INTERNATIONAL NEWS

Letter from the Himalayas 2: Community based health care

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In the second part of his letter, Ted Lankester describes the three pillars upon which the community health programme that he is implementing in Uttar Pradesh is being built.

A village meeting to discuss the appointment of a village health worker had been called for 19.00. As we set out by road the great Himalayas to our north rose in stark silhouette against the darkening sky as the sun's dying rays turned them gold and vermilion. As we neared the end of the road a full-orbed yellow moon was rising over those same peaks.

We picked our way down the steep path, passing scrub and cowhouses and finally reached the mud-strewn courtyard of the village, several hundred feet below. This settlement, typical of so many in the mountains, comprised only three extended households, each with about 20 members. We were ushered into the largest of the three where we inched our way in the guttering candlelight over the bodies of children and adults in various stages of measles and dysentery. The stinking filth of bacillary pools on the floor seemed to us, if not to them, a potent mandate for urgent health teaching.

The meeting now due to start was our first sortie in this area into persuading people to elect their own village health worker for training. One of our team, himself from the mountains, explained the purpose of our visit and encouraged the villagers to verbalize their own felt needs and ways they might be met. We explained, in answer to their request, how we could not bring them a hospital and that even our weekly clinic was of limited value; no sooner had medicine effected a cure than they were sick again with the same illness. But if they so wished, we could train one of their own village women, who in turn could teach each of them how to prevent illness, practise good hygiene and promote child nutrition.

Health worker speaking at a village meeting

The headman, through a lattice of alcohol, first objected, then bubbled his enthusiasm as he began to grasp these ideas. Two hours later, after a cup of warm, unsterile buffalo milk and farewell *Namaste,* we left the village with their promise that a volunteer would be sent the following week.

The village health worker

Apart from running six integrated health clinics our Himalayan medical programme is attempting to train an elected representative from selected mountain villages. When trained, these volunteers, who are usually illiterate women with grown families, will be health promoters and educators to their own people, fulfilling a similar role to that of the Chinese barefoot doctor.[1]

Within her own village each will visit all pregnant women and children under five years old, and arrange for weighing, immunizations and appropriate curative care. She will identify leprosy and tuberculosis patients, referring them to the clinic and afterwards ensuring patient compliance. She will liaise both with the mobile health team and with village leaders about community hygiene measures such as the provision of a clean water supply and the disposal of human waste. At the end of her 60-lesson theoretical and field training she will be issued with a simple medical kit with which she can cure the minor ailments that make up 80 per cent of a weekly clinic attendance. Those with illnesses beyond her competence to treat she will refer to the weekly subcentre clinic or the district hospital.

Beyond the specific roles just described the village health worker will carry with her a philosophy of self-care and self-help. She will teach people how, when sick, they can first draw on their own resources before running to the nearest medical practitioner. She will propagate the view that health is a people's movement where the health professional in general and the doctor in particular are no longer dominant.

House-to-house survey

Village health worker training,[2] now well established in many developing countries including India, is the first pillar in our community based health care system. Linked with this is the second, a house-to-house survey to identify all those whose health is at risk and to help draw up a community diagnosis.

Having explained the reason for our visit we record basic health data for all family members on the outside of a family folder. This includes the maternal and family planning status of women and the immunization status of all

children. Enquiries are made about the presence of serious or chronic illness with especial reference to tuberculosis and leprosy; this enables us to identify any family member whose health is at risk. Sample families have a more detailed socio-economic survey completed.

Appropriate insert cards are made out for the following family members and placed within the family folder: all children under five years old, all pregnant women, those eligible for family planning and any suspected of serious or chronic illness. They are asked to attend the clinic, respectively for weighing and immunization, antenatal care, family planning advice and any necessary tests and treatment. Each insert card is ringed with a future date by which the patient should have attended. Once a month these cards are checked and any defaulters are visited at home by a member of the survey team or by the village health worker.

As in Britain, contact with patients in their homes usually means more to both patient and health worker than contact in a clinic. The mutual knowledge and trust thus gained are probably the most valuable outcome of house surveys.

Such surveys, still in their early stages in our project, are a more elaborate equivalent of the age–sex register.

Weekly integrated clinic

The third pillar of our community based health care system is the weekly integrated clinic. From the patient's standpoint this is the most important service offered. We try and combine curative care for people of all ages with a strong maternal–child health emphasis.

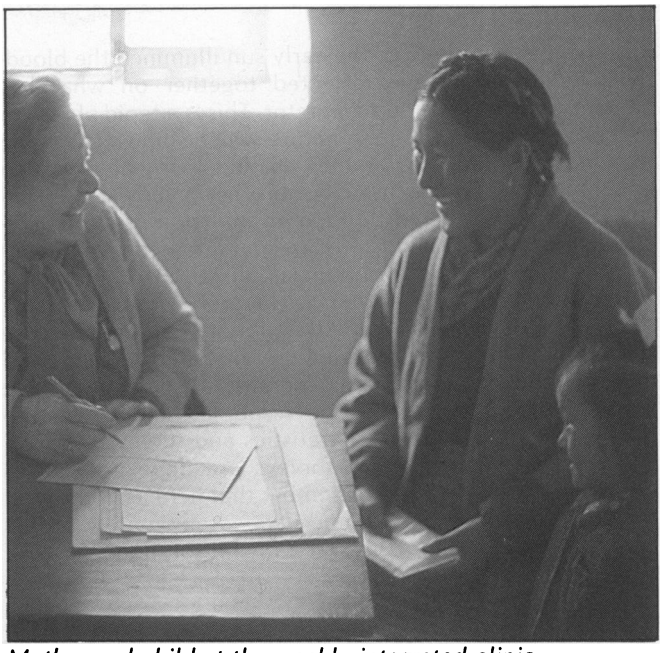
All patients coming to the clinic are first registered and charged a small fixed sum which includes examination, tests and a week's supply of medicines. Children's weights are plotted on self-retained road-to-health charts.[3] The real value of this lies not in the first weighing when most mountain children will fall into first or second degree malnutrition, but in subsequent recordings when a static or declining graph warns of imminent danger and where a climbing graph often implies that nutrition teaching previously offered has been well heeded.

From the weighing station mother and child proceed to the doctor or health worker. Here both felt and real needs are elicited and treated, the latter often through advice on nutrition, hygiene and family planning. Teaching of prime importance will be repeated by the dispenser or nurse who have posted on the walls of their rooms a list of standard treatment and prevention drills. Repetition of the same advice by two or more members of the health team is especially important amongst a largely illiterate population.

Before visiting the dispensary patients needing basic investigations are directed to the field laboratory, where sputum, stool, urine and simple blood tests are done on the spot and the results are available within the hour. This facility is of especial value in diagnosing people with pulmonary tuberculosis who are usually admitted to treatment only after positive sputum tests. We have found that basic diagnostic services enormously increase the value of treatments offered which can then be tailored more to cause than to symptom.

After a brief reattendance with the doctor or health worker the patient visits the nurse or dispenser. The nurse, apart from carrying out routine procedures, immunizes all eligible children. The dispenser is provided with a basic supply of cheap, effective preparations made within India and generically classified. Our aim is to prescribe as little as is consistent with patients' needs and expectations.

These three pillars—village health worker training, house-to-house surveys and the integrated clinic—would appear to be a sound basis for primary health care. In Third World situations, however, health care can never be isolated from the rest of development— indeed, illness, rather than being a prime cause of personal and social malfunction, is often a mere symptom. The truth of this was compellingly shown by an experience I had some weeks ago.



Mother and child at the weekly integrated clinic

A poignant pregnancy

Arriving early at a clinic we were summoned to a nearby summer grazing hut or *chand* to attend a pregnant woman in severe pain from sciatica. The full extent of the social dynamic of this troubled household was revealed to us as we sat in the fetid darkness awaiting the mandatory cup of sweet Himalayan tea.

The woman, now in her fifth pregnancy, had only one living child. (We could just discern a dishevelled toddler in the smoky room, teetering near the open fire, playing with sticks whose business ends were heating the kettle.) Three other children had died in their first two years of life. The cause of this tragedy appeared to be twofold. On the one hand the family held to the erroneous belief that mother's milk was dirty and that cow or buffalo milk should therefore be substituted. On the other was the sheer non-availability of nutritious food. Accompanied by poignant hand movements the father intoned how first one child, then another, had grown weaker and weaker and finally died. I glanced at the emaciated, ancient-looking bearer of a severely small-for-dates child, whose own conjunctivae were a bloodless white. It became all too clear that pious advice about good nutrition would fall on deaf and bewildered ears.

The eager recruit to community health would at this stage volunteer the services of an agriculturalist, yet here again he would fall short of the mark by confusing causes with symptoms. Low caste families such as this are entitled to government subsidies to help offset their low incomes. In practice this family receives only 30 per cent of this entitlement, the remainder being creamed off by dishonest officials. To help make good this deficit land has to be transferred to the production of the cash crop, potato. In consequence less land remains for vital food crops. Whole families thus suffer as a direct consequence of corrupt practices. As we rose to leave it became apparent that a purely medical input can achieve little if the interspun web of agriculture, education, social justice and personal honesty is not unravelled.

The human factor

Returning to the clinic as the early sun illumined the blood-red rhododendrons we reflected together on what has become known as the human factor. This is a tepid phrase to describe the rock of human nature which shipwrecks many worthy plans and programmes. Hadn't I originally got to know this very family through a brother, nearly dead from septicaemia contracted through an injection of streptomycin for backache, administered by an untrained practitioner by a dirty needle and for financial gain?

Here as in Britain this human factor is crucial to each stage of health care delivery: the primary care team whose smooth working depends as much on shared laughter and mutual sympathy as on plans and programmes: the patient himself whose needs must be respected and dealt with before becoming fodder for statistics and surveys.

As health workers learn, surveys are done and clinics established we do well to remember that here as in the west the success of our programme depends ultimately on the human factor, or dare I say, on a divine solution?

References and Further Reading

1. Lee R. Chinese and Western medical care in China's rural communes. *World Health Forum* 1982; **3:** 301 .
2. Many analyses of the role of the village health worker have been written and village health manuals have been published in many countries. See for example *Primary health care and the village health worker.* Contact Special Series No 1 53. Geneva: Christian Medical Commission, 1979; and Wood E. *Community health workers' manual.* Nairobi: African Medical and Research Foundation, 1982.
3. Morley D. *Paediatric priorities in the developing world.* London: English Language Book Society and Butterworths, 1977.

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FROM THE FACULTIES

Smoking habits of doctors and their spouses in South East Scotland

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Earlier this year the South East Scotland Faculty Health Education Committee sent a questionnaire to all general practitioners in South East Scotland to ascertain how many of them still smoke, and especially how many still smoke cigarettes. It was hoped that the results would demonstrate to the public that doctors take the threat of cigarette smoking seriously.

Table 1. Numbers of responders who do, do not or did smoke, and numbers of these doctors whose spouses smoke.

	Doctors	Doctors whose spouses smoke
Smokers	117 *(19 per cent)*	32 *(27 per cent of 117 smoking doctors)*
Nonsmokers	279 *(46 per cent)*	25 *(9 per cent of 279 nonsmoking doctors)*
Exsmokers	211 *(35 per cent)*	25 *(17 per cent of 211 exsmoking doctors)*
Total nonsmokers	490 *(81 per cent)*	50 *(10 per cent of total nonsmoking doctors)*
Total responders	607 *(100 per cent)*	82 *(14 per cent of responders)*

Table 2. Smoking preferences of doctors who smoke and numbers of these doctors whose spouses smoke.

	Doctors	Doctors whose spouses smoke
Cigarette smokers	36 *(6 per cent of responders) (31 per cent of smokers)*	17 *(47 per cent of 36 cigarette smoking doctors)*
Cigar/pipe smokers	81 *(13 per cent of responders) (69 per cent of smokers)*	15 *(19 per cent of 81 cigar/pipe smoking doctors)*

THE questionnaire was sent out on three occasions until a reply had been received from 81 per cent of the 750 doctors written to (Tables 1 and 2).

117 (19 per cent) of doctors still smoke but only 36 (6 per cent) smoke cigarettes, the main cause of morbidity. It is interesting to note that 47 per cent of these doctors' spouses also smoke, while only 9 per cent of non-smoking doctors' spouses smoke. Although this can be readily understood the implications are important.

Pessimistically we had feared it likely that most of the doctors who did not respond to the three questionnaires were smokers, but an analysis of answers to the third questionnaire revealed a higher percentage of nonsmokers than in replies to either of the first two questionnaires. We therefore contend that the final figures are fairly accurate assessments of doctors' smoking habits.

General practitioners in this area do not smoke cigarettes as we believe that cigarette smoking harms health. The habit can be given up and we would ask all smoking doctors to consider if they could stop smoking. We suggest the idea of a sponsored stop, sponsored perhaps by your family, your partners or anyone else. The wider the net and the more people involved the more effective will be such a campaign.

I wish to acknowledge help received from the Health Education Committee with special thanks to Dr Lelia Watson and to the doctors who took the trouble to reply.