

Dr. N. H. Antia

A brief bio

Dr. N. H. Antia, (b. 8-2-1922), MBBS, FRCS (Eng), FACS (Honorary), USA, is Director and Trustee of the Foundation for Medical Research and Foundation for Research in Community Health. In a career spanning nearly five decades, his major areas of interest have been Plastic and Reconstructive Surgery, Biomedical Research and in Community Health including Panchayati Raj and Rural Development.

Dr. Antia has served on several committees and panels including that of the Indian Council of Medical Research, Indian Council of Social Science Research, Ministry of Health and Family Planning, Planning Commission and the Planning Board of Kerala.

He has been President of the International Congress of Plastic and Reconstructive Surgery, Indian Leprosy Association and the Association of Rural Surgeons of India.

He was honorary Professor of Plastic Surgery at the Grant Medical College and Head of the Tata Department of Plastic Surgery at the J.J. Hospital for 21 years and Senior Plastic Surgeon at the Jaslok Hospital.

He has over 300 publications on various subjects and has delivered several National and International Lectures and Orations based on his pioneering work in the field of Leprosy, Burns, Plastic Surgery, Biomedical Research and Community Health. He was the Member-Secretary of the path breaking ICSSRI ICMR report, "Health for All : An Alternative Strategy".

Dr. Antia is the recipient of the Hunterian Professorship of the Royal College of Surgeons of England in 1962, Honorary Fellow of the American College of Surgeons in 1979, Padma Shri in 1990 and the G. D. Birla International Award for Humanism in 1994.

WOMEN AND HEALTH

Dr. N. H. Antia

Health is cherished by all whether rich or poor, for it concerns both physical as well as mental well being. Eight hundred and fifty million of our people who *live* in 7 lakh villages and urban slums suffer from the diseases of poverty which chiefly affect the younger age group and which are relatively easy to prevent as well as cure at low cost. And yet a small affluent section that lives in urban enclaves suffer chiefly from diseases related to the normal process of ageing as well as of the mind, both of which are equally distressing and far more difficult to prevent and/or treat at far greater effort and cost.

It is also unfortunate that health is now being increasingly observed in its failure, not only because of the fear of illness but because of its increasing cost when sold as a marketable commodity in a field where consumer resistance is at its lowest. The result is that the rich are dangerously over investigated, overmedicated and oversurgicalized while the middle class is pauperized when they fall ill. Even the poorest find that their expenditure on illness care is next only to dowry as the cause of indebtedness. The reason why a profession that has till recently been respected is now considered another health hazard needs to be examined in both the present as well as the historical context. This is essential if the distortions in both health and illness care have to be addressed in its proper perspective prior to instituting corrective action.

There is probably no better understanding of health as well as the care of illness than in our own systems of Ayurveda and Yoga. These systems deal with the mental and spiritual components even more than mere treatment of bodily diseases. Their emphasis has been on the individual and his personal life style which in turn is related to his family, community and the environment of which he is a part; a holistic approach. Over the millennia this has become a part of the life style of the people of this subcontinent as reflected in the elegance and simplicity of life, of their diet, habits and behaviour, also in the acceptance of unavoidable hardship and suffering, the normal process of ageing and the inevitability of death. If human happiness and life with dignity is the ultimate goal then the achievements of the majority of the inhabitants of this sub-continent is certainly high as observed by

the smile on the face even of those who live under severe economic deprivation and the equipoise of the women under even greater stress. This is in marked contrast to that of the harassed workaholics of the affluent countries, and now increasingly of our own elite who try to imitate this 'modern' acquisitive and competitive life style not realizing that the endless pursuit of comfort for gratifying the senses is addictive like opium and equally destructive of the mind and the cause of unhappiness.

The colonization of this subcontinent by the British has had a significant influence in arriving at the present health scenario. They imposed their own system of medicine as being 'scientific' and hence considered superior. They also denigrated our age old health culture and life style ~s also our highly evolved systems of health and medical care like Ayurveda and yoga which deal as much with the mind as with the physical body. Ruthless economic exploitation led to repeated famines in what was a rich and fertile land and resulted in severe malnutrition and widespread prevalence of the diseases of poverty. Those like me who have personal experience of the effects of three centuries of plunder prior to Independence have vivid memories of the bare foot, ill clad walking skeletons who paid the annual toll of life from small pox, plague, malaria and cholera, leave aside tuberculosis and a host of other endemic diseases. These diseases were controlled with the then available knowledge and technology within the British cantonments but not without. The life span of our people at Independence was 27 years, equivalent to that of the U.K. three centuries earlier. Our Sanskrit medical texts were burnt on the orders of Macaulay in order to replace our indigenous systems of health with their own formalized medical one based on hospitals, doctors and nurses. This system was further promoted by the opening of Western style medical schools and colleges for training" of the children of our elite in what was considered the superior system of the rulers. Even in this the emphasis was on the curative aspects of their medicine while the most relevant and useful aspects for Public Health based on the knowledge of microbes and their vectors was relegated to the low profile Preventive & Social Medicine Departments of these colleges. This despite the fact that they were most effectively used by the colonizers in their cantonments. Medicine was hence used as a subtle means for inculcating Western dominance into the local elite who willingly accepted the 'superiority of this science and culture', especially of its lucrative curative component.

This is also the reason why the cadre of the three year trained Licentiate doctor who lived and served in rural areas under the Raj was disbanded rather than

promoted following Independence. Medicine was based on the predominantly Western curative model and became the monopoly of the urbanized MBBS doctor and now increasingly of specialists who have failed to serve the basic health needs of the rural population at the Primary Health Centre even after being trained at public expense. Unfortunately this persists even half a century after the departure of the colonial rulers since a new hierarchy has replaced the old.

This is despite the remarkable experience of the first two decades following Independence when malaria which affected 100 million people and resulted in two million deaths each year was reduced to 65,000 cases with no deaths by 1965. This was the most dramatic example of public health intervention ever achieved in the world by involving the people in what are problems affecting their own health and welfare. An achievement by a newly liberated and enthused people supported by a few equally enthused public health professionals trained under the British and with an equally supportive political leadership. And yet this unique and unsurpassed achievement in health achieved by involving the people in their own welfare has failed to receive its due recognition and acknowledgement even to this day. Small pox was also eradicated in the same period and cholera and plague brought under control, these being the four major health problems of the pre-Independence era.

And yet the credit for the remarkable improvement in the health status of our people following Independence as shown in Table 1 is sought to be taken by the predominantly curative urban oriented allopathic medical profession. They have failed to acknowledge the peoples' own contribution as also the pre-dominant role played by the social and economic development of our country following Independence, even though it has been more limited as compared to that of China. This also demonstrates how a marked improvement in the health

Table 1
Health Care in India

| Indicators | 1951 | 1971 | 1991 | 199 |
|--|------|------|------|-----|
| Population (Millions) | 361 | 548 | 846 | 98 |
| Infant Mortality Rate (per 1,000 live births) | 146 | 129 | 80 | 67 |
| Life expectancy birth (yrs.) | 32 | 46 | 59 | 62 |
| Birth rate (per 1,000 population) | 41 | 37 | 30 | 26 |
| Death rate (per 1,000 population) | 19 | 15 | 10 | 9 |

Source: Chiefly

status of a country can be achieved by even a modest improvement in the socio-economic conditions achieved by merely freeing the people from external and internal exploitation. This has also been the experience of USSR, Cuba, Chile under Alande, as also of Nicaragua and Vietnam even while fighting a war. Medicine can play a limited but useful supportive role especially its preventive aspect.

In fact reopening our doors to the West in the 90s after the demise of the USSR has demonstrated a slow down and even set back in the health status of our people with recurrence and/or resurgence of many diseases like tuberculosis, malaria, dengue, water borne diseases, typhoid, kala azar, filariasis and encephalitis. This is in keeping with the increase in poverty and its diseases during this decade which saw a 20% reduction in the Public Sector financing for health as a result of the Structural Adjustment Policy imposed by the IMF on a sector which provides public health services to all our people as well as curative services to those who cannot afford to pay for private medical care. This decade has also seen promotion

and proliferation of the curative profit oriented Private health sector, many of whom are trained at public expense. Both the Public as well as the Private Sectors are now virtually dictated by Western agencies and institutions like the World Bank, USAID, WHO and UNICEF who promote programmes which have little relevance to our peoples' overall integrated health problems and needs, while increasing the country's foreign indebtedness in the process; a vicious cycle which perpetuates poverty and disease. The predominant socio-economic aspect of health has been converted into a top-down techno- managerial exercise. Their demand for handing over public institutions like hospitals together with their assets to a profit hungry private sector which now accounts for 3/4 of our inflated health expenditure has little regard to the universal experience that this sector has converted health into a lucrative medical business in collaboration with the pharmaceutical and instrumentation industry. Signing of the WTO will now deprive the poor even of basic health services as well as of cheap essential life saving drugs dominated by a purely profit oriented and foreign dominated pharmaceutical industry. Tehelka explains why such perverse antipeople treaties are signed by our so called elected leaders behind closed doors without consulting those who have to eventually bear the unfortunate consequences.

A detailed study of three districts by FRCH, one in Maharashtra and two in MP, revealed that even the poorest are now being forced into diverting 20% of their meager household expenditure from food to the wrong type of doctors, medicines and injections. Since illness cannot be predicted it leaves little choice but to seek the 'best' that is available for the care of a beloved one when the relatives are distraught and have little time or choice in selecting the most rational and cost effective form of care and its provider. This approach has unfortunately been promoted by the government itself by creating an exaggerated impression of inefficiency of their own Public Sector after starving it of funds and by political interference, while simultaneously boosting the image of the Private Sector which claims it alone can provide the latest and best medical care, regardless of the cost or relevance. What is the answer when the public is made to believe that health is a subject so complex that it can only be 'delivered' to the people either by the Public, the Private or the Voluntary sectors, and that There Is No Alternative (TINA).

And yet health is too important a subject to be left entirely in the hands of the medical profession and the powers that exist in the public or private sectors who are in league with the drug and medical instrument industry and now with the

private medical insurance sector. All these can only serve as a supportive service but not to appropriate peoples health for their own benefit. There is' ample evidence that effective and appropriate health care can be provided to all citizens at remarkably low cost without any need for private insurance. This was demonstrated by China, Sri Lanka, Costa Rica and our own state of Kerala as reported in the Rockefeller report 'Good Health Care at low cost' in 1985. This is feasible only if the people themselves are involved and in control of a health system devised to suit their own requirements without unnecessary frills and the excessive profit motive.

For this we have to return to the basics as stated in the beginning of this lecture. We have to strengthen and not weaken the age old health culture and practices that have sustained the bodily and mental health of our people over the ages when used together with the most appropriate and relevant aspects of all available systems of health and medical care. Equally important is the use of traditional folk practices and-home remedies which are not only often effective but can also serve as useful placebo whose contribution to medical care is not adequately appreciated because of its low profile and insignificant cost. More often than not the patient seeks medical advice to ascertain whether the condition is serious and requires urgent care, or can become serious if neglected, or whether it is self healing with simple medication like a common cold. These practices together with the use of four indigenous remedies and systems can also serve an important role in reviving faith in our traditions, culture and practises which are being eroded in a heavily medicalized and marketized model of so called health care. The general practitioner has now replaced the family doctor with his ubiquitous injection, intravenous saline and pills for real or imagined ills. There is also increasing nexus between him, the pharmaceutical industry, the diagnostic clinics and the specialists. Enlightening information and knowledge is important in avoiding such unnecessarily expensive and even dangerous practices of allopathic medicine to which even practitioners of the other systems are also falling prey. It is important that despite having a useful and definite role for well defined conditions in both health as well as medical care, this allopathic system of medicine carries with it the unfortunate Western trait of converting all goods and services into a commodity for sale in the market place at the maximal price that it can command. As a result it fails to promote, leave aside utilize, its best and most cost-effective aspects for preventive, promotive as well as curative functions. Yet this should not prevent us from using it selectively in keeping with our needs and our culture. Fortunately it is the ICSSRIICMR report *Health*

for All: An alternative strategy of 1981 that provides us a remarkably appropriate model for tackling most of our problems of health as well as medical care by utilizing appropriate knowledge and technology from all available sources. The 73rd and 74th Constitutional Amendments of 1993 with health as one of the 29 subjects under Section 11 of the Act, now provides the necessary opportunity to our people for implementing the recommendation of this report.

This report starts by defining the existing problems and their underlying causes. It differentiates health from its failure which concerns medical care. Even in the latter it further differentiates the important mental, as well as preventive and promotive from the curative aspects of medicine which unfortunately dominates the present health scene. More important this report defines the social, cultural, economic and political influences that play the dominant role in the non-medical as also in the medical components of health care, and in implementing the alternative people oriented and people operated strategy. It defines the role of the people themselves, of their own health functionaries, of the paramedicals and of the medical and nursing profession at all levels, from the village to a specialist hospital services operating as an integrated Community Health Care System within the Block/Taluka level. It also described the social, cultural and the technical strengths and limitations of each of these functionaries as also the knowledge, skills and facilities required at each level. Only this can help to ensure an acceptable as well as sustainable service in keeping with the available human and economic resources and local health requirements while permitting latitude for variation in different regions, states and even at the Panchayat and Nagar Palika levels ..

The imparting of such information, knowledge and skills to the people and their local health functionaries is most effectively achieved often under a tree or in a temple of the village rather than by didactic lectures in a distant formal 'training centre'. This ensures intimate interaction in our guru-shishya tradition between those who will subsequently work as a team under conditions which are relevant to local needs local culture as well as the local social and economic reality. This is chiefly in the form of discussion encouraging the use of existing local knowledge of health and medical practices as also of all relevant and cost effective available methods and systems for prevention as well as treatment in a highly cost effective manner. All this requires intimate relationship, local knowledge, empathy and constant availability which are skills inherent in such a functionary

which no public or private or even the voluntary sector can ever achieve or provide.

It was also interesting for us to note that the readily available medical knowledge for many of the activities even of allopathic medicine is so 'high' that it can be communicated in simple language seated on a floor to even semi-literate and even illiterate women since the knowledge, skills and facilities required for most of such work which can be carried out in the village setting is remarkably simple yet effective safe and cheap. This needs overcoming our normal confusion between education and intelligence. Above all this village worker is always available and far more accountable to her community than any external functionary as she is part of her own community who she considers as an extended family of 50 households.

There is no reason why- semiliterate local women with inherent social skills and provided with simple but effective medical knowledge and skills cannot undertake these functions if adequately trained and supported by another two year trained similar local functionary at the 2500 or 5000 population levels. This can ensure a graded referral service from the village to the Peoples Health Complex at the 100,000 population (taluka/block) level in which is also incorporated a Health Training Centre as well as a Peoples Hospital providing broad based medical and surgical specialist services. Except for the doctors and nurses all staff of this Community Health Care System are locally recruited and trained to serve specific functions at each level including certain clinical pathology, immunization and other paramedical and peri-medical functions.

It can be appreciated that there may be resistance in the early stages from the established professional and bureaucratic sectors. Yet in actual practise such a decentralized system which can be semiformalized at the village and Block level can help to screen medical problems and support the professional services by relieving the doctors and nurses of unnecessary overload and thus enabling them to devote more of their time to problems requiring their higher professional knowledge, skills and facilities in which they are interested and for which they are trained. This would also help to reestablish the important doctor-patient relationship which has been eroded. As a specialist I am convinced and have demonstrated that the majority of specialist care can also be undertaken effectively at remarkably low cost at such a Peoples Hospital with basic surgical and medical facilities. This could also apply to the large urban public and private hospitals If the profit and false kudos motives are eliminated.

It is evident that the majority of the functionaries at almost all levels must be women since 70% of the population consist of women and children and 90% of all health and medical problem concern this group. It is also this gender which has the natural caring and nurturing instincts so essential for health care. The majority of these functions require no hard manual labour. In the USSR 80% of all health workers from the feldsher to the super specialist were female.

The Village Health Functionary should be a married woman of her own community willing to provide part time services to her extended family of about 200 people more as a social than as a health function. Our experience shows that such a woman once activated will also undertake several other functions such as veterinary medicine, khelwadis for children, provide public information, run local micro saving groups and other activities for her community.

There is no better method for womens empowerment while simultaneously providing gainful employment to millions of her gender within their own community and home whether it be a village or an urban mohalla. The danger of such medical malpractice which is often raised can be readily overcome by informing the community of her training and its limitations, for she is trained only in those medicines that are prescribed by WHO for use by non professionals.

A major problem of the existing Public sector is its over professionalized, over centralized and consequently over bureaucratized and impersonalized nature. Together with transfers and target pressures to cater to 5000 population, the far more highly paid ANM cannot establish the social rapport and commitment to the community she is paid to serve. Her functions are not decided by the requirements of her local community but in distant Delhi or State capitals and dictated to her as 'targets' to be achieved in a formal top-down bureaucratic manner. The agenda of her work is dictated by international organizations, agencies and donors rather than by the actual local needs of the people which vary not only from region to region but from village to village and even within each village.

The 73rd and 74th Constitutional Amendments of 1993 have ushered the necessary preconditions for a decentralized form of governance of the people by the people, namely Panchayati Raj, which provides them the constitutional authority for self-governance right up to the village Gram Sabha and the urban Ward. Health is one of the 29 subjects within their domain. The Bhoré

Committee's and the Alma Ata Declaration of WHO for achieving Health for All will continue to remain an idle cliché until the people are provided the necessary authority and support to implement what is rightfully within their domain. It remained for the ICSSRIIGMR report *Health for All: An alternative strategy* of 1981 to define such an alternate strategy which can now operate under Panchayati Raj. Universal adult franchise provided by the vision of the founder father of our nation now enables the people to rather than the Representative form of democracy. Though it would be a slower process than was in China by the use of force, it will be in keeping with our unique culture of non-violence which still prevails in Bharat at the grass roots. This will also help to correct the dehumanizing urban industrial form of a jobless type of growth and enable a more stable social and economic change in keeping with our values and tradition which extend beyond crass materialism that is being imposed on us under the guise of export oriented development which benefits a few at the cost of the majority.

This new form of health and illness care may also provide a unique contribution to the world at large which is drifting to mindless materialism based on ruthless exploitation even in a field like health.

The following are a few examples how even some of the major diseases and health problems can be tackled in such a comprehensive Community Health Care system.

Acute pneumonia is the commonest cause of mortality in children. Drs. Abhay and Rani Bang have demonstrated tribal mothers have been able to markedly reduce these deaths by simple monitoring of respiratory signs and giving a simple sulphonamide antibiotic.

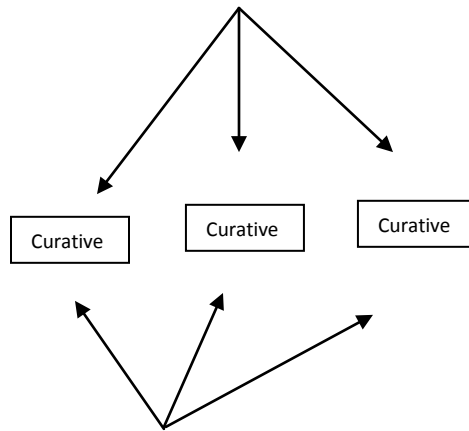
Eighty percent of illness in rural areas are due to water borne diseases. Once the microbes in their water are demonstrated to them under their school microscope and taught how to clean and chlorinate the sources, the Village Health Functionary (VHF) can mobilize the community for this purpose. She can also ensure rehydration therapy in the early stages and refer a few advanced cases to her own Sahayogini at the group Gram Panchayat level for intravenous or intraperitoneal rehydration.

Since the Village Functionary knows the index case of Tuberculosis in her community she can readily suspect new cases in the locality utilizing the five cardinal symptoms taught to her. This enables early detection and reference to the Peoples Hospital for confirmation of diagnosis. Continuity of treatment as well as prevention of spread can be ensured by her by personal communication, example and support. This can be far superior to a separate vertical programme of DOTS operated by a highly paid external functionary; all at virtually no cost. Any complication of the diseases or the drugs can be referred to the next level/s of reference which are available to her.

In an intensely personalized problem like Family Planning there can be no better functionary than the local village health functionary who is a friend, who will guide her in contraceptive practices suitable for her specific needs. She will also take care of the mother as well as of her children without 'target' pressures. This can help her achieve results better than a far more highly paid Auxiliary Nurse Midwife serving 5000 population.

Chart 1
Organizational Structure
Community Health Care System (CHCS)

| Population (approx.) | Functionary | Responsibility to | Approximate Proportion Of the total Services covered |
|----------------------|------------------------------|----------------------|--|
| 200 | Community Health Functionary | Neighbourhood Group | 70% |
| 1,000 | Village Health Functionary | Gram Panchayat | |
| 5,000 | Sahyogini (Referral Center) | Group Gram Panchayat | 85% |



1,00,000 People's Health Panchayat Samiti 95%
 Complex

The organizational chart (Chart 1) demonstrates that about 70% of all health and medical care can be undertaken by such part time Village Health Functionaries covering about 200 population living in 50 households in her neighborhood when supported by a similar two year trained village women at the 2500 to 5000 population level who has greater knowledge, clinical skills and facilities and supported with simple telemedicine and Communications at her command It is estimated that about 85% of all problems can be tackled at this first referral level while 95% can be undertaken within the Block/Taluka with its Peoples Health and Hospital complex. All staff from the village to the Peoples Health Complex must be under the Panchayat administrative and financial control at each level if this system has to function efficiently. This would leave only a few problems for superspecialist care at the District or city Hospital. This would enable reallocation of resources for optimal use.

This also ensures continuous education of all functionaries within this system and maintenance of a traditional guru- shishya relationship between all functionaries. A Reverse Referral system ensures weekly contact for health and medical purposes between all functionaries, the community and patients. It also provides continuous education monitoring and support of all activities.

That such a system can be technically, socially and . economically self sustaining has been demonstrated in our project at Parinche near Pune. Of the 17 originally trained by us, six trained another fifty who have inturn trained 1400 in other district of Maharashtra besides those who have come to learn from other states. With the self confidence this has engendered they have proved to be highly effective communicators on health and many other subjects concerning rural development. They have also proved to be highly effective IEC functionaries since they also provide services.

The existing top-down system based on a series of vertical programes with little inter sectoral and intrasectoral collaboration and cooperation in actual practise, is alien to the integrated social, technical and economic requirements of the rural community with its holistic concept of life and health.

Table 2A to Table 2C demonstrate the cost effective nature of such a Community Health Care system. The existing public sector allocation of Rs.67 per capita per annum can certainly be increased to fulfil the governments promises to the poor. Such a cost effective system at the doorstep of the people will enable them to contribute at least half of the unnecessary expenditure they presently expend on the private health sector. An effective Health for All service can hence be provided at about Rs. 200 per capita per annum to cover 95% of all health problems at the Block/Taluka level and enable effective Health Care for all citizens at less than

TABLE 2A

Health expenditure in India : 1999-2000

| | |
|---|-----------|
| GDP at current market prices (Rs. Crore) | 19,40,000 |
| Estimated population (crore) | 99.1 |
| GDP per capita (rs.) | 19,600 |
| Break up of expenditure on health and Medical care including family welfare | |

| | Total (Rs. Crore) | Per capita (Rs.) | %GDP |
|---------|----------------------|---------------------|------|
| Public | 15,520 | 157 | 0.8 |
| Private | 51,631 | 521 | 2.7 |
| Total | 67,151 | 678 | 3.5 |

Break up of public expenditure (Rs. Crore) : 15,520
States 11,485
Centre 4,035

Table 2B
Health Expenditure:
Rural Urban and by purpose : 1991
(Percent)

| | Rural | Urban | Total |
|----------------------|-------|-------|-------|
| Share of population | 70 | 30 | 100 |
| Share of expenditure | 33 | 67 | 100 |
| By purpose | | | |
| Curative | 37.8 | 71.3 | 60.3 |
| Preventive | 32.5 | 23.3 | 26.3 |
| Others | 29.7 | 5.4 | 13.4 |
| Total | 100.0 | 100.0 | 100.0 |

Source : Reddy and Selvaraju (1994)

Half the present expenditure of Rs. 678 per capita (1999-2000). All this in a more personalized, humane and cost effective manner. Even allowing for another Rs. 100

per capital for tertiary care as well as administrative costs such a Community Health Care System which can also be adopted for the Nagar Palikas will be able to provide Health

TABLE 2C
'Indicative' cost structure of the Community Health Care System for 100,000 population.

| Levels | No. of Units | Staff Nos. | Salaries p.a. | Drugs & supplies* p.a. (Rs. In Lakh) | Total cost p.a. (Rs.) | Per Capita cost p.a. (Rs.) |
|----------------------------|--------------|------------|---------------|--------------------------------------|-----------------------|----------------------------|
| Village level | 100 | 500 | 28.80 | 19.20 | 48.00 | 48.00 |
| 5,000 Population level | 20 | 80 | 19.00 | 12.67 | 31.67 | 31.67 |
| People's Hospital | 1 | 44 | 29.00 | 19.33 | 48.33 | 48.33 |
| People's Health Complex | 1 | 18 | 15.00 | 22.50 | 37.50 | 37.50 |
| Sub-total | | 642 | 91.80 | 73.70 | 165.50 | 165.50 |
| Transport & Communications | | | | | 20.00 | 20.00 |
| Total | | | | | 185.50 | 185.50 |
| Approximate annual cost | | | | | | 185.00 |

For All citizens at less than half the expenditure of Rs. 675 per capita (1999-2000) releasing about Rs. 30,000 crores (1999-2000) for expenditure on auxiliary health giving activities like public information, education, empowerment of adolescent girls and women and improvement of the Pubic Distribution System.

The following are some of the reasons for the cost-effectiveness of the

community health Care system (CHCS).

- How visibility to all.
- Low salaries for almost all staff at local scales except for the few doctors and nurses recruited at the prevailing market rate.
- Use of locally available buildings and building material and facilities eg. Dharmashalala/s
- Use of limited number of drugs under generic names through bulk purchase.
- Use of all systems including folk medicine.
- Improved prevention, early detection and early treatment.
- Absence of the profit motive.

In the process it has the potential to provide useful employment to millions of women within their own community. It is also an effective means for womens empowerment by demystifying the most mystified of all subjects. This I believe is even more important than the health and medical care that it provides. A well informed self confident woman who can sustain herself economically by undertaking a variety of tasks within her community and society can also provide the basis for successful implementation of Panchayat Raj.

I hope that this lecture will hence be in keeping with the vision of Durgabai Deskmukh who as a social reformer had infinite trust as well as confidence in the women of this land. I believe that with their quiet strength they will help to enable us to achieve her goal. This will also enable the country to usher the only true form of democracy namely Panchayati Raj.