Beyond Medical Solutions

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TAKING SIDES. The Choices Before the Health Worker by C. Sathyamala, Nirmala Sundharam and Nalini Bhanot. ANITRA, 1986, pp 320, copies available at B-7, 88/1 Safdarjung Enclave, New Delhi 110 029. Rs 70.

THE authors address this sort of committed rural health, handbook written in English to middle level health workers' engaged all over the country in rural health services. They take as a starting point, on the one hand, the arguments raised in the last 10 to 15 years against the effectiveness of modern medicine, and the other hand, the failure of the alternative tried out to substantially improve the health situation in rural India. The reason for both is assumed to be the exploitative nature of a society of which the social, political and economic forces by shaping the way of life of the people produce the disases affecting by and large the population.

Those who immediately and hopelessly confront this social and economic reality of the people they work with, are the middle level health workers upon whom the health services actually rest. Yet, "it is these workers who are least involved in a critical examination of their work". Firstly, being located in the lower rungs of the hierarchy of medical services, they are just expected to follow orders. Secondly, their training does not prepare them to conceive, let alone to suggest, appropriate alternatives. Frustration, insensitiveness or despair eventually overcome them. Even so, out of their experience of training programmes, the authors are convinced that those scattered and isolated health workers could and should achieve a lot once helped to develop the proper perspective required with regard to rural health care. The four sections of the book make, therefore, an attempt to help middle level health agents to learn from their disillusion, and instead of relapsing into the apathy or the self-complacently irresponsible stands of public health employees, lead them towards attitudes and practices of social health activism.

The first section describes the baffling experience of Radha, a woman health worker who happens to leave her city hospital to work in a rural dispensary. Absolutely unprepared for this by her training and previous experience, she is progressively confronted with a series of puzzling questions regarding unexpected attitudes and behaviour of the villagers. She painfully realises that her medical knowledge and skill prove of little use. Unable to cope with too many doubts, she feels out of place; she is frustrated: she comes back to her city hopsital.

Around eight common incidents which helplessly bewilder her in the course of ther work, are structured eight chapters which discuss the issues involved. They clarify the health riddles that Radha could not solve on account of her inability to understand the nature of the constraints which inexorably bear upon people's lives. She had only medical answers of a curative type to issues and needs which required first of all a social and psychological analytical insight. The inadequacies of her technological responses lead her to experience that as a pure medical agent she is unfit to meet the health problems of a common man. The following are the questions which pushed her to the limit and that the book, in a second part of the section, helps the health worker to firstly come to terms with while embarking in tasks of rural health care:

> Why don't people rush to get treated early?
> Why do people have faith in local healers?
> Why don't common people have satisfactory access to health services?
> Why are rural areas wanting in good medical practitioners?
> Why do people not implement even simple health messages?
> Why should a health worker know whether and to what extent people are poor or rich, influential or looked down upon? Aren't diseases independent of any other consideration?
> Why do people prefer to impoverish themselves with too many children?
> Why is it that a few people avail of so many health facilities and so many have so little of them?

The first section shows how the health care system as a development asset, no more no less than land, water, credit system, etc., obtains the status of a commodity socially appropriated by those who can afford it or snatch it in proportion to their social, economic and political position of power. As a consequence, ill-health is an unequal access to health commodities when these latter are made unavailable to some—actually many—by others—a few. Ill-health, therefore, mirrors and measures the state of deprivation of the subaltern. Ill-health is injustice and no simple natural disorder, no less than deforestation, unemployment, hunger and malnutrition, starvation wages, etc. The survival strategies of the deprived sections do not bear witness to their ignorance and backwardness but to the sway of iniquitous social forces. Once socially unaware and naively well-intentioned health workers like Radha understand this, they may hopefully realise that they had better feel anything but frustrated, if they really mean to avail the common man of their professional capabilities. But then, a second stumbling block threatens them.

Limitations of Established Modern Medicine

The second section deals with the inadequacies of the health workers which should not necessarily be ascribed to personal failure or inability. They are largely due to the inherent limitations of established modern medicine itself, the assumptions of which need questioning. Its development is as much based on scientific and rational principles as shaped by powerful economic and political groups. The second section expounds how the interests of doctors and big businessmen while contributing to the development of modern medicine, created also a limited view of health, diseases and healing process. New theories shifted the focus of disease causation from the social conditions that bred disease to the

immediate cause which was the germ, and the attention was diverted from poor nutrition, bad living and working conditions, exploitative labour and sex relations, etc. Disease became a physical event within an individual's body and care focussed on drugs, surgery and hospitals. Preventive measures dealt with immediate environment and diseases at the individual level. Health became a neutral and purely technical subject with its experts wielding absolute authority and monopoly on medical research management and health care policies. Big industrialists prompted modern medicine in order to increase the productivity of their workers through control of diseases by therapeutic techniques dealing with the immediate cause rather than the primary reason of illhealth, i e, the exploitative social relations of production. Modern medicine served the interests of those in power and developed to the extent it served these interests. Medical theories justified even the inferior roles of women.

As a matter of fact, the potent remedies and techniques developed with the support of businessmen had a very small part in reducing morbidity and mortality in the western countries. Their major decline had already taken place before specific medical technology was introduced. Death rates for measles, scarlet fever, tuberculosis and typhoid were already negligible by the time effective medical interventions were discovered. This tremendous achievement was not the effect of drugs nor doctors. It was due to improvement in living standards and public health measures. Biomedical technology once introduced had a very limited impact in improving the health status of the population and was responsible for no sharp decrease (except for polio) in mortality rates due to infectious diseases. Only 3.5 per cent of this decline took place because of medical interventions.

Ill-health in Independent India

The third section looks at the development of health services based on modern medicine in independent India with regard to the activities commonly undertaken by health workers in rural areas. Their limitations are pointed out and explained by the fact that they have not been planned keeping in mind the social and economic constraints of the majority of the villagers. As a result, health workers fail to meet the people's needs and by-pass the major causes of ill-health. Examining the policies of the government regarding these rural health programmes it is shown how health needs are actually used as a cover for serving the interests of the wealther sections of the rural population. A comprehensive review of the following rural health problems provides the essential results of the studies in the matter together with an analysis of the inter-related factors: a health-worker can afford to ignore neither of them. In each case the inadequacies of the government health policies are exposed and shown as basically due to the narrow health concepts of a purely curative medicine system absolutely blind, to the structural-social dimensions of health issues.

Health of children: Data on high mortality and diseases occurrences are related to structural constraints such as low nutritional status, low education status of women, inadequate access to medical care at birth and clean water, switch-over to tinned food, sex discriminations etc.

Health of women: Sex-ratio, life expectancy, mortality patterns and causes of death, maternal mortality, nutritional status, access to medical services; amniocentesis, infanticide are determined by the discriminatory effect of the social and/or economic degraded status of women on the one hand and on the other hand, by the medical profession being concerned not with women's health but with their (male) child's issue.

Health of adults: Given the over-all importance of their undernutrition, the reasons for this and the inadequacies of the nutritional programmes are exposed at length. No health worker may fail to be conversant with the misleading debates and approaches in the matter, with the deceitful talks on the so-called minimum wage, with the criminal exports of high protein food, with the decrease of acreage under cheaper coarse grains, with the export of rice, with the wasted buffer-stocks of cereals, etc. In such circumstances, "feeding programmes and minimum wages themselves become oppressive strategies in the long run".

Health education: Some examples show how the official health education as much as health advertising, resembles a harmful brainwashing by its explicitly or implicitly false or socio-culturally repressive messages, and by its concealment of important aspects. The demystification through a critical reading of all health messages may indeed prove a skill difficult to acquire when everybody takes for granted that education is merely a useful transfer of necessarily objective information. Actually, the assumptions of health education as commonly practiced should be denounced as often biased in such a way as to prove in the long run to actually impair the health status of the majority of people. The emphasis on individual responsibility and fault, the theory that health problems cannot be solved without a lot of money, the persuasion that the poor being ignorant, illiterate, superstitious and backward cannot but turn a deaf ear to health advice, the greater importance of men's health, the dependence on modern medicines and the knowledge of doctor's who alone know best, etc are message which conveniently remove the responsibility for ill-health from those who create and maintain "the exploitative practices" conducive to the poor's helplessness.

Family Planning Policy, (FPP): The theoretical and use-effectiveness of the commonly used contraceptive methods are examined and advice in given to make them helpful in improving women's health, as they are a meaningful way to this effect. The present failures are shown to be due to the implementing strategies and false assumptions such as the primary interest for population control at all costs, the belief that population growth is the cause of poverty and underdevelopment, etc. Family planning methods will succeed only if they are accompanied by an overall improvement in the socio-economic conditions of everybody. Failing this, the failure of the FPP can be considered an effective 'resistance' by the poor against the detrimental effects in their everyday life of government agricultural, social and economic policies: a survival strategy in front of socio-political mechanisms of deprivation.

The Village Health Worker's Scheme (1977): It is discussed and evaluated in relation to one basic principle, viz, the selection of the workers by the village community.

Curative services: Overuse and misuse of drugs, harmful role of drug companies, cost of drugs, etc. such problems are discussed and suggestions are made to help health workers overcome them.

Setting Off Again on the Right Foot

The fourth section takes stock of the principles for an adequate practice on the part of health workers: focus on changing the social environment for long term improvement in the health status of the most affected groups among local communities; understanding of and dealing with, the root causes of ill-health; choice of identifying oneself with those who are the most likely to fall sick; decision to operate with all of them as a collective; will to develop their insight into the reasons of their ill-health and foster their collective strength to act against them; attempt to make use of all resources available at the village and block level in a self-help spirit and with the firm conviction of one's own right to health vis-a-vis the government health services, etc. Then, an alternative model of health practices and health education is chalked out for the guidance of a middle level health worker already working in a rural hospital, dispensary or health centre but willing to spare time and resources to operate along the above guidelines although deprived of any experience of village work. Criteria are suggested regarding the selection of two or three villages to work in/around her centre; directives are given to help her develop a proper understanding of those villages through a close relation with people and renewed patterns of communication; the necessity is stressed of bringing people together for them to consider collectively their own needs, find out the reasons of their ill-health and seek solutions; the modalities of selection and training of a voluntary village health worker are clarified; explaining how to keep a diary, conduct a survey or a group discussion on health, from a permanent group of concerned people, deal with problems in a manner really conductive to the group's collective initiative and ability to act on its own, organise people to get due services from the government.

We thought proper to give this rather extensive account of the contents of the book under review to convince the health workers it is addressing of the many practical advantages they cannot fail to draw from it: well-researched statistical information compiling the most relevant data on each topic, didactic synthesis summing up studies otherwise scattered and lengthy, eight pages of referential documentation, a glossary. Considering the alarming and relentlessly resilient extent of ill-health of this country, one cannot but expect many health workers to make choices and definitely take sides along lines expounded in this reference and guide book. Every medical practitioner should hopefully have the opportunity of getting through this book and honestly questioning his practices and the methods of his/her institution in the light of the critical insights provided by this challenging appraisal of rural health problems.

The approach rightly avoids two pitfalls. The first one is to simply ask for multiplying the rural health services (doctors, drugs, dispensaries, injections, surgical equipment, etc) as others agitate for more dams only to bring more health and irrigation facilities to those who can lay hands upon them, with the same result in both cases: the majority of the needy is kept deprived of the means to meet its primary needs of health care and of the water required for irrigating its staple food crops. An unflinching sociological insight only may preserve us from short-sightedly lapsing into this trap. The most commendable quality of this review of rural health problems is its permanent claim to refer health issues to related structural-social factors and the overall marginalising dynamics engineered by them. Disparities in health status measure the extent of social discrimination and unequal appropriation of the means of health. There is no health nor ill-health *as such*: this approach has been the treachery of the purely curative or biomedical modern medicine for reasons known to its promoters. Both of them are outcomes and symptoms of a given social structuring on the one hand, and socio-cultural/anthropological systems of representations on the other hand.

The two critical questions to be raised concern, firstly, the exploitative social relations of health based on the present system of established modern medicine, and, secondly, the system of cultural-anthropological health representations. If the first question, focus of the book, is methodically dealt with, the second dimension, although occasionally and commendably tackled (for instance, illness seen as the result of falling out of harmony with the universe, p 14-17, or the women's inferior value as an explanation for women's lower health status, p 148, 151), would yet deserve a wider and independent consideration that the somehow narrow socio-economic perspective of the authors overshadows.

Let us stress the importance of this second aspect with the example of the exorcism practices performed by religious healers. Around these latter, symbolic sets wave together in ritualistic health practices, the sick, the sacred power, the departed, the go-between-the holy man, the enemy, the genders, etc. (Poitevin). Especially in a traditional agrarian community, health, death, disease, injury, wound, infection, healing are no natural events. Body, blood, hair, sex, menses, birth, injections, etc, are invested with far-reaching and interconnected meanings. They are socio-cultural constructs before being subject to the specific and restricted medical constructs, outcome of the particular and alien assumptions of modern medicine. We cannot take for granted that these latter will easily erase the previous constructs. On the contrary, the traditional meanings are likely to turn up the new speech in such a way as to give it a fitting place in their midst. The point at issue is here that the working of the "exploitative forces" so often rightly referred to, would still be better understood once are discovered both the autonomy and the interdependence of those two levels of analysis. (Althusser, 1970). They overlap in reality as two aggregate dimensions the cumulative effect of which is to be understood in each given social formation under consideration.

A common and easy example may illustrate this interplay. Why do rural people feel a deep and pressing urge for injections? Some traditional unconscious drives and representations (for instance, expectation of a sudden and miraculous recovery through some mysterious device: pricking and pain may act here as a substitute to the ritualistic cutting the throat of a cock) have to be explored and brought out under conscious light. Why do medical practitioners not try to scientifically demystify and reveal to their trustful clients, the quasi-religious nature of their demand, instead of promptly complying with the people's expectations, if not anticipating them, often without any medical necessity? And why do they not, as a principle, entrust this task only to the nurse care? The reasons are known. In doing so, male doctors invest themselves with this very power otherwise attributed to the local healers whose practices are no less mysterious and

knowledge no more transcending their reach and consequently calling for the same complete trust (an important message conveyed by the health education programmes, as appropriately stressed by the authors, p 185). One difference: instead of accepting free gifts, the modern practitioner will claim substantial fees taking advantage of the anxiety and faith of his client—biting again into the starvation income of the needy. In short, in the process, the traditional set of feelings and representations as well as the passive, helpless and submissive relations of health woven around the sacred healers' practice provides the rationale for the acceptance and social sanction of the exploitative practices and the overall male domination of the modern class of medical practitioners. This acquires a specific gender dimension when we remember that it is mainly women who resort to the ritualistic healers (Herzlich and Pierset, 1984).

The book keeps clear also of a second pitfall which usually consists in resorting to health services offered by voluntary agencies with technical qualities and appropriateness of which the public health care system is deprived. The main concern is here for professional performance. This is short of the political will and thrust required to cope with the remote and determinant causes of ill-health as well as with the public dimension of a national service. Each citizen, especially the deprived one, is entitled to health as a right and not as a commodity to be made available even at a lesser cost and served wrapped in humanitarian feelings.

Strategically speaking, it follows from this that health for all cannot be achieved unless it is health by all, i e, obtained as a right by the majority of all those who are kept deprived of it. As neither the public health care system as it operates nowadays nor the troups of NGOs in rural health care can be expected to secure health for all in no century, those concerned with obtaining their right share of health facilities are left with one single alternative, viz, to fight and vindicate their right. This is the right perception which upholds the whole approach.

Need for Tactical Model of Action

To the tactical question "How to go about it?", the answer is that the proposed alternative approach is firstly to be monitored from within the low ranks of the health care system, by the middle level health professionals transforming from within their concept of health and practice of health care. They are staged as the sensitive category through which defiance and innovation will arise. Why we may ask, do the authors assume that this category is potentially fit for spearheading the envisaged radical changes which will reconstruct the established health system? From their own experience? From the fact that this category of workers remaining close to the common people while being technically trained, may prove immediately operative, provided they only shift their socio-cultural allegiance from the class interests of the medical profession towards the lower sections of the rural population? But then, why do the same authors, from the last chapter, characterise these middle level workers as short of experience of village work, deprived of proper training, used only to follow orders and the least involved in a critical examination of their work?

In the fourth section, they are shown a plan of action, and equipped with pedagogical skills enabling them to raise, mobilise and train village health workers in two or three villages around their dispensaries. From where and how do they become all of a sudden motivated for investing their time, energy and thinking capacity in tasks for which, as a professional category, they could only feel shy or have aversion? And we know that as a rule such is actually the case. Before showing how motivated health workers might motivate village health workers, we would also like to know how the low-rung health workers as a category could themselves become enthused in a proportion sufficiently significan as to make them a category and not only a few individuals, initiators pioneering the envisaged alternative methodology of health practice.

Barring exceptional cases which make no use of tactical model of action for social change, one fails to realise how an individual woman from the middle rung health workers may embark alone in such attempts without at least two minimal pre-requisites. The first one is institutional backing, however loose or informal it may be, not only to support her after she has started but to secure since the inception precisely what is taken for granted, viz. the means of a radical reappraisal of her whole training and practices. To put in her hands *Helping Health Workers Learn* (Werner and Bower) is no sufficient answer: a book does not offer a supportive group. In their final inset (p 307), the authors have themselves raised the question to leave it open: does the health worker continue to spend most of her time in her dispensary or in the village? Does she want to radically transform her role? Can she do it within her present institution or should she work with another group? How can she build up support for her work and herself? Unable to visualise a definite plan for mobilising the category they address, the authors satisfy themselves with calling those concerned to chalk out for themselves their course of action.

Here comes the second prerequisite. Irrespective of the forms and nature of the 'institutional' framework, the health worker will not be able to act according to the new role she wishes to assume unless groups of villagers either raised by her or anyone else, organise themselves and through a sustained effort of cultural action develop among themselves and the population that dynamics from the bottom required to put them on the way towards what we have labelled health by the people. Following the catalytic effect of the health worker, it is this organised strength, embryo and basic element of a wider health movement, which may come to effectively bear upon the health system to force it to change in the long run. One may finally wonder whether in the scenario imagined by the book under review and the course of action to be chalked out, the leading role is not to be more plausible ascribed to the villagers' organisation. Without this organisational prerequisite, an isolated female health worker in rural areas cannot achieve much whatever the clarity of her choices; but as a health professional taking sides with such organised groups of villagers she may, for sure, work wonders. To this effect, the chapters 3 and 4 of the 4th section deserve a careful attention.

Many paramedics trained by or working in, christian institutions especially in southern states, may be able to take advantage of this book directly in English. For the many others, let us hope that translation will appear in vernacular languages to make this precious handbook actually available

to all those whom it addresses.

The authors have made a successful attempt to wirte in a clear and accessible language without compromising the necessity for health workers and health activists to master the relevant terms and facts. The presentation of the tables and graphs deserves a special mention for its clarity, careful selection, relevance and attractiveness. Many graphs may not fail to impress even illiterate readers, such as the set showing the decrease in mortality due to infectious diseases for the USA, 1900-1973, in relation to specific medical measures (p 110): one is immediately, visually convinced of the very low significance of the medical interventions in the matter. No professionally competent health activist may afford to do without this handbook. We even consider that no health worker worth the name may go without the basic knowledge imparted by this book. We wish all institutions dealing with rural health care adopt it as a basic vade-mecum for all their workers. A didactic style and the arrangement of the contents in about 35 more or less self-sufficient units, make the book easy to be used as a reference book, to be read piecemeal or utilised a la carte, according to one's daily requirements.

The authors deserve felicitations too for enlivening their technical expositions with pictures and drawings which try to give a graphic visualisation of abstract ideas and often carry the appropriate emotional import. The big size of the book (21.5 cm x 25 cm) was skillfully taken advantage of to device a well-spaced out disposition of the drawing and matter, each page being divided into two parts with short lines: this facilitates the reading and helps to grasp and memorise the matter of each paragraph.

References

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Dalkon Shield Battle Continues

IN late January 1986, a former Dalkon Shield user suggested that the Women's Health Information Center (WHIC) was the appropriate body in Israel to organise a campaign to notify Dalkon Shield users of their right to apply for compensation for damages. The WHIC, a project of the Israeli feminist movement, consists of small group of volunteers who for several years have provided health information and education to women through a weekly open phone line, health fairs, lectures and other activities. We knew that the manufacturer of the Shield had been required by the Court in America to notify users of their right to sue, but that the company had made little or no effort to do so here. We decided, in February, to take on the job of locating Shield users. We also decided to work with an American lawyer, who could give us information and guidance and could later represent the women we located, if they so chose.

We knew that Robins claimed to have sold the Shield in Israel, but had no idea of how many were actually inserted in Israeli women. The Ministry of Health told a reporter from a local newspaper that there were none in Israel. However, in mid-February we placed a small ad in the same newspaper and over 100 women responded immediately! Some of them definitely used the Shield; others strongly suspected that this was the IUD they had once used. Daily calls poured in, and, helped by volunteers from the Feminist Center and the Rape Crisis Center, we responded by sending out information and forms, and listening to the horrifying stories of complications women experienced with the IUD.

In February and March the WHIC sent information to the press and some ten articles were published about our campaign in Hebrew, Arabic and English newspapers. We also spoke on radio and placed another small ad in a women's magazine. Women from every corner of the country-cities, villages, kibbutzim-requested help filing claims. In April we held a meeting to give potential claimants an opportunity to meet with the lawyer, ask questions and discuss problems they were having getting medical records.

Among the claimants was one who had already verified that the IUD she received at Kalpan Hospital was indeed a Dalkon Shield, and that she had been one of 500 to get a Shield as part of an experimental program. After several weeks of negotiation with officials of the Health Ministry, Kalpan Hospital and the General Health Insurance authorities, we received permission to notify these 500 women. Unfortunately half of the addresses had been lost in the hospital archives, so we were able to write to only 250, and we lost many of these women due to lack of forwarding addresses from their previous homes.

After the April 30th deadline, Kalpan Hospital suddenly FOUND the misplaced list of the other 250 women—but now it was too late to put in claims!

Meanwhile, women continued to call us even after the April 30th deadline passed. There is a definite possibility that not all Dalkon Shield users in Israel were located, due to the limited time and money that were available to us.

When women began to request their medical records they discovered: that many files had been destroyed (they seem to save files for only 7 years here); the hospitals would not cooperate with them; details were not carefully listed—only the word IUD appeared; most private doctors had no files; and some doctors were no longer alive.

[Information from WHIC, Israel from Women's Global Network].