Health

It never ceases to surprise us that the standard of health care available to the masses at costs they can be expected to afford continues to decline year after year - political promises, media maulings, and other such measures, generally **considered effective, notwithstanding.** The medical lobby still continues to be overconcerned with curative services, possibly unable to accept that a general prophylactic approach will lessen people's sufferings but at the same time lighten their own pockets (or wherever they put their money). Our capacity to provide remedial measures is severely limited, nor do we aim to be a parallel medical set-up. We would like to see a situation where people have far less need to go for medical care, where there would be far less illness.

The basic goals of simple health care are not really unattainable, particularly for a nuclear power, but somehow India seems to be doing worse than so many others. Our maternal mortality rate is 555 per 100,000, which is six times more than in Sri Lanka. And let us see where we stand in regard to another one of them. We give below a table showing the position of household toilets in 8 villages in December 1998. The table is based on data collected by our Kishore Kishori Bahini in these villages.

Village	Houses surveyed	No toilet	Toilet	Pucca	Kutcha	Semi-pucca
Bajitpur	167	100	67	40	19	8
		60	40			
Chandalati	213	110	103	58	10	35
		52	48			
Andharmanik	177	67	110	78	28	4
		38	62			
Kolsur	143	71	72	18	6	48
		50	50			
Uttar Media	481	268	213	209	4	
		56	44			
Fatullyapur	225	90	135	107	26	2
		40	60			
Beliyakhali	220	145	75	57	11	7
		66	34			
Gokulpur	676	370	306	261	45	
		55	45			
TOTAL-8	2302	1221	1081	828	149	104
		53	47			

These figures were reached after a few years of intervention by us with a toilet-building programme, and there are thousands of villages where this did not happen, and so there the figures will be more disappointing. We give below a list of villages where kutcha toilets were built this year by local labour under supervision of our affiliate organization.

Village	No. of **toilets built**
Magurkhali	4
Andharmanik	1
Kalinga	7
Purba Simulia	80
Antlia	18
Beliyakhali	76
Parpatna	70
Uttar Media	53
Gokulpur	42
Bajitpur	1
Chandalati	65
TOTAL -11	433

Our six health workers did their usual work in mother and child care, visited our schools to check the children there. All of them have now moved beyond their own village and their work is also gradually moving from individual or family-wise health-related activity to functions with more public and community concern. Thus they now interact with kitchen garden groups to spread awareness of nutritious diet, with self-help groups to bring their women into our activities, with youth and culture groups to help them spread various messages of health.

We have kept detailed records of family planning measures, pregnancy, abortions, births and birth weights, sex of new born, mode of delivery, maternal and child mortality, natural death etc in some villages. We continued with our clinics where our health workers supplied medicine at cost price for treatment of certain common diseases. Simultaneously we provided herbal medicines also. The table below is not a true picture of the respective popularity of the two methods, as many households now grow some herbs and use them without reference to our worker or just ask her what to give. Such advice is not recorded in our books.

Village	Allopathic section		Herbal section
	No.of patients	Cost of medicine supplied	No. of patients
Fatullyapur	864	Rs 2547.60	410
Sarfarazpur			320
Bhojpara			315
Punra			173
Bajitpur	923	Rs 1608.10	172
Dweep Media	348	Rs 824.80	163
Uttar Media			119

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Chandalati	21	Rs	13.00	232
Parpatna	1001	Rs	1310.80	820
Beliyakhali	699	Rs	428.65	20
TOTAL-10	3856	Rs	6732.95	2744

In villages where we do not have a trained worker there is no provision for supply of allopathic medicines.

We continued to hold village-level awareness camps. These were mainly for mothers, but anybody else was welcome to join. This year we often had members of our self-help groups among the participants. It is mainly our health workers who speak on some topic, but sometimes we had somebody else from outside, too, sharing knowledge and information. The table below says all.

Village	**No. of camps**	**Total No. of participants**
Fatullyapur	29	689
Sarfarazpur	26	559
Bhojpara	25	502
Punra	20	392
Bajitpur	23	459
Dweep Media	17	333
Uttar Media	22	356
Gokulpur	23	437
Chandalati	13	325
Beliyakhali	17	440
Parpatna	26	550
TOTAL-11	241	5042

Our health workers, the health supervisor, and on occasions an outside resource person conducted trainings on specific topics in various villages. Members of the local Kishore Kishori Bahini were mainly expected to attend but quite often they were joined by other teenagers. The table below gives details.

Village	Subject of training	Duration (in days)	No. of participants
Fatullyapur	First aid	One	22
Fatullyapur	Nutrition	One	21
Bajitpur	First aid	One	21

Bajitpur	Nutrition	One	Unrecorded
Gokulpur	First aid	One	15
Gokulpur	Nutrition	One	23
Uttar Media	First aid	One	20
Uttar Media	Nutrition	One	Unrecorded
Magurkhali	First aid	One	11
Magurkhali	Nutrition	One	Unrecorded
Kolsur	First aid	One	18
Kolsur	Blood donor motivation	Three	36
Chandalati	First aid	One	10
Chandalati	Nutrition	One	29
Beliyakhali	First aid	One	28

Three of our health workers attended 3-day workshops organised by us on life skill training for adolescents. Two attended a four-day training on all round health and development. The supervisor participated in a four-day workshop in Calcutta organised by the India-Canada Environment Facility on the arsenic problem. He also attended a five-day workshop on the same topic organised by OXFAM and a five-day workshop on malaria organised by the West Bengal Voluntary Health Association.

Apart from these outside trainings there are regular meetings within the organization to exchange information, experience and ideas, and also to interact with workers from other departments. We give below a selected list of such meetings and workshops.

Occasion	Number	Duration	Participants
Monthly meetings of health department	12	1 day	93
Bi-monthly meetings among health workers, motivators, village organizers	5	1 day	94
Workshop with pre-primary teachers on deworming	1	1 day	32
Workshop with health workers and village organizers on deworming	1	1 day	19
Orientation training for primary teachers on deworming	1	1/2 day	13
Training for Kishore Kishori Bahini on all- round development	2	3 days each	74
Workshop on planning & record keeping	1	2 days	7

Workshop on first aid	1	1 day	4
Life skill training to adolescent girls	2	2 days each	42
Follow-up meeting with pre-primary Teachers on deworming and planning the next campaign	1	1/2 day	34

We went into the deworming campaign with intensive planning. SAHAY, another NGO, was providing the medicines and after a series of awareness camps and meetings, in some of which there was active and helpful participation from Government health employees, we distributed in six villages 8004 tablets in the first phase and 3053 in the second. The number came down so drastically in the second because the Government had by then begun distributing free tablets through its sub centre.

Our workers visit our schools to check the children's health at regular intervals. Since they are not medically qualified we do not get ideal care but in matters of general cleanliness they see if the body is dirty, if the child has regular baths, wears clean clothes, has clean nails and hair, and finds out if he washes his hands before eating, after going to the toilet, and if he cleans his teeth properly. If anyone is found to be suffering from any simple disease he is told what to do and given allopathic/homeopathic/herbal/home remedies, whichever is found most appropriate. On their part the teachers, during home visits and frequent meetings with parents, and in class, talk about proper and cheap nutrition, the need for a balanced diet, home gardens for food and herbs, toilets, safe drinking water, and immunization. There are provisions for first aid in each school.

In immunization we work in 11 villages with a total population of 26000. In the 3 villages where we have had health workers from the beginning, things have fallen into an easy routine but in the 8 others where we have spread out gradually, they can be much improved. Government staff are unable, maybe unwilling, to go to distant villages and so in 5 of these 8 we have to take people, mainly women and children, a long distance to get to where ,the immunization camps are set up. We still have not been able to build up an awareness level which will overcome such obstacles.

As is to be expected in a tropical region we have a lot of people suffering from cataract and among them are many who are poor and/or lonely, unable to get any help. We have made arrangements with the Government so that after proper screening and checking we can take a number of patients to the district hospital at Barasat, about 35 km from Andharmanik, and bring

them back after operation. The Government reimburses us some of our expenses, and is also supposed to give the patients proper powered glasses but this takes so long that we have had to give these ourselves. It has also happened in a number of cases that the patient has not been able to come back for the checking for the power and so never got the new glasses. Our workers take care of the patients, when they come for the screening, again when they come to spend the .night at Andharmanik before going off to Barasat, and at the hospital there before and after the operation. Altogether 364 persons reported at the three screening camps and 63 were selected for the operation, in two phases. On both occasions, a few extra patients became our responsibility as they found, on somehow reaching the hospital at Barasat in ways totally independent of us, that they had nobody to look after them. So we had to care for a total of 69 persons. Of them 59 came to us for the powered glasses.

New villages keep coming to us asking for help in their area but we are generally not inclined to take responsibility for more than what we can properly supervise and run well. However, sometimes we are convinced of the need for future intervention that may be of benefit to our present work also. So this year we appointed two motivators, at Punra and Gokulpur, and they started work on a base line survey of the families that will be under their care. In this sort of work we act in close co-operation with the Government departments that function locally. The total number of such motivators is now 7.

We had a target of 1000 bottles of blood for the Government blood banks this year and are happy to say that we collected more, as the table below will show. We work in co-operation with village organizations, some of them affiliates of Swanirvar, some independent and who join hands with us for this purpose. We generally make all the external arrangements and help the organizers with propaganda and other help.

		Donors			
Organization and village	Date of camp	Total	Men	Women	Blood bank
Nabakallol Gram Unnayan Samity, Rudrapur	30. 04.98	67	47	20	Cent. Blood Bank (CBB)
Khelaghar, Andharmanik	28.06.98	51	41	10	Basirhat
Gramin Development Society, Kolsur	4.08.98	76	56	20	CBB
Vivekananda Smriti Seva Sangha, Uttar Media	10.10.98	71	62	9	Basirhat
Nabodaya Krishak Sangha,	31.10.98	50	47	3	

Gokulpur					
Janakalyan Samity, Magurkhali	7.11.98	170	130	40	R. G. Kar
Jyoti Sangha, Bhojpara	15.11.98	60	55	5	N. R. S.
Suprabhat Sangha, Beliyakhali	17.11.98	36	25	11	Basirhat
Netaji Seba Sangha, Bajitpur	31.11.98	70	60	10	Basirhat
Sanghasree Club, Punra	8.01.99	66	63	3	Basirhat
Dilip Kumar Memorial High School, Baduria	9.01.99	29	27	2	Barasat
Bankra Gokulpur Panchayat	27.01.99	34	31	3	Basirhat
Eastern Standard School, Dattapara	6.02.99	100	83	17	Basirhat
Al-Mustafa Hospital, Mandra	11.02.99	48	44	4	CBB
Gram Unnayan Kendra, Fatullyapur	17.02.99	76	59	17	CBB
Basirhat Subdivision Environment and Health Development Centre	21. 02. 99	30	28	2	Basirhat
Punra BKMP Institution	22. 02. 99	61	57	4	CBB
TOTAL-17		1095	915	180	

Women thus form 16.5% of our donors, which is a considerable achievement, given the various constraints in a village that would pull them back from such a public act of community service, and also a personal gesture. We are part of a local movement to keep the blood bank in our subdivisional hospital at Basirhat active and working, and so we tried as often as we could to ask them to work as the collecting
agent. This was not always possible, and even when they came it was not always in a spirit of cooperation. The West Bengal Voluntary Blood Donors' Association recognized our efforts by the presentation of a handsome trophy in a public ceremony.

As all the above indicates we are taking steps to meet our health goals in various ways. Some of these are. very tentative, some too inadequate when the magnitude of the problem is considered, and there is no call for complacence, certainly nothing to crow over. But we trust we have not lost sense of the right direction. Only in the matter of arsenic in drinking water are we totally baffled. This is because nobody seems to know the true extent of the danger and nobody knows what exactly to do and how. There is no consensus on the definition of arsenic poisoning, the WHO feels high concentrations of arsenic in a community's well do not necessarily correlate with high levels of arsenic symptoms within the community, and the level

village andharmanik, north 24 parganas, west bengal - 743 401, india.

of actual intake is almost impossible to determine so future health effects cannot be predicted. Then again
health effects from consuming arsenic-contaminated drinking water are delayed, and so it is difficult to convince people about the danger. Moreover arsenic concentrations in wells in close proximity may vary widely.

As of now, there is no proven technology for the removal of arsenic at water collection points, nor is there any simple technology for household removal of arsenic from water. The most important remedial action is prevention of further exposure by providing safe drinking water, best done by utilising rain water and sources of uncontaminated surface water. We have dug a couple of wells, and are telling people to devise ways of preserving the abundant water that we receive during the monsoon but this is much easier said than done. We are tackling the menace on another front. Studies suggest that malnutrition and Hepatitis B will accentuate the effects of arsenic poisoning. So we are giving priority to popularising ways of getting inexpensive nutrition for the whole family.

This threat of arsenic poisoning, a threat that has become a fatal reality in a number of families in a number of not necessarily neighbouring villages in our work area, also draws attention to a basic dilemma: is human intervention doomed to prove counter availing? Experts seem to agree that apart from other reasons, mainly to do with the overdrawal of ground water for cultivation, populations have now been exposed to this arsenic problem as an unexpected side-effect of man's success in controlling the incidence of several diseases like diarrhoea, dysentery, typhoid, cholera and hepatitis - all transmitted by contaminated water. Programmes to provide "safe" drinking water meant people were no longer collecting their drinking and cooking water from rivers and ponds, sources that had no arsenic. The Resident Coordinator of UN Agencies in Bangladesh, a country facing a similar problem with arsenic as West Bengal in India, recently said in a speech, "The very tubewells that were considered a boon for their supply of safe, affordable and easy-to-fetch drinking water turned out to be a source of poison. . . What started out with good intentions is now becoming anathema. It is now recognised as a potential environmental disaster which will play havoc with millions of human lives, society and the economy in the coming years."