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Health Based Development

A brief review of the health status in India revealed inadequate medical personnel, severe malnutrition and majority of the population unable to eat a balanced diet, an associated high birth seems to paint a very gloomy picture. Improvement of health care facilities in the rural areas is therefore an important aspect of rural development. Certain defects in the existing health care services are discussed along with the concept of primary health care and the principles underlying its approach. Problems likely to be encountered in the implementation of this programme along with areas for further study and research in this field is discussed.

Health Status in India

No country has ever faced or is likely to face the health problems that India has had to and still does. A growing population, largely dependent with many languages and hundreds of dialects, make the Government's task to provide comprehensive health care extremely difficult. 80% of our population live in our villages and only 20% of doctors choose to work there. As such the average of one doctor for a population of 5,100 is deceptive because there are many tracks in the countryside where the doctor/population ratio is as low as 1 : 50,000. Generally speaking in India people become aware of their health only in times of illness. People are generally resistant to preventive measures against deficiency or infectious diseases. The recognition of the relationship between environment and health is limited to the educated minority. The population in our rural area surveyed showed that only 4% of households had latrines and 12% had a protected water supply. When it is estimated that approximately $\frac{1}{3}$ of all morbidity and mortality is due to lack of pure drinking water and poor sanitation, the seriousness of the situation is even more significant[1].

A number of studies have indicated that malnutrition is the single largest contributor to the high rate of maternal, infant and child mortality and morbidity in the country. The nutrition survey among pre-school children showed that in 90% of them, the heights and weights were below the tenth percentile values of American children of corresponding ages. Classified according to weight deficit for age, 18% of children were suffering from grade III malnutrition (weight deficit of 40% or more), 6.5% of children were suffering

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from grade II and 14% from grade I malnutrition (weight deficits of 25-40% and 10-25% respectively).

Vitamin 'A' deficiency is another major nutritional problem responsible for blindness in India, which accounts for nearly one million cases at any given time. There is no reliable data available about the children who die as a result of advanced malnutrition, however, an estimate is that even with the best form of treatment, 10 to 15% of all children suffering from advanced state of malnutrition do not survive.

Malnutrition among pregnant women is also widespread. It is estimated that more than 17% of all births in India are premature, caused by maternal malnutrition which is responsible for low birth weights and poor nutritional status of the infants and a major factor underlying infant mortality[2].

According to Gopalan[3] the present average per capita availability of food of the order of 2,000 calories, and of 50 gms of protein masks the true extent of the problem of malnutrition, in view of the markedly uneven distribution of food as between different regions, between different socio-economic groups, and indeed, even among different members of a household. The level of current income of a sizeable proportion of the population is such that even while spending nearly 80 percent of their total income on food, they cannot afford the least cost-balanced diet proposed by the ICMR. If we take Rs. 20 at 1960-61 prices, accepted by the Planning Commission to represent the minimum desirable consumption standard considered necessary from the nutritional point of view, it has been estimated that at the beginning of the Fourth Plan, nearly 48 per cent of the people were below this line. According to Minhas[4] nearly 39% of the population in 1973-74 and 27% by 1980-81 will be below the minimum level of living; the number of people in this category will still be 232 million and 186 million respectively.

It is estimated that at the present rate of population growth, India's population will double in about 31 years. In absolute numbers, the population is increasing by about 12 million a year. At any one time in this country, it is estimated that there are five million expectant mothers in the last trimester.

According to Kumudini Dandekar[5] in order to achieve the goal of 25 births per 1,000 of population by 1980, it would be necessary to increase the level of acceptance of family planning from 15% at the close of 1973 to 50 or 60% of the couples by that date. This seems almost unattainable because the States which are most successful in family planning programmes have only 23% couples protected from childbearing as against the requisite 50% indicative of feasibility of achieving the national goal.

Health and Rural Development

Improvement of health care facilities in the rural areas will therefore lead to less suffering and disease. As is well known, agricultural labourers often fall ill during busy sowing and planting seasons. This may be due to either a low nutritional intake or inadequate health care facilities or an interaction of both these factors. This may lead to poor agricultural production and a further deterioration of the nutritional state. Availability of basic health services will help in reducing the exodus of population from the rural areas. A household survey in city slums often show the number of relatives from the villages who are being

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heltered temporarily for medical care. Improved quality of health care in the villages will reduce infant morbidity and mortality. Many studies in India and abroad show that there is a lowering of birth rate with improvement in child care facilities. A high population density will create undue pressures on the land and lead to exodus to city slums. Therefore there is a strong positive relationship to improved health care facilities in the rural areas contributing to an improved quality of life.

Flaws in the Existing Health Care Services in India

The existing health care facilities provided to a majority of our countrymen are far from satisfactory. The defects can be grouped generally as follows :

1. They are hospital based and disease-oriented.
2. They are entirely dependent on borrowed foreign technology, leading to over-sophistication, thus making them ill-suited to the needs of the rural community.
3. Attitudes, skills and approaches of trained personnel are entirely unrealistic. In short, it is a cure-oriented system as opposed to a system intended to keep the population healthy.
4. Health services are viewed as an end in themselves.
5. They are inaccessible to a large part of the population in physical, social, cultural and financial terms.
6. There is lack of community participation in health activities. The system is impervious to consumers' influence.

Concept of Primary Health Care

What is primary health care ? Many definitions have been attempted. The word 'primary' implies that there are secondary and tertiary aspects of health care, which immediately connotes "cure orientation towards health". Health is a total concept. It cannot be split into primary and non-primary aspects.

Health is also a positive approach as opposed to disease. All efforts which go towards prevention of disease and the promotion of positive values of health should be deemed primary aspects of health care and all efforts which go towards treatment of a person once he has succumbed to a disease, should be treated as secondary aspects of health care.

Primary health care is taken to mean a health approach which integrates at the community level all the elements necessary to make an impact upon the health status of the people. Such an approach should be an integral part of the national health care system. It is a response to the fundamental human need of a person to understand and be assisted in, the actions required to live a healthy life and to know where to go for relief from pain or suffering. A response to such needs must be a series of simple and effective measures in terms of cost, technique and organisation, which are easily accessible to the people in need and which assist in improving the living conditions of individuals, families and communities. These include preventive, promotive, curative and rehabilitative health measures and community development activities.

Principles of the Primary Health Care Approach

This approach can be summarised by the following general principles which should be adhered to if primary health care efforts are to succeed.

1. Primary health care should be shaped around the life pattern of the population, it should serve the community, and meet its needs.

2. Primary health care should be an integral part of the national health system, and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

3. Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

4. The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought in line with local needs and priorities. The identification and selection of community needs requiring solution should emerge from a continuing dialogue between the people and the services.

5. The health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are present in each country.

6. Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

7. The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities.

Community Participation

What is a community ? It is defined as an identifiable group, with an internal social organisation ; shared cultural, economic and political patterns ; common interests, aspirations and problems including health and usually a spatial identity. Communities can be clustered or dispersed, fixed or migratory. Community participation is to be regarded as fundamental to the extension of coverage of health services. It is the process by which individuals change themselves in accordance with their own needs, for their own welfare as well as that of the community, building upon their ability to contribute to the development process. The community has to be progressively trained, informed and educated ; but the community needs have to be understood. One must recognise, and respect, the knowledge that the people possess ; their human dignity and their ability to contribute to their own development. Then alone can the community express its will to change. Community participation establishes a continued dialogue between health personnel and the people. It implies that educational processes are used to prepare the community and to help set in motion a course of action that community and the health personnel have decided conjointly. This is the way to tap community resources.

Primary Health Centres

The primary health centres were conceived as nuclei from which primary health care services would radiate, through sub-centres, over the country side. Their operational responsibilities would cover medical care,

formin control of communicable diseases, maternal and child health — including nutrition and family welfare — environmental sanitation, school health, collection of vital and health d as a statistics and health education. These centres soci function as the first anchor against disease ic an and ill-health in rural areas. Medical relief , aspi such centres is designed mainly as an th an stitutional service. The out-patient depart- ies ca ents give diagnostic and therapeutic services ratory or minor and moderate ailments. Four to six led a eds attached to each centre are used for verage bservation and emergency services. Primary which ealth centres are neither equipped nor rdanc xpected to treat cases requiring sophisticated welfare iagnostic facilities, surgical procedures or a uildin ng period of hospitalisation. Since a centre velop not completely self-sufficient, it is orga- to be ically linked to institutions at higher levels, cated hich function as referral centres. These under- clude tehsil/taluq and district hospitals or spect entres where laboratory, X-ray and specialist ; thei ervices are available.

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ommunity Health Workers Scheme

ne can The scheme began with the training of ange mmunity health workers in 777 selected conti- imary health centres spread over the l and untry. Structured around the central philo- tional phy of "placing people's health in the nunity ople's hands", the scheme envisages the action ovision of one community health worker onnel or every village or community with a popu- ay to tion of 1,000. India has 580,000 villages erved by 5,380 primary health centres. The heme is programmed to train 580,000 mmunity health workers, selected by the eived spective villagers, to be in position by 1981[6].

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roblems Encountered in Implementing rimary Health Care

care, Many difficulties are encountered by a person/organisation in implementing primary health care.

1. There is an acute dearth of trained personnel paramedical workers to implement such programmes.

2. There are very few institutions either on a national/regional level with a prescribed syllabus to train such workers.

3. Due to poverty, illiteracy etc. motivation is often lacking in the rural masses to become involved as "partners" to this whole process of community participation in primary health care.

4. India being a developing country, not enough resources in the form of equipment, salary etc. can be apportioned for the smooth functioning of the primary health care system.

5. Very few successful innovation models in primary health care exist in this country from which experience can be drawn.

Need for Further Research

The areas of medical and behavioural sciences need more research and detailed study to improve primary health care delivery systems in India. The indigenous systems of medicine which are low cost have to be thoroughly investigated. They have a wide acceptance and are cheap compared to allopathy or western medicine. They can be integrated very effectively in the primary health care system. Practices, attitudes of rural families particularly to health and food must be investigated in depth. Certain healthy practices ingrained in the current beliefs (e.g. washing hands, feet etc. before eating) should be strengthened. Harmful practices such as starving a child with diarrhoea and witholding liquid should be discouraged.

Managerial and administrative skills

required to implement programmes in primary health care is conspicuously lacking in health care personnel administering such programmes. These areas need to be strengthened with more research and study. Special emphasis should be placed in implementing integrated programmes in health and socio-economic development and determining their efficacy.

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