community is able to select the suitable candidate, the scheme provides certain guidlines to it which broadly encompass the consideration of candidates keeping in view his motivation, acceptability, leadership quality and educational qualification.

On the completion of the selection process the selected persons are provided three months training in basic health services at PHCs by the health team attached to it. After the completion of training each CHV is provided with a kit containing specified simple medicines and a work manual. Safe, selected and specified medicines costing upto about Rs. 50 are provided to him on a monthly basis. In addition, each CHV is paid a stipend of Rs. 200 per month during the period of training and an honorarium of Rs. 50 per month after training is completed.

Summary and Conclusions

The paper discusses the development of the concept of people's participation in the delivery of health services in our rural areas as is reflected in the recommendations of various health committees. It may not be wrong to say that people's participation and involvement forms an integral part of present day's ideological concept of health development.

Depending on the innate collective capacity of the community, people's participation has a wide range of application from consultation to a minor or major role in decision making, setting of priorities, mobilization of internal and external resources and actual involvement of community members not only in promotive and preventive health services but also in carrying out elementary type of curative services. Theoretically, the degree to which community exercises this innate capacity may be taken as a direct measure of their involvement, which could be conceptualised in terms of a broad spectrum. Where the

capacity is least exercised, the community may be 'participating' in health development but only in the sense of being passive recipient of some of the benefits. On the other hand, the situation where the purpose and content of health development originate with the people and where individual voluntary contribution to programmes and projects take place, contributes to a 'collective' sense of belonging and dignity. Between these two extremes of involvement is the more prevalent situation where members of communities share to a limited degree in decision making and have marginal physical interaction with the decision-makers and where channels for communicating their opinions to the 'authorities' may be reduced to the use of mass action. These situations in turn are influenced by a set and complexity of various factors.

Studying the recommendations of various health committees leads us to believe that these committees have realised and stressed the need and importance of enlisting community's participation in health development programmes though some committees/groups appeared to have diversified opinion about the nature, scope and the extent of such participation.

The Health Survey and Development Committee stressing the need of people's participation recommended the establishment of village health committees in each village so as to stimulate health consciousness among the villagers and to assist and co-operate with health workers, to influence the villagers to accept health measures designed to promote health welfare. In the opinion of the committee, village health committees should be involved in carrying out indirect health services, i.e., in the sphere of environmental sanitation, collection of vital statistics, control of communicable diseases, etc. The recommendations of the Committee, it would be observed, do not include the involvement of the community in the delivery of elementary type of direct health services. More or less, the views of the Committee were also endorsed by the Health Survey and Planning Committee and the Committee on Basic Health Services.

The report of the Group on Medical Education and Support Manpower for the first time visualised a much broader view on the extent of people's participation in the delivery of health care services in the rural areas. The Group, while suggesting the strengthening of the infrastructure of health services and the need to reorient the training of medical personnel, also included in its recommendations a viable and economically feasible alternative suited to Indian conditions by placing greater emphasis on human efforts. It suggested the involvement of the community itself in the delivery of both direct and indirect health services so that these could be provided to the people at their first level of contact through the agency of part-time trained para-professional persons belonging to the local communities. The Group recommended that these volunteers should be involved not only in the promotive and preventive aspects of health but also in the delivery of elementary type of curative services.

The New Rural Health Policy includes Community Health Volunteers Scheme as one of its major components. These volunteers who are selected by the community itself, after training, are expected to play a vital role—both vertically and horizontally—in making primary health care available in rural areas. Thus the concept of people's participation which till recently had remained confined to their involvement in indirect health services alone was extended to their involvement in the delivery of basic curative services also. It is expected that this approach will succeed in enhancing the acceptability of CHVs in rural areas as they will be able to render basic curative services which are the 'felt-needs' of people. This in turn will improve their effectiveness in implementing various health programmes based on the 'real-needs' of the villagers.

(Concluded)

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IMPORTANT CORRECTION

The cost of TINAI Badge is Rs. 5. It has been inadvertently printed as Rs. 4 in the November issuse of the **Journal.** Readers are requested to note the correct price.

SNA Unit Subscription per member is Rs. 3 for all categories of students. Rs. 2 has been wrongly printed in the November issue.