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COMMUNITY PARTICIPATION AND HEALTH

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OBJECTIVES

Swasth Hind (Healthy India) is a monthly journal published by the Central Health Education Bureau, Directorate General of Health Services, Ministry of Heath and Family Welfare, Government of India New Delhi. Some of its important objectives and aims are to :

REPORT and interpret the policies, plans, programmes and achievements of the Union Ministry of Health and Family Welfare.

ACT as a medium of exchange of information on health activities of the Central and State Health Organizations.

FOCUS attention on the major public health problems in India and to report on the latest trends in public health.

KEEP in touch with health and welfare workers and agencies in India and abroad.

REPORT on important seminars, conferences, discussions, etc., on health topics.

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A HAPPY NEW YEAR

In this issue

Articles on health topics are invited for publication in this Journal.

State Health Directorates are requested to send reports of their activities for publication.

The opinions expressed by the contributors are not necessarily those of the Government of India.

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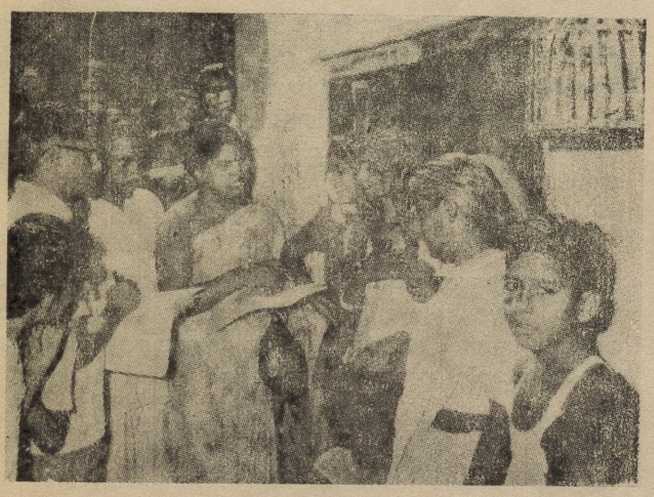
India is committed to achieve the target of health for all by 2000 A. D. This requires careful planning with built-in mechanism of community participation at all the stages right from planning to implementation and evaluation. If people take active part in the health programme there is no reason for not being able to achieve the target.

COMMUNITY PARTICIPATION AND HEALTH EDUCATION

DR B.C. GHOSAL



THE phrase "Community Participation" is used loosely by various community workers and personnel working in the allied field. It is, therefore, essential that 'Community participation' must be clearly defined and explained. While using the world participation, it must be seen whether action is involved or not. If action is not involved, it cannot be called participation in true sense of the term. For instance, the job of a health educator in a particular situation is to motivate the mothers to get their infants immunized on their own. Being convinced that it is in their interest, we can say that there has been action on the part of the mothers. Mothers should also feel that this programme is meant to cater to their needs and interest.

Positive action is possible only when people are willing to accept the programme, however, acceptance can come only when people are convinced that this is their own programme. Mere owning the programme is not enough. They must also make commitment publically for action. The whole system of commitment involves scientific knowledge and positive attitude towards the problem by the people. To make people act it is essential that they should know the details of the programme in terms of social as well as medical multi-dimensional aspects of the programme.

It is also important to know the decision making process to find out whether there was actual "community participation". People must be educated to help themselves in taking appropriate decisions for action. However, for a real interest in health promotion, it will have to be ensured that the people are able to take correct and appropriate decisions frequently and take necessary actions for healthful living.

Health education

Health education and community participation have been our keys of success in bringing about desirable changes in health behaviour of the people which resulted in happy and healthy long life. Therefore, it is of paramount importance that health education should become a part and parcel of life. To make the health education part and parcel of life, it is significant that health education must be integrated at all levels of our health delivery system.

The model below clearly indicates the Community Participation System in relation to 'Action' :

	INTEREST	
Own the Programme	Action	Make commitment
	↓	
	Know the programme	
	↓	
	Decision making process	
	↓	
Worker	Rapport	Community

Health education aims at bringing about a change in human behaviour related to health. For bringing about a change in behaviour, many factors have to be taken into consideration. The most important factor in the change process is to understand "why people behave, the way they behave". Although it appears very simple, but to find out multi-dimensional factors which operate during the process of decision making require careful analysis of the entire socio-economic and psychological factors operating at a particular point of time.

Behavioural change

Human behaviour is need-based and problem-centred. All human beings want to satisfy their felt needs. Many a time the real need of a person is not reflected in his demand for the fulfilment of his desires. In other words many needs are not felt need, although comparatively they may be more important. To bring about a change, it is significant to understand the level and heirarchy of needs of the people. This requires careful analysis of functioning of mind with respect to various needs. Needs of individuals and groups can be classified into the following stages:

Conscious	Felt Need
Sub-Conscious	Unconscious

HEALTH EDUCATION

Felt needs

The needs of individuals and group members may be either at unconscious level or sub-conscious level or conscious level. Therefore, it is essential that we must know the position of the need. Generally, when a person suffers from a disease, his immediate need is to go to a doctor, and get the treatment done. For getting the treatment done, he makes effort, verbalises his state of mind which is known as felt need or expressed need. But various aspects of promotional health including preventive aspects are not at the conscious level in the people. Therefore, it is very essential that the people should be educated in such a way that their unconscious and sub-conscious needs are brought at the surface level. For translating the sub-conscious and unconscious needs into the felt needs following procedures are to be applied.

The health educator has to play a pivotal role of a change agent. The role of change agent is a difficult one, but a person who knows the community intimately, can bring about a change in the health behaviour of the people through the process of education and motivation.

Understanding the community

As a change agent, the health educator will have to understand the culture of the people, their needs and aspirations, resources of the community, life style of the people, power pyramid and social structure.

For this, it is essential to:

1. Know the programme,
2. Know the area,
3. Know the Community,
4. Know the leaders and leadership pattern,
5. Know the channels of communication, and
6. Know the resources in terms of men, money, material and means.

After understanding the above six factors, the next step is to establish the rapport with the community. In establishing the rapport, one has to be careful about the value system of the community. In the light of values of the community, one has to develop working relations taking into consideration the emotional appeal.

The working model given below indicates how change in behaviour can be brought about by

HEALTH EDUCATION IN ANCIENT INDIA

From time immemorial, health practices are interwoven in the cultural fabric of the Indian society. The concept of healthful living was practised by the ancient saints and the people of this country. Studies related to ancient health practices indicate that various scriptures are available right from the *Vedas* in which this subject has been dealt in great details. According to *Susruta Samhita* there was a time when different types of diseases had spread among human beings, and everyone felt helpless in the face of these sufferings and loss of human lives. Susruta and other saints approprached the King Divodasa of Kashi (now Varanasi), the incarnation of Lord Dhanvantri. Dhanvantri assured Susruta and other saints and also imparted knowledge for healthful living, longevity and getting rid of the prevailing diseases which were causing so much ill-health among human beings. Great importance was attached to health education, self-help and modality of bringing about a change in health behaviour. Besides, Charak has written many chapters on the qualities and the effects of different types of food. Specific health instructions have been laid down regarding types of food to be taken, time of taking it, its quality and combination, the method of serving and cooking the food, etc. Charak also stressed the importance of nutrition education.

About transmission of disease Vagbhatta in his chapter on *Dincharya* has recommended that one should not sneeze, laugh or yarn without covering one's mouth. Nose and ears should not be picked with fingers. The concept of *Dincharya* was applied in day-to-day activities, *i.e.,* right from the morning till one retires to the bed. According to this concept one had to follow certain health practices for healthful living.

About drinking water Susruta has said that if the water is unclean, it should be purified by boiling or exposure to the sun or by throwing hot iron balls in it. For environmental sanitation Kautilya has laid down golden rules for keeping the city and villages clean. Kautilya in his book *Arthasastra* states, ".....from each house a water course of sufficient slope at a distance of three *padas* (foot length) shall be so constructed that water shall either flow from it continuously or fall from it into the drain. Violation of this rule shall be punished with a fine to 54 pannas.". According to the Charak samhita, the cause of epidemics was to be found in abnormal weather, winds, unsafe water and soil. In other words, importance was given to:—

(a) Personal hygiene,

(b) Environmental Sanitation,

(c) Water borne diseases,

(d) Air borne diseases,

(e) Health education and community participation,

(f) Rules and procedures for bringing about a change in undesirable health practices to desirable health practices.

According to Bhel Samhita, stress has been laid on regional variations of diseases and it has also been mentioned that climate and food play an important role in healthful living. He has pointed out that "the people living in the eastern region who eat fish and rice, in them the *Kapha* and *Pitta* are predominant and elephantiasis and goitre are commonly seen in them.

It may thus be concluded that since the Vedic period Indians knew the art of living a fuller and healthier life. It may further be supplemented by the statement of I-T Sing, 673 A.D., who lived with an Indian Buddhist monk. He says, "The rule of eating and drinking, bathing and brushing the teeth and such other desirable health practices which were important for the longevity of life were being practised.". He has also stated that promotional health activities (health education) were given great importance as a part of Indian culture and tradition.

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bringing about a change in the need pattern of the community:

		FELT NEEDS
		Socio-cultural factors
		Location of the area
Sub-conscious }		
Unconscious }	Rapport	Leadership
		Channels of communication
		Resources

Problem diagnosis

This above mentioned working model has been tested in various situations in this country like rural, urban, semi-urban, industrial areas, etc., and has been found to be very effective. Once the various needs of the community come at the surface level, the role of the change agent is to motivate and help the community to identity their needs in clear terms and rank them in order of priority. After ranking the needs

in order of priority, the change agent will have to make all possible effort to help the community in diagnosing the most pressing problems faced by the community.

Educational content

In this process the communicator or change agent or health educator will have to develop a systematic plan of operation in close collaboration with the community taking into consideration educational contents based on the educational needs of the community. Although it appears to be difficult task, but is not at all difficult for a skilled and professional health educator or change agent. The model given below highlights the activities to be undertaken based on experiences of working with various types of communities having different life styles and socio-economic set-ups:

Collaboration and coordination with the community		
Community Diagnosis	Educational diagnosis	Health Education Strategy
	Educational contents	
Change in health practices		

Selection of message

During the process of working out the plan of operation, the most significant factor is the selection of *message* or *stimulus*. If the stimulus is effective, there is no reason why people will not react favourably and once the people react favourably, the change in human behaviour is bound to take place. It is worthwhile discussing the various aspects of stimulus. The stimulus may be either negative or positive, but there may be a situation in which the stimulus may not be either negative or positive but neutral. Therefore, for a change agent, it is of pivotal importance to understand the role of stimulus and also its effectiveness at a particular point of time, in a given situation. In other words every stimulus must be so selected that its effect is positive. The diagram given below indicates the process of stimulus response situation.

Stimulus				
		R1	E1	
		R2	E2	
		R3	E3	K
	+	R4	E4	
		R5	E5	
	—	R6	E6	

The above diagram points out three important aspects:

For maximum community participation, it is essential that the health and family welfare worker must be able to create a positive image of the service agency.

The stimulus may produce positive reaction, but these positive reactions (R1, R2, R3.....) may be divergent, if the reactions are positive, but divergent the role of change agent is to converge the reaction through education to a point say 'K' and this is known as motivation. For motivation the process of education has two aspects: (i) de-education and (ii) re-education. By de-education we mean removing the misconception and by re-education we mean increasing the knowledge through introducing scientific knowledge.

Therefore, health education and behavioural change are directly linked, and health education is a process of bringing about a change in knowledge, belief, and behaviour. These changes can be brought about through the educational process of de-education and re-education, that is, a change from undesirable health behaviour to desirable health behaviour.

Research in health behaviour

In this country various studies have been conducted to find out the factors responsible for change in human behaviour. Various demographic training and research centres have conducted studies in which it has been proved that if the stimulus provided has produced positive reaction, people have accepted the programme. One of such studies was conducted by the Central Health Education Bureau regarding 'Motivating hundred cases for tubectomy--a case study' in which various health education techniques were applied to change the behaviour of women to accept

(*continued on page 26*)

Community-Based Health and Family Planning

Progress toward the goal of "Health for All by the year 2000" requires new approaches. One approach now being emphasized is community-based distribution (CBD) and services. In CBD programmes, lay workers from the community provide important services and supplies with minimal day-to-day reliance on clinics, professional medical personnel, or complex diagnostic, screening, and record-keeping procedures.

THE Community-based distribution (CBD) approach is already being used with some success to deliver various primary health measures, including family planning. For example, in the last 12 years more than 70 community-based family planning programmes have been undertaken in at least 40 countries. These programmes vary greatly. They involve village leaders, women's clubs, traditional midwives, or local retailers. Local workers distribute condoms, oral contraceptives, and sometimes other items, either free of charge or for a small fee, sometimes on a household-to-household basis, sometimes through convenient community supply points. An objective they all share, however, is to improve access to family planning services by removing some of the geographic, financial, bureaucratic, cultural, and communication barriers that limit use of these or any health services. Greater availability is an important goal of all community-based services.

Criteria for CBD Services

Certain primary health measures are better suited to a community-based approach than others. For lay workers to be effective, CBD programmes should focus on:

- common and important health problems of the community.
- health problems for which there are effective remedies,
- services and supplies that are relatively safe and easy to deliver.

Among the measures that have been considered and/or provided through CBD programmes, in addition to family planning, are oral rehydration therapy for diarrhoea (ORT), malaria treatment, intestinal parasite treatment, nutrition education and supplements, and immunizations. Each of these measures offers special benefits but each also raises special problems for CBD.

Oral Rehydration Therapy

Oral Rehydration Therapy (ORT) is used to treat dehydration due to diarrhoea. Diarrhoea is extremely common among children under age five and a major cause of death. Although ORT does not prevent or cure diarrhoea, it is effective and safe in treating dehydration if it is prepared and administered properly. Technically, ORT is simple. The oral rehydration solution can be mixed from prepackaged ingredients and water or even made with household sugar, salt, and water. Programmatically, however, ORT is demanding. Because too dilute a solution may be relatively ineffective and too strong a solution can be dangerous, CBD workers and village women need careful and repeated demonstrations and training. Moreover, mothers should be taught to continue breastfeeding and to give other liquids and food during diarrhoea. Teaching the mixing and use of ORT requires more skills than teaching people to take a pill. Therefore, close supervision of CBD workers is necessary. Despite these demands, ORT is a valuable CBD measure with the potential for saving many lives.

Treatment of Malaria

Malaria is an endemic in many developing countries and may kill at least one million people annually, most of them in Africa. Community workers can use chloroquine and possibly other drugs to treat malaria. Single doses of these drugs lower fever, eliminate symptoms, and can cure the most dangerous type of the disease. Thus malaria treatment can have an important health impact. In areas where chloroquine is effective, treatment of acute cases of malaria is relatively simple, safe, and inexpensive. Because treatment produces immediate results, community interest is likely to be high. Preventive doses for all children and pregnant women may be even simpler than treatment but in the long run can reduce natural semi-immunity and encourage the development of drug-resistant organisms.

Intestinal parasite treatment

In many areas almost everyone is infected with intestinal helminths, or worms. Drugs to combat these parasites are relatively inexpensive, quick-acting, and easy to administer either to a whole village or to specific groups. Thus CBD programmes have found substantial community support when antiparasite programmes are started.

Although common, worms rarely lead to serious illness or death. Thus, the health impact of antiparasite medication, compared with other CBD measures, has been questioned. Furthermore, reinfection usually occurs after four to six months unless regular treatment continues or sanitation improves markedly. As a result, community interest may diminish as repeated treatment is needed. Thus it is not clear that treatment of worms should have high priority in CBD projects. If it is included, antiparasite medication might best be reserved for those who specifically complain about worms in their stools.

Nutrition measures

Poor nutrition occurs worldwide, especially in impoverished areas. CBD programmes have sought to deal with two nutritional problems—(1) insufficient protein and calories and (2) specific vitamin and mineral deficiencies. Diet supplements of protein and calories have been used extensively, but the results are difficult to measure. Food supplements do not always reach the women and children who need them most, or else they substitute for other food. In addition, protein-calorie supplements are expensive and raise logistical problems for CBD programmes. Some programmes weigh infants regularly to alert families to infant nutritional needs. This form of nutrition education may be useful, provided families have enough food to give more to a poorly nourished child, but most of these programmes have not been thoroughly evaluated.

Although insufficient food is by far the greater problem, CBD programmes can deal more effectively with deficiencies of specific vitamins and minerals. CBD workers can distribute vitamin A capsules to children every four to six months to prevent eye problems. Iron and folate supplements should be taken every day and their lack of obvious effects may make compliance a problem. It may be feasible, however, for CBD programmes to distribute these supplements to pregnant women. In areas of iodine deficiency, CBD workers can cooperate with mobile injection teams or distribute oral doses of iodine to prevent goiter and cretinism.

Immunization

Immunization against diseases such as diphtheria, whooping cough, tetanus, measles, and polio has a substantial impact on health, but immunization programmes are too complex for most CBD efforts. The main problem is that vaccines must be kept refrigerated at a constant temperature or they lose their effectiveness. Furthermore, with some vaccines, once a vial is opened, the contents must be used that day. Waste can be enormous. Vaccinating each child three times at the proper intervals during the first year of life further complicates logistics. CBD workers can play an important supporting role in immunization programmes, however. They can encourage women to have their children vaccinated and to be vaccinated themselves. They can also coordinate and publicize the visits of the immunization teams, which can be the occasions for delivering a variety of primary health care services.

Problems of implementation

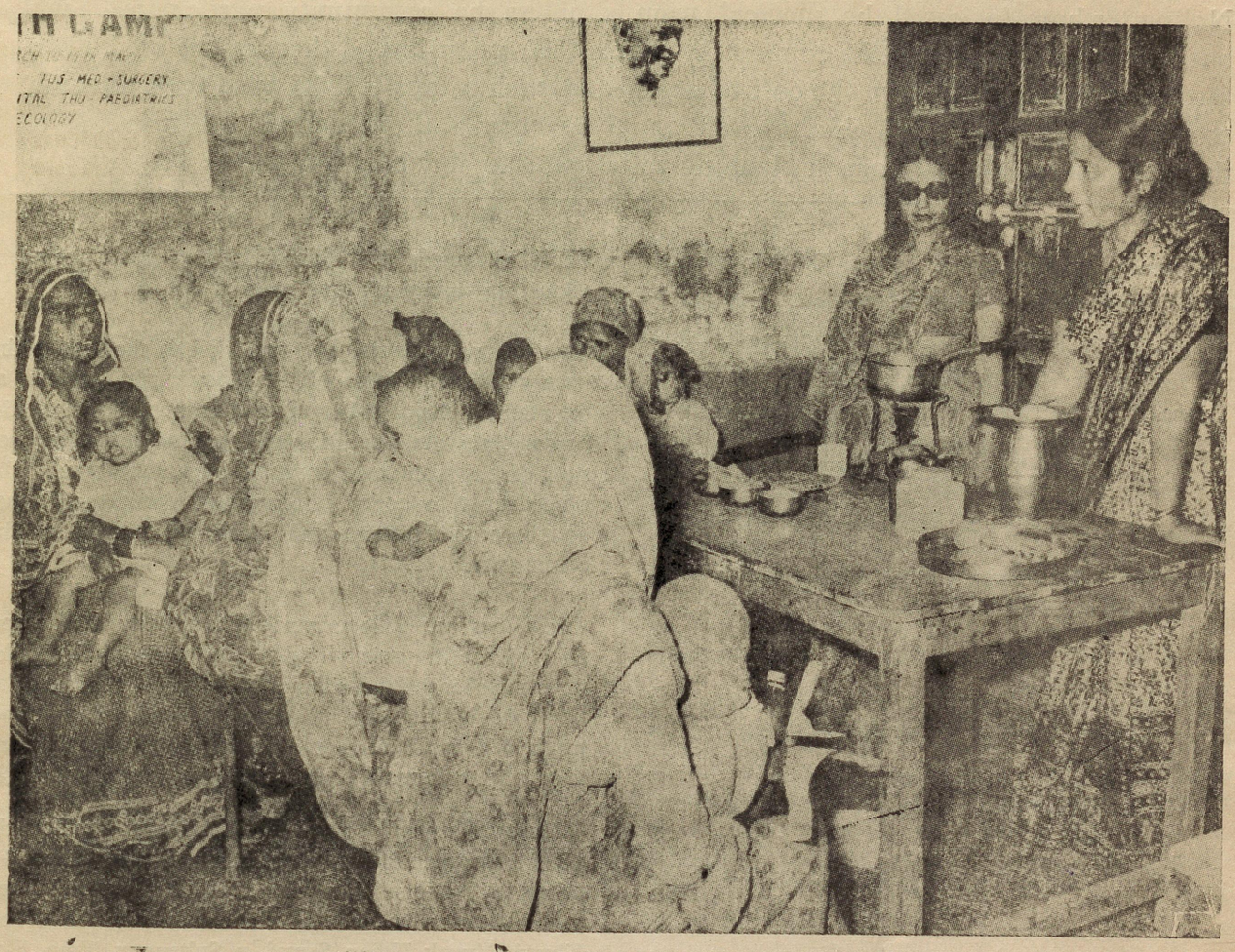
Regardless of which measures are undertaken or in what combinations, the most difficult tasks in a CBD programme are likely to be recruiting and training workers, providing continued supervision, coordinating backup with the existing medical system, keeping supplies flowing, and evaluating the programme and revising it as needed. Lack of sufficient attention to these problems has limited the impact of many CBD programmes.

Experience to date in family planning and health CBD programmes, is limited and inconclusive, but a few basic lessons stand out concerning integrated programmes.

- CBD projects should avoid a service overload, in which community workers with limited training are expected to learn and do more than they can.
- New activities should be phased in on a step-by-step basis so that both workers and users learn each measure thoroughly before another is introduced.
- Training and supervision must be a continuing part of any CBD programme.
- Community participation is desirable through village leaders, women's groups, or other organizations. Also communities must eventually share the cost of primary health care through fees or other means.
- Combining family planning with other health services has not proved necessary to make family planning acceptable at the community level, but combined efforts may help meet other primary health care needs.
- Operations research is needed to discover how best to design and implement an integrated CBD programme. In the meantime, programme managers must be alert and ready to respond to problems as they arise.

—**Editors' Summary**

Courtesy: POPULATION REPORTS
No. 3, Nov-Dec, 1982.



Community Participation Through Rural Mobile Health Clinics

DR LALIT KANT AND SMT URMILA PANT

THE method of achieving the goal of health for all by the year 2000 is through primary health care approach. An International Conference held at Alma Ata in 1978, described primary health care as "..... essential care.....made accessible to individuals and families in the community through their full participation....."

Community consists of people living together in some form of social organization. Its members share the common political, social and cultural characteristics as well as interests and aspirations including health. And to evoke community participation it is essential to encourage individuals to assume responsibility and to develop their capacity to contribute towards their own and the community's development. Community participation, thus, assumes a pivotal role in providing health care successfully.

The ways in which the community can participate vary not only from one country to another but also in different set-ups.

India lives in villages and her doctors in cities. Thus a large area, mainly rural, is left unattended. How

No matter how dedicated the medical team is, unless the community participates it will not be successful. When the community shares the responsibility, there is less of botheration and it also cuts down the cost of organising such camps. It is vital to involve the community leaders, school children, influential members and voluntary organisations of the community at every stage in planning and organising any health-oriented activity.

do we reach the unreached? Rural Mobile Health Clinics provide part of the answer.

Each medical college in the country has been given three such clinics by the Government of India. The Maulana Azad Medical College, New Delhi, has been using these clinics to provide health care in rural areas of the Union Territory of Delhi.

Objectives

There are four main objectives of the camps organised through these clinics:

— to provide general health care facilities in unattended areas.

— to make available specialists' services to the community.

— to immunize the children and pregnant women of the locality.

— to disseminate health eduaction on health topics.

For achieving these objectives the community is approached through local influential people. Once the leaders are convinced about the services provided by the mobile clinic the task of implementing these services becomes easier. The objectives for involvement of influential people of the community in the programme are:

— to seek their social sanction and support.

— to make physical arrangements for the camp and educational activities with their help.

— to carry out publicity work, utilising the available channels of communication.

— to seek their support in carrying out the camp in an orderly fashion.

— to seek their help in follow-up services.

Methodology

From the office of the Block Development Officer, a copy of all the villages in that block is obtained. Those villages which do not have a government-run allopathic dispensary are marked for a visit.

First contact : During the first visit to the village the team contacts any one of the following : worker at the malaria clinic, staff of ayurvedic/homoeopathic dispensary, private practitioners, school headmaster or staff of any voluntary organisation active there. The objective is to collect information about the formal and informal leaders and influential people of the community.

Local leaders ; Village *pradhan* is usually the accepted leader. In some villages, Metropolitan Councillor or a member of the Municipal Corporation may also be available. An influential *zamindar*, a school teacher, a social worker or a retired government servant also command a lot of respect and are helpful.

Voluntary organisations : The team also contacts the voluntary organisations functioning in the villages for example, National Kasturba Gandhi Memorial Trust in Bakhtawarpur, St. John's Missionaries in Khera Khurd, Yuvak Uthan Samaj in Sultanpur, Yuva Ekta Manch in Prasad Nagar and United Farmers Service co-operative society at Alipur. And at one occasion the team had co-operated with the National Service Scheme of Ramjas College in organizing the camp.

The team introduces itself, spells out its objectives and the services that it offers and the duration of the camp.

It is made very clear at the outset that this will be a 'people's camp'. Whole community should participate in making it a success.

Once a decision is made to hold the camp in a particular village information is collected on the socio-demographic picture of the area from knowledgeable people.

The camp is of two weeks' duration. The first week is spent in doing spadework and the second week is devoted to the implementation of the programme.

Preparatory phase

The camp site is selected in consultation with the village leaders. Usually it is the village *chaupal* or the *panchayat ghar, barat ghar,* or a spacious house belonging to a villager, where the camp is organized.

For physical arrangements people take up job responsibilities. A group of young boys volunteer to keep the place clean, some arrange for tables and chairs, and someone lends his fan.

Alongwith a volunteer from the community the team conducts house-to-house survey in the entire village. Presence of a local person helps to establish a quicker and better rapport with the community. Information about the camp and the services that would be provided is given to families and a copy of the schedule is made available.

In village Sultanpur the members of *Yuva Uthan Samiti* came forward to help in these visits, while in Prasad Nagar the volunteers of *Yuva Ekta Manch* helped, and in Alipur it was the *Balmiki Samaj.*

The posters giving the schedule of the camp are prepared in the colloge itself and the young lads of the village are given the responsibility of putting them up at prominent places in the village. Since they put in their effort to paste these posters, they prevent others from taking these off.

School children as communicators

In Bakhtawarpur, the team tried out a noval media of relaying the message for the camp, i.e. the involvement of school children. After obtaining the principal's permission the team members visited each class and distributed the handout to the children. The students were made to repeat aloud the schedule of the camp printed on the hand-bill and were asked to spread this information to other members of their family and also to neighbours and later to paste the handout on the front gate of their house. On visiting the village next day, the team members were happy to see the message on each door. And the swelling attendance at the OPD, later, spoke volumes of this method.

Most traditional and commonest method of spreading the message in villages is through the drum-beater. And usually the *Pradhan* takes the responsibility to pay for this service. During the day, volunteers from the community go round the village talking to 'hookah-group' about the camp.

Indigenous *dais* are also contacted and briefed about the camp. They are very effective in mobilizing patients with gynaecological problems.

Health education

Depending upon what health problems the villagers have, the team organises health education sessions. The common problems, that are encountered are: worm infestation, teeth problems, eye diseases, diarrhoeas, skin infections, and malaria. The teaching aids that are used include charts, flannel graphs, models, flash charts, and films. The health talks are usually arranged in large and spacious houses. For the film-shows usually a *baithak* is chosen and the owner gladly lets the team use his electricity.

Action phase

On the first day of the action phase—the most senior member of the community is requested to inaugurate the camp. And once the camp sets going, the volunteers from the community help in bringing the old and needy from their homes, encourage mothers to get their children immunized, maintain order at the OPD and the drug counter, and at times they mediate to pacify an irate person.

In Alipur, for example, a women had come of her own accord for insertion of an IUD. When her husband came to know of it, he was furious and was bent upon using physical force and he used abusive language alleging that the team had forcefully inserted the IUD. If there were no community support the team would have had a tough time dealing with him.

Conclusion

It is the community participation which infuses life in the camp approach to provide health care in rural areas. No matter how dedicated the medical team is, unless the community participates it will not be successful. When the community shares the responsibility, there is less of botheration and it also cuts down the cost of organizing such camp. It is vital to involve the community leaders, school children, influential members and voluntary organizations of the community at every stage in planning and organizing any health-oriented activity. △

THE PARTICIPATORY IMPERATIVE IN PRIMARY HEALTH CARE

MARY RACELIS HOLLNSTEINER

Five years after the declaration of Alma-Ata, what are the significant issues which have been identified in community participation, an essential element of the PHC *strategy?*

The author reviews some of the issues which have arisen in the course of the implementation of PHC *programmes: the difference in the goals attributed to participation in* PHC, *its political or non-political dimensions, the status of the participants, the question of sectoral or integrated activities, and the selection and training of community health workers.*

In a second part, drawing on these experiences, six major areas for action are suggested, along with some guidelines for the future.

A health care system based on Primary Health Care (PHC) would have the following characteristics: (1) accessibility of services to everyone with the poor receiving priority attention; (2) relevant and effective services which meet the health needs of the majority poor and which are socially and culturally acceptable to them; (3) functional integration with higher technical levels of the health system; (4) cost-effectiveness through improved efficiency and the allocation of resources so as to achieve the greatest benefit for the majority at the lowest cost; (5) intersectoral collaboration involving close contact with agricultural services, nutrition cadres, educational entities and the like, similarly oriented to the needs of the majority poor; and (6) community participation in the planning, management, and evaluation of health services at all levels. Let us focus on the least understood characteristic, community or people's participation.

People's participation in PHC

People's participation is intrinsic to Primary Health Care (PHC). On this much all PHC advocates agree. Beyond that consensus, however, lies a host of arguments that need resolution.

Means or end?

Many proponents who hold the narrow view of PHC as a set of activities still pose this spurious dichotomy. They view the active involvement of people in health planning, implementation, and evaluation as merely another "component"—although a particularly important one—for achieving better levels of care. In this instrumental sense, participation is a means to that end. On the other hand, those who regard participation as an end in itself—an obvious good that will enable people to mobilize for their collective benefit—must reckon with socio-political realities. The ends argument, while correct in identifying health as a basic right, can too easily be distorted by elites to justify self-reliant participation as the substitute for tangible health care benefits for community residents. This strategy all too readily enables elites to free themselves of the burden of sharing resources and power with grass-roots majority. Genuine PHC therefore, eschews the unidimensional means-or-end, either-or concept of community participation in favour of a holistic fusion.

Who is the community? Who are the people?

Again, there is general agreement that people's participation refers not to everyone in an identifiable community—since local elites already have a strong say in decision making—but rather to the poor majority with little access to resources and power. The equity principle of PHC militates that it is these groups who, being most in need of better health care, should organize themselves for achieving it. How to do this effectively nonetheless poses problems. For

one, peasants frequently maintain a functional paternalistic relationship with one or a few local elite families who would feel threatened by the dependent partners' linking with others of similar class interest. To cut oneself off from dependency upon one's patron is to court economic disaster in the form of losing access to land and other employment. The resulting economic insecurity and deepening poverty obviously has its effects on the family's capacity to achieve even the level of health previously maintained.

Add to this the urban poor, many of whom in the larger cities reside in illegal squatter settlements. They tolerate an appalling lack of amenities—clean water supply, sanitation, and housing—which in combination with high levels of unemployment, malnutrition, and poor education leave them in the most deprived of situations. With only a few exceptions, city authorities resist any attempts at providing amenities "lest these squatters be encouraged to stay and attract other rural migrants here". Because of their "illegal" status, participation by these embattled urbanites in health care or other access programmes generates greater resistance than in rural settings. Yet one of the most important features of urban PHC programmes in Indonesia and the Philippines is that the poorer populations are being contacted. "Contact is the *sine qua non* of everything. It is especially so for urban squatters who live in relative isolation (or dread) from local authorities." The need for organized participation thus becomes even more compelling for the urban poor.

Sectoral or integrated?

If health is a basic right, not only the health sector but all service sectors should adopt it as a goal. This can create problems, however, when sectorally organized government bureaucracies introduce their wares piecemeal into communities not sufficiently organized to integrate them into an ongoing programme of activities under the people's control. In such a setting, health-related activities remain segregated from the life of the community, imposed by outsiders on a passive population.

In contrast to the heavily community-based development of countries like China, Ethiopia, Tanzania, and Viet Nam, developing countries of more capitalist persuasions face difficulties motivating communities to organize themselves for self-reliant development. Each sectoral bureaucracy vies with others in introducing its particular product in hopes of organizing people around that set of activities. Thus, medical personnel trip over nutritionists who elbow out agricultural production technicians competing with water engineers for the farmer's attention. Occasionally, one of these sectoral agencies does succeed in mobilizing people around a specific sector. It soon finds, however, that people do not perceive this to be a discrete set of activities, but rather integrate it over time with other life concerns. The result may well be a positive shift from agency to community control. Nonetheless, this achievement may be viewed by certain powerful elements in a negative light.

A NEW HEALTH CARE STRATEGY FOR ALL

The second—and correct—interpretation of PHC views it as *a general strategy or approach* which embodies explicit principles and values. Those familiar with the concept of "alternative development" will recognize its kinship to PHC in its avowal of certain values and principles as requisites of good health care. These are the following:

1. *Equity and justice.* The basic right of every individual to heatlh implies the reduction of gaps between those who have access and those not, to health and other resources necessary for maintaining health—such as income, food, employment, education, etc. It postulates a redistribution of resources with particular advantage going to those having the least and whose needs are the greatest.

2. *An overall development strategy that gives high priority to social goals in addition to economic ones.* Recognizing that health is the result of a complex set of socio-cultural, economic, physical, biological, and other components, this principle points to the eradication of poverty as the basic requirement for health.

3. *People imbued with a strong sense of self-reliance and control over their own lives exercising responsibility over their own health.* The role of governments and agencies is not to act in the people's behalf to "deliver" health, but rather to support their efforts and take joint responsibility for health.

4. *The emergence of a new international economic order coupled with a new international development strategy.* A solidarity that transcends national boundaries as regards health for all grows out of a global concern over equity among nations and balanced world development.

The evidence suggests, therefore, that PHC works best in a community that is organized to tackle all the problems its members face in an integrated manner. When sectoral agencies approach such a community, their expertise can be successfully utilized by an experienced local group. Where communities have not actively organized themselves, the advent of a sectoral agency generates a "top-down" transfer of its narrow body of information to the community in such a way that the people never really integrate it into their lives. Monitoring and evaluation schemes developed and undertaken by the community will go far toward diagnosing these kinds of distortions.

Selecting and training community health workers

Primary Health Care (PHC) supporters unanimously advocate community residents' selecting their own local health workers. The rationale for this lies in the credibility the worker will have with prospective clients. Moreover, having been selected by them, he or she is far more likely to feel accountable to them. Yet, the selection process raises many challenges. Often, village officials make the actual choice independently of their constituents. This occurs when the mass of the village population is not adequately organized around their own interests and, being dependent on the village heads, feel relatively powerless to intervene—if they care at all. The party in power also has its say about the candidates the community selects, usually in the form of prior or post-selection approval. In some societies men rather than women are believed to be the appropriate choices.

Levels of education constitute a pre-condition for selection in some countries, given their view that community health workers should possess minimum formal education credentials—completed elementary or secondary school. The average community member does not have this and, therefore, is ineligible to serve. Where countries have low female literacy levels, this stipulation especially undercuts community women's access to health care by severely limiting the number of female health workers available for women to consult. Other programmes deliberately favour the selection of traditional birth attendants on the assumption that they already enjoy the community's confidence, especially among women and children. Because these birth attendants are frequently older women with their own repertory of folk cures, however, in many instances they resist the expanded functions included in PHC programmes.

The training of community health workers must necessarily correspond to the varied skills they are expected to have. These are as much organizational and motivational as technical. A list of tasks (especially *a*, *f* and *g*) formulated in the early days of Viet Nam's PHC programme illustrates this:

(*a*) prevent epidemics (smallpox, cholera, plague, typhus, encephalitis, etc.) by means of mass vaccinations;

(*b*) stamp out common infectious diseases gradually (typhoid fever, influenza, dysentery);

(*c*) fight social diseases and parasitic diseases (malaria, trachoma, tuberculosis, etc.);

(*d*) attack common diseases (pneumonia, infantile diarrhoea, etc.);

(*e*) treat common urgent cases (infantile diseases);

(*f*) launch a vast campaign to promote hygiene and prophylactic measures dealing with water supplies, sanitation and rubbish disposal;

(*g*) undertake a mass immunization campaign for the whole population.

Meriting examination is the debate as to how much curative medical training a community health worker should receive in view of the great strides forward achieved through preventive approaches—immunization, clean water, sanitation, nutrition, and health education, for example.

If community health workers are chosen by an organized community conscious of its needs, experienced at trying collectively to satisfy them, and appreciative of the health workers' assistance as expressed in a willingness to compensate them in cash or kind for their services, these health workers are more likely to remain and serve the community. This assumes they have the kinds of curative and preventive medical skills that correspond to what people want, the social skills necessary for effective motivation and communication, and the administrative capacity to gain access to existing health facilities—including the auxiliary support services of physicians and other medical personnel—and to appropriate technology ranging from herb gardens and basic drugs to bicycles and common medical instruments.

Political or non-political ?

The process by which groups or individuals vie with one another for access to limited resources and decide on how allocations are made can be called political. As PHC aims ultimately to effect the redistribution of resources and decision-making powers so

that ordinary citizens at the community level obtain a reasonable share of them—and therefore have more of a say about their own lives, especially health care —then PHC is clearly a political process. Other voices reflecting an experience with grass-root groups are powerful advocates of PHC as a political process :

> Those who are involved in creating an alternative system of health care and people's education should believe more firmly that it is also their task together with others, to bring to life the features of a new society in which the means of production and distribution will no longer create two classes of citizens whose health for all will be a symbol of "All Progress is for All".
>
> In our own work of training about 200 health workers, most of them illiterate harijans and tribal women, we had evidence that the step by step growth of people is a realistic approach.

The above writer goes on to define four steps in the community health worker's growth in knowledge, skills, and social awareness, two of them relatively non-political : (*1*) early detection and treatment of common diseases and health education rooted in the culture, beliefs, and customs of their people ; and (*2*) a more critical understanding of the totality of beliefs that the people connect with health. The third and fourth steps are clearly political in that they implicitly challenge existing power and resource alignments :

> (3) probing deeper with the people into issues of exploitation through moneylending, low prices in the village markets, bribes extracted by officials such as the forest guards ; creativity in health care and health education ;
>
> (*4*) playing a catalytic role among the women and the community ; organization of the women in the *mahila mandals* as a platform for on-going education and united action; helping the community understand the possibilities of tackling marketing and moneylending as systems of exploitation ; knowledge of protective legislation and development schemes; creating a new atmosphere among the people of self-confidence and critical understanding of their place in society; collaboration with village animators and adult educators.

Sara Kaithathara Community participation in Primary Health Care, Social Action, *vol* 31 *no.* 3, *Indian Social Institute, New Delhi,* 1981, *pp.* 355-356.

The issue is not whether PHC is political or non-political. Achieving health for all cannot be anything but political. Professionals in public administration are beginning to recognize this :

> Social development is a political process—its central purposes being to build the power of the powerless. The social develepoment manager is not a value free technician; he or she is inevitably a political actor in this process. Coalition building, reciprocity, compromise and the creative use of crisis are all power tools with which the social development manager is well advised to be familiar.
>
> —Frances F. Korten

The real issue centres on whether or not governments and the medical establishment will accept people's active involvement in decision making as a ***positive*** force rather than a situation to be avoided or actually repressed.

Obviously, perceived threats to the existing power arrangements perpetuating present elite-oriented health care systems are not easily tolerated by those in charge. Let leaders truly interested in promoting "progress for all" will recognize that between the two extremes of apathy and violent confrontation lies a broad range of legitimate and effective participatory behaviours that can lead to people's development and genuine structural change. This range may include degrees of participation from consultation and harmonious cooperation with the authorities to a kind of militant (but not necessarily violent) confrontation and effective mobilization around issues of concern to the community.

Some guidelines for the future

Much more could be said about people's participation in primary health care. Let us content ourselves here with final reflections on eight summary propositions postulating that a community-based health programme :

1. reflects and responds to the political context in which it develops ;
2. recognizes that conflict situations are inevitable and develops a strategy to deal with them which is most acceptable in the cultural and social values of the community ;
3. does not depend on identifying "felt needs" of the community but rather on developing a process for dialogue between the professionals and people in the community ;
4. recognizes the tension between flexibility and replicability and tries, as far as possible, to keep a balance between the two;
5. includes health services but realizes that the provision of services may not be the best entry point for developing community participation in development programmes ;
6. recognizes the basis of the programme as an educational process, identifies the process, and establishes training programmes to teach this process ;
7. recognizes "self-reliance" as an important objective and, therefore, carefully considers how foreign aid can best be used to promote this objective ;
8. seeks to evaluate its success based on the positive change in attitudes and commitment of the community to improve its standard of living.

These propositions may well serve as PHC guidelines for the rest of the century and beyond as people struggle not only toward health for all, but, more broadly, toward human progress and dignity for all.

— Susan B. Rifkin. Community participation in health—eight propositions

AREAS FOR ACTION

If PHC is to move away from being an incipient global movement, heavy on ideology, advocacy, and pilot projects, but light on implementation and distributive health results, large-scale, all-encompassing programmes will have to permeate the national scene. The key question is, how is this to be accomplished? How can the system be turned around to be responsive to the needs of the unserved or underserved majority? In particular, what measures can outside supporters take to foster people's participation : (*1*) at the community level? (*2*) at the bureaucracy and medical practitioner level? (*3*) at the policy-making levels of government and of the medical establishment? and (*4*) at the international level?

Strengthen community organisation and awareness of health issues

Community organizers and awareness building : Communities not already well organized will benefit from the presence of trained community organizers who live in their midst and help conscientize them—that is, make them consciously aware of their life situation, why it is so, and what alternatives they have or can create to redress its deficiencies. A first step is to fund organizers to serve in the communities for a period of one to two years. Where no such organizers are available, support should go to training programmes to produce them Non-Governmental Organizations (NGOs) or those government extension agencies that have developed successful experimental training programmes can serve as the nuclei for this venture.

Credit and finances : Organized groups will not get very far without access to funds for their activities. While most can mobilize some of their own resources, access to no-interest or low-interest credit schemes on terms compatible with their situation boost participatory grass-root efforts for health or any other aim. Providing a revolving credit fund, even outright grants, therefore, is a desirable action for governments and donor or volunteer agencies to take.

Training in a variety of needed skills: While people know their traditional technologies, occupational skills, and organizational requirements, they also seek to expand these in the light of new demands in society. Men and women can be assisted in formulating training programmes in improved technology appropriate to their needs ; in organizational skills that include, for example, leadership, project development, implementation, monitoring and evaluation, accounting ; and in occupational skills corresponding to present and future local needs as they see them. Information and education on the elements of health care and related issues help community residents define their needs in a broader perspective.

Reduce the constraints imposed by government bureaucracies and medical practitioners

A service rather than a control orientation : Since bureaucracies are created largely for the control function of extending the authority of national leaders over the local level, one can understand why it is difficult to promote the concept of a service-rendering bureaucracy accountable outward to people as clients rather than inward and upward to supervisors. Most of the administrative procedures in existence have grown out of a "top-down", inflexible orientation and have been sustained by the patronizing, even disparaging attitudes of most bureaucrats toward their poorer clients.

Observes of a PHC scheme which fostered community control over the community health worker encountered the greatest resistence to this from the PHC outreach workers at the lower levels of the bureaucracy. They insisted that, as the bureaucracy personnel in direct contact with the community health workers, they should have formal control over the selection and day-to-day supervision. Defending their position, some insisted : "Control is a must because people are dishonest." "PHC doctors and supervisors must be given powers to evaluate the health workers" work and to deduct their monthly allowance if found negligent." "Without our supervision they will not comply with our demands, as many of them are leader-types."

Other evidences of bureaucratic inflexibility and patronizing attitudes emerge in conflicts over which agency does what, in sectoral infighting, in continued reliance on output measures for evaluation (like the number of health clinics in existence) instead of impact measures (like the health status over time of women and children in the clinic area), in rigid work schedules incompatible with the people's schedules, in frequent transfers of bureaucracy outreach personnel just when people are getting to know and trust them, and in the continued issuance of prescriptions for medicines unavailable or out of the financial reach of the poor.

Preparation of medical practitioners for community work

Physicians share many of the bureaucrat's biases, coming as they do from urban-based, highly specialized medical schools.

A checklist for use in identifying participatory components of projects

The following checklist can be used to assess project proposals as well as for project monitoring and evaluation.

A Highly participative
B Participative
C Somewhat participative
D Non-participative
E Authoritarian

1. Project planning process:
   - —through initial open discussions with the community of its problems and how to solve them *A*
   - —through a discussion of the project proposal with opinion leaders from the community *B*
   - —through discussions with government/non-government organizations at district/block/project level *C*
   - —project thrust from the outside without discussion *D*
   - —project imposed in absolute disregard of community's wishes *E*
2. Identification of the needs:
   - —by the people themselves *A*
   - —by local opinion leaders *B*
   - —by a government agency *C*
   - —by a centrally sponsored scheme *D*
   - —by fiat *E*
3. Extent of resource mobilization for the project:
   - —by the community *A*
   - —by the community and others *B*
   - —through matching contributions *C*
   - —through massive external assistance *D*
   - —with no contribution from the community *E*
4. Identification of project workers:
   - —by the community with its own criteria *A*
   - —by the community with imposed criteria *B*
   - —appointment of local persons by outside implementing agency *C*
   - —appointment of outsiders *D*
5. Development of social and/or technical skills:
   - —through short, local pre-service training, followed by regular, on-the-job, in-service training in parallel with the training of trainers from within the community *A*
   - —through short, local pre-service training, followed by regular, on-the-job, in-service training *B*
   - —through pre-service training within the district/town followed by some in-service training *C*
   - —through pre-service training in a remote institution without any follow-up in-service training *D*
   - —no training or training in an unfamiliar language *E*
6. Project implementation:
   - —under community control (especially the remuneration of project workers) *A*
   - —under community supervision *B*
   - —with some community involvement *C*
   - —with no community involvement *D*
7. Periodic evaluation/monitoring of progress:
   - —by the community *A*
   - —some evaluation by the community *B*
   - —outsiders' evaluation with results reported to the target community *C*
   - —outsiders' evaluation *not* reported to target community *D*
   - —no evaluation *E*

This checklist needs not only initial but also continuous refining in the light of the growing understanding of the concept of community participation and its implications. It should be seared with those formulating and/or submitting project proposals—which means that there must be some common understanding of the conceptual framework of community participation between all those concerned with project formulation and implementation.

There are in addition certain general points to be looked for in assessing projects:

- ○ Does the institution move out into the villages instead of expecting people to come to it?
- ○ Is the project working with primary institutions?
- ○ Has the government given in its stamp of approval to agencies at the local level involved in the project?
- ○ Does the project work with women?
- ○ Is there a specific methodology suggested for community involvement?
- ○ Does it include a specific methodology for involving people in monitoring/evaluation?
- ○ Does an infrastructure exist for an exchange of information at the local level?
- ○ Is there an acknowledgement of possible conflict areas by the project?

(Excerpted from the *Report of the Community Participation Workshop*, Agra, May 1981, organized by UNICEF, New Delhi, Pp. 13-16.)

To bridge the gaps between physicians and community health workers a Bangladesh doctor with long grass-root experience speaks of the "doctor of delivery" and the "doctor of information". The latter—the physician—has the sophisticated knowledge of what is required for physical health, while the community health worker—the doctor of delivery—is equipped to make this knowledge effective. This division of labour and modus operandi are possible of course only if the medical hierarchy is ready to accept its new partners and allow them to practice their assigned roles. The PHC project mentioned above demonstrated the difficulty of this reorientation. Many medical officers participating in the training programmes stated that they were neither trained nor interested in taking a position that would bring them into direct involvement with local politics.

Clearly, mechanisms have to be found that will encourage bureaucrats and medical practitioners to favour and internalize a participatory approach to health. Exposing medical, nursing, and other health care students to effective PHC projects as part of their regular curriculum and enabling them to interact with and learn from community residents as part of a team can help bring about this conversion. The experience should impress upon them that the physician's role, for example, is that of auxiliary, a specialist called upon by the community health workers for referrals, advice, appropriate medical training, and the 2 to 3% of illnesses that neither the health workers nor the residents can handle. This relationship tips the skills pyramid on its side and accustoms the budding physician or nurse to it being the health worker who takes the lead, "so that the doctor is on top and not on top".

Increased accountability to the community : The institutional arrangements at the point where the medical practitioners and bureaucrats interface with the community also need re-examination, especially, in terms of bureaucracy responsiveness to grass-root initiatives. Mechanisms of accountability to the community may be devised, such as including people's evaluations of the PHC programme in the bureaucrat-practitioner's performance rating. Turning over the management of the basic drugs to local health groups is another case in point. Meetings held at times selected by local groups as most convenient for them tests the flexibility norm.

Such changes will not likely take place solely through verbal advocacy on the part of reformers inside the bureaucracy or practitioner groups. Rather they will stem from pressures exerted by grass-root constituencies, in the context of actual people-bureaucrat communication, as together they painstakingly work out solutions to people-defined problems. The outside team members will then fall closer to the community-supportive pole of the participation continuum, instead of the community-oppressive one that gives lip service to self-reliance and human dignity but which operates in a fundamental authoritarion, paternalistic, and dependency-creating mode.

Foster at policy-making levels the political will to implement PHC

Policy makers genuinely concerned about the majority poor can be encouraged to rethink the existing health care system when they see facts and figures that testify to its shortcomings or outright failure. An intellectual grasp of the situation, however, is generally insufficient for motivating policy makers to break through the barriers to PHC and create meaningful legislation and new organizational arrangements. Also needed is direct contact with PHC teams and organized community groups. Changing outlooks and introducing needed reforms in the health system require both intellectual and experiential challenges.

Policy-maker roles also include legisation for more PHC-responsive financing and accounting schemes ; for reforms in medical education, conditions of service, financial incentives, and reward systems for health professionals ; for some control over the private sector ; and for pharmaceutical importation, production, and prescriptions. Restructuring the bureaucracy so that rewards go to those personnel operating effectively at the community level, and decentralizing the power in sectoral ministries and to local authorities for greater responsiveness to grass-root initiatives, can rekindle the spark of credibility in the government and the medical establishment long since abandoned by disenchanted peasants and urban slum dwellers. By rejecting the spurious contention that high participatory consciousness and organizational capability invariably result in violent confrontation or even social revolution—and therefore should not be fostered—enlightened government and health policy makers affirm the contrary assertion—that people's participation and empowerment build a citizenry and strengthen a society. If they deny this and repress grass-root participatory efforts as a trade-off for false stability, it is they to whom history will attribute the accumulation of human frustrations that subsequently explode into revolution.

(continued on page 23)

An Action Research Study in the field of water supply was initiated in India towards the end of 1977 by the National Environmental Engineering Research Institute (NEERI), Nagpur, in collaboration With the World Health Organization: International Reference Centre (WHO: IRC). The research project were undertaken in four states. These were: Burujwada in district Nagpur (Maharashtra), Kammaya Koudan Patti in district Madurai (Tamil Nadu), Pothunuru in west Godawari district (Andhra Pradesh) and Abub-Shahar group of villages (Abub-Shahar, Sekta Khera and Dhani Rajpura) in Haryana.

HEALTH EDUCATION AND COMMUNITY PARTICIPATION IN SLOW SAND FILTRATION PROGRAMME

DR B. C. GHOSAL
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&
P. S. BAWA

THE overall responsibility of incorporating health education and ensuring community participation in the Slow Sand Filtration Project rested with the Central Health Education Bureau (CHEB).

The Health Education Strategy developed by the CHEB was modified in the light of comments and suggestions received at the International Meeting on Expansion and Community Participation in Slow Sand Filtration (S.S.F.) Project held in Voorborg (Hague, Netherlands) in May-June 1978. The strategy was again discussed in details in an Inter-State meeting organised by the CHEB and NEERI in Nagpur in July 1978. The comments/suggestions and recommendations received from the participants were included in the final strategy.

For co-ordination and co-operation there were Advisory Group at State Level, District Level and Block Level. In order to get a feedback from the project areas, the CHEB developed a suitable mechanism. Monthly progress reports were submitted by the Medical Officers-in-charge of the Primary Health Centres to the District Health Authorities who in turn prepared quarterly reports in prescribed proforma and passed them on to the State co-ordinators. These reports after scrutiny were submitted to the CHEB.

Data regarding Health Status of the community were gathered through duly pre-tested schedules. These were: Village Information Schedule; Family Health Survey Schedule; Family Welfare Schedule, and Educational Diagnosis Schedule.

The Project at Burujwada (Maharashtra) was developed as a pilot project area for demonstration purposes and the methodology developed and operated in the village Burujwada was extended to other three project areas.

Objectives

The specific objectives of the study were to:

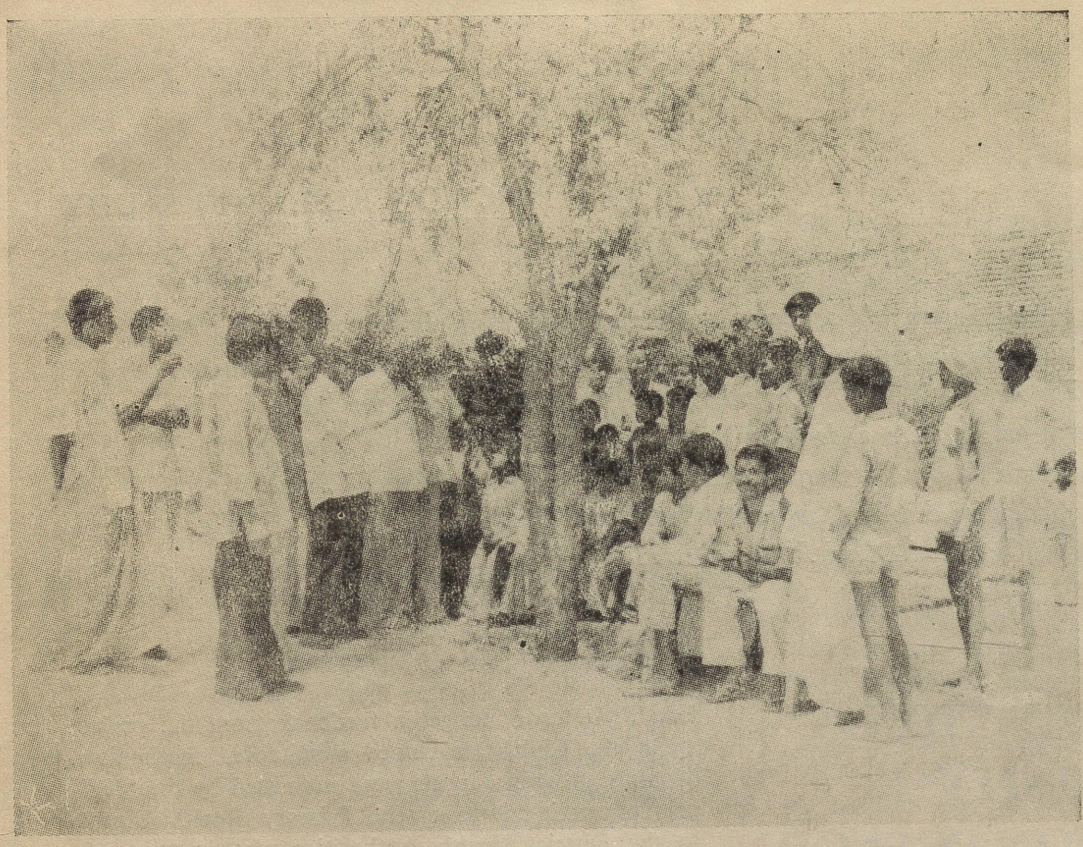
(a) undertake a study of the community with a view to assess its resources, potentials and educational needs;

(b) develop suitable educational aids, materials for use in the community;

(c) educate the community on acceptance of improved water supply for drinking purposes;

(d) find out the extent to which the community uses improved water supply for drinking purposes;

(e) identify the problems (financial and other) faced by the people in utilizing improved water supply;



Group discussion with Villagers

(f) help people of the project areas to acquire adequate knowledge regarding general health, environmental sanitation, selected communicable diseases and availability of health facilities;

(g) assess the impact of health education and improved water supply on health of the people.

Planning

A sound health education service programme for each of the project areas was felt necessary after analysing the collected educational and sociological data, programme planning was done keeping these points in mind: interests, customs, beliefs, attitudes, taboos, past experiences, educational level, socio-economic status and leadership pattern of the community. The main activities planned for the effective implementation of the programme were:

(i) Orientation training to health, block development staff and local leaders;

(ii) Organization of school health education service programme;

(iii) Organizations of mass meetings, group meetings, displays, exhibition, poster compaigns and individual counselling and guidance.

Implementation

As a first step in developing leadership, formal leaders of the community were identified. All those who were willing to extend cooperation in the programme were given on orientation training with a

FORMS OF COMMUNITY PARTICIPATION

Many different types of activity are pursued under the designation of community participation.

1. Consultation
2. A Financial Contribution by the Community
3. Self-help Projects by Groups of Beneficiaries
4. Self-help Projects Involving the Whole Community
5. Community Specialised Workers
6. Mass Action
7. Collective Commitment to Behaviour Change
8. Endogenous Development
9. Autonomous Community Projects
10. Approaches to Self-sufficiency.

In this classification, the first five items are forms of participation in which the role of the external agency remains paramount. In the last five, the role of the external agency is more limited, often to that of advisor or educator ("animator"), or the initiative is in the hands of the community. In general, the order in which the items are presented is that of increasing depth of involvement on the part of the community members but this is not a single dimension, and there may be greater or loss depth of involvement *within* each of the categories also.

Source : Community Participation in Water and Sanitation, W.H.O. Technical Paper Series 17.

view to make them understand the programme activities and their expected role therein. The leaders helped in organizing mass meetings, filmshows, group meetings, individual contact with the families, organising the service programmes and thus helped insolving problems that arose during the implementation phase.

Education of the community was undertaken by the health workers through local leaders, youth organizations, *Mahila Mandals,* local social workers and volunteers and local schools.

For health education service programmes in the school, the teachers were given training in the areas relating to water and water-borne diseases; diseases of the children; health education for schools; and role of the teachers in school health education programme.

An International Appraisal Meeting of the participating countries held in September 1980 provided an opportunity to share experience between the technical and non-technical aspects of rural water supply.

Specific educational aids were developed by the CHEB, and literature on water-borne diseases and environmental sanitation was prepared. Health education charts, specially for school children and flash cards on water-borne diseases, environmental sanitation, malaria and immunization were developed and supplied to respective States.

Evaluation

A plan for evaluation—concurrent, mid-term and terminal was developed. Individual State Health Education Bureau with the technical help from the CHEB carried out the evaluation.

The programme was considered successful when it was observed that 80 per cent of the families had begun using filtered water at least for drinking; and storing in proper clean vessels for drinking purpose.

A summary of the major findings of the evaluation for each of the project villages are presented below.

Findings of the Study

Burujwada (Maharashtra) : The evaluation in the area of Burujwada reveals that the Slow Sand Filteration Programme was very successful in this area. People began to use tapwater supplied by Slow Sand Filteration Plant for drinking and cooking purposes. Drinking water was properly stored though the cleanliness of the Jug used for dipping into the stored water pot could not be ascertained.

In respect of sanitation also people constructed hand flushed latrines though some of them were not in working condition, still the villagers knew about the utility of those latrines. Most of the families disposed off refuse and garbage and animal dung in the allotted pits.

People acquired appreciable knowledge regarding washing of hands after defecation; signs and symptoms, causation, mode of spread, treatment of and prevention of water-borne diseases. Thus the incidence of water-borne diseases, significantly showed a trend of decline.

Health education to the village women by the Sub-Centre staff

Kammayya Kounden Patti (*Tamil Nadu*): The community participation in Slow Sand Filtration Programme was quite satisfactory here. More than 80 per cent families used tap water for drinking and majority for washing and bathing purposes. The sanitary conditions in the village also improved. People became aware of the causes of water-borne diseases and acquired correct knowledge about the signs and symptoms, mode of spread and the prevention of those diseases.

Pothunuru (*Andhra Pradesh*): A majority of the people of this village used tap water for drinking and washing purpose provided by the Slow Sand Filtration Plant as they were aware that contaminated water may cause water-borne diseases. But their abultion habits were not satisfactory as only 29.6 per cent of the community members were washing hands with soaps after defecation.

Fifty four per cent respondents knew the signs and symptoms of diarrhoea, dysentery, cholera and some knew both the causes and the prevention of these diseases.

Abub-Shahar (*Haryana*) : In this group of villages the use of drinking water available through Slow Sand Filtration Plant reached upto 84 per cent families. Some families used canal water for drinking purposes, because the tap water was not available to them. All the village people washed hands after defecation and mostly with soap or ash. Sanitation also improved with the construction of soakage pits.

People were aware of the ill-effects of contaminated water. Most of them had good knowledge of the signs and symptoms of the water-borne diseases though their knowledge about the correct causes of the diseases was comparatively less.

Conclusion

The findings of the evaluation report show that the Slow Sand Filtration Programme was very successful in these areas which were selected for the project. Inspite of some problems, the community participation as a result of health education was very satisfactory. The problems faced were: (i) the late release of the insufficient budget for the project; (ii) involvement of other health agencies was sought late; (iii) as the Directors of Health Services were not fully involved in the project, they had indifferent attitude resulting in problems for the field staff; (iv) the village *sarpanch* of Pothunuru (Andhra Pradesh) was not in favour of Slow Sand Filter. This delayed the launching of the health education programme in the village; (v) joint field visits by the staff of NEERI and CHEB could not be possible. So it took much time to coordinate the activities of the two institutions ; (vi) In the Abub-Shahar group of villages the health staff had to face a tought time as the villagers were not cooperative due to the distance of the installation of the stand post and also due to some misunderstanding for the location ; (vii) the frequent transfers of the local peripheral health staff was also a problem ; (viii) Slow Sand Filtration Plant used to supply water only for a limited period which caused frictions in the community; (ix) due to pre-accupation of the health staff in the project they found difficulty in adjusting the time to collect the morbidity data on water-borne diseases.

Learning Experiences

Some of the learning experiences were: (i) The budget provision should be adequate to facilitate proper planning and implementation; (ii) full participation and involvement of the health authorities is necessary; (iii) The site of the plant and the position of water stand post should be decided with the consultation of the beneficiaries and they also should be involved through their leaders. △

Ten reasons advanced for Community Participation

1. With participation, more will be accomplished.
2. With participation, services can be provided more cheaply.
3. Participation has an instrinsic value for participants.
4. Participation is a catalyst for further development.
5. Participation encourages a sense of responsibility.
6. Participation guarantees that a felt need is involved.
7. Participation ensures things are done the right way.
8. Participation uses valuable indigenous knowledge.
9. Participation frees people from dependence on others' skills.
10. Participation makes people more conscious of the causes of their poverty and what they can do about it.

Source : **Community Participation in Water and Sanitation**, W.H.O. Technical Paper Series 17.

COMMUNITY PARTICIPATION IN HEALTH CARE PROGRAMMES

DR (BRIG) S. L. CHADHA

THE concept that health is not only a basic right of man but also one of his essential responsibilities should be promoted vigorously in order to bring about greater community involvement in health care programmes. The present tendency of the community to look at health as the sole responsibility of the State and something to be administered by the Government to the people needs to be changed. The community should be given a feeling that health is a joint responsibilty to be shared by the Government and the people.

The pattern of community involvement will differ from place to place. It is important that involvement is in tune with the local felt needs of the community which must be identified. Once the community gets confidence that health programmes will help it in meeting its own needs, the participation can be easily achieved.

The community should be involved in all aspects of health care and family welfare including maternal and child health programmes, nutritional programmes and family planning services. The importance of the mother for promotion of health within the family and through the family, or in the community as a whole should receive due recognition. The forum of orientation camps needs to be utilised fully to increase the community involvement in all health care programmes.

What can people do about their health by individual and community action is enlisted below:

Individual Action

- Have sufficient food of right kind.
- Make safe water available and protect it from pollution.
- Insist on acceptable standards of hygiene.
- in and around their homes.
- in places of work such as factories, offices, shops and markets.
- in schools.
- in canteens/restaurants.
- Ensure personal hygiene.
- Learn how to space the children to give each and everyone of them a good chance of survival, reasonable education and a decent quality of life.

Women : can help each other to—

- remain healthy during pregnancy.
- report regularly for antenatal care.
- insist on safe midwifery practices.
- ensure breastfeeding.
- seek advice of health personnel as and when required.

Parents : can learn how to—

- rear their infants and children in a healthy manner.
- look after them when they get minor ailments like diarrhoea, respiratory infections, etc.
- get children immunised against infectious diseases.
- recognise serious conditions that require attention of health workers.

Teachers : can promote and maintain health of school children by:

- detection of early departure from normal health, *e.g.*, indifferent behaviour.

The pattern of community involvement will differ from place to place. It is important that involvement is in tune with the local felt needs of the community which must be identified. Once the community gets confidence that health programmes will help it in meeting its own needs, the participation can be easily achieved.

— providing safe and hygienic environments in class-rooms and hostel.

— providing playground and other recreational facilities.

— teaching good habits and discipline.

— teaching health education.

— growing vegetables/fruits in the school gardens.

— giving first aid for ailments/injuries.

Priests: can assist in moral and character building.

Community Action :

Social and religious bodies, trade unions, political parties, voluntary organisations and people at other places of congregation can assist in:—

— Identification of community health needs to ensure their active participation.

— Implementation of health care programmes.

— Construction of sub-centres, Primary Health Centres, maintenance of water supply works and sanitation programmes.

— Source reduction measures such as filling pits, draining water collections, dressing of drains, etc., to prevent mosquito breeding.

— Keeping villages, towns and cities clean.

— Insecticidal spray for pest and vector control.

— Antirat and anti-stray dog measures.

— Care of elderly and disabled/handicapped in homes for aged and infirm.

— Organisation of orientation training camps.

— Training of school staff and children in first-aid and elementary care of minor ailments.

— Availability of common drugs at low cost.

— Learning to live under stress of city life.

— Organise playgrounds, dramas and other recreational facilities.

— Preparation of audio-visual aids for health education.

— Promotion of family welfare.

— Monetary contributions to health care programmes.

ALL PEOPLE HAVE THE POWER TO ACT FOR HEALTH; THE TIME TO ACT IS NOW. THIS IS OF PARAMOUNT IMPORTANCE FOR ACHIEVEMENT OF OUR GOAL— HEALTH FOR ALL BY 2000 *A.D.* △

DR S. S. VERMA MEMORIAL AWARD

The Indian Public Health Association (Delhi Branch) has instituted the Dr S. S. Verma Memorial Award for unpublished original work based on research studies/article in the field of Community Medicine by scientists below 35 years of age. The award carries a scroll and cash award of Rs. 500. In case of more than one author, all should be below 35 years and the award will be shared among all co-authors. The entries (5 copies) must reach the undersigned by 31 March 1984.

Copyright of the publication of the selected papers will rest with the Indian Public Health Association (Delhi Branch).

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COMMUNITY PARTICIPATION AT LOCAL LEVELS

The term 'participation' many a time, appears to be ambiguous and confusing. It may mean different things to different people. Actually, it varies in meaning, content, nature and style from context to context.

Sometimes it is used so lightly that it means nothing more than securing acceptance—tacit or implicit—of government policies and programmes by the people at large. In other cases it may mean so serious and complex a thing as to involve a significant number of the people in the entire politico-administrative process of a given political system. All this explains the reason as to why we have a number of expressions in relation to participation: some of them are used interchangeably or as synonyms. 'general participation', 'political participation', 'popular participation', 'people's participation', 'citizen's participation', 'development participation', 'rural development participation', 'civic participation', 'community participation', 'local participation', 'social participation', 'economic participation' and 'management participation' are some of the examples to count a few.

In such circumstances, asking 'What is participation?' may be the wrong question, since it implies that participation is a single phenomenon. "It appears more fruitful to regard participation of a significant number of persons in situations or actions which enhance their well-being, e.g., their income, security, or self-esteem". It seems more instructive to think in terms of dimensions of participation in development. Then, questions worth considering would be: (a) What is the kind of participation under consideration? (b) Who is participating in it? (c) How is participation occurring? and (d) Who is participating in benefits?

Yet there is another important question, perhaps most impotant one, to be considered is 'participation for what?' This demands probe into values (political ideology) or concrete material achievements sought, at a point of time or both.

People's participation is said to be the hallmark of a democratic political system. Reasons for ensuring 'genuine' and 'active' have (as against 'symbolic' and 'passive') participation of the people in the process of development (including decision-making in institutional setting) are so obvious that they do not require any enlisting here. Actually, the concept of people's participation is a very comprehensive one, which includes almost all the activities concerning community life such as social, economic, and political.

Shri B. S. Bhargava, Asstt. Professor,
Instt. for Social and Economic Change,
Bangalore, in KURUKSHETRA,
Sept. 1983.

(*continued from page 16*)

Develop at the international level policies leading to a NIEO and strategies favouring PHC

International and bilateral assistance agencies can significantly influence national trends towards adopting PHC by advocating a need-oriented, endogenous, self-reliant, and ecologically sound development strategy. One concrete approach is specifically to fund participatory processes in country programmes. The success of this endeavour can be ascertained in part by building into evaluation criteria that assess

> ...process and outcomes related to acceptable levels of community participation performance...establish cost-benefits or effectiveness and methods to integrate such evaluation into current or planned monitoring and information systems...Investment dialogue can help to demystify the subject by dealing with it in concrete terms, i.e., defining specific, observable and measurable performance by community members or groups.
>
> —*Arlene Fonaroff*

Included in the evaluating teams on a project level must be the people of the community themselves, men and women contributing their particular perspectives. The combined views of many communities can then go into the formulation of the next programme phase. This procedure will encourage foreign donors to restrain themselves from imposing preconceived but often inappropriate ideas ; to be more flexible about, for example, accounting schemes or implementation schedules ; and to avoid the creation of a dependency relationship between those community groups usuing the funds, on the one hand, and the government as well as international donors, on the other. Again, political will must come strongly into the overall equation.

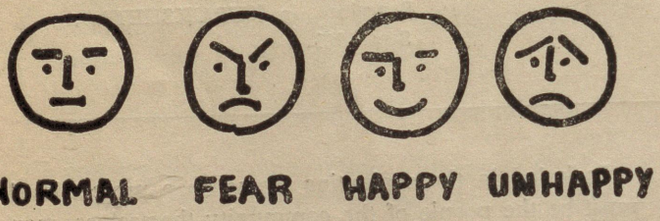
(Based on a Paper presented at the international conference, Towards an Authentic Development : the Role of Adult Education, Paris, October 1982, organized by the International Council for Adult Education.)

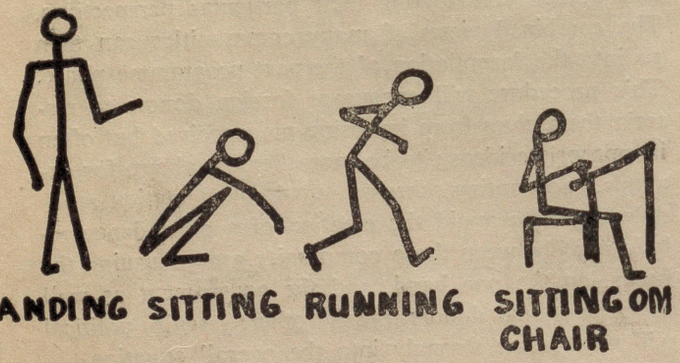
Courtesy: **Assignment Children 59/60 2/82**

LOW COST TEACHING AIDS FOR HEALTH INSTRUCTIONS IN CLASS ROOM

J. P. SHARMA

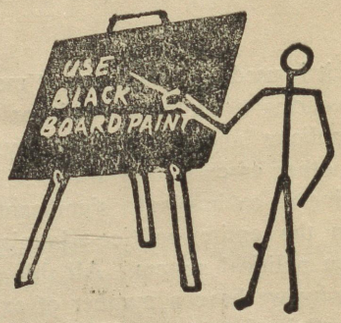
USING aids during teaching is not new. Since long these aids have been used by teachers. The blackboard is being used since times immemorial. Specimens of different objects are also used by teacher to acquaint the children with a particular item. Low cost teaching aids are powerful means of imparting knowledge quickly. The mind can always grasp a picture, whereas it cannot comprehend printed material so easily. Even the spoken words do not have a lasting impact as compaired to visuals. Visual aids, if properly used, can bring wonder, but the impact depends upon: BREVITY, SIMPLICITY, IDEA, LAYOUT and COLOUR. The aid must be supported by the teacher because the aid cannot substitute the teacher. With imagination and a little effort attractive, informative and educative aids can be prepared. Self-made aids will save money and time and also help in pretesting. Proper selection of aid is very essential for good communication. Therefore, one should know the students, their background and resources in terms of manpower, money and materials. For preparation of aids one should know 'How to draw' and 'How to prepare' simple drawings as below:





Blackboard

Size 4′ × 8′ or more; audience 20 to 30. Use blackboard paint on a piece of cardboard, plywood, tin



or on cemented wall. This paint, after it gets dried, is water proof. Wash the brush with kerosene oil.

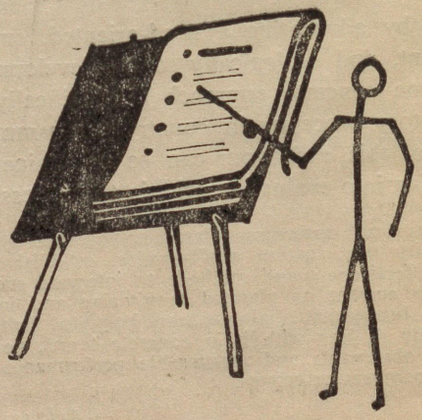
This paint is available in packs of 250/500 grams etc. from paint shops.

White, yellow, orange, light colour chalks can be used for writing on the blackboard. Writing on the blackboard should not be crowded. The board should always be kept clean after the class.

Flip Chart

They provide permanent record. For preparing a flip chart use offset paper in the size of 20″ × 30″ and

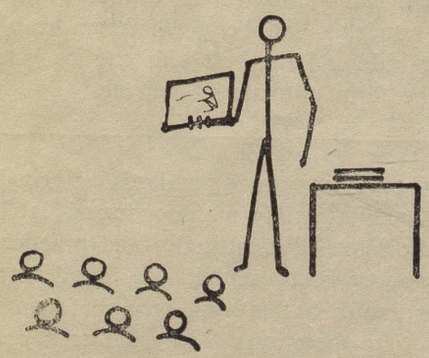
- write points only,
- use short sentences,
- give proper spacing,
- use pointer.



For better writing the colour markers can be used. Newspaper pages can be used to prepare flip charts if offset paper is not available or the chart is to be used only once. Red colour stands well on the surface of these pages.

Flash cards

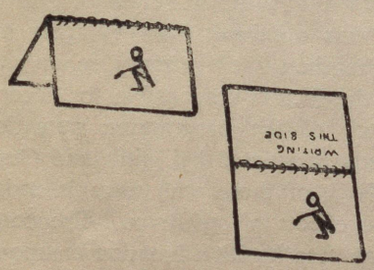
Flash cards hold interest, focus attention when each card is exposed to the group of people. The size of the cards can be any but the most convenient size is 11″ × 14″. Diagrams, photographs and illustrations



may be used on the cards. Pictures from the magazines, etc., relevant to the subject can also be used. All the commentary part should be given on the back of the related card. The number of cards should not exceed 10 to 12 and should be kept intact in sequence.

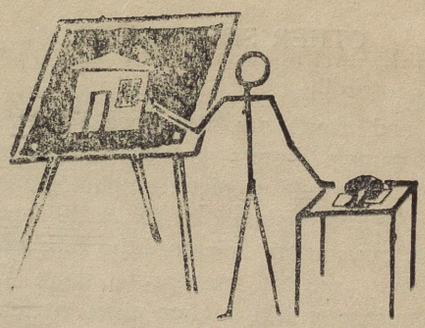
Flip book

Flip book is like a table calendar. The matter should go on the page facing the illustration. Flip book can be prepared out of a flash card set. The top should be bound with spring which is called spiral binding.



Flannelgraph

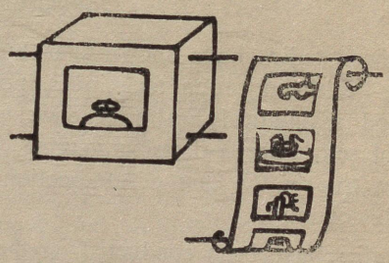
Sand paper is fixed on the back of the picture, photograph or illustration to enable it to stick on the flannel cloth or rough *khadi* cloth. Use limited number of pictures, take convenient size of pictures and cloth, and keep pictures in sequence. When flannelgaraph



is used outside the room, see that the flow of the air is not much.

Simple Models

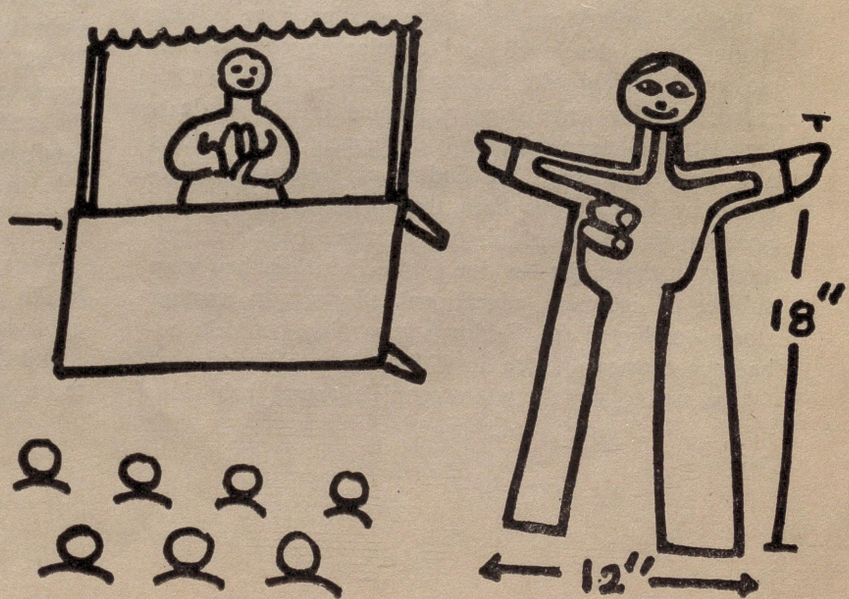
Simple models can also be prepared out of cardboard boxes, plaster of paris clay. Scroll can also be prepared by using tracing cloth or paper roll by tracing on the tracing cloth or drawing on the long strip of paper in series. The strip can be fixed in a box and the rollers can be fixed to move the frames. Coloured



cryons or colour markers can be used to prepare sketches. In the night by putting a candle light on the back of the scroll, the effect of translite can be given.

Puppets

Puppetry is very popular media specially in the rural areas. Education can be given through entertainment. Glove puppets are very simple and inexpensive and can be prepared from rubber balls and cloth pieces. It is simple to plan and manipulate, and easy to play.



OTHER SIMPLE AIDS

Posters

Posters and charts are also good for class room teaching. Simple posters and charts on health can be prepared by cutting pictures, photographs, illustration, etc. The size should be 20″ × 30″ approximately. Use one or two pictures, because the poster should convey single message—a single idea. It conveys message quickly. For chart we can use 4 to 5 pictures on one chart paper with suitable heading on top with sub-headings.

Printed or duplicating material

Leaflets, folders and handbills can also be prepared by getting these stencilled, if the printed copies are not available. These can be illustrated by drawing stick figures on stencil paper with a stencil pen available with typists. By folding paper we can make dummy to have the idea before getting it stencilled. These can be distributed among the children. Simple and non-technical language should be used so as to make them easily understandable. Children should also be involved in preparing such aids.

Much of the materials required to prepare these aids are available in schools, i.e., paper, colours, brushes, the scissor, old magazines, cardboard, etc.

Display of the aids in the class room will give encouragement and initiative to the students. Some times the students can be given some health topics to prepare aids and the best aids can be given some prize in the form of material set, etc. △

(*continued from page 4*)

family planning, taking into consideration their value system.

Many other studies have shown that by applying appropriate health education techniques, people have accepted and maintained health practice which was the result of self-imposed decision making. This was found to be true in the case of eradication of smallpox from this country.

Many studies have been conducted on the influence of leaders in changing health behaviour of the community. Some studies have been conducted by P.R.A.I., Lucknow, in which it has been proved that satisfied consumer of health services can be motivated in such a way that multiplier effects start generating through person to person communication based upon their own successful experiences of availing the health services. Such techniques have also been used by Agriculture Extension Department and Adult Education Programme. In Adult Education Programme attempts have been made to change human behaviour through *each one teach one*.

Besides Indian studies, many studies have been conducted in developed and developing countries in the world dealing with factors influencing change. One of such studies have been conducted in U.S.A. dealing with beliefs associated with cancer, tuberculosis and dental disease. The finding of the study undertaken by Krischt has been that majority of the respondents failed to exhibit one or more beliefs associated with these diseases due to the fact that they were subject of intensive educational efforts. In another study conducted by Feldman regarding people's behaviour towards health in U.S.A. it was found that "there was a gap between people's actual behaviour and their own expressed standards of good health care". A similar study was conducted in Japan to find out the knowledge, attitudes and practices of the public regarding health and it was found that women had better health habits than men, but another finding was that there was no significant correlation between knowledge and practice.

Based on the findings of diagnostic studies, health education strategies have been evolved for changing the undesirable health practices into desirable health practices with great success. Thus, there is a similarity between national and international studies, so far as the change in behaviour is concerned. If we are really interested in bringing about a change in behaviour, we will have to study the socio-cultural factors which operate in formation of specific health behaviour. One of the most important example for change of behaviour is the study conducted by K. P. Srivastava and K. N. Maurya. In this study information was obtained from villagers as well as vaccinators, teachers of primary schools and other leaders and the factors responsible for acceptance and non-acceptance of the programme were found. In a similar study conducted by Mitra and Gupta, it was found that 90% of those who were interviewed were aware of the effects of smallpox. The conclusion of the study was "the health education component of the smallpox eradication programme did play a useful role in bringing about knowledge and attitude change".

Thus, for maximum, 'Community participation' in health promotional activities, it is essential that health educator must be able to build rapport with the community to create a positive image of the service agency through logical decisions. △

ARTHRITIS : FACTS AND FADS

DR A. N. MALAVIYA

People are often confused over the terms rheumatism, rheumatic pains and arthritis. The word arthritis is comparable to fever or any other similar symptom the cause of which is to be found out by the doctor. The author discusses different types of arthritis; fads, facts and cure of the disease.

THE word ARTHRITIS by itself does not define any specific disease. It simply means that there is a joint disease without indicating the name, nature or the type of disease. In other words it just indicates a manifestation of a large number of diseases which can involve joints. Thus, the word arthritis is comparable to "fever" or any other similar symptom, the cause of which is to be found out by the doctor. The use of pseudomedical terms like "rheumatism" or "rheumatic pains" must be discouraged because they do not mean anything and cause unnecessary confusion. "Doctor I have pain and discomfort in my joint" is a much better way of expressing your complaint than "Oh, I have arthritis" or "I have rheumatism".

Arthritis in different age groups

A widely prevalent misbelief is that arthritis occurs only in old age. In fact, more severe and incapacitating varieties of the diseases of joints occur in young children, young adults or middle age persons too. These include rheumatoid arthritis, juvenile chronic arthritis and seronegative spondarthritides. In comparison to these arthritides the arthritis of old age, i.e., osteoarthritis would be considered mild and easily controllable.

In children : Considering the different types of arthritides in different age-groups, in children arthritis due to injuries is common. Often the injury might be forgotten, only the joint pain may be the symptom. One must be aware of this for making a correct diagnosis. "Rheumatic Fever" is another common condition in children where joints are involved frequently and heart can also get involved. But, the commonest and most severe form of arthritis in children is called "juvenile chronic polyarthritis". Some people also call it juvenile rheumatoid arthritis but the former term is preferable. There are several varieties of this disease. It is necessary to characterise the subcategory in any given patient correctly because the treatment differs from one category to the other. Incorrectly treated children develop crippling disease with severe growth retardation and general ill health. In spite of the fact that this disease is the commonest arthritis in children there is very little awareness about it in lay public as well as among doctors.

In adults : In the young and middle aged, two of the most serious and severe forms of arthritides occur. One of these is three times more common in women. It is called rheumatoid arthritis. It is actually a systematic disease with weakness, anaemia, weight loss, etc. In addition, it produces a crippling arthritis of small joints of both hands simultaneously (symmetrical involvement is characteristic), both wrists, both elbows, shoulders, knees, ankles and feet. Fortunately, the most severe form of this disease is not very common in India. The second disease called seronegative

spondarthritis is 16 times more common in young men, quite often with a family history of the same disease. Pain in lower back, stiffness in bending forward, symptoms worse at night, involvement of joints predominantly below waist and heel pain are important features of this disease. Some of these persons develop "bamboo-spine". Several other organs of the body may get involved. Majority of these patients belong to the tissue type HLA B27.

Tuberculosis of joints is also a common joint disease in young adults. Usually single joint is involved. Features like night sweats, weight loss, etc., give away the diagnosis.

Old age : In so-called old-age arthritis called osteo-arthritis, the important thing to remember is that it can start as early as 30 years of age. This is especially so in the joints which are excessively, strenuously and vigorously used e.g. nodding and head shaking among upper and executive class, vigorous competitive sports, unnatural and unphysiological postures like squatting on Indian style lavatory, sitting cross-legged, using high pillows, carrying heavy weights on the head or back, 'cracking' knuckles frequently etc. Also, osteoarthritis occurs early in a joint earlier involved in injury or any other disease. The common sites of involvement include neck, shoulders, small joints of the hands, knees and lower back. Often gross crackling sounds are audible on moving the involved joints. There is no 'morning stiffness' (as is typically seen in rheumatoid arthritis) but the first movement after being in a particular posture for a prolonged period of time is very painful. The pain becomes less after moving the joint a few times. Cervical spondylosis, lumbar spondylosis etc. are just other names given to osteoarthritis occurring at different parts of the body like neck and lower back.

General principles of management

Most of the diseases of joints are slow in onset and chronic in course. Obviously "instantaneous cures" are not possible. The patient has to be patient. The 'treatment is actually more like a project in which a team of persons try to help the patient and the patient herself/himself is the most important member of the team. This team tries the most important thing, i.e., maintain mobility, stability and function of the joints. This is achieved by extensive physiotherapy, patient education regarding correct postures, splinting of joints at night and other physical measures. The actual medicines for different forms of arthritis, of course, differs with different disease and this aspect is looked after by the physician trained in joint diseases (the rheumatologist). To say that "there is no cure of arthritis" is just not correct because arthritis is not a disease but only a symptom of a large number of diseases of joints. Even in a serious joint disease like rheumatoid arthritis desease-modifying drugs like D-penicillamine, goldthiods and chloroquine can arrest the disease in the majority of cases. For osteoarthritis, however, the only treatment is intensive daily work-out with physiotherapy. Actually, it can 'cure' the disease. But it must be done correctly and under guidance. Medicines play no role in Osteoarthritis.

Fads and fiction in arthritis

One of the most harmful and widely prevalent misbeliefs, equally among lay public and the doctors, is that 'there is no cure for arthritis. With this excuse doctors "finally" prescribe cortisone, a medicine which should never be given in any arthritis ordinarily. It spoils the case completely and makes the patient resistant and reluctant to take the correct medicines. This drug quickly leads to major and serious complications. Do not take cortisone preparations for arthritis even if prescribed by your doctor.

Diet and food has nothing to do with any arthritis (except a very rare disease called gout). Therefore, do not rush to the latest food fad for the cure of arthritis. Do not impose any diet restrictions, it does not achieve anything except producing weakness. Take normal nourishing balanced diet with vitamins and minerals. Overweight persons must reduce weight.

Do not rush to the doctor with the latest press report of a magic cure of arthritis. Thousands of such reports have come and gone. Stick to correct scientific programme of management. You will feel the benefit in the long run. Aspirin is still the best drug for inflammatory arthritides in spite of hundreds of press reports against its use. Aspirin if used properly is harmless. The common misbelief that it causes heart disease can be totally ignored. Actually, aspirin is extensively used for preventing heart attacks.

Take-home lesson

The take-home lesson in arthritis is that: be patient, get the disease correctly diagnosed, and get going on the long-term project-like management programme. Physiotherapy exercises, correct medicines, balanced diet would go a long way in controlling the problems. Depression is bad for all arthritides, try not to get depressed. Arthritis is not always incurable. △

(Based on a public lecture at the All India Institute of Medical Sciences, New Delhi)

BOOKS

ECONOMIC APPRAISAL AND HEALTH SERVICE DECISION MAKING. DRUMMOND M.F. EFFECTIVE HEALTH CARE. 1983 JUNE; 1(1): 25—33.

In many countries increased pressures on health service resources have led policy makers, administrators and clinicians to search for more cost effective ways of delivering services. This in turn has led to an increased interest in methods for appraising alternative programmes or treatments from an economic perspective. This article reviews the contribution of economic appraisal to health service decision making. First, the methodology of economic appraisal is reviewed, comments being made on the design of studies, the measurement and valuation of costs and benefits, and the allowance for differential timing of, or uncertainty in, costs and benefits. It is concluded that, despite the methodological problems, a coherent approach to analysis has emerged.

Second, the practice of economic appraisal in health care is discussed. Examples are given of published studies dealing with assessments of the economic burden (on the community) of various diseases, the economic efficiency of preventive programmes (such as screening procedures), the costs and benefits of technological developments in diagnosis, and the economics of alternative strategies in treatment and rehabilitation (such as in elective surgery and care of the elderly). Examples of studies from a number of European countries are cited. It is concluded that useful information has been generated by empirical work but that the published work is variable quality. In any case economic appraisal should be viewed as an aid to decision making and not as a substitute for it.

Finally, the relationship of economic appraisal to health service decision making is discussed, a distinction being made between decisions made at the planning level and those made at the clinical level. With respect to planning decisions, some limited evidence on the impact of economic appraisal is presented, although it is recognised that decisions are likely to be influenced by a number of factors. Given that there will never be enough resources to undertake formal appraisals of all planning choices, it may be the 'way of thinking' embodied in appraisal that is most useful. With respect to clinical choices, it is recognised that ethical or moral obligations placed on the individual practitioner may limit the use of appraisal. However, a number of interesting attempts to introduce economic considerations into clinical decision making in Europe are described.

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EDUCATION AND PUBLIC AWARENESS OF SEXUALLY TRANSMITTED DISEASES, SACKS, S. L. BOWIE, W. R., AND STAYNER, M. CANADIAN JOURNAL OF PUBLIC HEALTH, 1983 MAY/JUNE; 74 (3) : 176—8.

This study reports the findings of a survey of educational programmes to control Sexually Transmitted Diseaess (STD)—both in undergraduate/post-graduate medical schools as well as in public education programmes—in Canada. These educational programmes were found to be delivered in an irregular and uncontrolled fashion. Evaluations of successes are almost entirely lacking. Three broad categories of recipients of these educational programmes were identified: these were (i) health care providers; (ii) health care consumers; and (iii) the public. Needs of each of these groups are discussed and recommendations are made to make the programme effective in providing minimum or basic information in STD to these three groups.

—*Highlights from Current Health Literature*, Vol. II, No. 14, 1983, National Medical Library, New Delhi-110 029

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"The welfare and prosperity of our country will depend on our success in controlling the growth of our population. Convenient means to limit families are available and the importance of family planning is too well-known to require repetition. We must now proceed with determination to persuade eligible couples to have small families in their own interest and in the national interest."

—INDIRA GANDHI