

PRESIDENTIAL ADDRESS

POVERTY, HEALTH AND QUALITY OF LIFE¹

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At the very outset I take the opportunity of expressing my deep gratitude to the distinguished members of our Society for the honour they have conferred on me by electing me as the President for the year 1985. I am thankful to the members for reposing confidence in me to take the onerous responsibilities of our worthy society. I am aware of my limitations, for which I do share your indulgence and request for constant support and guidance for taking our Society forward.

National Health Policy

The introduction to the Statement on National Health Policy (1982) states, "the Constitution of India envisages the establishment of a new social order based on equality, freedom, justice, and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health, and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, man and woman, specially ensuring that children are given opportunities and facilities to develop in a healthy manner".

India is committed to attaining the goal of "Health for All" by the year 2000 A.D. through the universal provision of comprehensive primary health care service. In this context, health has been defined as a

positive sense of physical, mental and social well being and not merely an absence of illness. To obtain the overall objective, that is, **a level of health which will permit the people to lead a "socially and economically productive life.**

A careful analysis of this objective will suggest that **health is closely interlinked with social and economic problems** and has intimate relations with other sectors of National Planning. But in real practice there is either little or often there is no purposeful communication between these sectors. Planning should therefore be a comprehensive one in which all allied disciplines should be taken into consideration.

The most significant problem hindering the progress of health in India today is poverty. In the past, eminent economists have made major attempts to understand and suggest methods to solve the problem of poverty. A few sociologists have also tried to put some knowledge to tackle it. However, health professionals by and large have kept themselves away from this problem. If at all they have studied it, they have done it in a detached way mainly assigning the role of poverty in the incidence and prevalence of various diseases. Similarly, Planning Commission has also inadvertently not taken health experts into confidence. The overall result is a unhappy one.

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Poverty and Health

Poverty and health are closely interlinked. Firstly, poverty is attributed as a significant cause for various morbidity and mortality in a population. But poor health as a cause of poverty, has not been given due attention by health professionals. If we have to attain the goal of "Health for All", we must grasp the intricacies of poverty and use "Health" as one of the major agents to remove it. Most of our leading economists have suggested that mass poverty in India is basically a rural problem (Tarlok Singh, 1969). According to Ojha, (1970), the poor constituted 51.8 % of the rural population in India. In 1961-67 the figures rose to 70 %. Bardhan's (1970) estimates of the rural poor were 38 % in 1960-61 and 53 % in 1967-68. According to many economists, poverty in the rural area has been constant over the years with 40 % of the population remaining below the poverty line. Many economists feel that poverty is implicit in the structure and economic basis of our rural society and according to them if we have to abolish poverty we must rebuild the social and economic foundations of rural population (Dandekar & Rath 1971, Minhas 1970, Dube 1974).

Urban Poor and Health

However, **poverty is not only limited to rural sector but is also ubiquitous in urban population.** When we try to analyse the urban poor, we find that the problem of slum and pavement dwellers is much more appalling. In their book **Urban Poor**, Andrea Menefee Singh & Alfred de Souza (1980) systematically analyse many studies conducted in many urban slums in India. According to one study done in 1975, an estimated 73.7 % of Delhi's population of over 4.5 millions lived in slum or near-slum conditions. In the city of Bombay which is a

city of trade, industry and commerce, at least one-third of the city's population is said to be living in "Chawls" and "Jhopad Patis". In the city of Calcutta it was reported that in 1974 approximately 35 % of Calcutta's population lived in recognised or unrecognised slums. In south, according to one of the estimates about 33.49 % of Madras city's population was living in slums. In their attempt to define the poor people living in slums and magnitude of poverty of some slum dwellers in different Indian cities, they bring out some of the inherent problems of urban poor at the macro level. From their analysis it is evident that the poverty is not only restricted to rural areas, but is also widespread in urban sector. This suggests that the phenomena of poverty is universal and is as complex as society itself. It connotes different standards of life and suggests different sets of causes to different groups in rural and urban communities.

To understand poverty we should understand its intricacies and all the factors which influence its causation and continuation of poverty.

Genesis of Poverty

Let us first examine the aspects of poverty with respect to human evolution. Man, as a primate biological organism, has not changed much since antiquity. The recent knowledge in the field of ethnology and other behavioural sciences have added a new dimension in understanding this problem. For 99 % of the time that man has existed, human societies flourished in small populations in hamlets. The most primitive people lived on hunting and later they settled in agricultural settlements. This phenomenon was more known after the accidental discover of corn and fire. These two significant, but accidental discoveries in human

history have changed the course of human evolution. This resulted into the structural changes in the primitive societies. The pace was further accelerated with the growth of simple technology in the form of tools and sharp instruments like spears, arrows and swords which gave additional strength to the powerful man of the community and slowly the practice of exploiting the weak and the poor came into being in the world. This phenomenon becomes more evident when we examine the behaviour of primates and the recent knowledge in the field of ethnology. More recently, the structural and functional change in human societies has become vast and rapid with the growth of industrial environment. It has resulted into a gradual but visible disintegration of small human populations which were since ages living in hamlets and villages. This rapid growth of our urban planet has taken barely few hundred years in the west and less than that in some developing countries. This change on our planet earth, is not just simple but has resulted into a conflict between requirement of technology and its anticipated economic consequences. This change is of our own making and is influencing our life, thinking and emotions in one way or the other and has further created conflicts between the predisposition of our biology that is very old and the rapid socio-technological change leading to the basic problem of survival of the poor who are not able to cope up physically, economically and emotionally to this sudden change. Because of the rapid socio-technological change poverty has become more manifest and a major subject of interest in many fields.

In 1846, when Proudhon published his two volume treatise on economic inequality under the title, "The philosophy of Poverty", it so enraged Karl Marx that he

wrote a small rejoinder to it and derisively called it "The Poverty of Philosophy".

Max Weber (1958), in his book, "The Protestant Ethic and the spirit of capitalism", explained economic changes essentially from a psychological point of view, treating them as dependent upon attitudes. Attitudinal and motivational changes were thought to cause economic development. The prospects of economic development in non-western countries are now believed to commensurate with some socio-cultural and psychological predispositions, broadly called "modernity". Modernity is a psychological concept and is an aggregate of certain personality cum attitudinal traits which facilitate individual growth and development with social responsibility and make the individual an effective agent of socio-economic and political development (A. K. Singh, 1984). Capital investment, it is argued, may be necessary but it is certainly not sufficient, perhaps not even the crucial guarantee for economic development. Thus, the motto: "Invest in a man, not just in a plan" is gaining ground.

Poverty is one of such problems which is the result of the failure of a society to adopt to its social institutions and culture to the growing and changing needs. It is not the monopoly of a specific social tribe or a nation. It is all pervasive. Even the most advanced nations have not been able to control poverty. Even the biggest cities and most planned cities of the world have their share of slums.

Definition of Poverty

Poverty is a relative term. The poverty line in any given society is determined by the customs and modes of living. The poverty line in India is not at the same point as in the U.S.A. or in Europe. As defined by Gillin & Gillin (1942) - "Poverty is that condition in

which a person, either because of inadequate income or unwise expenditures, does not maintain a scale of living high enough to provide for his physical and mental efficiency and to enable him and his natural dependents to function usefully according to the standards of the society of which he is a member.

As such, poverty is relative to the scale of living in a given group or a country. For example, a whole group may be better off relatively than a whole group in another culture and yet feel poor in comparison with others in the same culture group. Status is determined by relative position. Further, the scale of living may be different in different social groups in the same culture, and each group tends to formulate a standard of living that is considered necessary for a decent living. The actual scale of living compared with the standard of living measures the extent of poverty.

Absolute poverty means that he is not able to maintain a minimum decent standard of living to maintain himself and his family, which could be expressed in terms of either a minimum monthly per capita expenditure of Rs. 15-30 (at 1960-61 prices), or a minimum caloric requirement of 2250 units a day. Ojha (1970), Bardhan (1970), and Dandekar & Rath (1971), find poverty either on increase or constant at a higher level.

In the past poverty has been traditionally studied by the economists, who have been concerned with the material aspects of poverty. Poverty is a phenomenon of multiple determinants, not merely an economic and technological problem. Socio-cultural, educational, motivational, health and institutional factors play equally important roles. This has been the main theme of the Nobel prize winning book "Asian Drama: An enquiry into the poverty of

nations" by Gunar-Myrdal (1968). Poverty is such a pressing and multifaceted problem that it has to be analysed and attacked from all angles, if one is serious about its eradication.

Factors Predisposing Poverty

These factors broadly include the individual abilities, economic factors, social organisation, physical environment, urbanisation and industrialisation, disasters like flood, famine and war.

Only few reasearch workers have explored the relationship between poverty, health and behaviour (A. K. Singh 1983, 1984, Sinha '80). It has been reported that the poor not only suffer from scarce physical resources at his disposal but is also unable to acquire such mental skills which will enable him to partake in the consumption of such paltry resources which are at his disposal. Besides the poor also develops basic defects in perception, cognition, and skills or recognition of nuances in the complex social field. Because of the complexity of the problem and also a general apathy, health and mental health consequences of poverty have not been systematically studied. Some of the behavioural scientists have concentrated more on what may be termed as "psychological concomitants" which may have detrimental influence on the general functioning of the individual rendering him less capable of overcoming poverty by personal efforts which unfortunately he is unable to do because he does not have adequate physical, emotional, social and economic support at his disposal.

It has also been shown by various investigators (A.K. Singh 1980, 1983, 1984 ; Gordon 1971 ; Sinha '80) that poverty retards the personality growth and the individual lacks in intellectual, emotional and cognitive abilities. Poverty also reflects itself in other inhibiting factors

such as illiteracy, poor health indicators like high infant and maternal mortality, high physical and mental morbidity, high broken homes with higher crime, alcohol and drug abuse. Similarly, the widespread violent, aggressive behaviour among poor is part of their adaptive behaviour which promotes the survival of the individual as well as the group.

More recently, some researchers in U.S.A. (Gordon 1971) have conducted studies on the impact of disadvantages suffered by minority groups, especially the low class blacks. Similar studies on scheduled castes and tribes and their differences with high class Hindus are being conducted in India (A. K. Singh, 1980, 1983, 1984). Other related variables are under-privileged or socially disadvantaged groups in rural sectors. In any case, poverty as reported in psychological literature is not a unitary concept but a multiplex of heterogeneous indices. Due to these factors, poverty has been conceptualised in terms of "Ecology of the poor" because it is the inputs and stimulation emanating from the environment of the poor, whether physical or social that underline the differences observed in the behaviour and general development of the individual.

Some researchers have been exploring the relationship between poverty and such individual matters as psychopathology (Cleveland & Longakar, 1957; Stone et al 1965) and pattern of family life (H. Gans, 1954) and life style (Deutsch, 1964).

Literature also shows concern with the individual who lives with those conditions which Leighton has called "Poverty in the context of social disorganization" (Hughes et al, 1970; Leighton, 1959, 1964).

Poor Health & Poverty

My attempt would not be to discuss all

these factors in detail but I will try to focus the attention on few of these factors which have direct relationship with health and poverty. Very little data exists regarding the relationship of health and poverty as most of the health professionals working with the poor people do not collect comprehensive medical data which could place such data in proper perspective. Therefore, any conclusion drawn must be considered as tentative and suggestive until more objective data are available. Some of the available data indicate that diseases like tuberculosis, jaundice, diarrhoea, helminthiasis and malaria are more common in rural and urban poor. In one of the surveys in urban poor in Delhi (TCPO 1975), it was found that 56 % of the household in one slum had suffered from malaria within the previous one year and 27 % from diarrhoea, besides other respiratory diseases, jaundice, etc. Similarly in another pilot survey of an improved Basti in Calcutta it was found that 76.4 % of the slum households reported a respiratory disease in the past one year, 65 % gastro-intestinal disorders, 62.4 % diseases of mouth, teeth and gum, 35 % fever, 25 % viral infections, 23 % accidents and injuries, 17.1 % tuberculosis, 15.6 % diseases of heart and circulatory system, 15 % skin diseases, 14 % ENT diseases besides many other nutritional problems.

The majority of illnesses were chronic in nature and average duration of illness per sick person in Basti area was quite high. It was found that mental disorders among slum population was more than double the residential areas (18.2 % compared to 7.7 %), and women and illiterate were more prone to mental illness than others (Singh and de Souza 1980). These data clearly suggest that poor people are more exposed to greatest physical and mental stresses. In the same interesting study it was also high-

lighted that most of the urban poor in Calcutta do not go to quacks or to traditional healers when they are ill. Allopathic practitioners in all studies were most likely to be consulted by the poor when they were ill. It was observed that they do not generally seek treatment for an illness until home remedies have failed or until disease has reached an acute stage. Interestingly in the same study it was also noted that poor take medicine only till the symptoms go away and as a result they have more chance of developing chronic diseases. One interesting finding of the study was that poor spend a higher percentage of their income on health than those living in residential areas (4.3 % of income compared to 3.2 % of residential areas). In another similar study in Bombay, Desai & Pillai (1970, 1972) pointed out that doctors who treated the urban poor do not have a clear understanding and right perception of the environmental conditions in which they live and such doctors often tend to blame their health problem only to the "poor food" they eat. There are no reliable statistics regarding general mortality rate among urban and rural poor, but the available data suggest that they have a higher death rate and more infant and child mortality rate. In one of the studies in Delhi it was found that child mortality rate was 220 (204 for males, 237 for females). These figures were higher than rural infant mortality rate which in 1971 were 132 for males and 148 for females (Bose 1974). Another important finding of Delhi study was that the child mortality rate not only varied considerably in the urban poor but among poor also it varied greatly with castes and regional groups, thus suggesting that poverty and prejudice are the two sides of the coin of social disadvantage, one economic and the other social (A. K. Singh, 1980). Similarly, it was also noted that

ignorance of family planning methods and dietary practices were also widespread among both urban and rural poor.

All these studies clearly highlight that poverty not only influences the health but also reflects in low level of their education and in poor possession of skills so necessary for good adaptability to their environment. There is a complex relationship between the income of the individual and his health and education but economy alone is not the factor which can influence the poverty behaviour. There is a vicious circle between the poverty behaviour and health, but this interrelationship is rarely understood by the health professionals with whom the poor come into contact. There is an indisputable evidence that the poor as a group suffer from higher morbidity and mortality than rich. They also have greater nutritional deficiencies, lower literacy levels and unequal access to health and wealth and other supportive social services. There is also higher level of fertility rate combined with lower age at marriage, among poor. Poor also have no resource reserves to tide over the family in a crisis.

Poverty highlights a pervasive set of life conditions which include, besides material deprivations, unstable social conditions, lack of pattern of leadership and followership, a weak fragmented network of communication, lack of a sense of community and a super-abundance of hostility both directed at those outside the culture and expressed among the members of the culture themselves.

Based on various studies, certain aspects of personality functioning among the disintegrated poor emerge with sufficient clarity and frequency. These may be classified as -

- 1) personality traits.
- 2) level of skills
- 3) the state of psychological well being.

1. Traits – A lack of future orientation, an inability to defer gratification, apathy, and suspiciousness (Leighton, 1964). These characteristics serve to perpetuate the culture of poverty.
2. Skills – Individuals living in conditions of social disintegration fail to develop these abilities and skills, the use of which will enable him to function within the larger culture's technology and thus he is unable to partake in the consumption of goods and services available to those who are better endowed. Accumulating evidence suggests that the poor suffer deficits in basic aspects of personality functioning such as perception, cognition and the use of language (Reissman et al, 1964).

The poor also lack the ability of recognition of nuances in behaviour, the ability to assess another's motivations accurately and the discrimination of affects both in one's self and in other people (Wittenberg, 1964).

3. Psychological well being – The disintegrated poor suffers from a deficit in their skills and studies indicate that their difficulties are further complicated by a plethora of symptoms like tuberculosis, leprosy and other psycho-physiological reactions, psychoneurosis, alcoholism and other conditions generally labelled sociopathic (Srole, 1961, Stone et al 1965).

In spite of rapid socio-technological change in most countries of third world, poverty is increasing at an alarming rate with its accompanying misery, poor mental health and social unrest (Tsung Yilin,

1983). It has been shown that technological change is invariably accompanied by psychological and social unrest and with the rise in physical and mental morbidity and mortality. This becomes more immense and significant in rural areas, and especially those rural areas with strong tribal influence. The socio-technological changes due to industrialisation is invariably accompanied by migration of people from villages to cities resulting in the growth of slums. Some epidemiological surveys confirm high prevalence of mental and physical morbidity and other socially deranged behaviours when such changes take place.

Strategy for Poverty Reduction

As early as 1928, Jawaharlal Nehru voiced his concern about poverty in the following words: "Poverty is not a good thing, it is not to be exalted or praised, but is an evil thing which must be fought and stamped out. The poor require no petty services from us or charity. They want to cease to be poor. That can only come by your changing the system which produces poverty and misery". In spite of more than 50 years since these historical remarks were made, the problem still remains beyond our grasp and strategy adopted by our planners to tackle it remains elusive. One thing is clear that poverty is a multi-factorial phenomenon and as such it has to be tackled at different levels. Besides economic and social approaches the effective intervention should also include the role of health professionals and behavioural scientists. Any remedial measure must be directed at all these categories simultaneously. In this context it may be reiterated that change and shifts in one dimension need not produce changes in other dimensions. For example, economic gain does not necessarily ensure automatic attainment of other health goals. In Kerala State which has the

lowest infant mortality rate and a longer life expectancy than the rest of India, in spite of widespread unemployment, there is a low level of economic development and a lower per capita income than the national average (Panikar, 1984). These health determining factors are in turn governed by levels of education, life style, low caste and income. Any strategy for poverty reduction and to improve the quality of life must take them into account. Improving economic conditions without improving education and health will be ineffective. This point has been lucidly brought out by Moynihan in the book edited by him, "On Understanding poverty". Moynihan (1969), stresses that the vicious cycle in which poverty breeds poverty occurs through time. There is no beginning to the cycles and no end. Therefore, there is no one right place to break it in. It has to include all the components. Moynihan has further suggested three principal stages to attack poverty at one or more of the following levels:

1. Prevent the problems from developing.
2. Rehabilitation of persons who have been hurt.
3. Ameliorate the difficulties of persons for whom preventions or rehabilitation are not possible.

Gandhi's Dream

"India lives in its villages – the main objective is obvious and it is to gain independence; not for the literate and the rich in India, but for the dumb millions. I shall work for an India in which the poorest shall feel that it is their country in whose making there shall be no high class and no low class people". These sentiments were voiced at the time of our Independence by the Father of the Nation, Mahatma Gandhi (1947).

Consequently, during the last six successive 5 year plans, our planners have focussed their attention on rural development to remove poverty, which has been amply reflected in the contents of all the plans. A number of programmes like community development schemes, small farmers development agencies and the command area development authorities have been developing in the country for improving the condition of the rural poor. However, all these programmes were found to be inadequate in view of the vast dimensions of our rural poverty. In consideration of these factors an integrated rural development programme was launched in 1978-79; its aim being to reduce unemployment in rural areas and provide inputs and assets to the rural poor. There is also a National Institute of Rural Development and a Council for Advancement of Rural Technology. The significant role of technology and strategies for its wide adaptation for rural development needs no further emphasis. The Government has regarded science and technology as the basis of economic progress. In spite of this, **unlike the technologies in other fields, the health technology has not reached the rural poor.** We have at our disposal, simple health technology which can be extended with good results on a large scale. To cite few examples in the field, one can mention such simple technology like oral rehydration, immunisation programmes, providing clean drinking water and treating some common mental illnesses with simple inexpensive medicines can bring immediate relief to the rural masses.

The problem of mental health is as vast in the rural population as in the urban rich. At the same time our rural people are not getting adequate health care including mental health which makes their problem

more serious. What we need is a bold initiative and a proper direction not only to contain and cure diseases but also to promote health. This is only possible by reinforcing and integrating mental health with general health care, and also by interacting with other sectors in the community. It is only in this way that we can reach the benefit of what we have, to the largest number of our people in the shortest possible time. This cannot be realised by medical people alone ; new economic factors, poverty, ignorance and illiteracy stand in the way of attainment of health. These must be tackled by specialists in many fields. **Healthy man can produce more and remove poverty.**

It has been noted that in the past, economic planners often tended to neglect both the human and health factors involved, while the health planners and professionals tended to overlook the need for health planning within a broad socio-economic framework. If health planners ask for greater claims to a sufficient share of plan resources in such currently fashionable terms as input-output or productivity which can be seen in sectors like power, agriculture and industry, they have to support their claim with adequate scientific data. This also raises the question ; which is more valuable, the human being or economic efficiency? Obviously our planners would set different values on such objectives. **The aim of all economic development is for the betterment of the people** who are the ultimate beneficiaries, but which people are more benefitted can be better understood in a committed democracy like India where there is a greater emphasis on equalising access to 'Health for all' approach both in rural and urban sectors, which till recently was available only to a few. However, it has in practice meant a silent exploitation by the elite group. As a

consequence there is a greater emphasis on traditional system of medicine on the one hand and on the establishment of highly developed institutions of training and service with the prestige, power & privileges on the other hand. This kind of a conflict have emphasis on simple technology and at the same time investing more in high technology, politically satisfies both the elite and the unserved and underprivileged population. In the process the maximum beneficiaries are the elites. The other point which needs emphasis is that health planning must shift from a generally static approach of containing, curing and preventing diseases to a more dynamic approach of promoting the continued improvement of physical and mental health and the general social and economic welfare of the people. Thirdly, dynamic health planning for the poor must be based on collaboration among various agencies available in the community as parts of the general development of the nation. We health workers cannot work isolation (Sharma, 1968, 1976).

Fourthly, if we have to improve the quality of health of the poor, there is a need for new departures in our professional training to change the attitude of health professionals. Without the interest and active participation of health professionals, no health planning can be successful. This requires to re-identify and clarify the role of health professionals in a balanced social and economic development. There is no doubt health professionals are eminently suited as powerful agents to bring desirable change in the community. For this, there is a need for change in our attitudes and our values regarding development. At government level there is a need to provide necessary opportunity to facilitate and encourage dialogue between health and other socio-economic agencies. The health planners must

know the details of planning in other sectors like agriculture, irrigation and animal husbandry. In this context one could also think for a wider interdisciplinary training for health professionals and other socio-economic experts. This kind of a collaboration would help in increasing the communication and better implementation of national programmes. We must remember that the economic progress in general and health improvement are not automatic consequences of economic development; therefore there is a need for greater attention to the social and health settings in which economic intervention occurs and its ultimate social consequences follow. Any uncoordinated economic planning may not only fail to reach its true objective but actually endanger health and quality of life. Some of the health problems of poor are unique. Some of these problems are known and well defined and others are ill-defined, hence there is a need for a constant re-analysis of health problems of urban and rural poor which needs greater flexibility in planning and operability.

Available Health Services among Poor

In most of the States the health service in the rural and the urban poor sectors are scarce, ill equipped and poorly staffed. Mental Health services among poor are conspicuous by their absence. This accentuates the health problems of the poor. It is a challenge to the health professionals and we, Mental Health professionals, can take lessons from some of the recent valuable experiments and knowledge developed in the field of oral rehydration therapy, immunisation programme, mid-day meals for poor children which have brought visible changes to improve physical health. Any intervention programme in mental health

should be simple and easy to implement and should also take into account the affordability and acceptability when propagating it. So far the medical profession was guided by the individual needs of the patient and as such the emphasis was more on the patient in a hospital setting and not the health professional reaching the community. Secondly there is a need for more innovative and integrated approach to the intervention programme where the main focus should be the community rather than the individual. To illustrate some of the dimensions of the community life, interventions related to health and Mental Health could be as follows: (WHO, SEARO, 1983 and Sharma, 1984)–

1. Community action/apathy.
2. Community decision making.
3. Coping mechanism (e.g. preparedness in a crisis).
4. Community maladjustment.
5. Perceived community integration.

1. Community action/apathy

It has the following indicators:

- (a) *Mutual help practices* – Mutual health groups develop from a need to share common problems and way to cope with them. The group members control resources and policy, seeking help from each other. These are of an informal nature and may concern neighbour's help at the time of patients coming to the hospital during child delivery and child care etc. This group also includes community actions like alcoholic anonymous, spastic society etc. In Goa we tried involvement of parents in a mental retardation school where parents were required to give at least one day in a month to the school for accepting a child into the school, with very good results.

- (b) *Mutual help/interest associations* – These associations have a formal structure such as religious societies, credit or marketing cooperatives, health committees, cultural groups and associations for helping patients to become aware of their rights. Such associations exist in many places. Friends of NIMHANS in Bangalore is an association of this type, where many good activities are done with community support.
- (c) *Externally sponsored institutions* – It may include institutions like “Sulabh Sauchalaya” (clean toilet facilities) which started in Bihar and has been praised for its innovative idea and has resulted into the improvement of sanitary conditions among poor and is a fine example of providing health without wealth, a philosophy of health approach (Ramalingaswamy, 1984).
- (d) Community links with services for intervention, e.g. police, health and other social services like Samaritans in Calcutta and Bombay, who help suicide prone and other such cases in need of some help.

2. Community decision-making

Community may have different types of mechanisms of decision making, like Village Council or ‘Panchayat’. Community decision-making by ‘Panchayat’ can improve the health of its members and may be effectively used by health professionals. For example, a Village Council of a tribal village in Ranchi has decided to forbid alcohol consumption by its residents with consequent marked reduction in alcoholism and is a fine example of effective intervention by village councils.

3. Coping mechanisms of (or in) the Community

These indicators should describe the

ability of the community to cope with situations that are either stressful to the community as a whole, (e.g. flood, drought etc.) or to individual members or individual families (e.g. loss of spouse, separation, destitution of families, family breakdown, abandonment of children). Many villages in Bihar are regular victims of flood havoc where mortality and morbidity rates are very high. However, some villages have developed effective coping methods to face this kind of disasters in the form of “alarms and ready boats”, so that people could be taken to safe places quickly in face of danger.

4. Community Maladjustment

a) At the level of Community

It may be characterised by the lack of community care, e.g. in regard to underprivileged groups or the disabled and aged, abandoned children, victims of violence and the poor. There is a need for providing such intervention services by the community. Examples of such interventions are many; in Goa there is an institution known as ‘Providoria’, a voluntary organisation to help orphan children, old people etc. with community support.

b) At the level of individual

It includes rates of social problems/criminal statistics, e.g. crime, violence including battered women, child abuse, suicide rates delinquency and drug or alcohol abuse. There are hardly any institutions to help delinquent children. One such institution is located at Kishore Nagar in Ranchi where with minimum inputs and with one dedication person, more than 500 children are looked after and is a good and effective model of intervention programme among delinquent children and there is an urgent need to spread the message of such institutions to other parts of India.

5. Perceived community integration

It should include community's sense of belonging and its perception on self. There is a need that scientific temper should reach the community. Recently, one of the reports emanating from Bhopal tragedy has suggested that the poor were the worst sufferers through the chemical agent was the same for both rich and poor. It was reported that high mortality among poor was also linked with the inadequate knowledge to the people regarding simple preventive measures. Hence, there is a need to develop a scientific temper among poor so that the basic scientific knowledge and skills reach them.

An experiment on perceived community integration was conducted in Baroda during the sixties by "The Baroda Community Development Service" (Lowell Wright, 1968). In this pilot programme one of the hypothesis was that professionals should go into a neighbourhood without pre-determined goals and help that neighbourhood, identify its felt needs, then develop a programme of action based on the interest and desires of the local residents. **The message in this pilot project was that we should try to plan with the people and not for them.**

Another idea which was tested in the Baroda project was to see whether people in low economic groups can develop leadership of their own which promises to be self-sustaining and capable of meeting problems in a democratic self-energizing way, not wholly dependent on a paternalistic or authoritarian approach. Another interesting highlight of the project was that the workers in this project were provided with no tools, no enticement, no matching funds or financial aid, only themselves with the specific training in human relationship

based on a fundamental principle of respect for every human being irrespective of caste, education, income or occupation. These workers were also alert to common health problems like T.B., malnutrition, infectious diseases, physical and mental handicaps and also serve as a useful referral link with existing medical institutions, but the most important role was in the prevention of mental illness.

There is evidence to suggest that a large number of mental illness arise from prolonged frustration in attempting to cope with the ordinary problems of life: a mental patient whose disorder is a so called psychosocial problem or functional disorder, not arising from an identifiable physical cause such as brain damage is likely to have had great difficulty in coping with his problems of relationship to other people - to his mother or father; to his teacher; to his employer; to his peer group. The illness lies partly in himself, in his own capacity to develop a healthy ego, and partly in an environment which can be described as hostile just as virulent and infectious, in one sense, as if he regularly drank polluted water or suffered constant exposure to cholera or T.B.

Mental Health can give Quality to life

So, if a health worker could create an environment in which small democratic groups can cooperate in solving everyday problems of child care, sanitation, health protection through immunization, income supplementation, enhancing the status of women, enlarging educational and cultural opportunities, and strengthening relationships-he is in a very real sense a mental health worker. I hope we mental health professional can effectively use the "vaccine of hope" to prevent the infection of frustration from spreading to epidemic

proportions among millions of our people, and also by providing necessary care and support to the developmental activities and thus raise the quality of life. Friends, as Mental Health Professionals, it is our responsibility to act individually and collectively to implement National Mental Health Programme (1982) and make it as an integral part of all the programmes in the field of Health, Education and Social Welfare and to use health as an effective agent to contain poverty and give quality to life.

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