

**Research Notes****EVOLVING A RURAL COMMUNITY – BASED, PARTICIPATORY HEALTH CARE MODEL BASED ON INDIAN INDIGENOUS SYSTEM OF MEDICINE****B. HYMA, A. RAMESH\* AND N. L. SUBHADRA\****Department of Geography, Faculty of Environmental Studies, University of Waterloo, Waterloo, Ontario, Canada N2 3G 1**Department of Geography, University of Madras, Madras – 600 005, India.**\*For a full text of the following summary / reflections – please contact the authors.***Received: 19 June 1986****Accepted: 28 July 1986**

Based on the principles of primary health care as outlined by WHO / UNICEF at the Alma Ata conference, in the Soviet Union in 1978, many developing countries including India, have been formulating organizing and experimenting with primary health care (PHC) programmes both in the public and private voluntary sectors. So far in India, the Government's centralized health care services using modern medicine and PHC approaches have been faced with many administrative and bureaucratic weaknesses in implementation and have been unable to meet the health needs of the rural populations, in terms of accessibility, affordability availability, acceptability and effective utilization. Some of the shortcomings are discussed.

Many voluntary organizations in India prefer the development of new alternative, indigenous designs of community – based health care through developing strategies based on principles of self – reliance, participation, felt – needs and priorities and indigenous technology. Any health care system to be really meaningful and effective must be environmentally, socially, culturally

and politically closer to the masses of people. In this context, the Indian indigenous system of medicine is seen to offer a useful and complementary role in the preventive and curative aspects of PHC programmes.

With the above objectives in mind, the investigators undertook a brief survey of a “Comprehensive Rural Health Project” at the invitation of Arya Vaidya Rama Varier Educational Fountain of Ayurveda (AVREFA) – a private Indian indigenous medical organization (established in 1978). Their project, comprising of a Rural Health Center (RHC) and an Ayurvedic medical college (established in 1978), started in April 1984, in a village 30 kms outside of Coimbatore in South India. It is jointly financed by USAID (75%) and the AVR Educational Foundation of Ayurveda (25%).

1. The project has multiple objectives : RHC has formulated a comprehensive integrated health system model where education, training, participatory and clinical research will stem from RHC and the college, and will be linked

through the establishment of satellite units and village posts, in the regional / local setting, acting as nuclei for social health movements. The participants and beneficiaries will be surrounding underprivileged, underserved, deprived, neglected, and often exploited peripheral rural and tribal (hills) communities with a combined population of 150,000 in 22 villages.

2. RHC is developing innovative alternative methods using the popular Indian indigenous system of medicine (IM) namely Ayurveda and Siddha within a framework of the PHC model. This involves identifying, classifying, simplifying and integrating relevant materials from popular IM principles, formulas and treatment into a PHC model as well as development of appropriate instructional materials for education, training and research.
3. To introduce a geographic survey of distribution of medicinal plants and provide protection, conservation, utilization and systematic cultivation of forest and medicinal plants of value for the use of local village communities, and mobilization and maximum utilization of local human and physical resources of the area.
4. To develop community self – reliance in health services to achieve a need oriented, people-based research – oriented and an ecologically sound, preventive and rehabilitative health care model that is acceptable to the community which will be involved in

decision – making, planning, implementation, management and control of the programmes. It would also include the guidance of RHC organizers, the College, International Institute of Ayurveda and indigenous practitioners. Group leadership, village committee formation, participatory methods and commitment in development work will be introduced through community workers programmes.

Since the determinant of health and illness is founded in the human environment in its physical, socio – economic, demographic ecological and political process of development, the paper examines broad characteristics of the study area. It also presents some perspectives on social poverty and underdevelopment, poor accessibility, insufficient and inefficient infrastructure facilities of the study area and the process of marginalization of peripheral rural / tribal village communities. Incomplete assessment of geographic / resource capabilities in terms of land use, water, forest and medicinal plant and other bionic resources of the area, and socio – economic, demographic, epidemiological and infrastructural needs of the villages can pose severe difficulties, and ambiguities in the formulation of plans, programmes and their implementation. So far the initial preparatory phase includes a situational analysis survey consisting of a spot survey using sounding techniques and a comprehensive base line survey which is highly complex and time consuming. The guidance of geographers, biologists, botanists and anthropologists is sought.

**Social Learning and Social Health  
 Health Practices**

- a process of self-learning, sensitization rather than just training, sharing and comparing experiences
- cultivate behaviour and social skills
- health education - indigenous folk themes, communication and skills
- self-control, self-help, self-reliant, self-determining and self-governing
- community mobilization and participation: discussions, dialogues, demonstrations, group meetings, articulation of felt-needs and priorities
- above interactions set in motion a process of critical awareness, consciousness, mobilization, organization and action among community members
- learning by investigation, observation and experimentation

**Education and Training**

- community health workers
- health committee
- indigenous medical practitioners
- traditional midwives

**Mother and Child Care  
 and Family Welfare**

- Identification and utilization of traditional methods of proven value

**Nutrition and Dietary Habits**

- time, season, physiological status and disease status in planning of diet

**VILLAGE COMMUNITY**

- village development committee
- a decentralized participatory democratic functioning
- social and economic reform

**Immunization**

- modern methods as well as traditional methods to build general immunity against viral infections.

**Mental Health**

- yoga, meditation, recreational activities etc.

**Research and Development**

**Local Resources**

- mobilization and maximum utilization (towards self-reliance)
- cultivation of herbs for extraction of medicine for local consumption
- garden farming at household and community scale

**Appropriate Technology**

- indigenous technology and traditional practices - low cost efficiency

**Better Farming, Irrigation  
 Water Control and Management Techniques**

- Income generating activities**
- to encourage food production
  - to promote village industries

**Protection and Improvement  
 of Physical Environment**

- drinking water supply: traditional methods of clarifying water and protection of the sources
- personal hygiene and cleanliness
- building of small houses
- identification of traditional practices of proven value

**Control and Prevention of Common and Chronic  
 Disease and identification and utilization of  
 Essential Drugs of both modern and indigenous origin**

*Courtesy: International Trust of Ayurveda*

Evolving a rural community-based, participatory, self-reliant, and indigenous medicine-based social health system

The following part deals with the structure, organization and functional aspects of RHC and the College. It describes functional linkages from RHC to project villages and some of the processes at work particularly in relation to the introduction of participatory health research methods and related responses from village communities. The project's success depends on the special training and education of not just the villagers, but the staff themselves, in participation research techniques at individual and community levels which is a new experimental / action – oriented research model. Community organizers from RHC and community health workers being trained for this purpose form the backbone of the programme. Their roles are examined.

The final section presents a discussion of the scope and advantages of this project as well as many of the gaps and constraints to be overcome in experimentation. The strength of the project lies in factors such as creating a working process from within the system, giving wide scope for utilization of indigenous resources and medical technology, facilitating everyone to participate in planning and decision – making, working with people as equals, modest capital investment, low cost effectiveness, simplicity, wide scope to assess felt – needs and then devise suitable approaches to satisfy them creating a process of critical awareness, education and action, trust, hope, confidence and enhanced collective understanding of people's own social, economic and political realities.

Many constraints are seen or anticipated in the work process. Some of these are related to: the difficult task of developing

communication skills and interaction between the urban – educated Project organizers and their rural counterparts; the extent of community responses, willingness, long – term commitment dedication, social will; humility and hard work involved. Training, time, place, content, expectations, responsibilities, meeting schedules, attendance are all to be sorted out and managed efficiently in the process. It is not an easy task.

Final discussion centers on the sustainability and time limit to the project approach to rural development in terms of the financial resources, incentives and commitment, the time limit for different types of activities, the potential for income generating activities, self- reliance, paternalism and dependency.

Though the project has identified its philosophy, role, and goals of development, it is still faced with many ambiguities and inconsistencies, incomplete information and strategies in the initial phase of implementation. Several difficulties will be encountered in trying to achieve multiple objectives, especially those related to: (1) incomplete geographic information of the area, (2) the task of raising people's critical consciousness, awareness, co-operation and participation, as well as the community workers role, functions, and performance in relation to institution building at RHC and local capacity building and (3) restructuring of Village communities present unfavourable socio – economic order. Many bureaucratic, medical, professional and technical bases have to be overcome with regard to recognizing the scope of indigenous medical systems as playing a complementary role in PHCs programmes.

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