

MPRA

Munich Personal RePEc Archive

Participatory approach to community health: Sustainable strategy from India

Sudha Venu Menon

27. February 2007

Online at <http://mpra.ub.uni-muenchen.de/1938/>
MPRA Paper No. 1938, posted 27. February 2007

PARTICIPATORY APPROACH TO COMMUNITY HEALTH: SUSTAINABLE STRATEGY FROM INDIA

Sudha Venu Menon

Introduction

‘Long years ago we made a tryst with destiny and now the time comes... we shall redeem our pledge. At the stroke of the midnight hour, when the world sleeps India will awake to life and freedom. A moment comes, which comes rarely in history. An age ends and the soul of a nation long suppressed finds utterance. The achievement we celebrate today is but a step, an opening of opportunity to the great triumphs and achievements that await us’...

Jawaharlal Nehru.

59 years have passed since this famous “tryst with destiny” speech. At the time of independence, our founding fathers were committed to the objective of building up of a democratic and socialistic framework, which can eradicate poverty, grant universal education access to health care and can ensure participation of every citizen to collective and political life. Thus, the entire political and economic edifice was created to attain radical socio-economic restructuring and a sustained growth with equity. Expanding public sector, development planning, effective implementation of public distribution system, various poverty eradication and employment generation schemes, safe drinking water and health care strategies etc. are declared by the government as the march towards the establishment of a welfare state. In this broad policy initiative the pioneering and interventionist role of the state is well defined. As a result, India has made considerable progress towards poverty reduction and improving economic development. The incidence of poverty has declined from 50% in the 1950s to less than 30% in the 1990’s. The literacy rate has increased from 20% in 1951 to 65% in 2001. The Human Development Report of 2002 ranked India 115 out of 173 countries, in terms of Human Development Index. India has moved from low human development that of medium human development (Dev and Mooij: 2002).

However, in the social development sphere, India’s performance is still lagging behind many Sub-Saharan African countries. There are also disparities between the urban and rural sectors and between privileged upper class and the socially disadvantaged groups. Widespread illiteracy, avoidable morbidity, premature mortality and deep-seated inequality of opportunity are still prevailing in India. India’s achievements in dealing with life expectancy, elementary education, nutritional well being, protection from illness, social security and consumption levels has been substantially and systematically

out passed by many other developing countries (Dreze and Sen, 2002). Compared to other countries, social sector expenditure is negligible in India, especially when compared it with UNDP recommended ratio. This decreasing trend in social sector expenditure is further aggravated by the inauguration of structural adjustment programme in 1991. On one hand the state is retreating from its welfare commitments and on the other it aggressively intervenes in favour of foreign capital. When the state becomes a vehicle for transmitting the global market discipline, its priority towards social security measures is relegated to the background. As a result of this 'facilitator approach' the 1990's witnessed a steep decrease in social sector expenditure. Recent studies show that Social sector expenditure of GDP declined sharply during 1990's. The share of development expenditure also declined during this period. With regard to education, the share of expenditure from all the Departments declined from 4.1% in 1991 to 3.8% in 1998. Health sector also is not an exemption. The studies reveal the existence of interstate disparities in social sector expenditure. Also there has been under utilisation of 10% plan expenditure during the east years of 90's. They further argue that social expenditure is slow in India the post reform period as compared in 1980's (Dev and Mooiji 2002). Needless to say, these drastic cut in social expenditure by both central and state government resulted in declined growth in social indicators.

The central issue, here is how to sustain economic growth with equitable distribution of resources in a liberalised economy. In the case of Indian state we can see that accelerated growth rate does not to have led to a corresponding change in living condition of rural poor. Here lies the importance of participatory mode of approach. The provision of social security cannot rely exclusively either on market forces or on the state initiative. There is an urgent need for participation in the distribution of social security measure. The move towards participatory growth calls for an integrated view of the process of economic expansion. In the neo-liberal market led economy, NGOs are expected to perform significant role including mobilising local initiative and resources, building self reliant sustainable social capital, moderating between government and people, transforming the attitude of people facilitating development education etc. Hence it is important to study the functioning of NGOs in participatory development.

The UN has defined community participation as '*the creation of opportunity to enable all members of a community and the larger society to actively contribute to and influence the development process to share equitable the fruits of development*'. This participatory mode of development views village community as the site for intervention. In this process it has to mediate through agencies working at that level. This is most commonly done through NGOs.

In this broader context of Indian state's commitment to liberalization, the present paper attempts to study the participatory intervention of a NGO in community health. For a detailed study, success story of **AWARE** - NGO working among the marginalized people in rural Andhra Pradesh is selected. The paper does not project NGO as viable alternative to fill the space vacated by state. But it only tries to establish that the objective of "Health for All" can be achieved only through community participation. The present paper is divided into 4 parts. The first part briefly outlines health sector performance and trends during the post reform era and its outcomes. The second part

analyses the status of health sector in Andhra Pradesh, major indicators and initiatives. The third part in detail discusses the sustainable strategy of AWARE and its impact on health sector in rural Andhra. The final part contains major findings and concluding remarks.

PART-I

Health Sector in India – Status and Trends

Health is an important factor in development and is closely intertwined with socio-economic and other factors. Since independence, India had made some progress in health sector, by way of eradication of disease like small Pox, implementing mass immunisation, control of leprosy etc. But we have a long way to go in achieving the Alma Ata Declaration of “Health for All” especially in the case of the marginalized people. Health services and facilities are distributed unevenly in India.

India’s Infant Mortality Rate at present is 74 percent. [HDR: 2004]. Health status of China and India was more or less same when India became independent. But now China has gone ahead of India. The main reason behind this limitation is attributed to India’s expensive hospital based curative health strategy in contrast to China’s low cost and community based strategy. For all these years India had attempted specific relief measures for some of the most prevalent disease. This has failed to achieve the development of a health infrastructure for delivery of comprehensive and integrated basic health services. Moreover, in spite of rhetoric statement in planning documents on the centrality of health care, the field was suffered from persistent neglect in public policy in general and development planning in particular. A direct consequence of this inadequate official attention is that India’s population is still exposed to high incidents of communicable diseases. India’s share of worldwide leprosy case is as high as 68% (World Bank, 2001). The incidents of under nourishment and under nutrition are also very high by international standards. Apart from this, health sector is characterised by sharp inequality, rural – urban divide and gender divide. As already mentioned, these ground reality in health sector is closely linked to the persistent neglect of this sector in public policy. Public expenditure on health in India is very low compared to other countries – i.e. only 0.8% of GDP. According to Sen and Dreze among 12 countries for which relevant data are available, only 6 i.e. Burundi, Cambodia, Georgia, Indonesia, Myanmar and Sudan have a lower figure of public expenditure on health as proportion to GDP. The low level of public expenditure on health in India is further aggravated by a highly inefficient use of available resource and sharp inequality in access to health care based on religion, class, caste and gender. Another important point to be noted here is that public expenditure is declining since the inauguration of liberalisation policies. Neither the states, nor the central government increased their health expenditure. The first half of the 90’s was especially bleak. In the second half of the 90’s the per capital real expenditure in health by the state increased, but there was no increase in terms of proportion of GDP (Jose and Mooji 2002). Another problem with regard to health sector is that it is essentially market based and diagnosis and drugs are treated as a commodity. The liberalisation process led to sharp increase in the price of essential drugs and transnational pharmaceutical industry now has complete control and domination over the system. Another problem with the health strategy in India is that it is based on western

model which is mostly curative, hospital based, top down and elite oriented. Private provision of health care also poses its own problems that private practitioners have little incentive to get involved in preventive medicine and public health care initiative.

Thus what we need is a social intervention in health sector to make it community oriented. The lessons that we learn from China is that they are strongly based in community and their health facilities have extended to the entire population. Here the target group themselves become the subject of process. In India, nearly 70% lives in villages. So 80% of the health care need of the population is primary. This primary health care should be the basis of our health care system; Self-reliance and social awareness are key factors. The approach should be multifaceted, aimed at overall development of persons and community at grass root level. Thus we must have a need based sustainable programme with community participation at all levels.

All these points towards a participatory approach in health care. Actually 'community participation' as we understood it today was popularised by the declaration on primary health care at the Alma Ata conference in 1977. As mentioned earlier, community participation needs agencies to mediate the objective and this is commonly done through NGOs and local participatory democratic institutions.

The present study thus focuses on the effectiveness of an alternative strategy for community health care successfully practiced by rural NGOs in Andhra Pradesh – AWARE. The strategies have been in implementation so far in 9620 villages spread over Andhra Pradesh, Orissa and Maharashtra. The following sections, in detail discuss this sustainable experiment.

PART II

Andhra Pradesh –Profile and Health Indicators.

The state of Andhra Pradesh ranks 5th in the country in terms of area and has 7.9% of India's total population. In socio economic dimensions, Andhra Pradesh presents a mixed picture, combining wide disparities in development. In terms of conventional indices of development, the state ranks among the top 4 in the country, but in terms of welfare indices, it falls among the bottom 4. And in terms of Human Development Indices Andhra Pradesh comes in the middle. Andhra Pradesh is among the state designated as educationally backward with literacy rates lower than national average i.e. 44%. Illiterate population is 4th largest in the country. 50% of the rural household do not have access to safe drinking water and in terms of health parameters, the state records one of the most glaring inequalities between the rural and urban areas, with the rural – urban infant mortality rates of 1.7%. Only 6.62% of rural household have toilet facilities as against the national figure of 9.48%. Around 11,200 maternal deaths take place per year in the state and gynaecological problems are endemically affecting 70-80% of rural women in the reproductive age. In terms of sex ratio, 13 of the 23 districts have ratio of less than national average of 929. For rural women, the sex ratio is even lower at 900. Out of the 35 districts in India with female age at marriage below 15 years, 6 of these are

in Andhra Pradesh. Out of the 41 tribal and backward districts identified by the government in 1998 as famine prone, six of which are described as vulnerable are in Andhra Pradesh. Next to Bihar, the second largest number of landless labourers is in Andhra Pradesh (8.5 million). The state also rank second after Orissa in terms of number of registered unemployment [Census Report: 2001].

With a history of being a strong feudal society, the state still shows emerging manifestations of oppressive power relations between landed class and peasants. The infant mortality rate has been brought down from 90 to 65, but in some remote areas, the IMR is still found to be as high as 400.

Though Andhra Pradesh lags behind other states in terms of social indicators, the state government expenditure on social sectors indicate a declining trend. This negligence gathered momentum with the introduction of economic liberalization. The World Bank documents on the finances of Andhra Pradesh traces the financial crisis in Andhra Pradesh to the mismanagement of fiscal structure under the earlier regimes. It stressed the need to prune down public expenditure on subsidies especially on social sectors. Under the programme envisaged by World Bank Rs.2200 core is given to Andhra Pradesh government to reconstruct Andhra Pradesh economy. From this the state government allotted only 233.6 crore for primary health care. It is against the failure of this strategy that we must look into the alternatives put forwarded by **AWARE**.

PART III

AWARE - Alternative Strategy in Health Care

AWARE is an organisation exclusively serving the tribals and economically depressed groups in Andhra Pradesh, Orissa, and Maharashtra. The strategy of **AWARE** seems to be sustainable because it reversed the conventional sequence of development assistance. In conventional model, economic assistance is followed by awareness generation and empowerment opportunities. But in **AWARE** model development assistance and aid is provided only after awareness creation and awakening of community consciousness.

This secular, non political voluntary organisation was set up in 1975 by Sri P.K.S.Madhavan. Unlike other voluntary organisation which seeks to set up for direct service, **AWARE** decided to take on an indirect role of sensitisation and generating awareness in order to improve the utilization of services.

*“It is the basic strategy of **AWARE**, says it’s Chairman, “to awaken the people, to make them identify their own problems and to prepare them to devise their own solutions and plan of action. The oppressed must not only recognize that they are oppressed but must also be aware of what they can do legally, peacefully and constructively, to overcome their oppression”.*[interview with Chairman].

AWARE's objective simply stated is to increase the role of tribals and other lower castes in the business of development. Through their psychological empowerment, AWARE seeks to attack the culture of submissiveness. Socio-economic interventions are then pursued to minimize poverty. The strategies deployed by AWARE are three-fold:

1. Psycho-social mainstreaming of the tribals.
2. Higher production directly benefiting these groups ; and
3. More even distribution of resources for better co-existence of people.

To do that, AWARE builds an organizational system that can function autonomously but at the same time can also interact, interlink and network with other systems and structures in pursuit of the objective of creating self-sustainable rural and tribal societies. The process involves specifically.

- 1) Creating organizations or associations of people at various levels (village, cluster of villages, and taluk or block levels) to represent their own interests and causes,
- 2) Supporting such organizations and their members to have access to development resources and services available through government.
- 3) Phasing out once the organized population has a level of articulation and autonomy.

In that sense, the transitory nature of AWARE's engagement is evident and is aptly conveyed through its spirited slogan: '*Awareness must stay, AWARE must go.* [Data collected from Head Quarters of Aware].

As the objective of AWARE is awakening and empowerment of rural population, healthcare play a pivotal role in it. Its health philosophy is designated by the words *Jeevana Sravanthi* which implies *health as a continuous life sustaining force.*

The initiative of AWARE in health care started quite unexpectedly after a cyclonic disaster and following cholera epidemic in coastal Andhara Pradesh in 1978. AWARE undertook mass immunisation and set up a way side clinic to treat hundreds of patients with a wide range of disease directly attributable to the cyclone such as palpitation, stiffness in leg, diarrhoea , tendency to carry among women, loss of milk among lactating mothers and other signs of trauma deprivation. After the cyclone relief measures, AWARE decided to close the wayside clinic. But the local people did not allow. Thus with the enthusiastic support of the community AWARE decided to convert the clinics into a permanent community health centre. The Centre was formally inaugurated almost a year later at Chinnapuram in Krishna district on January 1979. Despite their depleted economic conditions and meagre income, the people contributed towards the partial maintenance cost of centre. Thus with the active participation of the rural community, a one time emergency relief centre turned into a permanent community health centre. This was the initial stage. By 1989 AWARE set up community health centre at Padkal, Naidu and Jaggam in Khammam Sreekakulam and Pukhemundui in Orissa. AWARE rural hospitals are established in Goppili in karuppam in Vishaya Nagaram district, Petra in

Visakapatnam, Makhiavarigudam in West Godawari, Kurvi in Warangal and Gala in Khamam. It has initiated the process of establishing a chain of 100 rural hospitals within 5 years.

Recognizing that many of the health problems were outcome of unsafe drinking water, by pressuring the local government to dig wells and build drinking water tanks and drainage systems, AWARE ensured that every village in the Chinnapuram, Pakdal and other health centre area has a source of clean drinking water as well as drainage facilities.

All these centres are engaged in promoting a similar concept of community health. Each centre (except in Kunnavaram) has a 30 bed base hospital. The services include:

- Curative health care
- Preventive services including health education
- Training of community health workers and paramedical staff to serve as health educators and to work in the health outposts and
- Health and nutrition camps.

In addition, each community centre has its own focal activity- environmental sanitation in the case of Chinnapuram and Narayanapuram, leprosy in the case of Naidupet and training of health works and health education in the case of Padkal. The base hospital serves as a nucleus of the health care system. It combines the functions of a referral hospital with medical research, monitoring and training. There is provision for collective health information of the project area and updating it by routine surveys. The practical, experience and knowledge gained from treatment and survey work serves as a useful resources fro developing health education and training materials which reflect the local health context and needs peculiar to the project area.

Unlike other NGOs who talk health camps for namesake, AWARE regards these as effective rallying points for promoting health objectives. Camps are organised around the prevailing priority health needs such as nutrition, vegetable growing, clean water, diarrhoea preventing and treatment, personal hygiene, eye care, identification and treatment of leprosy etc.

AWARE is concerned that it is only when health programmes are backed and implemented by the people that the goal of health by people and for the people can be materialised. So it aspires eventually to create self sustaining health sustaining health societies aptly expressed by its slogan “*health without a doctor*”

AWARE health department is a well structured body. The apex functioning of the health programme in each Community Health Centre is the director aided by an Assistant Director. These are medical doctors with specialisation in preventive medicine. One of the two doctors is exclusively in charge of the health education programme as well as training, assessment and review activities. Health care is entrusted to the other doctor. These functioning are assigned on a relative basis. The doctors are aided by 3 tiers of health workers consisting of

- Paramedical workers or community health workers
- Village health workers and
- Dais or traditional pre-natal and post natal assistants.

Community health workers are trained for 6 months during which they acquire the basic knowledge of medical assistance including first aid, treatment for simple disease, handling emergency cases before the doctor can be reached, after care and follow up and maintenance of health records. On completion of training such workers can manage a health outpost or shelter and function as medical extension workers

The village health workers are nominated by village associations. They are trained for a month at the base health centre. To be nominated no formal qualification are required except the ability to absorb and transmit simple health measures. Training of these workers, touches on identification, prevention and treatment of seasonal and other common diseases, personal and environmental hygiene, malnutrition and other aspects.

The training of *dais* focussed additionally on safe delivery, prenatal and post natal care and immunisation. Training is conducted through casual informal conversation, slides, picture, songs and dramas.

Thus in all its functions, linkage between health and development and the economics of health are fostered by AWARE. The Community Health Clinics, for instance, are encouraged to become economically self reliant by setting up income generating projects like agriculture, animal rearing, dairying etc. Income from these activities helps the running of the centre. The involvement of medical discipline with the process of development is the unique thing in AWARE strategy.

The story of AWARE will be incomplete without mentioning the **Kunavaram Boat hospital**. If innovative methods are a yardstick, AWARE boat hospital or floating community health centre operating out of Kunavaram village is a winner. In the rugged Bison Hill range, on either side of the river Godavari, AWARE has a novel strategy for reaching health care to the Koyas and Konda Reddis – two key tribal groups. Living in 300 odd villages along the river, these tribes have been boycotted for decades both psychologically and in terms of service infrastructure. There are neither roads nor any other means of easy access through the Bison Hill terrain. The only communication possibility and one which AWARE grabbed eagerly was the mobility offered by the river. It decided to set up a floating hospital. The Government of India and the State Government were persuaded by AWARE to finance the cost of a mobile health programme located on a launch. The hospital floats on the river every day. Beginning at 7 a.m., it touches 5 centres on one of the banks each day. The medical crew halt overnight at a place called Kolhur. The following morning, the cruise is resumed with the boat stopping at another five centres located on the other bank. The boat has facilities for minor operations, inpatient care and a laboratory for urgent diagnostic work. There is a Doctor on board who is aided by the ANM and a computer. The crew is sufficient and knowledgeable in boat maintenance and repair.

The boat berths on the river side at a designated place. Outpatient services are delivered on the boat except to the aged and the infants who are unable to come personally and are therefore, visited in their homes by the roving medical team. The tribals come down the slopes to get immunization, first aid, prenatal and postnatal check ups or general health services.

Apart from this CHCs and boat hospital, AWARE has recently built a 300 bed multi-speciality hospital with internationally renowned specialists. The hospital situated in Hyderabad and provides 24 hrs services with 50 specialised departments. This hospital is now worked as the apex medical complex of the health activities of AWARE.

IMPACT AND ACHIEVEMENTS.

The impact of the strategy tried out by AWARE should be assessed seriously. Ford Foundation's health research team conducted a detailed study on the impact of AWARE experiment on village life in general and health sector in particular. They compared 3 types of villages:

1. Second generation villages where AWARE motivation strategy was in operation for more than 10 years,
2. First generation villages where AWARE strategy has started within 2 years and
3. Controlled villages where AWARE have not started work.

Interestingly, the study shows that health status and other social indicators are comparatively high in AWARE villages. The studies shows that infant mortality rates, epidemic and communicable disease rates etc. are low in AWARE villages. Another interesting thing is that people themselves now feel impelled to seek periodic visit of CHCs. There are 23 village Health workers in a single CHC, who disseminate health information in their respective communities. Since Village Health Worker is one among them and lives in their midst, unlike auxiliary nurse of government hospital, who just visit once in a month, it result in a better rapport and readiness among the village women to seek medical intervention. While visiting some AWARE villages the researcher can see the difference in their attitude towards a healthy environment. The general health record is better than found in controlled villages, where there is no such dissemination. In terms of nutrition the diet of the people in controlled villages seemed deficient as compared to those in AWARE village. The following table gives an indicator of the kind of health care benefits that has achieved within 10 years of intervention of AWARE.

TABLE 1

Impact in AWARE villages	1979	1986
Crude birth rate	32	30.8
Crude death rate	14.2	10
Infant mortality rate	110	65
Child mortality	85	68
Natal registration	10	50
Deliveries conducted by VHW	3	30
Mothers receiving post natal care	5	50
Children with malnutrition	52	4

Source: Ford Foundation.

The Crude birth rate arrive from 32 in 1979 to 30 in 1986, IMR decreased from 110 to 60, child Mortality rate decreased to 60. The most drastic improvement is the reduction in IMR at the end of 7 year period.

The experience of AWARE thus proves that backwardness can be checked through awareness generation and collective action. But unlike other NGOs, AWARE does not try to de-politicize development. Community participation is ensured with the close supervision of local democratic institutions including the village Sarpanch and Mandal President. Thus AWARE put forward the idea that participatory development is an integrated process and state has to play an active interlinking and understanding role in it. The alternative strategy adopted by AWARE proved to be successful in community participation, mainly because of some factors which make it unique and novel.

Firstly, AWARE strategy, described by Ford Foundation as one of the most powerful and effective in the country, consists in addressing the apathy of the community rather than extending monetary or material assistance. Once the community is sufficiently motivated and ready to undertake projects, then does AWARE step in with economic programme and loans and that also strictly limited a matching- whatever resources the community is able to mobilize on its own first and the kind of economic intervention the community itself wants.

Secondly, AWARE's approach arise mainly from Human Rights Perspective. It views health as a legal right of the people and not as service or charity rendered to them. It also perceives health as fundamental duty. People are not merely motivated to use a service where it exists or to demand one where it does not but are encouraged and expected to get involved in the development of the health service expects the people to organize themselves not only to demand the health to which they are entitled, but to ensure that such health is equitably enjoyed by every person in the community. As its Chairman said, *development must be seen as an unfolding of people and humanization of personal and group relations*. In the view of AWARE a comprehensive health care

programme should make it possible for each individual in the community to attain the highest level of health in a given situation.

Thirdly, AWARE strategy believes that the health of one is interlinked with health of other. As health programme recognises how this impact on each other and therefore creates a basis for individual and collective initiative towards a better common health.

Thus AWARE's conceptual as well as practical strength lies in rooting health and development functions firmly on people. People's support and accountability into their health is a product of their own understanding or awareness. Once awareness is created, the spectrum of health action that follows has to run the centre from prevention and treatment to health promotion. The infrastructure for the delivery of health care has to develop a strong vertical axis running from the base hospital or referral centre to the CHCs and sub central, health outpost and shelters, community based services and home care. Moreover the health care professionals must include doctors, paramedical staff, auxiliary and middle level workers and those trained from community to expand health outreach.

The convincing factor of AWARE health care has seen in attitudinal change in the population it works. Within 25 years, it has achieved tremendous progress in social indicators. Thus it is clear that AWARE has successfully socialized community health and medicine and used both to the advantage of the rural population.

This novel Social experiment carried out by AWARE successfully in Andhra Pradesh, where the conventional sequence of development was turned on its head, reveals the fact that Socio-cultural development can be achieved easily in cost effective manner, if community intervention and participation is sustained through out the process of development. Any alternative strategy which promises to deliver improvements in person's lives especially those who live below poverty line can use this people centric programme of action. It is also clear from the AWARE experiment that the kind of development in which a few people take all developmental decisions through the idiom of paternalism stands non sustainable, disseminating information through a non-conventional approach based on participatory programme empowers the recipients with the basic tools for them to be able to able to and will charge their own lives at the community level. The case study of AWARE described in the present paper highlight the kind of chain reaction that takes place when awareness is created through the sharing of information and motivation. To conclude, we can say that, if we are to derail the maximum social benefits from the resources invested in our development plans, we need an alternative strategy that treats people as participants, not as targets or beneficiaries.

Reference

1. Mahendra Dev. S, Jose Mooiji [2002]. *Social Sector Expenditure in the 1990's*, Economic and Political Weekly, March 2.
2. Dreze Jean , Sen Amartya [2002]. Hunger and Public Action, Oxford University Press, Oxford.
3. World Bank Report 2001
4. www.aponline.com
5. Report of Ford Foundation 1986
6. Census Report 2001

This document was created with Win2PDF available at <http://www.win2pdf.com>.
The unregistered version of Win2PDF is for evaluation or non-commercial use only.
This page will not be added after purchasing Win2PDF.