



## **Health Scenario in India & Aarogya Rakshak**

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## 1. Statement of purpose

For a long time in India as well as in other developing countries, what went wrong in the health sector was neglect of the community as a rich resource and partner. Decades ago, in 1941, medical historian Henry Sigerist wrote, "The war against disease and for health cannot be fought by physicians alone. It is a people's war in which the entire population must be mobilized permanently." Our approach therefore has to shift fundamentally to placing the community in the centre-stage, and building competencies and partnership within it for low-cost and affordable, people-centred, preventive and curative health services. From an approach of health for people, we move to a 'de-medicalised' model of **health by people**, involving them at all stages of planning, implementation and evaluation.

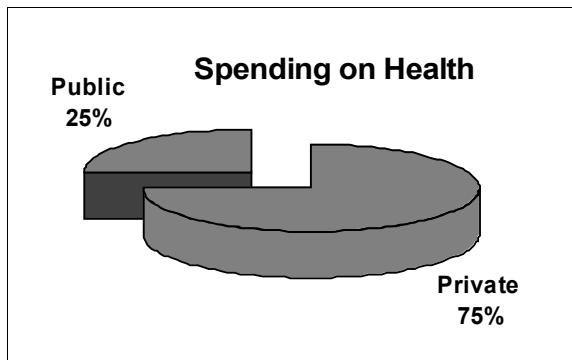
The Aarogyarakshak project is envisaged to be a strong vehicle for the "Health by the people" paradigm in health sector in India.

## 2. Problem analysis

The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. The understanding of health scenario includes the cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and current bio-medical understanding about health and illness.

### 2.1. Current health care scenario in India

Health care covers not merely medical care but also all aspects of preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure- within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. (R. Srinivasan, 2005)



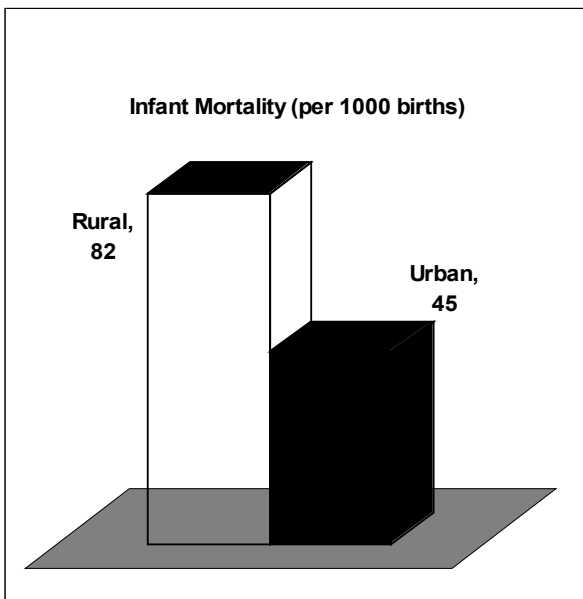
Public health spending accounts for 25% of aggregate expenditure the balance being out of pocket expenditure incurred by patients to private practitioners of various hues. Public spending on health in India has itself declined after liberalization from 1.3% of GDP in 1990 to 0.9% in 1999. Central budget allocations for health have stagnated at 1.3% to total Central budget. In the States it has declined from 7.0%

to 5.5% of State health budget.

The current annual per capita public health expenditure is no more than Rs. 160 and a recent World Bank review showed that over all primary health services account for 58% of public expenditure mostly but on salaries, and the secondary/tertiary sector for about 38%, perhaps the greater part going to tertiary sector, including government funded medical education.

## 2.2. *Neglect of preventive care*

Out of the total primary care spending, as much as 85% was spent on or curative services and only 15% for preventive service (World Bank 1995). About 47% of total Central and State budget is spent on curative care and health facilities. Many surveys confirm that when services are provided by private sector it is largely for ambulatory care and less for inpatient care. There are variations in levels of cost, pricing, transactional conveniences and quality of services. There is evidence to suggest that disparities in income as such do not make a difference in meeting health care costs, except for catastrophic or life threatening situations. Finally it has been established that between 2/3rds to 3/4ths of all medical expenditure is spent on privately provided care. Every household on the average spends up to 10% of annual household consumption in meeting health care needs. This regressive burden shows up vividly in the cycle of incomplete cure followed by recurrence of illness



and drug resistance that the poor face in diseases like TB or Kalazar or Malaria especially for daily wage earners who cannot afford to be out of work.

The vast variations of rural-urban, class, caste, gender and regional variations hide the magnitude of health deprivation of large masses of the most disenfranchised. For instance, IMR in rural areas at 82 per 1000 live births is nearly double the figure of 45 for urban areas. While urban middle classes in India today have ready access to health services which compare with the best in the world, only 20 countries have a higher IMR than Orissa's tragic figure of 110 per 1000 births.

## 2.3. *Comparing with contemporaries*

The experience of China has been far more successful in achieving basic health care for her people. Its success has hinged substantially on developing an enormous cadre of health personnel for preventive and curative health services for all levels from the village to the country. It is only in the country (district) hospital that doctors trained in medical colleges as we understand them, are found. Village clinics and Primary Health Centers are managed by Village Doctors (a new terminology replacing the old 'Barefoot Doctors') who are trained in preventive and curative medicine of both traditional Chinese and Allopathic schools, for periods ranging from one to three years. These skills are constantly upgraded by apprenticeship and in-service courses.

Each country or district has such a training school for high school graduates selected after a competitive examination, which annually turns out enough of such health personnel to adequately service the health needs of the massive rural populations. A vigorous referral system operates, so that only complicated cases arrive at the country hospital.

This effective public health outreach system, with its stress on integrating traditional medicine, and a stress on preventive health has had a dramatic impact on the health profile of the Chinese people. The average life-expectancy of the Chinese people has gone up from 35 years in 1949 to 69 years in 1985. Infant mortality fell from 250 to 35 per 1000 between 1949 and 1989. In the same period, medical and health institutions increased 86.4 times and hospital beds 67.7 times.

### **3. Summary of proposed project**

#### **3.1. Concept of Aarogyarakshak**



Aarogyarakshak is a local person (usually young) trained in preventive health care, early identification of major diseases, nutrition, and hygiene. This person carries a kit of basic medicines and apparatus. He/she visits each village that is assigned to him on a regular basis. Refresher trainings and inputs by the district team guide the Aarogyarakshak in his work. The district team is made of able doctors and social workers. This team decides the focus area, e.g. they foresee an epidemic in a particular season and plan appropriate action. The Aarogyarakshak is supported and monitored by a Group leader (per every 10 Aarogyarakshaks) and by a Unit leader (per every 50 Aarogyarakshak). The network of Aarogyarakshak works as an interactive medium of health: they take health-service to the people, and bring feedback of people to the service-providers. He/she plays multiple roles for the villagers: a health-educator, a point of first referral, and a health-counsellor. The Aarogyarakshak is trusted by the people. He/she is a local person and is a volunteer. He/she is not paid and does not have any commercial interest in this work.

#### **3.2. Relevance to the need**

As described in detail in the previous section, rural areas are not having adequate number of doctors and are also lacking in awareness on preventive health care. Many diseases and the consequent spending of hard-earned money on medical aid can be prevented if adequate awareness and early referral is available. This needs a standing network of alert and trained volunteers, which remains easily approachable for the people at any moment of need.

Aarogyarakshak serves precisely this purpose. Furthermore, the network is locally adaptive in its nature. The district team can decide whether and when to focus on which issue, e.g. drinking water, immunization, women's health etc. The network keeps in loop the available local resources and makes effective use of public and private health care facilities.

#### **3.3. Reach of proposed project**

The project is envisaged to reach every state and every district of India within next seven years. The project will begin with pilots in select districts in select states and shall gradually scale up to cover all districts. Maharashtra and all seven states of Northeast are already selected as the pilot states and initial need assessment is completed.

No. of States	28
No. of Union Territories	7
No. of Districts	593
No. of Inhabited Villages	593,731

Source: Census 2001

### **3.4. Impact envisaged**

- Change in perception of people: from ‘doctor’ centred health care to ‘self-motivated’ holistic healthy living
- Decentralisation of basic curative health care
- Elimination of diseases by ensuring effective immunization
- Mitigation of water-borne diseases by ensuring proper water purification practices
- Awareness about balanced, nutritious, and affordable diet for infants and mothers
- 24X7 emergency support to people till reaching a hospital
- Revival of traditional medicine and home medicine practices to precede and reduce the use of market medicines
- Government and the people coming together to complement health services

## **4. Project plan**

### **4.1. Approach**

- Efforts by various agencies in solitude create islands of good work, but do not reach the needy millions. It is imminent that healthy living becomes a reachable and affordable reality for masses in India. The sense of urgency of this goal requires that a convergence of energies of local NGOs, Government, and other community-based organisations be pooled together.
- The need is felt to create a ‘common utility vehicle’ to launch an All-India project. Aarogyarakshak India project is expected to act as a common utility vehicle of all stakeholders involved in community health.
- The scale of this project shall not only make capacity building and monitoring feasible, but will also do justice to the wide-impact fast-track nature of this project.
- It is quite a proven fact that collaborative and integrated approach works. Collaboration with government and non-government already active in public health sector is a key principle of this project. The local NGOs shall act as implementing partners and they shall liaison with government health facilities.
- Voluntary Aarogyarakshak is a distinguishing feature of this project. The Aarogyarakshak does not have any commercial stake in this work; he/she is solely motivated for the good of the community. This role does not demand a lot of working time and it is therefore feasible to have voluntary health workers. The purity of

motivation of an Aarogyarakshak enhances the trust of the community. On the other hand, it ensures that the person does not promote the vested interests of medicine businesses.

## **Annexure 1: A glimpse of health issues from Newspapers**

NEW DELHI: India's rural poor may soon have to rely on divine intervention to help them recover from illness as the health centres supposed to serve them run critically short of trained staff. The country's 22,669 primary health centres, the first port of call for the sick in rural areas, are a sorry picture, thanks to an acute shortage of trained medical personnel.

According to the recent National Rural Health Mission report, nearly 8% PHCs don't have a doctor while nearly 39% were running without a lab technician and about 17.7% without a pharmacist. The PHCs are supposed to have one medical officer supported by paramedical staff.

To compound the problem, PHCs in some states don't have adequate labour rooms and operation theatres. While not a single of UP's 3,660 PHCs have either a labour room or an operation theatre, the number stands at 208 labour rooms (13%) and 218 (13%) OTs in Bihar's 1,641 PHCs, 105 (20%) LRs and 50 (10%) OTs in Chhattisgarh's 518 PHCs and 131 (14%) LRs and 108 (12%) OTs in Kerala's 909 PHCs.

The condition of 3,910 community health centres, supposed to provide specialised medical care, is equally appalling. Out of the sanctioned posts, about 59.4% of surgeons, 45% of obstetricians and gynaecologists, 61.1% of physicians and 53.8% of paediatricians were found to be vacant. Moreover, there is a shortfall of 70.2% specialists at the CHCs. The report says, "Clearly, there is a huge challenge to meet the shortfall for rural health infrastructure, specially the manpower."

According to Planning Commission figures, India's CHCs require 3,910 surgeons. While only 2,372 are sanctioned, just 972 are in position, creating a vacancy of 1,381 posts for surgeons and a shortfall of 2,376 surgeons in CHCs. As for physicians, CHCs require 3,910 of them. There are only 832 in position with 1,296 vacant posts and a shortfall of 2,516 physicians. Of the 3,910 paediatricians required, only 1,951 posts are sanctioned of which just 837 are in position. There is a vacancy of 953 posts and a shortfall of 2,511 paediatricians.

This sorry picture has made the Union Health Ministry decide to make a one-year stint in India's most backward villages compulsory for all MBBS students from the next session.

[Times of India 22.11.07]