Since the earliest days of civilization, 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 survival. The reason is that the word 'survival' is the root of 'invention', which is part of everyday life.

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 in the brain. Even great scientists like Albert Einstein 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 short span of time, Einstein had admitted that he had done precious little than standing on the shore of the ocean of knowledge and gazing at a frond of the wave.

The story of civilizations has been strewn together with stories of unbridled quests. It is thus no ordinary coincidence that when Abhay Bang and Hari 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 organization 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.

Health being one of the most vital yet neglected issues was thus angled 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 attention. It is possible and desirable to solve many health problems by community-based solutions. What 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 latter of the system should not mean that the NGOs start duplicating the
Background

Before going any further into the present activities of SEARCH, it is important to understand the twin issues of the rural and the remote 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 Abbey Bang (a doctor couple and a sociologist), came to Gadchiroli to work in the most backward district in the Maharashtra area. They had then their two sons - nine years and another six months old, a trunkful of luggage - mostly books and papers, an ambulance, three workers, and lots of ideas.

Abhay’s parents were farmers and workers in a sugar factory in Mumbai. He had spent his childhood in Garibaldi Adrom. In contrast, Rani came from a Sengar family and her father was a doctor. Rani studied together in the medical college at Nagpur. Abhay, a university senior throughout, was an active member of Jayprakash Narayan’s youth organisation, Taran Shami Sena. Later, he was a key activist in J.P. movement for “Total Revolution” in 1975. His parents were also politically active in the movement and were jailed during the movement against Emergency.

After completing MBBS from Nagpur, he had joined the Post Graduate Institute of Medical Education and Research (PGI) in Chandigarh to complete his residency. Here he realized that health care programmes in the country were not focused on the reality in rural India. Doing his residency, he appeared for the All India MD (obstetrics and gynaecology); stood first, but refused to continue to study at PGI. He argued that the PGI faculty wanted the assistant professor to train a doctor at PGI would have been enough to meet the health care needs of the rural poor, yet most MDS from PGI were migrating to USA. To oppose against this, he left PGI and formed the ‘Medical Friends Circle’ in 1977 along with other friends in Tarni Shanti Sena. They made an effort to involve the medicine to work for rural and poor sick. He lived and worked in a tribal area in Umar Pradip to test his own preparation. He subsequently completed his MD in gynaecology with the Gold Medal.

It was at this time that they got married and moved to Wardha and joined, along with Abbey’s family, ‘Ganpati Ugar’, an NGO named 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 organized 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 activities in Maharashtra which finally forced the government to accept the new level of wages proposed.

This episode made the Bangs realize the power of authentic research. They had realized 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 Johns Hopkins University in the USA 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 attained distinction for being a true example of grassroot training to community health. This USA was not their homebase. They came back to India and after a short while, started work in Gadchiroli in 1986.

Facets of Gadchiroli

Gadchiroli was a relatively unknown 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 wider notice. That is an account of Gadchiroli district and SEARCH area.
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 peering 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 Nistar districts 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, now 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 1,200 kms away. The district is about 105 kms north-south and 60 kms east-west. Nearly 70% of its area is under forests - a part of the ancient Dandakaranya forests.

On the western border of the district is the river Waiwanga. Until a few years back (all 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 inaccessible during the rainy season. The western part of the district, adjacent to the river Waiwanga, is inhabited by some tribal farmers. One of the total of 17 tahsil, three belong to this category. The eastern part of the district is predominantly a hilly and forest area inhabited mostly by the tribal. Like in the rest of the country, there has been widespread deforestation.

The tea demographic data of the district that was available from official sources was for the year 1985, which showed a total population of 6,50,651 out of which 4,23,166 (64.8%) were Scheduled Castes and 2,25,333 (35.2%) were Scheduled Tribes. The main tribe was the Munda. The population density was only 41 per sq km. About 70.3% of the people lived in 150 villages, and only 2.5% lived in the towns of the district. The literacy rate was 27%, with female literacy being 12%, and the literate rate of tribal women 9%.
seeking monetary returns from patients. The health department of the state was only interested in achieving the family planning targets. It is ironic that according to official data, Gaddiwar, with such a poor ‘health care’ and high child mortality had stood first in the state for three successive years (1982-83) in respect 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 small ‘ju STHA’ godown in the Gaddiwar town which was lent by a local resident. In the very next month, floods cut off the 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 organizations is path finding or research. Shorn of their 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 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 gravity of the 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 technocratic 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 approach with the government in 1985. It was intended to see the national that since government health services were run in public 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, Mahabaleshwar, SEARCH accepted the responsibilities of:

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

The personnel and finance would remain with the government, but SEARCH was given some advisory powers. However, the ground reality 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 Gaddiwar where any posting was considered as a punishment. Average stay at Gaddiwar of these three civil surgeons was only five days a month. One day, even the civil surgeon was caught accepting bribes 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 Banga was the only doctor working at the hospital. To the Banga, it seemed that the system "had found few 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, that will 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 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 scarred and food and drug supply was regulated. Attendance increased by 50% within a year.

The Health Minister was so pleased with the results that he passed SEARCH in a public meeting at Gaddiwar. 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 in the best interest of 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 Banga realized that the health department looked at this experiment as an adversary and was not willing to learn from it. Banga also started observing that since people in Gaddiwar were not involved in the effort to change the government institution, they believed that this improvement and the presence of exceptional doctors like Banga 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, misrule and false reporting, two other 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 centralized and the relationship within the department extremely hierarchical and autocratic.

SEARCH came to the conclusion: “It is possible in the short run to impose the functioning of the government health care institution. However, the efforts to change or improve generate resistance from within the system. External political will is necessary to overcome this resistance. It is another desirable and feasible responsibility for a voluntary organisation to take up this role. The goals, role, and work culture of the Government and voluntary organisations are different.

SEARCH served its link with the government programme after two years of this experiment in 1986 and started working directly with the people.

The government health services, due to their centralized 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 organisations can work in direct collaboration with people, rather than accepting an implementation role 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.

Community Based Rural Health Care

SEARCH started its work firstly in a programme area of 18 villages of Gadchiroli district covering a population of nearly 35,000. The main emphasis of this work was 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 Anganwadi (messenger of health) and the all 3 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, counseling 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 these 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 Sholapur.

The non programme area (the control area for field research) has 47 villages with a population of 65,000. 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 3 doctors, including Rani and Abhay, three nurses, lab technicians, a paediatrician, a nutritionist, a doctor who gives religious-cultural discourses in the villages, a team working with youth, 6 field supervisors, women social workers, computer

Sampling Blood to Test for Sickle Cell Disease

programmer, statistician, office and support staff. The community based worker are 120 data and 80 anganwadi - 35 women and 45 men. The gate keeper, driver, registration clerk, deaddiction workers - many of the workers at Sholapur are educated. The gate keeper runs a shop and keeps himself productively occupied.

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 vehicle 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

Bugs this realisation did not come easily and instead they had to tangle a more convoluted path.

A simple survey conducted by SEARCH in 1987 revealed that the prevalence of sickle cell trait in the population in Gadchiroli district was 19%. It was found that nearly 100,000 persons carried the disease gene, and about 6,000 persons (1% population) were homozygous cases of sickle cell anaemia. The report was submitted to the government for further action. The State Government publicly acknowledged the work, honoured Abhay with the ‘Adressi Sood’ award, but no concrete action followed on combating sickle cell disease.

The people seemed unmoved about action by the government. Abhay and Rani soon realised that for the people Sickale cell disease was SEARCH’S problem and not theirs. People were gaseous in donating their blood for
In the 1940s, women's health was usually ignored with maternity and family planning. But Banga noticed that a large number of women had gynaecological diseases, and "white discharge" was the most common symptom. Women patients complained about "white discharge"—usually considering the smell of white discharge: Banga realized that other doctors working with them perceived this problem as a matter of curiosity and treated accordingly. It took living in Gadhiloli to understand the importance of treating women. This made them realize the importance of knowing local expressions of symptoms.

Review of medical literature revealed that diseases in rural women had been ignored. The required study of women in defined villages was conducted in the study. The study discovered that 92% of women in the village had gynaecological problems and had, on average, 5.6 diseases per woman. Only 1% had ever received proper medical care. The most common problems were reproductive tract infections (RTIs), urinary disorders, and genital problems. Surveys were conducted among the gynaecological problems that were relevant to women's health, and the results were used to plan medical care. When women came to the hospital, they were first asked about their health and then treated accordingly.

The prevalence of gynaecological problems adversely affected the ability to work, usual sexual functions, and marital life. It also caused depression and loss of productivity because of gynaecological diseases.

4% 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 (mainly on gynaecological sex) were shared in all villages at group meetings and through a health examination unit.

This study was published in The Lancet in 1949, and was considered a landmark study as it showed the policy makers and officials worldwide the hidden incidence of women's health issues and brought out gynaecological care as a public health priority.

Table 1: The gynaecological and sexual problems in rural women found in the Gadhiloli study, 1999

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% of women in villages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Amminator</td>
<td>5.7</td>
</tr>
<tr>
<td>2. Oligomenorrhoea</td>
<td>22.4</td>
</tr>
<tr>
<td>3. Micturition</td>
<td>15.2</td>
</tr>
<tr>
<td>4. Dysmenorrhoea</td>
<td>56.5</td>
</tr>
<tr>
<td>5. Infection</td>
<td>14.6</td>
</tr>
<tr>
<td>6. Psychosocial disorders</td>
<td>31.0</td>
</tr>
<tr>
<td>7. Tuberculosis</td>
<td>14.6</td>
</tr>
<tr>
<td>8. Cervical erosion</td>
<td>34.1</td>
</tr>
<tr>
<td>9. Bacterial vaginosis</td>
<td>62.2</td>
</tr>
<tr>
<td>10. Cervical erosion</td>
<td>46.7</td>
</tr>
<tr>
<td>11. Carcinoma</td>
<td>40.7</td>
</tr>
<tr>
<td>12. Pelvic inflammatory disease</td>
<td>28.1</td>
</tr>
<tr>
<td>13. Symphysis</td>
<td>12.3</td>
</tr>
</tbody>
</table>

Training youths for reproductive life

Some 50% of the adolescent girls and boys surveyed practiced sex, and sex education was an important issue. Two HIV positive cases were detected in Gadhiloli by SEARCH in 1998. Hence, SEARCH is presently giving priority to sex education.

A seven day reproductive health education programme for adolescents has been developed by SEARCH. The idea is to prepare the youths for marriage, responsible and safe reproductive life which includes sex and contraception. Knowledge of such practices cannot be held in Shaligram; each was attended by about 50 to 100 gals and boys on an average.

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

Understanding people's culture of health and disease

The other factor which has made the people accept SEARCH's programmes is the organization's sensitivity to the people's culture. This includes food 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 innovative normal techniques, but has not necessarily documented from the data information on medicinal and other uses of 500 local plants - the food they use as a permanent contraceptive, and nulla foresworn with water for fungal infections like typhoid.
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" (1978). They suggested that all policy, programmes, services and research should be directed towards the reproductive health of both women and men. The concept of reproductive health was acknowledged by CARE when it introduced its Community Development Programme in 1982.

Women's Reproductive Health

Women's health has four components:

- Participation in reproductive health
- Education on reproductive health
- Village-based reproductive health care
- Referral services

Zahy (1979) emphasized that only 1 in 2 women in rural India were trained in midwifery or in community health services. The need for reproductive health services for men was also emphasized. The importance of reproductive health was further highlighted by the World Health Organization (WHO) in 1985.

Saipathy Parbhoo, 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 health and disease. Various names and expressions used to describe symptoms of various illnesses are employed, understood and recorded. It is a bank to store people's own wisdom and expressions.

Abhay said that SEARCH was recording these from people to reinforce the value of mental 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. It was the opinion of the doctors that such material should be a part of the curriculum for medical students.

Bhau were surprised when, following Women's Health Yatra, even from 2 villages submitted report cards signed by hundreds of men urging SEARCH to undertake similar study on men's health care. A "rape police" was identified to identify, diagnose, and treat reproductive tract infections in women. Referral services are provided at the SEARCH hospital at Shodaghar.

Training

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

- Village level health workers (village health workers)
- Health workers (VHWs)
- Village Health and Family (VHFs)

Reproductive Health Problems of Men

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

- Village level health workers (village health workers)
- Health workers (VHWs)
- Village Health and Family (VHFs)
Training is extremely important for SEARCH as the main objective is to develop local health workers for village-based health care and research. 80 Auxiliary Nurse Midwives (ANMs) and 125 data have been trained at SEARCH. Over the years, these nurses have been ‘bornout researchers’. Some of these have been upgraded to become supervisors and apart from their usual duties, have become trained enough to conduct difficult research protocols like ‘verbal autopsy’.

The methods of training are quite different. Non-formal training methods are used especially for data who are illiterate. They are taught and have very short attention spans. 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

- Aguntuva and data are comparatively handling care of pneumonia amongst infants and children, everyone gastroenteritis, pneumonia, diarrhea and medical care. Through these research protocols, SEARCH has demonstrated the feasibility of delivering 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.

- Mahesh, aged about 40 years, is a data from the village Gopinath. She was initially trained by the medical student. He 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 slice of blade, check the newborn’s body by hanging a yam with a metal pipe, and place a piece of mud and oil or turmeric powder to cover the navel.”

- She now washes her hands with soap and disinfectants, uses a sterilized 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 data now use proper disinfectants to

Educating people for health, training health workers from the community, and involving people in planning is deeply a medical care. It can also create the basis for success in battles with difficult diseases. SEARCH’s experience proved that it was possible to pneumonia as well as sick enough that infant mortality and gastroenteritis in villages it also could be reduced and controlled.

The initial work of a campaign against injures when and been adopted. A study of those injection received injections; and 60% of these injection such as B Complex, B12, streptomycin, sulfa, analgesics, etc. were unnecessary. Health workers of SEARCH say that “too many unnecessary injections occur in the injection process.”

In conclusion, a 50% reduction in the injections given, thereby avoiding 15,000 unnecessary injections per year in the CHD of the 20 bed hospital at Garibandi.”

In the villages, people had developed a misconception that only injections could cure a quick and complete cure, which made them psychologically dependent on doctor and vulnerable to exploitation. During the course of the SEARCH campaign against unnecessary use of injection an intravenous injection of routine needed. A woman from the village Pattedu said “I used to give my son injections to reduce body aches. This training was documented and published through videos to drive home the point that injections were unnecessary in most cases and could even be harmful.

Even today, the practice of health education continues and underscores the fact that SEARCH does not look at education as an end in itself. Currently, the programme of health education is being conducted through:

- Women’s group meetings and village evening using slide shows, audio films, posters and flash cards. As a part of this programme, a Health Education - a poster competition was distributed in 20 villages.
- A full form of religious discourse (kirtan) 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 Drive” in 1997. It included an educational and cultural programme: an exhibition of pictures and poems on women & child health, traditional medicine and environmental issues. There were site shows on STIs and reproductive health, a competition on ‘clean home and surroundings’, songs, dances and community awareness 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 dangers of child bearing.

More than 39,000 people attended the Jana which was organized at 17 places.

Thus the success of SEARCH has been able to grasp the fact that today there are definite signs of increasing awareness and acceptance of the people of the alternatives suggested by the activities of SEARCH.”
Learning to Count with Tools: The Breath Counter

Akhbar has developed a simple device that has been named 'breath counter' to count the respiratory rate of a child to diagnose pneumonia. The device has two sides with a set of blue and red beads and an electronic digital timer. Since TBAs can't count respiratory rate up to 60 yr/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 seed has passed (four minutes), it means that the child has pneumonia. When the data were used to diagnose pneumonia by using this device, the accuracy of their diagnosis is compared to the doctor was 82%.

Control of pneumonia in children

Acute respiratory infections (ARI), especially pneumonia, have been recognized as the most frequent cause of infant mortality annually killing about 4 million children in developing countries. Akbar and Raina realized its importance when he saw an ANM officer in Godhra died of pneumonia just before a child died of pneumonia in Godhra in 1986. They were quick to realize that if this was happening among the older 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 data to diagnose and treat pneumonia in children. Since this was a bold experiment in eighteen, a rigorous field trial was planned with a control arm for comparison of results.

In two years (1990-92) nearly 2200 cases of pneumonia in children were treated by the trained ANM workers and data 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 35% and child mortality by 30%.

This study, published in the Lancet in 1992, 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 UNICEF in 1991.

At the beginning of the field trial, SEARCH was refraining from treating pneumonia with antibiotics as per the guidelines of WHO. Maroju Jagade is a class 10 pass young man who...
Table 2: The impact on childhood mortality and pneumonia mortality at the end of two years of intervention

<table>
<thead>
<tr>
<th>Description</th>
<th>Control Area</th>
<th>Intervention Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of villages</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Total population</td>
<td>34,856</td>
<td>45,629</td>
</tr>
<tr>
<td>Children below 5 years</td>
<td>3,367</td>
<td>4,636</td>
</tr>
<tr>
<td>Birth Rate</td>
<td>30.1</td>
<td>31.8</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>121.6</td>
<td>79.77</td>
</tr>
<tr>
<td>Pneumonia mortality rate per 1000 children under 5 years</td>
<td>17.48</td>
<td>4.64</td>
</tr>
</tbody>
</table>

was seized and trained as an appraiser. He soon mastered how to diagnose and treat pneumonia. A doctor was called but he refused to treat the baby because of high risk. Desperate, the family called Marvi. He treated the symptoms but nothing the symptoms, he bandaged the child for 8 hours constantly observing the patient and managing the parents. The baby survived. Today, Marvi's village sees him. Many private practitioners in villages now refer cases of pneumonia to him and appraisers.

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: commendable respiratory infections in children (ARI). One, to ensure that TBAs and village health workers, the responsibility to manage pneumonia in children, thereby achieving almost 100% coverage of pneumonia cases in children in their catch area. Second, even the measure 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 incorporated such steps, its efficacy 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 immediately two thirds of the total mortality rate in developing countries.

Table 3: Comparison of two strategies of ARI Control

<table>
<thead>
<tr>
<th>I. Children of 0-2 months age.</th>
<th>Strategy based on current government guidelines</th>
<th>Alternative strategy developed by SEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of care</td>
<td>Hospital</td>
<td>Case management at home</td>
</tr>
<tr>
<td>Necessary</td>
<td>Hospital</td>
<td>Trained VHW TBA in each village</td>
</tr>
<tr>
<td>Notes sick children (at 50% coverage)</td>
<td>1.4 million</td>
<td>1.4 million</td>
</tr>
<tr>
<td>Cost of care/year</td>
<td>Rs. 1.475 million ($ 48 million)</td>
<td>Rs. 6.2 million ($ 22.14 million)</td>
</tr>
<tr>
<td>Reduction in pneumonia mortality rate</td>
<td>31%</td>
<td>A little more than 33%</td>
</tr>
</tbody>
</table>

II. Children of 2-59 months age.

<table>
<thead>
<tr>
<th>Place of care</th>
<th>Community</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of care</td>
<td>Community</td>
<td>Community</td>
</tr>
<tr>
<td>Prevention of pneumonia cases achieved</td>
<td>30-25%</td>
<td>More than 90%</td>
</tr>
<tr>
<td>Expected reduction in pneumonia mortality rate</td>
<td>5-10%</td>
<td>75%</td>
</tr>
</tbody>
</table>

III. Total 0-5 years.

<table>
<thead>
<tr>
<th>Inpatient mortality</th>
<th>Network of hospitals</th>
<th>1 million health worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception cost of care/year</td>
<td>Rs. 1,138 million ($ 4.1 million)</td>
<td>Rs. 122 million</td>
</tr>
</tbody>
</table>

1502 million
People's movement against alcohol

By 1998, 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 adder that SEARCH encountered was Gokhori, a malnourished and disheveled woman suffering from alcoholism. She was referred to a clinic for treatment.

There have been some associated studies relating to alcoholism and health problems. One of the interesting methods used for identifying individuals suffering from alcoholism is the 'drunken test.' The test involves having the individual eat a meal and then observing the effects of alcohol on their behavior.

The study revealed that 55% of the study group were found to be alcoholics. However, only 2% of the respondents were found to be suffering from other health problems.

Emoting Ills of Alcoholism: Using Culture to Make A Point

In one village, the village elders imposed a ban on liquor in 1998. Despite the ban, alcohol was smuggled into the village.

Subsequently, SEARCH had organized a series of village-level meetings of women and youths to discuss their health problems. Alcohol use was discussed and banned.

Many women recalled how they had been wives of alcoholics or other alcohol users. Alcoholism among men was prevalent in the area. Women also faced challenges in their daily lives due to the consumption of alcohol by their husbands or other male family members.

In conclusion, the village ban on liquor was successful in reducing alcohol use among men and women. Women also benefited from the reduced alcohol consumption, leading to improved health outcomes.
One 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 the 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 present drinking expenditure on liquor, common symptoms due to drinking.

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, insomnia, accidents and injuries, loss of employment, family problems, mental demagreement and death.

- About 1,00,000 men in the district were frequent drinkers and 10,000 were addicted to alcohol.

- Realisation of a constitutional provision prohibiting sale and consumption of liquor in tribal areas, the state government had given permits to 25 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 subagents to sell liquor in the villages.

- Annual sale of liquor in the district was above 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:

  - exhaustive realisation about the problem of alcohol;
  - concrete facts and data to back up;
  - consensus will to tackle the problem.

A 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 100 villages, half of them women. A district level ‘Dennamukh 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 for 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 suspension of government sponsored sale of liquor 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 wavering. A mass petition of about 42,000 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 concerning 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 Gadhikhali on 24th October, 1992 to declare the start of ‘People’s Prohibitions’. 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 vendor’s 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 begun. Permanent committees were set up to ensure the proper working of the prohibition at the village level. But the problem of officials remained. Denial/eviction programme for alcoholics emerged as one more challenge for SEARCH.

There was of course a backlash from the liquor lobby during this period and also 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. These were repeated investigation by the government. The charges against Rani were not only cleared but they were praised by the state authorities for the excellent work they were doing in very difficult areas.

Shodhigram

The SEARCH office was based in the Gadhikhali town for the initial seven years. To become more accessible to tribes it was decided to move further inland in 1995. They set up their present headquarters 17 kms from the Gadhikhali town on a 32 acre agricultural land in the town. It was named Shodhgram - a watch village. Gadhikhali had named his Ashram 'Sevagram'. Abhay, who spent his childhood...
A Distinct Look: People Friendly Hospital

end of the prayer, Rani and Abbey give the host with a rendering of "Jai Shakti Homo homo dana dana..."

The tribal friendly hospital

The referral service is provided through a small hospital at Shodigram. About 15,000 patients from 12 blocks of Goddabail and Chandrapur districts receive care every year. An 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 120 villages. The tribals told them that they feared a visit to the Government hospital, did not feel as 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 feb very lonely and insecure and preferred to die at home.

Moreover, the doctors and nurses in the hospitals had very little time to look after the patients. (Abhay confirmed this aspect. During their stay at the government civil hospital, they had found that the doctors’ patient contact was only for 5 minutes while that of the patient—time hardly 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:

- The absolute number of million warranting a special policy.
- At least two genetic common amongst and O&O deficiency.
- Nutritional diseases are known to be tribal - Skin Cell Disease.
- Tribals are quite poor and they were displaced from their environment. Now, due to impoverishment faced up on them, illiteracy is rampant, especially among women and children.
- Tribals live in a physical environment which is full of accidents and trauma.
- The high prevalence of some diseases in tribal society (TB, hypoxia, malaria, anemia etc.) necessitate a health care plan appropriate to their needs.
- The standard government health policies and priorities have some virtue in the health needs of tribals since they have a different disease pattern as well as different health beliefs and customs.
- Some 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 from 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 tribes who interact with the NGOs and the "NGO buildings" are not. 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 culture and lifestyle. I feel that they don't understand the problem. I don't think there is a God in the hospital; the doctors themselves have become god there. How can a patient recover without worshipping the God?"

Cultural alienation was identified by SEARCH as the most profound factor leading to voluntary withdrawal of government hospitals in the tribal areas.

Therefore, a lot of thought went into designing the tribal hospital which, sits right from the entrance gate of the hospital; 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 huts - a traditional place in a Gond village where the solid and hollow stools are placed.

Instead of a large ward, the hospital consists of a number of cells where the tribal patient can stay with his family. The tribal liked the idea of "the hospital of his own" so much that the people from two villages contributed here for their parents much before the construction work by SEARCH started.

The hospital has been named "Ma Dukawari Davabhanu" by the tribals because they today believe that this hospital is theirs. People used to work at the reception and registration sections are tribal who speak the "Gondi" language, make the patients feel at home and also keep the doctors in understanding of the language given by the tribal patients. Besides the hospital there is a small garden/habitat 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, for their problems, and suggest culturally appropriate solutions.

A success and realization

During all these years of hospital activities, what was happening to the activist himself? Abhay had assumed that because of his interest in tribal and social work, he belonged to the "lower caste group" and was immune to the "dangers of the alliance". And yet he was a diabetic at 42. He had a severe coronary problem in April 1993, and had to be rushed to Nagpur for treatment. He underwent a coronary angioplasty during which his coronary artery was occluded. The time to open an artery on the circle. 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 Dr. Cyril's "Surviving Heart Disease" which showed him the way. He started a new regime of diet, brisk walks, yoganidra, pranayama and meditation. On completing one year after his
**A Few Posers**

There however, are a few questions that come to mind while analyzing 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 aware that senior members of SEARCH have already thought and debated on these issues.

- **Gaddarshikar:** 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 'interfere with everything.' A question often debated is whether the same organisations 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 identifying health workers from within the community to provide community based health care, the need for developing an appropriate form of social organisations which will support these community health workers without external support in the long run is of great importance. One does not expect that the political will of the government will change in the foreseeable future to suddenly become proactive, pro-woman or pro-poor. The need for developing appropriate forms of social organisations and sustainable patterns 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 supposed skills.

SEARCH has focused its mission primarily on developing community based solutions for the health problems. Only during the phase of the movement against feudalism, 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.

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**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, alcohol induced mental illness 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 rural population and showed the way to other NGOs and governments.
SEARCH believes that it is unrealistic to expect to raise the money for health work among poor from the target populations itself. Less than 22% of its expenses are covered by the fees charged to the patients. Hence it developed fraternal agencies. Many friends and relatives of money to support the 1987-88 support

1. Indian Council of Medical Research (1986-87) - Rs. 24,00,000
2. OXAM (1986-87) - Rs. 14,00,000
3. Ashoka Foundation (1985-86) - Rs. 1,00,000
4. The Ford Foundation (1987-88) - Rs. 9,00,000
5. Overseas (1991-92) - Rs. 75,000
6. The McArthur Foundation (1991-92) - Rs. 90,000
7. World Health Organisation (1993-96) - Rs. 4,00,000
8. UJIC Bikaner - Rs. 3,00,000
9. International Women's Health Coalition(1997) - Rs. 8,00,000
10. Individual donations - Rs. 8,00,000

Voluntary Health Association of India (VHA) is a non-profit registered society formed by the federation of Voluntary Association at the level of states and union territories. VHA links over 4000 grassroot-level organisations and community health programmes spread across the country. VHA's primary objectives and to promote community health, social justice and human rights related to the provision and distribution of health services in India. VHA fulfills these objectives through campaign, policy research and press and environment advocacy, through field-based training and information and documentation services, and through production and distribution of innovative health education material and packages, in the form of print and audio-visuals, for a wide spectrum of users both urban and rural. VHA aims to ensure that a people-oriented health policy is formulated and effectively implemented. It also endeavours to sensitise and educate public towards a scientific attitude to health, without ignoring India's rich traditions and resources.