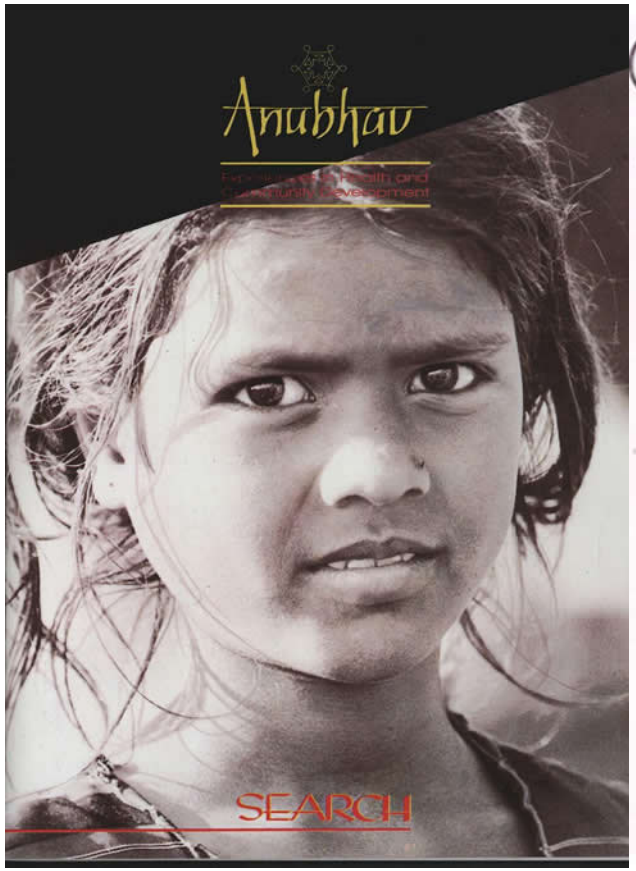

SEARCH

Society for
Education,
Action And
Research in
Community
Health

VOLUNTARY HEALTH ASSOCIATION OF INDIA
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Since the earliest days of civilisation, humankind has been driven by the urge to discover new things. From the earliest discoveries, humans tended to focus on activities that were needed for growth of society. No wonder then that the proverb 'necessity is the mother of invention' is part of every day lexicon.

The urge to discover, the desire for reaching out for the unknown, is a never ending process as the bank of knowledge can never be filled to the brim. Even great scientists like Albert Einstien have been humble enough to concede the limitations of the human mind. When asked about how he felt at having achieved so much in such a little span of time, Einstien had confessed that he had done precious little than standing on the shore of the ocean of knowledge and garnering just a fistful of the water.

The story of civilisations has thus often been strung together with stories of unended quests. It is thus no ordinary coincidence that when Abhay Bang and Rani Bang - both trained doctors driven by the urge to do something different from their fellow professionals - decided to work among some of the poorest people in a remote area in central India, they chose to name their organisation SEARCH - an acronym for Society for Education, Action and Research in Community Health. While committed to the socio-economic advancement of the people in the area they chose to work in, the duo was clear from the beginning that the issue of health needed to be given priority treatment. Health being one of the most vital yet neglected issues, was thus singled out by the Bangs while prioritising the agenda of SEARCH. In fact, Abhay Bang says:

"We in SEARCH believe that while efforts must continue to improve the socio-economic conditions of people, their health problems need immediate action. It is possible and desirable to solve many health problems by community based solutions. When this is done it empowers the community".

However, while correctly assessing that health was a priority issue in the course of working among deprived sections of Indian society, SEARCH is also clear that the role of the voluntary sector should not be confused with that of the government. There are certain facilities that the government is supposed to provide and the failure of the system should not mean that the NGOs start duplicating the

efforts. Abhay Bang has correctly assessed that the job of the NGOs is not to play the role of an alternate system, but rather to create pressure through mobilisation of the people to ensure that the facilities which the government is constitutionally bound to provide, is done in an an efficient people-friendly manner. Says Bang:

"We as a voluntary organisation primarily working on health issues do not believe that there is any need to duplicate any work on the aspects on which the government is either already working or has identified as a priority area for intervention. While awareness and mobilisation of the people must be carried on to ensure more effective functioning of various programmes, we are of the opinion that the present government health structures like hospitals are not helpful and acceptable to the ordinary people. Our priority is to identify areas and issues on which the government has no programmes and also does not consider it a priority area. Simultaneously, we also try to develop an alternative health delivery system which is pro-poor in nature and compatible and culturally acceptable to the people."

Background

Before going any further into the present activities of SEARCH it is important to understand the twin issues of its genesis and the personal background of the people spearheading the organisation. SEARCH was registered as a charitable Society and Trust in 1985 in Maharashtra. In 1986, its founder members, Rani and Abhay Bang (a doctor couple - she a gynaecologist, he a physician) came to Gadchiroli to start working in this most backward district in the Maharashtra state. They had with them their two sons - one six years and another six months old, a truckload of luggage - mostly books and papers, an ambulance, three workers, and lots of ideas.

Abhay's parents were Sarvodaya workers and were inmates of Acharya Vinoba Bhave's ashram at Wardha. He had spent his childhood in Gandhiji's Ashram. In contrast, Rani came from an Iyengar family and her father is a doctor. Both studied together in the medical college at Nagpur. Abhay, a university topper throughout, was an active member of Jayprakash Narayan's youth organisation, Tarun Shanti Sena. Later, he was a key activist in JP's movement for "Total Revolution" in 1975. His parents were also politically active in the movement and were jailed during the movement against Emergency.

Planning The New Initiative: Rani and Abhay Bang

After completing MBBS from Nagpur, he had joined the Post Graduate Institute of Medical Education and Research (PGI) at Chandigarh to complete his residency. Here he realised that health care programmes in the country were not focused on the reality in rural India. During his residency, he appeared for the all India MD selection test, stood first, but refused to continue to study at PGI. He argued at the PGI faculty council that the amount spent on training a doctor at PGI would have been enough to meet the health care needs of one lakh rural poor, yet most MDs from PGI were migrating to USA. To protest against this system, he left PGI and formed the 'Medico Friend Circle' in 1975 along with other friends in Tarun Shanti Sena. They made an effort to involve the medicos to work for rural and poor folk. He lived and worked in a tribal area in Uttar Pradesh to test his own preparation. He ultimately completed his MD in medicine from Nagpur University in 1977. Rani also passed her MD in gynaecology with the Gold Medal.

It was at this time that they got married, moved to Wardha and joined, along with Abhay's family, 'Chetna Vikas', an NGO started by them. The doctor couple began working in the villages. It was a period of intense education about the village reality. In addition to community health work, they organised landless labourers and farmers. During this work, Abhay found out that the minimum wages for agricultural labourers in Maharashtra were based on very faulty assumptions. Through research, he argued for the wages three times the prevailing rate. This research was widely used by various organisations and activists in Maharashtra which finally forced the government to accept the new level of wages proposed.

Anubhav

This episode made the Bangs realise the power of authentic research. They had realised that research was a very potent method to create support for change, and also that their clinical training was not adequate for working with the community health approach. In search of further knowledge, the couple left for the John Hopkins University in the U.S.A. in 1983 to do a course in public health. It was here that they learnt methodology of community-based health research. Abhay was a topper even here; and Rani attracted attention for being a rare example of gynaecologist turning to community health. But USA was not their *karmabhoomi*. They came back to India, and after a short while, started work in Gadchiroli in 1986.

Facets of Gadchiroli

Gadchiroli was a relatively unheard of district in one extreme corner of the state of Maharashtra. Yet during last decade, after the Bangs started working in the region, the place has come to wide notice. This is on account of

Gadchiroli district and SEARCH area

startling information generated at the couple's initiative. A sample:

- A community based study in Gadchiroli revealed heavy burden of gynaecological diseases in rural women. Women's perception studies showed that white discharge was the most important health concern for rural women. A new priority in women's health was discovered (1989). Traditional birth attendants were trained to help women by diagnosing and treating common gynaecological problems.
- In a field trial in Gadchiroli, village health workers and traditional birth attendants successfully diagnosed and treated pneumonia in children in 58 villages thereby reducing pneumonia mortality by 75% (1990).
- A sample survey of Gadchiroli district showed 6000 cases of sickle cell disease; and 1,00,000 persons as carriers of sickle gene (1987).
- Alcohol consumption was identified as a major economic and public health problem (1989). A mass movement was launched against alcoholism and it finally led to the closure of all liquor shops in the Gadchiroli district (1993).
- A study showed that 80% males in 15-44 years age group suffered from reproductive health problems. Rural males considered white discharge from urethra and hydrocele as the most serious health complaints of males (1996).
- 56% of home cared new born infants in rural area were found to suffer from one or more major morbidity during neonatal period (1995). Village health workers were trained to provide primary neonatal care at home resulting in nearly 50% decline in neonatal mortality (1997).

A Tale of Continued Neglect :
One of the Many Bridges Left Unfinished

The Area

The main reason behind such appalling health standards in Gadchiroli can best be understood by perusing the background and characteristics of the district and its people. Gadchiroli was carved out as a new district in Maharashtra in August, 1982. It is located at the eastern end of Maharashtra with the Bastar district of Madhya Pradesh in the east and the Telengana area of Andhra Pradesh in its south. Being a meeting point of three states, it harbours a diversity of languages and cultures. The district headquarters town Gadchiroli is located about 175 kms. to the south of Nagpur and 87 kms. from the nearest railway station Chandrapur. The State capital Mumbai is about 1,000 kms away. The district is about 230 kms. north-south and 60 kms. east-west. Nearly 70% of its area is under forests - a part of the ancient Dandakaranya forest.

On the western border of the district is the river Wainganga. Until a few years back (till a bridge was constructed on it), the district used to be cut off from the rest of Maharashtra especially during the monsoons. Even today, the interior areas of the district are unapproachable during the rainy season. The western part of the district, adjacent to the river Wainganga, is inhabitated by non- tribal farmers. Out of the total of 12 talukas, four belong to this category. The eastern part of the district is predominantly a hilly and forest area inhabited mostly by the tribals. Like in the rest of the country, there has been widespread deforestation.

The last demographic data of the district that was available from official sources was for the year 1985, which showed a total population of 6,35,651 out of which 43,718 (6.8%) were Scheduled Castes aad 2,50,599 (39.4%) were Scheduled Tribes. The main tribe was the Madia Gond. The population density was only 41-per sq.qm. About 97.5% of the people lived in 1661 villages, and only 2.5% lived in the towns of the district. The literacy rate was 22%, with female literacy being 12%, and the literacy rate of tribal women 4%.

Anubhav

Only 13.2% of the geographical area was cultivated, paddy being the major crop. Forests, which occupied, 70% of the land was the most important source of subsistence especially for the tribals. Collection of minor forest products - bamboo, tendu leaves, and fire wood, and selling them to local traders, was the major source of cash income. There were no industries or alternative sources of employment in the district. The forest collectors were at the mercy of middlemen who, needless to say, gave very low prices. This had led to the growth of the Naxalite movement in the district.

The health care was usually indigenous - magic cures or herbal remedies. Primary Health Centres were hampered by staff absenteeism as few wanted to live and work in such difficult area? There was a 30 bed 'District Hospital' where no successful Caesarean section had ever been performed. Doctors were either absent or

seeking monetary returns from patients. The health department of the state was only interested in achieving the family planning targets. It is ironical that according to official data, Gadchiroli, with such a poor health care and high child mortality had stood 'first' in the state for three successive years (1982-85) in regard to achieving family planning targets!

It was in this scenario that SEARCH started its work in the district in 1985. In the beginning, the SEARCH team functioned from a *tendu patta* godown in the Gadchiroli town which was lent by a local resident. In the very next month, floods cut off this small town from the rest of the country for seven days. This was how the 'search' began in 1986.

Philosophy and Approach

SEARCH believes that an important role for the voluntary organisations is path finding or research. Shorn of its elitist connotations, research in the context of SEARCH means to identify the problems of people and to develop new and appropriate solutions. In SEARCH this is done through a dialogue with the communities to identify their priority health problems, by conducting epidemiological research to assess the magnitude and the causes of the health problems, and by developing community based solutions. These solutions usually include health education about the problem, and making care available in villages by training village health workers. The impact is meticulously measured so that, if the approach is successful, a new model of community based solution is generated for one more health problem.

Explaining the impact of people-sensitive research, Abhay says: "Such scientific research can be a powerful change maker at other levels too. It can knock on the doors of policy makers, governments, and international agencies; and awaken them to the grassroots problems as well as to the possible solutions. Time and again we have found this 'action-research' approach worked successfully - both at the level of communities as well as national and international fora. In an ongoing battle between the hospital centered technocentric health care versus people centered empowering health care, we are trying to tilt the balance towards people by way of research and demonstration."

An Imperfect Beginning

However, SEARCH did not start out by having a negative attitude towards the government and its programmes. On the contrary, SEARCH began with a collaborative experiment with the government in 1986. It was tried out on the rationale that since government health services were run at public cost and were spread widely, the people would be greatly benefited if these services could be improved. In response to an offer from the Ministry of Public Health, Maharashtra, SEARCH accepted the responsibilities of

- Running two primary health centres (PHCs) in the Gadchiroli taluka.
- Providing specialised clinical services at the district hospital at Gadchiroli
- Introducing administrative reforms.

The personnel and finance would remain with the government, but SEARCH was given some advisory power. However, the ground realities soon proved to be different. SEARCH was supposed to implement reforms in the district hospital through a civil surgeon. In reality, no civil surgeon wanted to stay at Gadchiroli where any posting was considered as a punishment. Average stay at Gadchiroli of three previous civil surgeons was only five days a month. One day, even the civil surgeon was caught accepting bribe leading to his arrest.

The government doctors at the district hospital were often absent or busy in private practice. One day, none of the 11 doctors turned up for duty with the expectation that somebody else would cover up for their absence, and one of the Bangs was the only doctor working in the hospital. To the Bangs, it seemed that the system "had found free substitute labour in the form of a voluntary organisation".

However, their experience with the auxiliary nurse midwives ANMs and multipurpose workers of PHCs was better. By giving them training, curative role, opportunity for open discussion and due respect, their self esteem and interest in the work increased. Within one year, the functioning of the two PHCs improved and came to be considered the best in the district. People from the adjoining areas started approaching with a request that SEARCH should take over the responsibilities of PHCs in their area.

The general atmosphere and clinical care in the district hospital also improved. Specialised care was started and food and drug supply was regularised. Attendance increased by 50% within a year.

The Health Minister was so pleased with the results that he praised SEARCH in a public meeting at Gadchiroli. He also announced on the floor of the State Assembly that the government was willing to entrust running of the government hospitals and PHCs in difficult areas to other voluntary organisations.

However, this euphoria was short lived. This success was most probably not at all liked by the health department. Non cooperation and resistance from the health department started increasing. The department did not like the 'meddling of a voluntary organisation in its functioning'. It became a 'threat to their sovereignty.' There was also the fear that if this experiment became progressively successful, it would become a trend.

The Bangs realised that the health department looked at this experiment as an adversary and was not willing to learn from it. Bangs also started observing that since people in Gadchiroli were not involved in the effort to change the government institution, they believed that this improvement and the presence of unusual doctors like Bangs was only a passing phenomenon and would soon end.

These two years (1986-88) gave SEARCH the opportunity to observe the functioning of a government department from inside. Apart from the usual problems of corruption, red tape and false reporting on targets achieved, two other major problems were also identified:

- The health department was working not to meet the felt needs of the people but to meet its own targets.
- Decision making in the health department was very centralised and the relationship within the department extremely hierarchical and undemocratic.

SEARCH came to the conclusion: "It is possible in the short run to improve the functioning of the government health care institutions. However, the efforts to change or improve generate resistance from within the system. Enormous political will is necessary to overcome this resistance. It is neither desirable nor feasible for a voluntary organisation to take up this role. The goal, role, and work culture of the Government and voluntary organisations are poles apart."

SEARCH severed its link with the government programme after two years of this experiment in 1988 and started working directly with the people.

The government health services, due to their centralised and authoritarian management culture, are insensitive to the needs and feelings of the

people and even of their own workers. They therefore, neither respond appropriately nor work effectively. Many, including from the voluntary sector, see privatisation as the only solution. SEARCH today believes that voluntary organisation is not an another private sector organisation which is cheaper. It has goals, values and work culture very different from both the government and the private sector. *It is therefore* more appropriate for a voluntary organisation to work in close collaboration with people, rather than becoming an implementation contractor of the government programmes.

Today, when many voluntary organisations are trying to become the implementation arm of the government which is channelising more funds through NGOs, the SEARCH experience of clash of values and culture is of great relevance to other NGOs.

Lending a Helping Hand: A Village dai

Community Based Rural Health Care

SEARCH started its health work directly in a programme area of 58 villages of Gadchiroli district covering a population of nearly 50,000. The main emphasis of this work is to make community based health care possible through a band of trained community health workers who are able to take care of the majority of the health needs. The villagers nominate health workers who are called the *arogyadoots* (messengers of health), and the all Traditional Birth Attendants (TBAs or *dais*) in the village are involved. They are trained by SEARCH on a continuing basis.

In addition to treating common illnesses, conducting deliveries and providing health education, these workers are unique for they have also been trained to diagnose and treat gynaecological diseases in women, pneumonia in children, and care of the neonates. A number of them have also been trained and worked as investigators for collecting data for the studies undertaken by SEARCH. When necessary, they refer cases to the SEARCH hospital at Shodhgram.

The non programme area (the control area for field research) has 47 villages with a population of 45,000. Outside its direct programme area, SEARCH assists people when they approach the organisation for some assistance or advice.

The Team

The SEARCH team consists of 5 doctors, including Rani and Abhay, three nurses, lab technicians, a deaddiction team, a *keertankar* who gives religious cultural discourses in the villages, a team working with youth, 6 field supervisors, women social workers, computer programmer, statistician, office and support staff. The community based workers are 120 *dais* and 80 *arogyadoots* - 35 women and 45 men. The gate keeper, driver, registration clerk, deaddiction workers - many of the workers at Shodhgram are ex-addicts. The gate keeper spins on a *charkha* and keeps himself productively occupied.

Anubhav

Sampling Blood to Test for Sickle Cell Disease

Research on people Vs. Research with people

SEARCH found that if the issues of research are chosen in consultation with people, they participate enthusiastically and responsibly in research and action for solving their own health problems. Village youths and women have emerged as the main vehicles for research on their own problems and to deliver effective health care in villages. New research paradigms have emerged from these experiences - research not on people but with people." But, for the Bangs this realisation did not come easily and instead they had to tread a more convoluted path.

A sample survey conducted by SEARCH in 1987 revealed that the prevalence of sickle cell trait in the population in Gadchiroli district was 15%. It was found that nearly 1,00,000 persons carried the disease gene, and about 6,000 persons (1% population) were homozygous cases of sickle cell anemia. The report was submitted to the government for further action. The State Government publicly acknowledged the work, honored Abhay with the 'Adivasi Sevak' award, but no concrete action followed on combating sickle cell disease.

The people seemed unconcerned about non action by the government. Abhay and Rani soon realised that for the people Sickle cell disease was SEARCH's problem and not theirs. People were generous in donating their blood for

examination. They had nothing to do with the disease. It was the responsibility of SEARCH to conduct research and for the government to act. People had no role.

Abhay says that they realised that there was something "seriously wrong with the 'research and recommendation' method which alienated people from their own health problem. We decided that in future we will not choose the health problems for research and action on the basis of our medical curiosity alone. We will consult people or let the issues emerge from them."

Study of Gynaecological Diseases in Rural Women

In the 1980s, women's health was usually equated with maternity and family planning. But Bangs realised that a large number of women had gynaecological diseases, and 'white discharge' was the most important symptom. Women patients complained about 'weakness' thereby conveying the complaint of white discharge. Bangs recalled how they and other doctors working with them perceived this weakness as anaemia or anxiety and treat accordingly. It took living in Gadchiroli to understand the implication of this connotation. This made them realise the importance of knowing local expressions of various symptoms.

Review of medical literature revealed that prevalence of gynaecological diseases in rural women had never been measured. Estimating this required study of the entire population of women in defined villages. Group meetings of women and men were separately organised in villages and then together. They identified 'white discharge' as the most important and common problem of women. A community based study of gynaecological diseases in rural women was jointly planned and conducted in two villages, Wasa and Amirza.

The study revealed that 92 % of women in the villages had gynaecological problems and had, on an average, 3.6 diseases per woman. Only 7 % had ever received proper medical care. The most common problems were reproductive tract infections (RTIs), menstrual disorders and sexual problems. Women were anxious about their gynaecological problems but were reluctant to seek help from male doctors and be subjected to pelvic examination. Even when they sought help from the traditional healers (*vaidus*), the husband went to the *vaida* and told of the problem and got medicine for his wife. The menstruating women were considered 'impure', and had to stay in a menstrual hut.

Such high prevalence of gynaecological problems adversely affected the ability to work, caused repeated abortions, sterility, disturbed sexual and marital life. It also caused disreputation to contraception because it aggravated gynaecological diseases.

46 % of unmarried girls were found to have had intercourse which was against the belief that such practices were prohibited by cultural and religious norms in India.

After completion of the study, the findings (except on pre-marital sex) were shared in all villages at group meetings and through a health awakening *jatra*.

This study was published in The Lancet in 1989, and was considered a landmark study as it showed the policy makers and activists world over, the hidden iceberg of women's diseases and brought out gynaecological care as a public health priority.

Table-1. **The gynaecological and sexual problems in rural women found in the Gadchiroli study. (1989)**

	Diagnosis	% of women in villages
1.	Amenorrhoea - Primary & Secondary	5.7
2.	Oligomenorrhea	22.4
3.	Menorrhagia	15.2
4.	Dysmenorrhoea	57.5
5.	Infertility	6.7
6.	Psycho-sexual disorders	31.0
7.	Trichomonas vaginitis	14.0
8.	Candida vaginitis	34.1
9.	Bacterial vaginitis	62.2
10.	Cervical erosion	45.7
11.	Cervicitis	48.7
12.	Pelvic inflammatory disease	24.1
13.	Syphilis	10.5

Training youth for reproductive life

Since about 50 % of the adolescent girls and boys experienced premarital sex, adolescent health and sex education in rural areas became very important. Two HIV positive cases were detected in Gadchiroli by SEARCH in early nineties. Hence, SEARCH is presently giving priority to sex education.

A seven days reproductive health education programme for adolescents has been developed by SEARCH. The main idea is to prepare the youths for mature, responsible and safe reproductive life which includes love, sex and reproduction. About twenty such training camps have been held in Shodhgram; each was attended by about 50 to 100 girls and boys on an average.

The youths interviewed were very enthusiastic about the programme. They stated that many misconceptions about sex have been cleared and they have become aware of the problems of excessive consumption of alcohol, the risk of unprotected sex, and about STDs and AIDS.

Understanding people's culture of health and disease

The other factor which have made the people accept SEARCH's programmes is the organisation's sensitivity to the people's culture. This includes local terms which people use for expressing various ailments and their symptoms, and the rich traditional knowledge that people have to combat various diseases.

To SEARCH, education is a two-way process. Various interactions with the masses have taught the workers from SEARCH that traditional folk culture has many ingenious survival techniques. Rani has meticulously documented from the *dais* information on medicinal and other uses of 300 local plants - the *tendu* tree gum as a permanent contraceptive, and asafoetida mixed with water for fungal infections like tinea.

Women's Reproductive Health

SEARCH was one of the first voices in the world to speak with concrete evidence against the disproportionate emphasis on family planning, and to advocate 'women's *reproductive health*' (1989). They suggested that management of reproductive tract infections, sex and reproductive education, access to abortion services, care for infertility should be a part of the reproductive care for women. Bangs wrote in 1990 - 'Not MCH (maternal and child health) but WCH (women and child health)'

SEARCH's work on women's health has four components:

- *Participatory research on reproductive health*
- Participatory mass education on sexual, reproductive and social issues.
- Village-based reproductive health care.
- Referral services

Dais (TBAs), *arogyadoots*, and ANMs from 2 PHCs were trained to tackle common gynaecological problems. It was the first (and even today, probably the only) experiment in which TBAs were trained for and entrusted with the task of diagnosing and treating reproductive tract infections in women. Referral service are provided at the SEARCH hospital at Shodhgram.

Playing a Crucial Role : Sanjay Potphode

Sanjay Potphode is a young boy of 23 who has studied up to class 11. For the last three years he is working in SEARCH on a very interesting idea called **Wisdom Bank**. In this unit, recordings are made of traditional knowledge, beliefs and customs of the people regarding illness and treatment. Various terms and expressions used to describe the symptoms of various sicknesses are explored, understood and recorded. It is a bank to record people's own wisdom and expressions.

Abhay said that SEARCH was recording these from people to reinforce the value of mutual learning and as an important tool of communication. Such knowledge about the local expressions used by people to describe the symptoms can be used by the doctors working in rural areas. He was of the opinion that such material should be a part of the curriculum for medical students.

Such an effort should not only be encouraged and supported but an initiative taken at the national level for similar recordings in various languages and dialects.

Training

Basic and refresher training for health is conducted by SEARCH at regular intervals for different type of workers and local people such as

- Village level health workers (*arogyadoots*), both male and female - Village *Dais* (TBAs)

Reproductive Health Problems of Men

Bangs were surprised when, following Women's Health Yatra, men from 2 villages submitted memoranda signed by hundreds of men urging SEARCH to undertake similar study on men's health, because "we too have similar problems." A consultation meeting of the male '*sarpanchs*' was organised in 1990, in which they identified hydrocele and white urethral discharge - *Dhat* - as the important health problem of males. Bangs sensed another uncared area of public health importance. They conducted an epidemiological study in Gadchiroli which revealed that 80 % men had reproductive health problems, nearly two third of which were due to infections. SEARCH is of the opinion that a community based approach is urgently needed for male reproductive health care which should include prevention, diagnosis and treatment of STDs, promotion of condom use, sex education, management of urogenital filariasis, surgical care, and control of alcoholism. This is one of the selected priorities of work of SEARCH in the near future.

An Effected Resident

- Tribal leaders
- Nurses and paramedic workers
- Youth (both urban and rural)
- Teachers

Training is extremely important for SEARCH as the main objective is to develop local health workers for village based health care and research. 80 *arogyadoots* (VHWs) and 120 dais have been trained at SEARCH. Over the years, these *arogyadoots* have become 'barefoot researchers'. Some of them have been upgraded to become supervisors and apart from their usual duties, have become trained enough to conduct delicate research procedures like 'verbal autopsy'.

The methods of training are quite different. Non-formal training methods are used especially for dais who are illiterate. They love talking and have very short attention span. Games, opportunities to describe their own life experiences, songs, dances and a congenial atmosphere help them to shed their inhibitions. They now eagerly await SEARCH's invitation for the monthly review and training camp.

Unique health workers of SEARCH

Arogyadoots and *dais* are competently handling cases of pneumonia amongst infants and children, common gynaecological problems, safe delivery and neonatal care. Through these workers, SEARCH has demonstrated the feasibility of delegating such delicate and crucial responsibilities to village level workers, and effectively controlling these health problems. The edge of primary health care has been thus advanced towards people.

Malatibai, aged about 40 years, is a *dai* from the village Gogaon. She was initially trained by her mother-in-law. She has now been trained at SEARCH. She says that "earlier we never used gloves or washed our hands with soap and disinfectants. Now this has become a rule. Before this training, we used to pour cold water over the child immediately after delivery to make it cry, cut the umbilical cord with a sickle or blade, check the newborn's hearing by banging a vessel with a metal piece, and place a paste of mud and oil or turmeric powder to cover the navel."

She now washes her hands with soap and disinfectants, uses a sterilised scissors to cut the cord, and cleans the mother and baby with clean cloth immediately after delivery. She has also learnt that breast feeding should start immediately. Previously, breast feeding was not initiated for the first three days since the breast milk on these initial days was believed to be impure.

Trained *dais* now use proper disinfectants to

Playful Learning - Snakes and Ladders is not Just for Entertainment

Educating People for Health

Educating people for health, training health workers from the community, and involving people in planning can demystify medical care. It can also create the basis for success in battles with 'difficult diseases'. SEARCH's experiments proved that it was possible to successfully manage childhood pneumonia as well as sick neonates in villages. It also emerged that infant mortality could be reduced and gynaecological diseases controlled.

The initial work of SEARCH was to launch a campaign against indiscriminate use of injections when oral medication would have been adequate. A study at the out-patient department of the district hospital indicated that 33 % of the patients received injections, and 60 % of these injections such as B Complex, diazepam, steroids, analgesic, etc. were unnecessary. Health workers of SEARCH say that it "took a lot of persuasion of the doctors and the directorate to change the injection policy. This resulted in a 58 % reduction in the injections given, thereby avoiding 17,000 unnecessary injections per year in the OPD of the 30 bed district hospital at Gadchiroli."

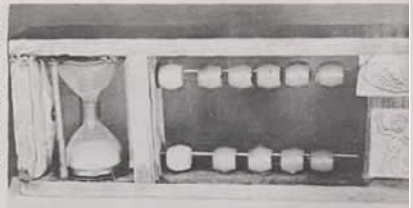
In the villages, people had developed a misconception that only injections could ensure a quick and complete cure, which made them psychologically dependent on doctors and vulnerable to exploitation. During the course of the SEARCH campaign against excessive use of injections an injection-induced case of fatality surfaced. A woman from the village Porla died as a result of injection given to reduce body aches. This incident was documented and publicised through slides to drive home the point that injections were unnecessary in most cases and could even be harmful.

Even today, the process of health education continues and underscores the fact that SEARCH does not look at education as an one-shot affair. Currently, the programme of health education is being conducted through:

- Women's group meetings and village meetings using slide shows, video films, posters and flash cards. As a part of this programme, *In Search of Village Happiness* - a poster periodical was distributed in 200 villages.
- A folk form of religious discourse (*keertana*) is used to educate against unsafe sex, alcohol, tobacco, discrimination against women, and superstitions.
- One of the major and successful programme conducted by SEARCH was the 'Women's Awakening and Health Jatra', in 1989. It included an educational and cultural programme - an exhibition of pictures and posters on women & child health, traditional medicine and environmental issues. There were slide shows on STDs and reproductive health, a competition on 'clean home and surroundings', songs, discussions on community management of diseases like childhood pneumonia. Lastly, a play was also produced entitled 'when the husband gets pregnant' that attempted to make the husbands conscious about the agonies of child bearing. More than 25,000 people attended the Jatra which was organised at 12 places.

That the strategy of SEARCH has succeeded can be gauged from the fact that today there are definite signs of increasing awareness and acceptance of the people of the alternatives suggested by the activists of SEARCH.

clean the wound, whitefield ointment for fungal infections and Gama Benzene Hydrochloride solution for scabies. They also visit the mother and new born baby at regular intervals for general check-up, and treat the duo if they are found to suffering from diseases they have been trained to manage.



Learning to Count with Tools : The Breath Counter

Two responsibilities they are trained for are unique. *Dais* in SEARCH can perform per vaginal examination using gloves and speculum, diagnose and treat vaginitis, and pelvic inflammatory diseases with medicines. They can also diagnose pneumonia in children and treat with co-trimoxazole. They have also been trained when and where to refer the patient to a doctor.

The *dai's* medical kit includes iron and calcium tablets, ointment for neo-natal conjunctivitis, anti-septic ointment for cracked nipples, artificial nipples, co-trimoxazole syrup for pneumonia, paracetemol tablets, vitamin A capsules, glycerin for mouth inflammation, soap, disinfectants and condoms.

Abhay has developed a simple device that has been named **'breath counter'** to count the respiratory rate of a child and to diagnose pneumonia. The device has two rods with a set of blue and red beads and one minute sand timer. Since TBAs can not count respiratory rate up to 50 or 60, necessary to diagnose pneumonia in infants by WHO criteria, she has been trained by using this simple device. A blue bead is moved for every ten breaths. If she has to move the red bead before the sand has passed (one minute), it means that the child has pneumonia. When the dais were trained to diagnose pneumonia by using this device, the accuracy of their diagnosis as compared to the doctor was 82%.

Display Items : Dais Show Their Kit with Pride

Anubhav

Control of pneumonia in children

Acute respiratory infections (ARI), especially pneumonia, have been recognised as the most frequent cause of infant mortality annually killing about 4 million children in developing countries. Abhay and Rani realised its importance when the son of an IAS officer in Gadchiroli died of pneumonia just before they reached Gadchiroli in 1986. They were quick to realise that if this was happening among the elite then what would be happening to the children in villages who develop pneumonia ?"

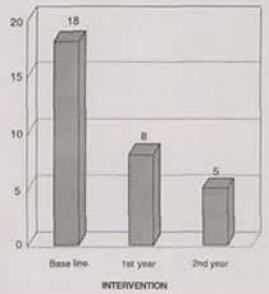
SEARCH tried an approach called case management of pneumonia, by training village health workers and dais to diagnose and treat pneumonia in children. Since this was a bold experiment in eighties, a rigorous field trial was planned with a control area for comparison of results.

In two years (1989-90) nearly 2,000 cases of pneumonia in children were treated by the trained Arogyadoots and dais with resultant case fatality less than one per cent. The childhood mortality due to pneumonia in the intervention area of 58 villages declined by 75 %, the infant mortality rate by 33 % and child mortality by 30 %.

This study, published in the Lancet in 1990, was considered one of the best in the world both for its methods and results. It became one of the models on which the Global programme of ARI control was planned by 77 countries in 1991.

At the beginning of the field trial, SEARCH was refraining from treating newborns with pneumonia as per the guidelines of WHO. Maruti Ingale is a class 10 pass young man who

Pneumonia Mortality Rate/1000 Children



Case Fatality in Children with Pneumonia

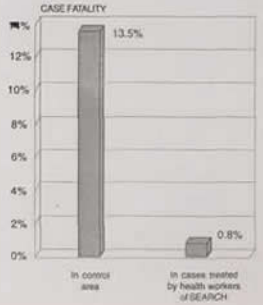


Table-2 **The impact on childhood mortality and pneumonia mortality at the end of two years of intervention**

Description	Control Area	Intervention Area
No. of villages	44	58
Total population	34,856	46,629
Children below 5 years	3,947	6,456
Birth Rate	30.1	31.6
Infant Mortality Rate	121.6	79.77
Pneumonia mortality rate per 1000 children under 5 years	17.48	4.64

was selected and trained as an arogyadoot. He soon mastered how to diagnose and treat pneumonia. A neonate in his village developed pneumonia. A doctor was called but he refused to treat the baby because of high risk. Desperate, the family called Maruti. He treated the neonate but realising the seriousness, sat beside the child for 36 hours constantly observing the patient and reassuring the parents. The baby survived. Today, Maruti's village dotes on him. Many private practitioners in villages now refer cases of pneumonia to dais and arogyadoots.

A sample survey was conducted among parents of children who had been treated for pneumonia by SEARCH workers. They were unanimous of two things:

- in case of childhood pneumonia, their first choice would be to seek care from SEARCH workers
- they did not think that injections were necessary for treatment pneumonia in children.

An alternative strategy for ARI control programme

SEARCH has made two bold departures in the programme to control acute respiratory infections in children (ARI). One, to entrust TBAs and village level health workers the responsibility to manage pneumonia in children, thereby achieving almost 100 % coverage of pneumonia attacks in children in their action area. Second, even the neonates with pneumonia are managed in the villages because parents are almost never willing or able to shift the baby to hospital.

Since the government ARI control programme has not incorporated such steps, its effectivity remains low. A comparison of the two strategies is presented in next table.

Primary neonatal care in villages

Mortality in newborn babies within one month of birth, constitutes nearly two thirds of the infant mortality rate in developing countries.

Table-3 **Comparison of two strategies of ARI Control**

	Strategy based on current government guidelines	Alternative strategy developed by SEARCH
I. Children of 0-2 months age.		
Place of care	Hospital	Case management at home
Necessary and Infrastructure	Hospital	Trained VHW TBA in each village
No.of sick children (at 50% coverage)	1.4 million	1.4 million
Cost of care/year	Rs.1470 million ($ 48 million)	Rs.4.2 million ($0.14 million)
Reduction in pneumonia mortality rate	31%	A little more than 33%
II. Children of 2-59 months age.		
Place of care	Community	Community
Providers of care	MPWs	VHWS + TBAs
Actual coverage of pneumonia cases achieved	10-20%	More than 90%
Expected reduction in pneumonia mortality rate	5-10%	75%
III. Total 0-5 years		
1. Infrastructure necessary	Network of hospitals + 0.1 million MPWs.	1 million health workers
Recurring cost of care/year ($50.2 million)	Rs.1538 million ($ 4.2 million)	Rs.122 million

Keeping a Hawk's Eye : **Arogyadoots** *Monitoring Health Status of Infants*

The typical medical recommendation is "immediately hospitalise every sick newborn." But since hospitals do not exist in rural areas, and since parents are unwilling or unable to shift the sick newborn to hospitals, SEARCH decided to develop a home based primary neonatal care for villages.

A study was started in 1995 in 39 villages to observe and record the type of diseases home cared newborn babies in rural area suffered from. Thirty six female *arogyadoots* from these villages were trained to visit families, examine newborn and record the findings. The study revealed that 95 % newborns were home delivered, 56 % suffered from one or more major illness (prematurity, birth weight less than 2 kg, pneumonia, sepsis, birth asphyxia, hypothermia or breast feeding problems) and 52 infants out of every thousand died. Only 2 % were treated by a doctor and barely 0.4 % were hospitalised. It was thus obvious that newborns needed to be cared at the village level.

In 1996 a primary neonatal care system was evolved in 39 villages and now trained *arogyadoots* visit homes, examine newborns and manage the sick ones. At the time of writing this report, the neonatal mortality in these 39 villages had decreased by 36 % and Infant Mortality Rate had come down from 74 to 44 %, lower than national figure of 74/1000 live births.

The two programmes - pneumonia management and primary neonatal care developed by SEARCH have the potential to reduce child mortality by 50 %.

Verbal Autopsy: Why do children die?

There have been some associated studies relating to reproductive health problems. One of the interesting methods adopted for identifying causes of child deaths was 'verbal autopsy' which is important in areas where medical certification of cause of deaths is absent. Upgraded *arogyadoots* have been trained to conduct this 'autopsy' with precision.

On the Prowl with a Purpose : Probing Reasons Behind Infant Mortality

People's movement against alcohol

By 1988 SEARCH had established close contacts with the local people and several tribal leaders in the district. It became clear that the two main issues of concern to people were alcoholism and forest rights.

The first alcohol addict that SEARCH encountered at Gadchiroli was a malaria control supervisor. It took six months of counselling and three bouts of hospitalisation to treat him. The next patient was a teacher who gave up drinking only after he was convinced that he was suffering from cirrhosis of liver and did not have many days to live. In the first two years, about 20 persons were assisted to overcome their addiction of alcohol. But at least 10,000 persons in the district were alcoholics. Given the magnitude of the problem, it was realised that medical approach alone would not be sufficient and effective. Having learnt a lesson from their research on Sickle Cell Disease, this time the Bangs decided to wait for initiative from people.

Emoting Ills of Alcbobol : Using Culture to Make a Point

A few months later, a young inebriated man quarreled with his wife and, in a fit of rage, threw his one-year old daughter into a well where she drowned. This incident resulted in widespread public reaction.

Subsequently, SEARCH had organised a series of village level meetings of women and youths to discuss their health problems. Alcohol cropped up as the common topic in all meetings. Women described how their lives were ruined because of alcohol addiction amongst males in their families. Women of Gadchiroli did not consume alcohol except on rare social occasions. Men got drunk, did not go for work, failed to support their families, beat their wives, quarreled, fought and even killed each other. They also often vomited blood after prolonged drinking, and died. Many women recalled how they had lost their husbands or other dear ones because of alcohol addiction. It became clear that practically all the women had suffered due to alcoholism amongst men. The youth also expressed great anger while condemning alcohol.

In one village, with the encouragement of SEARCH, the youth imposed a ban on liquor in 1988. Liquor bottles and dens were destroyed. Streets were patrolled at night to prevent smuggling of liquor; and those who were found drunk were fined. The ban was successful. However, the question arose whether this strategy would work on a larger scale.

Once in every three months a meeting was held at the district level where social workers, tribal leaders and voluntary organisations participated. In one such meeting, SEARCH presented its perceptions and experiences about alcoholism. Their views were widely shared and all felt that the abuse of alcohol was a problem of the entire district. It was finally decided to collectively launch a mass campaign against alcohol.

SEARCH agreed to help with supportive research. The research methodology took the form of focus group discussions. It was confirmed by everyone that consumption of alcohol was on rise. The sale of alcohol from unlicensed and government licensed shops was also examined. A group of teachers collected data on annual liquor sales from licensed shops; and the rules and regulations governing them. A survey was conducted in 104 villages by 43 village health workers to collect data on number and frequency of persons drinking, expenditure on liquor, common symptoms due to drinking.

United We Stand : Convention Against Alchoholism

Official documents about government guidelines on sale and consumption of liquor in tribal areas were collected.

As a result of the study several inferences emerged. They included:

- The main ill effects of alcoholism were chronic abdominal pain, loss of appetite, vomiting (including vomiting of blood), swelling of the feet and abdomen, jaundice, progressive weakness, impotence, accidents and injuries, loss of employment, family problems, mental derangement and death.
- About 1,00,000 men in the district were frequent drinkers and 10,000 were addicted to alcohol.
- Inspite of a constitutional provision prohibiting sale and consumption of liquor in tribal areas, the state government had given licenses to 57 shops to sell liquor, and drinking permits to 2,000 individuals who could buy and possess 12 bottles of liquor at a time. They often acted as sub-agents to sell liquor in the villages.
- Annual sale of liquor in the district was about Rs 200 million which was more than the government's allocation of development funds which was Rs 140 million for the district.

The research was conducted openly with participation of a large number of people and the findings were discussed which were easily comprehensible. Thus, three elements had emerged:

- collective realisation about the problem of alcohol.
- concrete facts and data to back up.
- common will to tackle the problem.

Large number of meetings were held by SEARCH in hundreds of villages to explain the findings. Within months, a mass movement against alcoholism emerged in the district. In November, 1988, a district level conference was organised which was attended by 3,000 delegates from 150 villages, half of them women. A district level 'Darumukti Sangathana' (Organisation for Liberation from Alcohol) was formed. A ban on the illicit sale and consumption of liquor was put into effect in 200 villages by the villagers.

The illicit liquor trade was stopped but the sale of liquor from the licensed shops continued. The movement led by SEARCH continued to build pressure demanding stoppage of government sponsored sale of alcohol in the district. Eventually, 346 village level organisations joined the movement and all three elected representatives from the district to the state Legislative Assembly, supported the movement. The government was still unrelenting. A mass petition of about 40,000 signatures were sent in August, 1992, to force the issue. The campaign got the support of the local press, social activists and leading personalities in the state. The formal decision conceding the demand was finally taken by the state government on 14th September 1992.

As expected, the liquor vendors challenged the decision in the High Court which stayed the government decision. The alcohol shops were still open. A major rally, which was attended by thousands, was organised at Gadchiroli on 2nd, October '92 to declare the start of 'People's prohibition'. A programme of picketing and sealing of liquor shops and destroying illicit liquor was announced. Abhay and Rani were arrested four times for picketing for closure of alcohol shops. At the same time, the movement filed an appeal in the High court. In March 1993, the High Court dismissed the liquor vendors' case.

The movement had won. Sixty shops were closed and 2,000 permits scrapped. At this stage, a survey conducted showed drastic reduction in alcohol consumption and a positive change regarding the economic situation, peace at home and reduced violence. However, the liberation from alcohol was by no means over - the process had just began. Protection committees were set up to ensure the proper working of the prohibition at the village level. But the problem of addicts remained. Deaddiction programme for alcoholics emerged as the next challenge for SEARCH.

There was of course a backlash from the liquor lobby during this period and after. Apart from threats to life and physical attack, it unleashed a smear campaign against Abhay and Rani which included allegations of Rani conducting illegal abortions and Abhay himself being an alcoholic! There were repeated investigations by the government. The charges against Bangs were not only cleared but they earned praise from the state authorities for the excellent work they were doing in very difficult areas.

Shodhgram

The SEARCH office was based in the Gadchiroli town for the initial seven years. To become more accessible to tribals it was decided to move further interior in 1993. They set up their present headquarters 17 kms from the Gadchiroli town on a 12 acre agricultural land in the forest. It was named Shodhgram: a search village. Gandhiji had named his Ashram 'Sevagram'. Abhay, who spent his childhood

A Distinct Look : People Friendly Hospital

there, felt that the main drive behind their work in Gadchiroli was seeking knowledge and solutions. Hence the name Shodhgram. The centre is designed similar to a Madia Gond tribal settlement with a small temple for the tribal deity 'Ma Danteswari' at the entrance.

The other buildings that have been built also have a similar touch of a tribal architecture and Gandhiji's Ashram. The buildings are a deaddiction centre, a pharmacy, the office and research building, training hall, trainees hostel, mess, canteen, quarters for the staff and visitors, prayer-cum meeting hall and a house for the Bangs. On all evenings, inmates and patients of Shodhgram gather for a prayer meeting. At the end of the prayer, Rani and Abhay give the lead with a rendering of *"Itani shakti hame dena data...."*

The tribal friendly hospital

The referral service is provided through a small hospital at Shodhgram. About 15,000 patients from 10 blocks of Gadchiroli and Chandrapur districts receive care every year. Ambulance service is provided to the villagers on demand.

Abhay and Rani told how the concept of this hospital had evolved after a number of meetings with the tribals from 100 villages. The tribals told them that they feared a visit to the Government hospital, did not feel at home there. The tribals, when they went to hospital, usually took their relatives along. But the hospitals kept the patients inside and pushed the relatives out. Patients in the wards felt very lonely and insecure and preferred to die at home.

Just Like Home : Wards That Have a Human Touch

Moreover, the doctors and nurses in the hospitals had very little time to look after the patients. (Abhay confirmed this aspect. During their stint at the government civil hospitals, they had found that the doctor-patient contact was only for 3 minutes while that of the patient-nurse barely 7 minutes a day.) As a result, for most of the time, the patients were really looked after by the patient's relatives who faced a lot of difficulties because they had no place to rest, sleep, or cook.

Through their experience of working with tribals, SEARCH has come to believe that there is a need for separate health policy for tribals because:

Tribal Health

- The absolute number of tribals in India is about 60 million warranting a special policy.
- At least two genetic diseases are known to be common amongst tribals - Sickle Cell Disease and G-6 PD deficiency
- Nutritional diseases were earlier not found among tribals unless they were displaced from their environment. Now, due to impoverishment forced up on them, malnutrition is rampant, especially among women and children.
- Tribals live in a physical environment which is full of accidents and traumas
- The high prevalence of some diseases in tribal societies (TB, leprosy, malaria, anaemia etc.) necessitate a health care plan appropriate to their needs.
- The standard government health policies and priorities have some times no relevance to the health needs of tribals since they have a different disease pattern as well as different health beliefs and customs.
- The human resources available to provide health care in tribal areas are very limited and different.

The other area of concern for SEARCH is the gradual depletion of the forests and increasing restrictions on tribals preventing them on exercising their traditional rights over forests and collection of forest produce which are essential for their survival. However, SEARCH does not have any major on-going activity concerning rights of the people over forests.

Most tribals who interacted with the Bangs said that the "big buildings scare us. We feel lost and confused in these hospitals. The language of the people at the hospital is different. They don't understand our language. They often ridicule our customs and lifestyle. There is no God in the hospital; the doctors themselves have become gods there. How can a patient recover without worshipping the Gods ?"

Cultural alienation was identified by SEARCH as the main factor for low utilisation of government hospitals in the tribal areas.

Therefore, a lot of thought went into designing the tribal hospital which, right from the entrance gate of Shodhgram, is designed in manner to give the message that all are welcome. The hospital looks more like a tribal village. The OPD has waiting and reception rooms which look like a *ghotul* - a traditional place in a Gond village where the social and cultural events take place.

Instead of a large ward, the hospital consists of a number of huts where the tribal patient can stay with his family. The tribals liked the idea of 'the hospital of huts' so much that the people from two villages constructed huts for their patients much before the construction work by SEARCH started.

The hospital has been named 'Ma Danteswari Dawakhana' by the tribals because they today believe that this hospital is theirs. Persons recruited to work at the reception and registration sections are tribals who speak the 'Gondi' language, make the patients feel at home and also help the doctors in understanding the history given by the tribal patients. Besides the hospital there is a small garden/herbarium of the medicinal plants used by the tribals.

The success of the hospital has demonstrated that if people really participate right from the planning stage, they come up with unique insights, list their priorities, and suggest culturally appropriate solutions.

Prabhakar Rao, a health worker who was promoted to become a field supervisor of SEARCH, was actively involved in the campaign to ban alcohol. He was convinced of the ill-effects of alcohol but was unable to give up his own habit of drinking which he had picked up at the age of 10 years. He used to play female roles in village theaters and used to have a drink to muster courage whenever he had to go on stage. The habit continued, even when he joined SEARCH.

About 4 years back, he confessed to Abhay about his problem. The initial reaction was one of anger and indignation at the thought that someone from SEARCH was an addict. (The thinking in the movement against alcohol at that time was that both the producers and drinkers were equally to be blamed and punished. It was only later that there was a realisation that alcoholism was a disease and had to be treated). Abhay, Rani and rest of the SEARCH team helped Prabhakar Rao give up alcohol. He now wanted to devote his life to help others to be free from addiction. SEARCH decided to develop a deaddiction team led by Prabhakar Rao, to respond to the problem of alcoholism in the post-prohibition scenario in Gadchiroli. A young professional social worker, Tushar Khorgade, committed himself for the deaddiction programme and became the able coordinator.

A shock and the realisation

During all these years of hectic activities, what was happening to the activist himself? Abhay had assumed that because of his austere way of living and social work, he belonged to

Deaddiction Movement

SEARCH first studied the functioning of deaddiction centres in other parts of the country before starting the programme. The most important question was how to make the deaddiction programme appropriate for a rural setting when most of the deaddiction centres were city based geared to the educated middle class client where the fees were much higher than what the people in and around Gadchiroli could afford.

A three tier programme of alcohol control has been gradually evolved by SEARCH. Awareness generation against alcohol by way of cultural and educational programmes and *kirtans*, education of adolescents, and village level social control form the first tier. Identification of the problem drinkers by village health workers or family members, and village based programme of one and three days for the drinkers to break their drinking habit form the second tier. Those found to be addicts are referred for a 15 days residential deaddiction treatment programme at Shodhgram forms the third tier. The final phase is one year follow-up through home visits. If the person is alcohol free for one complete year, his first birthday of sober life is celebrated at Shodhgram.

About 1500 alcoholics have been treated so far in the village based camps and additional 900 addicts treated at the deaddiction centre at Shodhgram. The results of follow up show that about 60 % addicts remain sober at the end of one year - figures better than those reported by the deaddiction centres in the West.

the 'lowest risk group' and was immune to the 'diseases of the affluence'. And yet he was a diabetic at 42. He had a severe coronary problem in April 1995, and had to be rushed to Nagpur for treatment. He underwent a stormy angioplasty during which his coronary artery was accidentally torn. The time he spent awaiting eminent death was the time of realisation. Why did he catch these diseases? What was wrong? Was it the end of the life? How could he continue to live and work? Life was too ephemeral and could not be taken for granted.

While in hospital, he got the book of Dean Ornish, 'Reversing Heart Disease' which showed him the way. He started a new regime of diet, brisk walks, yogasanas, pranyama and meditation. On completing one year after his

heart attack, Abhay wrote about his experience, realisation, and the life style changes that he had made, first to his friends by way of letters, and then in form of a long article - '*Maza Sakshatkari Hridayarog*' in a Marathi weekly 'Sakal'. The article proved to be a greatly popular and awakened the readers to the risk of heart disease, and life style changes as the solution. The article got the award as 'the best literary piece of the year' by the Maharashtra Council of Literature.

In the article, Abhay has described his own journey as an individual, as a patient, and his path of recovery both physical and spiritual. A spiritual outlook, non-competitive attitude, mutually supportive human relationships, and a healthy life style were necessary.

Besides local, national and international recognition for the community health work and the pioneering research, SEARCH has received a number of awards and citations. They include:

Awards and Recognitions

- 'Dr. M. K. Seshadri Prize' from the Indian Council of Medical Research in the year 1996 for SEARCH's outstanding contribution in the field of community medicine.
- *The Week* selected Abhay and Rani as 'The couple of the year' in 1996.
- 'Mahatma Gandhi Award' for Abhay.
- 'Adivasi Sevak Award' for Abhay.
- 'Natu Foundation Purskar' both for Rani & Abhay.
- 'Outstanding Woman Social Worker of Vidarbha' for Rani.
- 'Shamrao Bapu Kapgate Smruti Purushkar' for Rani.
- Rani addressed the World Health Assembly in 1993 on the issue of women's reproductive health.

Conclusion

SEARCH's work is very pioneering and their approach to the health problems of the rural people quite unique from that of other organisations. They have brought issues such as reproductive health, alcoholism, childhood pneumonia, and newborn care in rural areas to the attention of the public and policy makers. More importantly, they have developed innovative and effective community based solutions. This has improved the health of the local population and showed the way to other NGOs and governments.

A Few Posers

There however, are a few questions that come to mind while analysing SEARCH's work and contributions in the field of community health. These questions are relevant to different groups working at the community level and addressing health and other developmental issues of the rural poor. These are not new questions or issues and one is certain that senior members of SEARCH have already thought and debated on these issues.

➡ Gadchiroli is an extremely backward area with severe environmental degradation, very little land for agriculture, and non-existent alternative employment opportunities for the rural poor. Can health, or other problems of these people, be addressed or community based solutions arrived at, and be sustained without an equal or greater emphasis on basic issues of forests, land, employment and other immediate survival needs of the rural poor?

➡ One argument is often put forward by voluntary organisations that they have a certain priority and mandate according to the background of the organisation and therefore should not 'meddle with everything.' A question often debated is whether the same organisation should intervene with equal emphasis on issues of health on the one hand and questions of basic economic rights of the people on the other. Should they integrate both these issues as a part of a common belief, approach and methodology or work on any of them in isolation while leaving the other important issues for others to tackle?

➡ While one totally agrees with the SEARCH concept and priority of selecting health workers from within the community to provide community based health care, the need for developing an appropriate form of social organisation which will support these community health workers without external support in the long run is of great importance if one wants to preserve the present form of autonomous, decentralised form of decision making and social organisation of the tribals. Inspite of all advocacy efforts, one does not expect that the political will of the government will change in the foreseeable future to suddenly become pro-poor, pro-woman or pro-tribal. The need for developing appropriate forms of social organisations and behavioral pattern is required not only to sustain such health workers and the services they provide to the community but also to establish a process by which such community based workers become accountable to the society and do not become a part of the exploitative forces because of their improved skills.

SEARCH has focused its mission primarily on developing community based solutions for the health problems. Only during the phase of the movement against alcohol, it took up the leadership and built up a district wide movement and organisation. It is to be seen what mission SEARCH takes up in future.●

Financial support

SEARCH believes that it is unrealistic to expect to raise the money for health work among poor from the target population itself. Less than 10 % of its expenses are covered by the fees charged to the patients. Hence it developed fruitful partnership with donor agencies. Many individuals, well wishers, friends and relatives of Bangs also contributed money to support the work. From 1986 to 1997 the major support came from:

1.	Indian Council of Medical Research (1986-90)	- Rs.	24,00,000
2.	OXFAM (1986-94)	- Rs.	14,00,000
3.	Ashoka Foundation (1985-87)	- Rs.	1,00,000
4.	The Ford Foundation (1987-97)	- Rs.	90,000,00
5.	Misereor (1991-94)	- Rs.	75,00,000
6.	The McArthur Foundation (1991-97)	- Rs.	90,00,000
7.	World Health Organisation (1993-96)	- Rs.	4,00,000
8.	UUSC Boston	- Rs.	1,00,000
9.	International Women's Health Coalition(1990)	- Rs.	2,00,000
10.	Individual donations	- Rs.	8,00,000

Voluntary Health Association of India (VHAI) is a non-profit registered society formed by the federation of Voluntary Association at the level of states and Union Territories. VHAI links over 4000 grasroot-level organisations and community health programmes spread across the country.

VHAI's primary objectives and to promote community health, social justice and human rights related to the provision and distribution of health services in India.

VHAI fulfils these objectives through campaign, policy research and press and parliament advocacy; through need-based training and information and documentation services; and through production and distribution of innovative health education materials and packages, in the form of print and audiovisuals, for a wide spectrum of users-both urban and rural.

VHAI tries to ensure that a people-oriented health policy is formulated and effectively implemented. It also endeavours to sensitise and large public towards a scientific attitude to health, without ignoring India's natural traditions and resources.

Voluntary Health Association of India
Tong Swasthya Bhawan, 40, Institutional Area South of I I T
New Delhi - 110 016 (India)