COM H 1.1

Set file

Draft Summary for the Newsletter.

Participatory Reflection on Community Health at the Tibetan settlements in Karnataka particularly Mundgod.

The Deputy Secretary (Health) of the Central Tibetan Secretariat at Dharmasala, Medical Officers of Settlements in Karnataka and the CHC team had an initial brainstorming session in November 1988 on this issue. This was followed by a visit to the Mundgod Settlement by two members of the CHC team to obtain first hand impressions of the prevailing status. This culminated in a report containing observations and possible options for action in the follow up meeting with all the above participants.

The community participates in decision making and pays a substantial amount towards the maintenance of the hospital. However, there were some features unique to their health efforts:

a. The 'refugee' status of the population and the attendant cultural and socio-economic problems ranging from dilemmas of preservation of their culture in 'alien' surroundings to integration into the present ethos and search for income generation towards survival(eg large mobile population of sweater sellers).

TIBETAN SETTLEMENT FILE

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COMMUNITY HEALTH CELL

Ref. No. CHC 54:89

Date: 2 MAR 1989

Lok Swasthya Pa

b. A higher susceptibility to some diseases like tuberculosis in spite of adequate efforts towards controlling the problem.

c. The essentially Buddhist approach towards all forms of life and acceptance of diseases as part of their 'Karma'.

d. A large percentage of population of the 'Lamas' accepting a monastic life devoted to spiritual endeavour while remaining uninvolved with the problems of the lay populace of the settlements.

e. The problems of integration of the Tibetan Traditional medical system with the Allopathic model prevalent in the settlements.

The options that evolved towards a more community health oriented approach were:

a. Stregthening of community based activity and creative re-orientation of the available resources to focus on a larger range of primary health care problems.

b. Various avenues of better management of the tuberculosis control programme.

c. Fostering of good cultural and traditional practices in maternal and child health care.

d. Appropriate medical/administrative action to tackle the health problems of the large mobile sweater sellers population.

e. Education for health at school, pre-school and non-formal levels.

f. A holistic planning for health by integrating Tibetan Medicine and avoiding duplication of health efforts.

g. Promoting involvement of youth/youth clubs, women/women's clubs and the Lamas especially in preventive and promotive activities of primary health care.

h. Continuing education, regular staff development programmes, up-dating of the hospital library were considered essential for continued orientation towards community health.

i. Areas of study were identified with a view to improving the health of the community.

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COM H 5.2

WORKSHOP ON COMMUNICATION
held at Central Tibetan Secretariat, Dharamsala
24th - 28th October 1988.
Participants: 23 Community Health Workers from settlements around India.
Workshop Co-ordinator: Mr Padam Khanna, Voluntary Health Association of India.

Group discussion between Health Worker participants on the first day of the workshop produced the following account of the shared and individual problems experienced by the Health Workers in their everyday work.

We share this here, to lend encouragement and support to all the Communi Health Workers, in recognition of the problems you encounter and the hard work and dedicated service you give to the community, in order to strive for better health for all Tibetans.

1. Lack of education among community can cause misunderstandings, even after repeated explanations.
2. Language problems - faced in Bir settlement, with camp of new arrivals from Tibet , who may be speaking Amdo or Kham dialect or with Chinese words inbetween.
3. Blind faith, where people consult lama before CHW and may go to private Indian medical officer if lama recommends it. This can damage credibility of CHW. Most problems here are with people who have recently arrived from Tibet. Can only try to prove by example.
4. Antenatal care: some CHWs lack training in this regard and therefore have difficulties. Dehra Dun area has this problem. Some settlements find that local Indian doctors/hospitals will not take an interest in filling out the CHW's record card on each mother. Some misunderstandings among the mothers, e.g. that they think the Tetanus Toxoid vaccination is given to make their labour easier. The ideal situation is to teach mothers ante- and post-natal care in antenatal period, and repeat post-natal care after baby is born, e.g. while mother still in hospital or during home visits.
5. Breast feeding. Talks on this work best when mothers need the information, i.e. are pregnant. If not concerning them at present time, will not listen so carefully.

6. Family planning: "If we have fewer children, who will there be to fight the Chinese?"
7. Under-Five Clinics: parents cannot always attend regularly because of work commitments. For this reason, not every child gets all its vaccination doses when it should. One CHW finds that offering to give the family something for an underweight child will make parents attend clinic regularly, e.g. food supplement, iron tablets.
8. Practical problems: Bir experiences a lack of water supply, which prevents proper teaching on sanitation, personal hygiene, etc.
9. Health education: CHWs feel need for new materials, as people get bored with the same old flash cards, slides, etc. and thus do not pay proper attention.
10. Health talks must vary with seasons and seasonal diseases to make them relevant, e.g. seasonal variation in malaria, diarrhoea, conjunctivitis. If not relevant at the time, people do not want to listen.
11. People continue to take more interest in health cures than in the prevention of disease.
12. Defaulters or lack of compliance: if people go to local doctor, he may charge a lot of money for drugs, e.g. for TB. People cannot afford, so they stop taking them. Then they may go to CHW, but doubt that the CHW can cure them when the local doctor has been unable to cure them - as they see it.
13. One CHW has to pretend the same drug (aspirin) is different, by giving patients different brand names and shapes of the same drug. Otherwise, the people think he only ever gives out the one drug and they do not trust it to work for everything.
14. If there is a good relation between the CHW and the local District Hospital, the CHW gets a better supply of vaccines, etc. If relations are not so good, there can be little co-operation and the CHW's work is harder.
15. Some CHWs experience great difficulty in covering the distances involved between camps, carrying all their equipment with them. One example is Simla area - 1,200 people in two different places far apart from each other and only one CHW. She finds people are unwilling to attend clinics because the distance is too far.
16. Nutrition: people are poor so CHWs can only recommend nutritious foods if they are very cheap. Tibetan diet is not balanced, depending on availability and general reluctance to eat vegetables (although younger

people are usually better in this regard).

17. More acute TB problem among new arrivals from Tibet, e.g. in Sera monastery at present, there are 4 TB patients from Mysore and 24 TB patients who are new arrivals from Tibet.
18. People may continue to go to local doctor, even if not very happy with his work, out of habit or because they know him or because he cured them once in the past. Difficult to change people's attitudes, and especially to make them accept advice and suggestions of CHW.
19. One CHW finds it is sometimes necessary to create a rumour, e.g. about cholera in a nearby place, in order to get people to listen carefully to health talk on diarrhoea.
20. If people are reluctant to attend health talks, one idea is to advertise a movie video evening show, and when the people are there, to show a health film first.
21. CHWs generally feel people's attitude to health care is improving, e.g. more people using Oral Rehydration Solution now, and more interest taken in health.
22. There is a need to improve the family economy, as a broader aspect of health. Mrs. Takla also mentioned at this point that the issues of sanitation, water supply, family economy are known to the Administration, and that the newly formed Planning Council is looking into these matters now, with the aim of in time solving these problems

COMH 1.3

TENTATIVE PROGRAMME FOR THE PROPOSE SEMINAR-CUM-WORKSHOP ON INTEGRATED DEVELOPMENT PLAN FOR TIBETAN SETTLEMENT, MUNDGOD, NOVEMBER 13TH. & 14TH., 1988

November 13, 1988: (Sunday)	8.30 a.m.	Chairman: Dr. A.K. Basu Welcome & Introduction By South Zone Development Coordinator, Bangalore
	8.40 a.m.	Key note speech on the relevance of the Master Plan Mrs. Greta Jensen, Hon. Secretary, ApTT Trust - UK
	9.10 a.m.	Human Resource Development - traditional and modern technology - Initiator : Dr. A.K. Basu, Executive Director, Society for Rural Industrilization, Ranchi
	10.00 a.m.	Topic open for discussion
	10.30 a.m.	TEA BREAK
	10.45 a.m.	Re-organisation of village layout plan - Initiator : Prof. R.L. Chakravorty, Regional Planner, Adviser to the Government of West Bengal
	11.15 a.m.	Topic open for discussion

(Contd.2.)

11.35 a.m.	Eco-Development - Initiator: Prof. Madhav Gadgil, Head, Centre for Ecological Sciences, Indian Institute of Sciences, Bangalore
12.40 p.m.	LUNCH
1.30 p.m.	Land and Water Management - Initiator : Prof. I. Dey, Secretary, Society for Rural Industrialisation, Ranchi
2.15 p.m.	Subject open for discussion
3.00 p.m.	Harnessing of Underground Water, Maintenance of borewells, etc. by Mr. B.S. Bahadur, Geologist, Department of Mines and Geology, Government of Karnataka
3.30 p.m.	Topic open for discussion
4.00 p.m.	Agricultural Diversification with emphasis on organic farming-Initiator : Dr. J.V. Goud, Vice-Chancellor, University of Agricultural Science, Dharwar
4.30 p.m.	TEA BREAK

(Contd.3.)

	4.45 p.m.	DISCUSSION
	5.15 p.m.	Horticultural Development with particular emphasis on growing Mango, Coconut, chikku, cashew nut, etc. Initiator: Dr. Jaya Prakesh, District Horticultural Officer, Sirsi
	5.45 p.m.	DISCUSSION
	7.00 p.m.	FILM ON TIBET
	8.30 p.m.	DINNER
November 14, 1988: (Monday)	8.00 a.m.	Chairman: Prof. Madhav Gadgil Industrial Development - Initiators - Dr. A.K. Basu, SRI, Prof. J.S. Arwikar, Principal, Engineering College, Bijaipur and Dr. Balgopal T.S. Prabhu, Regional Engineering College, Kerala
	9.00 a.m.	Topic open for discussion
	9.45 a.m.	Energy - Initiator : Mr. Tency Baetens, Executive Director, Centre for Scientific Research, Pondicherry

(Contd.4.)

10.15 a.m.	TEA BREAK
10.30 a.m.	DISCUSSION
11.00 a.m.	Animal Husbandry Development with special emphasis on cattle breed improvement technics and care-Initiator: Mr. Dorjee Namgyal, Secretary, Kollegal Dairy Farm
12.00 p.m.	DISCUSSION
12.30 p.m.	LUNCH
1.30 p.m.	Consolidation of Seminar discussions, Planning for Phasing, Action Plan, Budget, sources
5.30 p.m.	THANK YOU TEA

South Zone Development Coordinator
Bangalore

COM H 1.4

DOEGULING TIBETAN SETTLEMENT MUNDGOD

On behalf of the Tibetan Settlers, I would like to take this opportunity to welcome the experts in this Workshop Cum Seminar being organised by the ~~Council for Home affairs~~ CTRC, Dharamsala, ~~sponsored by~~ and Appropriate Technology for Tibetans in this settlement.

This Settlement was established in the year 1966, where a total land of 3922.28 acres of Vergin forest land were distributed to 4302 settlers, at the rate of 32 guntas to the adults, 20 guntas to the minor below 12 years and 2 acres to three monks.

Bachangi Dam was constructed in 1979 with a view to faciliate irrigation to some part of the Tibetan Agricultural land, as such about 1000 acres of Tibetan land were developed for irrigation and the same were distributed at a reduced rate of 24 guntas to the adults and 12 guntas to the minor. The entire land to the extend of 3055.28 acres of cultivable land were reallocated to 3093 lay adults, 1097 minors and 600 monks of this settlement later. We have 9 villages, two Lama Camps and a home for old and Infirm people. Presently, we have a total population of nearly 9000. We have two Hospitals, one Allophathic and another Tibetan Medical Centre to meet the Health needs of the people. We have a Central School for Tibetans and it has two Branches. These schools are under the Management of Central Tibetan School Administration, New Delhi.

Co-operative Society:

This settlement has registered a Co-op.Society in 1967. All the Settlers are the members of the Society. It has a managing Committee being elected in the general body meeting. The Representative of Council for Home Affairs, Dharamsala is the Chairman of the Society. The Management of the Society meets as and when felt to discuss the major issues and it would be executed by the Co-op.Secretary. The main activities of the Society is to supply fertiliser, seeds and agricultural implements and other farm requisites in adequate quantity. It faciliates to own or hire godowns to store their products and arrange for its marketing and to provide other developmental activities to improve the economic condition of the farmers. This Society has the following units:-

1. Handicraft Centre

Contd...2

2. Workshop and Tractor Section
3. Consumer Shops and Fair Price shop
4. Flour Mills
5. Dairy and Demonstration Farm
6. Truck and photo Studio.

1.Handicraft Centre:

This Centre besides keeping the traditional skill alive. It also gives a gainful employment to the members. It gives trainings to the interested people of this Settlement. It is one of the highest paid centres in the South Zone. The Centre's finished products are being marketed through the Tibetan Charitable Trust Handicraft Exports division, New Delhi.

2. Workshop and Tractor Section:

It gives facility of tractorization to the farmers. It also carries out the complete overhauling and repairing work of the tractors. Minor motor parts are also manufactured. Major ploughing work of the fields are carried through this section.

3. Consumer Shops and Fair Price shop:

Through this Section, we make available all domestic needs of our Settlers at a most reasonable rate.

4. Flour Mills:

Through this Section, the society helps the members in grinding the flour and it has a rice shelling unit to help the Settlers.

5. Dairy and Demonstration farm:

Through this Demonstration unit, the techenical feasibility and economic viability of the a new agriculture are tested before it is adopted by the farmers. Series of demonstration had been carried out by cultivating paddy, maize, vegitables etc. but due to lime and heavy soil, it does not come out satisfactorily. A Dairy farm was introduced to motivate the farmers to replace their local cattle with an improved variety.

As a whole the Tibetan Co-operative Society makes all the efforts to provide more employment at a better wage/salary to our

Contd...3....

employees, for instance this society provides highest wages to our weavers in our handicraft centre compared to other centres in south, but it is still low compared to the income they get from the sweater business. Hence our people prefer to go for sweater business. To curve this drastic population drift to sweater business, this society needs more working capital on soft loan basis inorder to provide more facility to the members.

To conclude, I am extremly happy that this workshop cum Seminar is being conducted here to discuss on the Draft master Plan and to give solutions to the various problems that the Settlement is facing. I firmly request the experts and specilists to come out with concrete viable action plan for a substainable and integrated development of this Settlement.

MR. GYALTSEN CHOEDEN,
Representaive of Council
for Home Affairs,
Dharamsala, H.P.

COM H 1.5

EVALUATION REPORT ON TUBERCULOSIS CONTROL PROJECT OF DOEGULING TIBETAN SETTLEMENT HOSPITAL, MUNDGOD

INTRODUCTION:

Doeguling Tibetan Settlement is the biggest Tibetan Refugee Settlement in India, situated in Mundgod Taluk of North Kanara District of Karnataka, India. Before the resettlement of the Tibetans, the entire area was a thick forest which now has been converted into 4000 acres of farming land.

The Tibetans in this settlement live in 11 camps/villages and of which two are Lama Camps/villages. The first Tibetans to arrive in this settlement was in 1966. The main occupation of the settlers are farming, carpet weaving and a few of them do sweater selling during the winter season.

According to the first demographic survey conducted by the hospital, it was reported that the population was approximately around 9000 (excluding the floating population), but of late Tibetan refugees from Bhutan have also been resettled in this settlement.

In the beginning, a small dispensary was started by the settlers, however the present hospital was constructed in the year 1969 and an extra floor was added in 1986. The hospital though under the direct supervision of the Tibetan Department of Health, at the local level it has an Executive Committee, headed by the settlement Representative as the Chairperson, the medical officer as the Executive Secretary and camp leaders of the settlements as its members.

The facilities available at the settlement hospital are;

1) Maternal and Child Health
2) Dental
3) Eye
4) Laboratory
5) X-ray Service
6) Community Health Programme
7) Immunization
8) TB Control Project
9) Minor Surgery
10) Health Education

It is a 40 bed hospital with both out patients and in patients facilities and has separate wards for males and females and also a separate ward for TB patients. Save for two Indians, the hospital personnel including the doctor are Tibetans.

TUBERCULOSIS CONTROL PROJECT:

The Department of Health of Central Tibetan Secretariat was set up in the fall of 1981 by His Holiness the Dalai Lama's Government-in-exile. The top priority of this new Department was to look after the health problems of the Tibetan refugees.

The Tibetans in India have not been immune to Tuberculosis and infact Tuberculosis is in epidemic proportion among the population. Studies have shown that incidence of Tuberculosis amongst the Tibetans is atleast 2½ times the Indian population. Therefore, seeing the urgency of the Tuberculosis problems amongst the Tibetans, one of the very first task of the Department of Health was to bring incidence of Tuberculosis under control.

The Department of Health was able to start three Tuberculosis Control Projects in south India in 1984 with financial assistance from "BREAD FOR WORLD", West Germany. The Tuberculosis Control Project at Doeguling Tibetan Settlement was started in July 16, 1984.

In the same year, eight community health workers were selected from the various camps and given training at the hospital. The syllabus was similar to that of Tibetan Delek Hospital, Dharamsala with more emphasis on Tuberculosis.

After the completion of the training, each of the community health workers were introduced to their respective camp leaders and their role in the health delivery ysystem at the settlement was explained. Community Health Centres were set-up in each camp after consulting with the camp/village leaders. Also a branch dispensary of the hospital was opened in village No. 6.

To creat an educational atmosphere among the little children and the parents, one creche have been set up in all the nine camps. The first creche was opened on July 6, 1976 on the occasion of H.H. The Dalai Lama's thirty-first birthday commemoration. The Community Health Workers are using these creches for the under five clinic and place for health education of the community, especially the mothers. The health infrastructure at the Doeguling Tibetan Settlement is very good and the creat goes to the Hospital's Executive Committee. The hospital's Executive Secretary, Dr. Passang Norbu has been serving the Doeguling Tibetan Settlement for the last nine years as its doctor.

EVALUATION:

The preliminary Evaluation of Doeguling Tibetan Hospital's Tuberculosis Control Project was carried out from November 7 to 19, 1986 on the request of Department of Health, by Mr. Dawa, Diploma in Community Health Management.

GOALS:

1) To study and understand the strengths and weakness of Doeguling Tibetan Hospital's Tuberculosis Control Project.
2) To determine the progress made and to measure the achievements so far attained.

AIM:

To assess the efficiency of the functioning of the programme's activities.

OBJECTIVES:

1) To determine the efficiency of Case-finding,
2) To determine the coverage of under five children with BCG immunization,
3) To determine case-holding rate for the registered TB patients at the hospital,
4) To assess the effectiveness of the Health Education on Tuberculosis amongst the school children and general public.

TOOLS AND INSTRUMENTS USED FOR THE EVALUATION:

1) Structured questionnaire
2) Interview
3) Observation
4) TB patient's record cards

LIST OF RECORDS USED FOR EVALUATION:

1) Community Health Workers' TB Treatment Register
2) Laboratory Technicians sputum test Register.

METHODOLOGY:

Sample size of the survey;
- 200 families of the general population
- 25 school children from the local school

SAMPLE DESIGN:

From each of the nine villages 20 families and 10 each from the two lama camps were randomly selected. 25 school children from the Central School for Tibetans, Mundgod above class VI. In total, 200 general public and 25 school children were selected randomly to assess the effectiveness of the health education.

TOOLS CONSTRUCTURED:

Keeping in mind the objectives of the evaluation, a set of questions were prepared. The questionnaire contained 15 short questions on demography, suspect TB case, BCG coverage of under five children, health education on TB and etc.

PRE-TESTING:

The pre-testing of the prepared questionnaire was not done this time, as the workability was already tested during the Delek Hospital's Tuberculosis Control Project's Evaluation in October 1986.

PROCEDURE OF DATA COLLECTION:

Rapport building was considered very important by the inverstigator to collect accurate information. The purpose of the survey was explained in detail to each of the respondences. The community health workers played an important role here. However, when the name of Department of Health was used, the respondence welcomed the survey.

All the questions were administered in Tibetans.

ANALYSIS OF THE DATA

DEMOGRAPHY:

The total population of the sample survey at Doeguling Tibetan Settlement, Mundgod was 1236. The age ratio of the area in the study showed a high proportion of under five children (13.27%) and unproductive age group between 0-15 years of the population was 36.72%. The other unproductive age group i.e. over 61 years is 8.1%. The remaining population consist of 55.13%, which contributes to the productive age group. (see fig. No.1)

The study also shows that the sex ratio among the sample group is 907 females per 1000 males. (see fig. No.2)

HEALTH EDUCATION:

For the success of any health programme, health education activities is an important factor. This is done by means of discussions, talks, flask-cards, slides, posters, films and etc. To educate the community, all the hospital staff should be able to give some sort of health talk. The hospital has trained eight community health workers in 1984.

Since November 1984, the hospital's community health workers have been regularlyn. howing flask-cards and slides to the community both on TB and general health.

According the findings of the evaluation, 53.5% of the respndent know the ways and means how Tuberculosis can be prevented and 46.5 % were not able to provide a satisfactory answer. (see fig, No. 3)

Out of 200 respondent from general public, 89% received some health education from the hospital personnel and 11% expressed that they did not. (See Fig. No. 4)

24% of the respondent give correct answer for the causes of TB and 31.3% considered that TB is caused due to worries and anxieties. A small number of respondent considered it be caused by unhygienic conditions and smoking, 18.8% and 3.5% respectively. 20.8%.said.that they did not have any idea who TB was caused and 3.5% said it was due to Karma. (See fig.No.5)

When asked about the spreadof TB, 82.5% give positive answer and 2.5 had did not know and 15% had no idea. See fig No. 6) Though a very good number of respondent had provided positive answer on the spread of TB, however, 68.5 % did not know the sign and symptons of TB in adults.(see fig. No.7) It is very encouraging to know thaf 91% of the respondent said TB is curable. (see fig.No. 8)

The preventive methods being taken by the respondent's family to control the spread of TB are by not allowing other members ofnthe family use the same cups,spoons and plates, which amounted to 31% and 18.8% expressed to cover the mouth when coughing. Only 30.4% were not able to provide postive answers. (see fig. No, 9)

BCG Immunization:

There are two methods commonly used for the estimation of BCG coverage. The sampling method and the systematic cumlative method. In this evaluation study, sampling method that was applied was represnetative random sample on a house to house basis for the presence of BCG scars.

The under five BCG coverage rate of Doeguling Tibetan Settlement rate was 96.3% and 3.7% did not have the scar.(see fig.No.10)

According to the place of immunization, 95.1% of the under five children immunised in the hospital and 4.9% otherside.(see fig. No. 11)

KNOWLEDGE OF SCHOOL CHILDREN ON TUBERCULOSIS

(Central School for Tibetans, Mundgod)

In planning for future school health programme on Tuberculosis, a base line evaluative study was carried out to find the school children's knowledge on TB. The same questions as that used for the general public as administered. It was very encouraging to find that the knowledge on TB among the school children was far better then the general public.

However, the school children's knowledge on causes of TB was not so encouraging, as only 24.32% said it was caused by germs and 5.14% considered it being caused by worries and anxieties. The children do not consider that TB is caused by Karma, as compared to 1.6% of the general public said it was due to one's karma. (see fig. No.14)

76% of the children in the sample group know the various methods on the prevention of tuberculosis and 84% of them have attended health education sessions being given by the community health workers at their respective villages. (see fig, No. 12 and 13)

In answer to the question wether TB was a communicable diseases, all the 25 students agreed. (see fig. No. 15) It was interesting to know that all the students replying that TB was curable if one takes full course of treatment. (see fig. No. 17)

With regard to giving signs and symptoms of TB in adults, 60% of the school children in the sample group was able to give correct answer. (see fig. No. 16)

The average age of the students who were randonly selected for this evaluation study was 16 years.

LIMITATION OF THE STUDY:

1) Since no proper records and statistics were being maintained at the hospital, the investigator's objective number one and three could not be achieved satisfactorly.

SHORT COMING OF THE TB PROGRAMME:

1) Lack of following cards and register;
   (a) Individual patients treatment card.
   (b) Daily Record Card.
   (c) Master TB Register.
   (d) In the sputum test register separate columns should be maintained.
2) The community health workers should be given more support and encouragement both by the camp leaders and the community.
3) Low opinion of the community on the community health workers.

SUCCESS OF THE PROGRAMME:

Since the TB Control Project was started in November 1984, they seem to be drop in the prevalence of the TB patients in the settlement. At the present, during the time of evaluation, there was only 61 TB patients, of which only three were sputum positive. The approximate prevalence rate of TB in Doeguling Tibetan settlement is around 6 per 1000 population.

RECOMMENDATION:

1) Statistical work need to up-grade as soon as possible.

2) Community health workers should be given contsant encouragement, as they are the back bone of the TB control project and also the general health care of the community.

3) As the findings show that the health education of the school children on TB was amusingly good. Therefore, if more health educations were given to them, they could become means of to carry these health education messages to their parents and near ones. There by bring an improvement of health and awareness in the community.

POPULATION DISTRIBUTION OF THE SAMPLE BY AGE BY SEX

Fig. No. 1.

Age group	Sex		Total	Percent
	Male	Female		
0-5	80	84	164	13.27
6-10	65	69	134	10.89
11-15	92	65	157	12.70
16-20	55	62	117	9.50
21-25	44	49	93	7.52
26-30	39	34	73	5.91
31-35	33	31	64	5.18
36-40	49	43	92	7.44
41-45	35	31	66	5.33
46-50	42	25	67	5.40
51-55	31	26	57	4.61
56-60	28	24	52	4.20
	55	45	100	8.10
Total	648	588	1236	100.00

SEX RATIO DISTRIBUTION

Fig. No. 2.

sex	Number	Percent	Sex ratio
Male Female	648 588	52.43 47.57	907.41 per 1000 male.
Total	1236	100.00	

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON PREVENTION OF TUBERCULOSIS

Fig. No. 3.

Answer	Number	Percent
Yes	158	96.30
No	6	3.70
Total	164	100.00

DISTRIBUTION OF RESPONDENTS HAVING RECEIVED HEALTH EDUCATION ON TUBERCULOSIS

Fig. No. 4.

Answer	Number	Percent
Yes	178	89
No	22	11
Total	200	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON CAUSES OF TUBERCULOSIS.

Fig. No. 5.

Answer		Percent
Germs	46	24.00
Smoking	7	3.50
Karma	3	1.60
Worries and anxieties	60	31.30
Unhygienic conditions	36	18.80
No Idea	40	20.80
Total	192	100,00

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON MODE OF SPREAD OF TUBERCULOSIS.

Fig. No. 6.

Answer	Number	Percent
Yes	165	82.50
No	5	2.50
No Idea	30	15.00
Total	200	100.00

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON SIGNS AND SYMPTOMS OF TUBERCULOSIS IN ADULTS.

Fig. No. 7.

Answer	Number	Percent
Yes	63	31.50
No	137	68.50
Total	200	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO the treatment of tuberculosis.

Fig. No. 8.

Answer	Number	Percent
Yes	182	91
No	-	-
No Idea	18	9
Total	200	100

DISTRIBUTION OF RESPONDENT ACCORDING TO PREVENTION OF SPREAD OF TUBERCULOSIS.
Fig. 9.

Methods	Score	Percent
By not allowing other member of the family from using the same cups, spoons and plates.	61	31.10
By covering the mouth when coughing	37	18.80
By not spitting everywhere	10	5.10
By living isolated	29	14.70
No Idea	60	30.40
Total	197	100.00

DISTRIBUTION OF UNDER FIVE CHILDREN'S IMMUNIZATION STATUS (BCG IMMUNIZATION VERBAL REPORT AND CHECKING FOR SCAR.
Fig. No. 10.

Answer	Number	Percent
Yes	158	96.30
No	6	3.70
Total	164	100.00

DISTRIBUTION OF UNDER CHILDREN ACCORDING TO PLACE OF IMMUNIZATION
Fig. No. 11.

Answer	Number	Percent
Yes	156	95.10
No	8	4.90
Total	164	100.00

S C H O O L C H I L D R E N' S F I G U R E S

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON PREVENTION OF TUBERCULOSIS.
Fig. No. 12.

Answer	Number	Percent
Yes	19	76
No	6	24
Total	25	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO HAVING ATTENDED ANY HEALTH EDUCATION ON TUBERCULOSIS.

Fig. No. 13.

Answer	Number	Percent
Yes	21	84
No	4	16
Total	25	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON CAUSES OF TUBERCULOSIS.

Fig. No. 14.

Answer	Number	Percent
Germs	9	24.32
Smoking	3	8.10
Worries & Anxieties	19	51.14
Unhygienic conditions	6	16.22
No Idea	-	-
Total	37	100.00

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON SPREAD OF TUBERCULOSIS.

Fig. No. 15.

Answer	Number	Percent
Yes	25	100
No	-	-
Total	25	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON SIGNS AND SYMPTOMS OF TUBERCULOSIS IN ADULTS.

Fig. No. 16.

Answer	Number	Percent
Yes	15	60
No	10	40
Total	25	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR KNOWLEDGE ON THE TREATMENT OF TUBERCULOSIS.

Fig.No. 17.

Answer	Number	Percent
Yes	25	100
No	-	-
Total	25	100

DISTRIBUTION OF RESPONDENTS ACCORDING TO PREVENTION OF SPREAD OF TUBERCULOSIS.

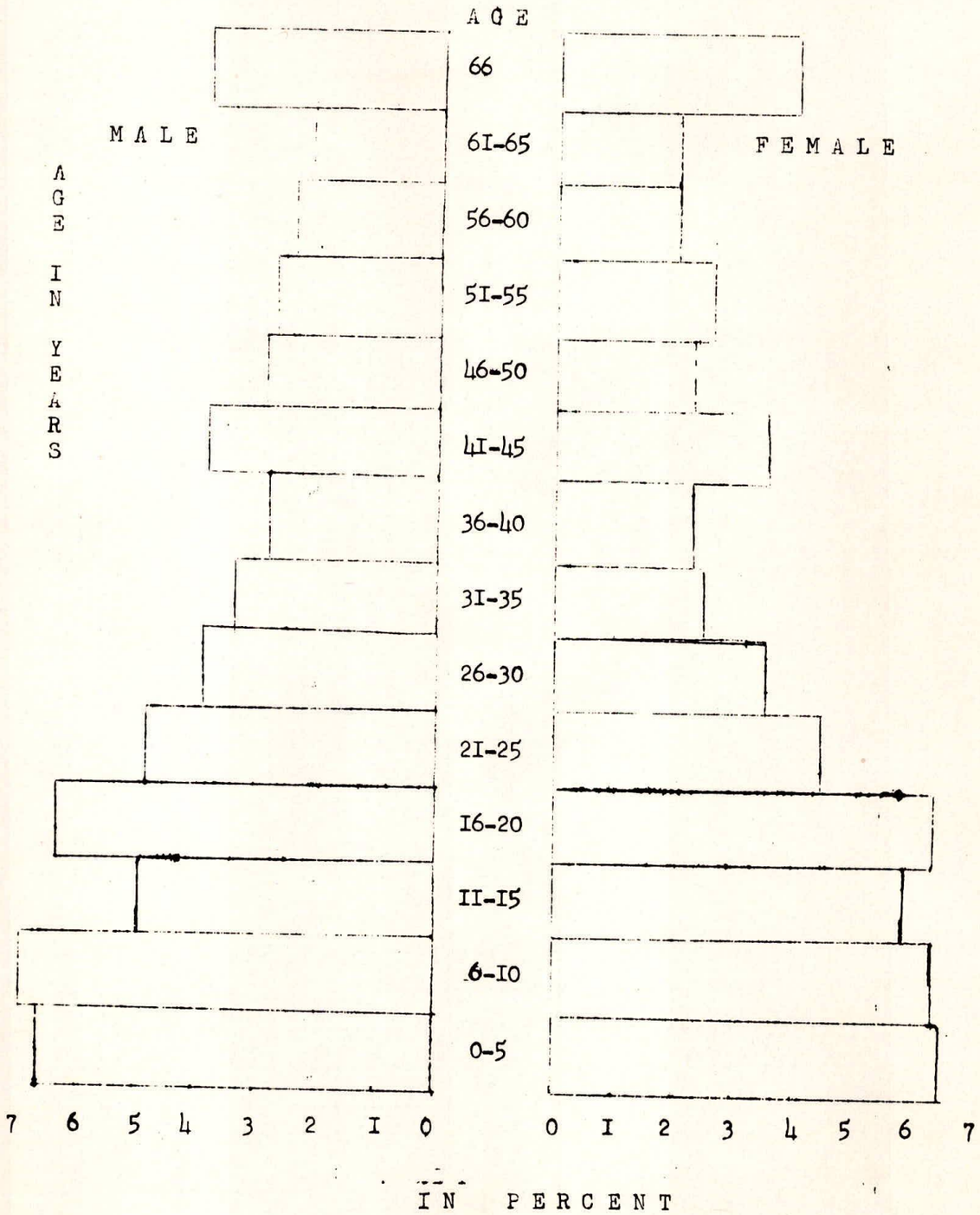
Fig. No. 18

Methods	Number	Percent
By not allowing other members of the family from using the same cups, spoons, plates and etc.	14	34.15
By covering the mouth when coughing	14	34.15
By not spitting everywhere	1	2.43
By living in isolation	9	21.95
No Idea	3	7.32
Total	41	100.00

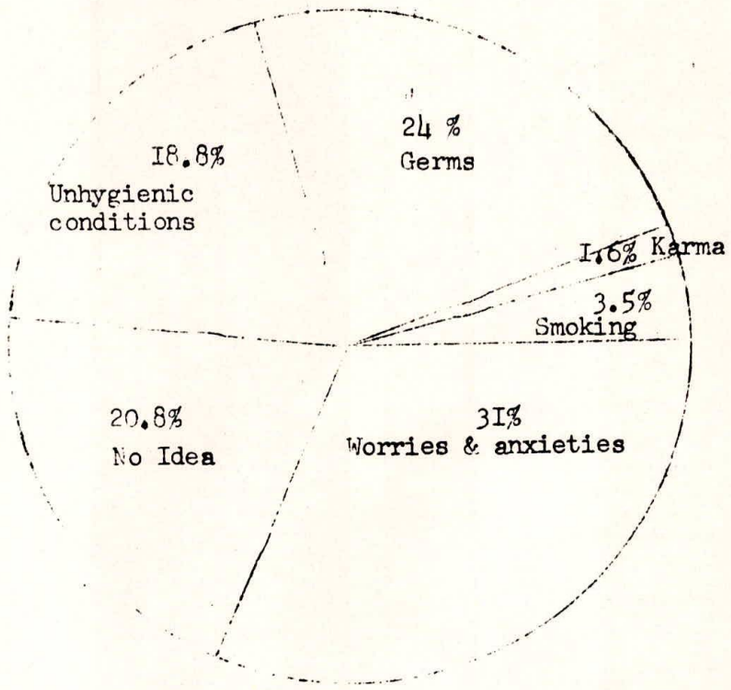
T I M E P L A N

Date	Event
Nov. 1986	
6th	Journey to Mundgod
7th	Discussion with Dr. Passang Norbu la.
8th	Discussion with CHW, visit to CHW's centre and going through hospital records, registers, etc.
9th-15th	Community Sample survey.
16th-	Analysing data
17th	Rest Day
18th	School sample(CST above class VI to X) Morning class for CHW, meeting with settlement Representative and in fater with Dr. Passang Norbu la.
19th	Class for CHW in the morning Left Mundgod in the afternoon.

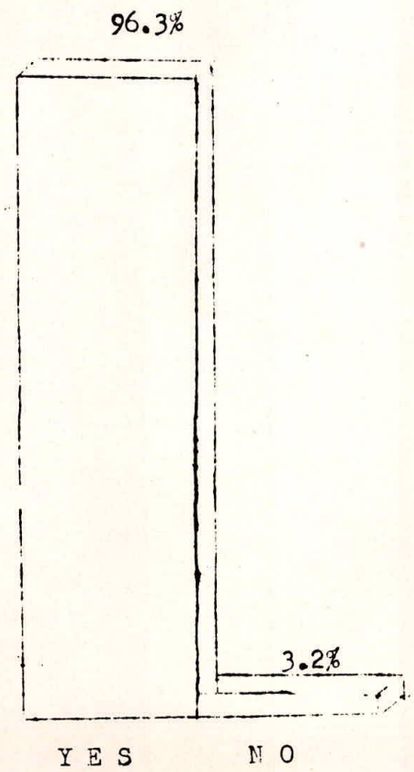
DISTRIBUTION OF POPULATION OF THE SAMPLE SURVEY ACCORDING TO AGE AND SEX



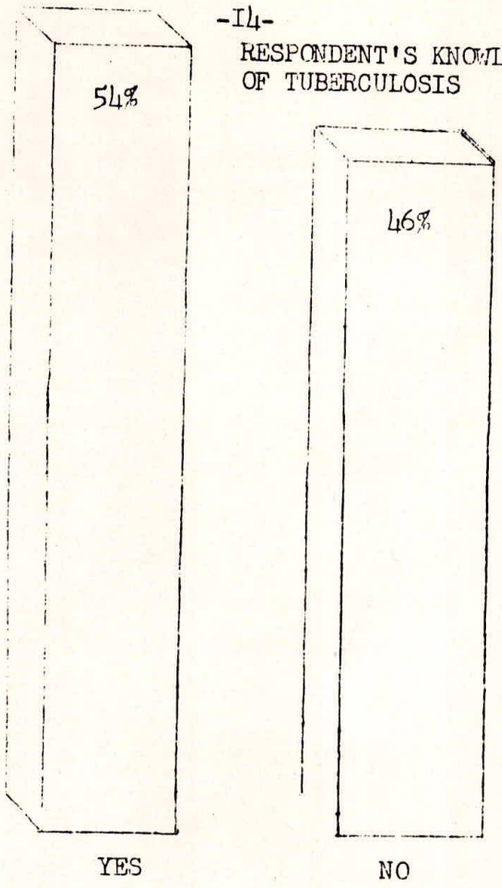
RESPONDENTS KNOWLEDGE ON CAUSES OF TUBERCULOSIS



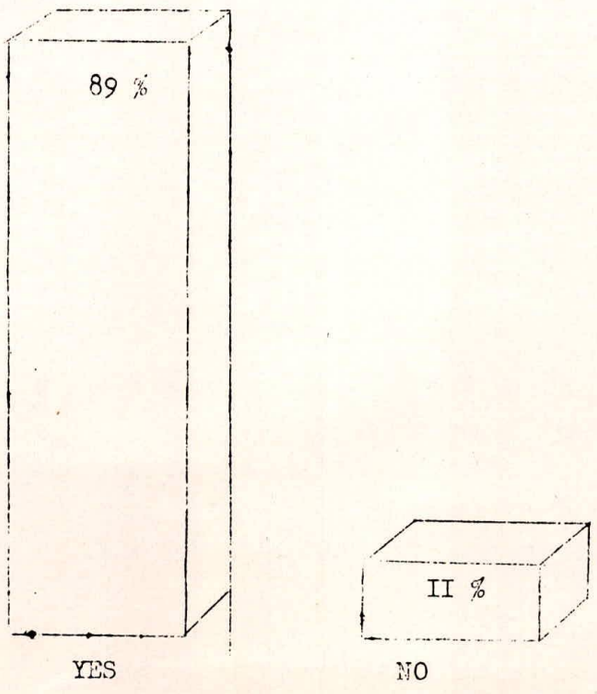
Under Five Childfen's Immunization status: BCG



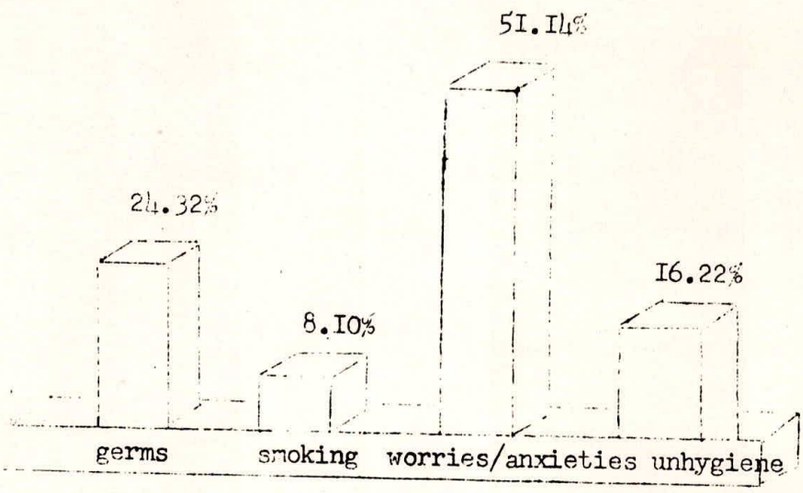
RESPONDENT'S KNOWLEDGE ON PREVENTION OF TUBERCULOSIS



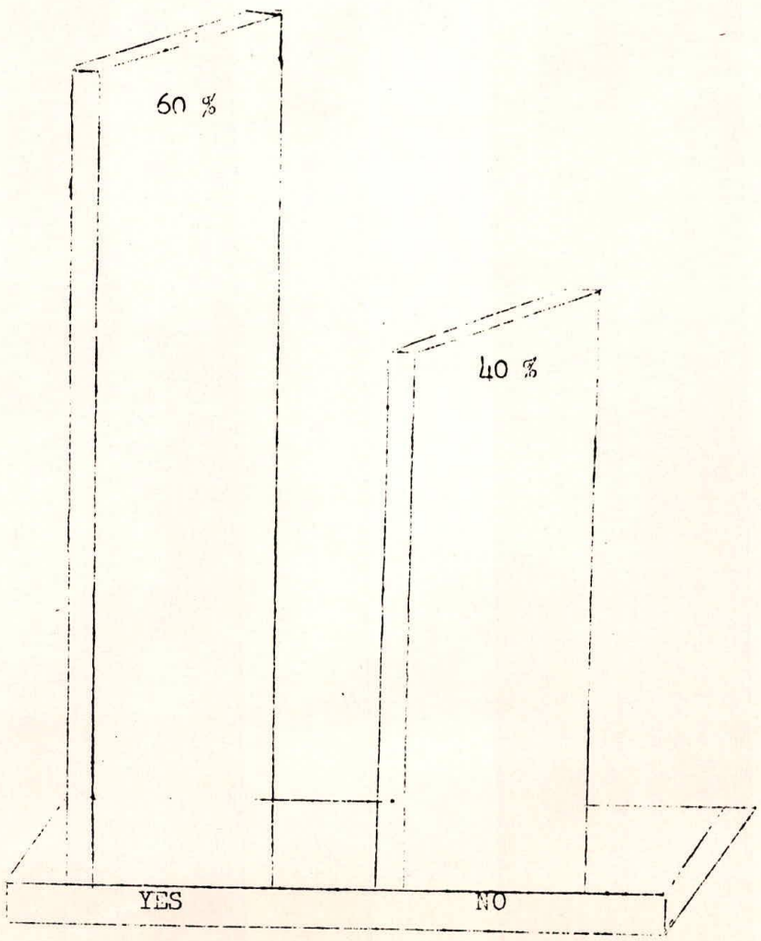
RESPONDENT'S HAVING HAD HEALTH EDUCATION ON TUBERCULOSIS



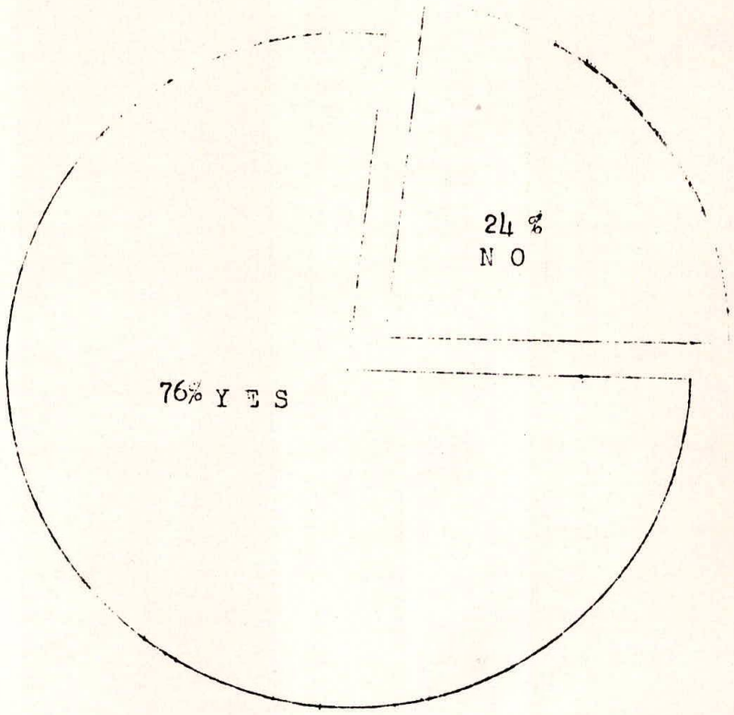
SCHOOL CHILDREN'S KNOWLEDGE ON CAUSES OF TUBERCULOSIS



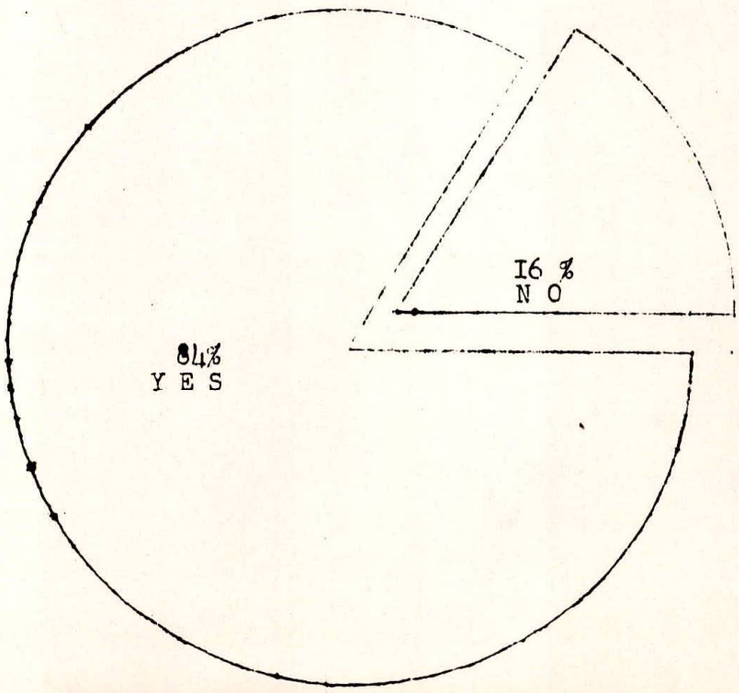
SCHOOL CHILDREN'S KNOWLEDGE ON SIGNS AND SYMPTOMS OF TUBERCULOSIS



SCHOOL CHILDREN'S KNOWLEDGE ON PREVENTION OF TUBERCULOSIS



CHILDREN WHO HAD SEEN HEALTH EDUCATION GIVEN BY HOSPITAL STAFF



COMH 1

YEARLY UNDER FIVE

YEAR	0-1	1-5	ANAEMIA	UNDER WEIGHT	HANDICAPPED	HOME NO IN SCHOOL	TOTAL
1985	141	600	78	70	17	66	741
1986	107	657	49	56	17	93	764
1987	103	593	36	32	15	78	696
1988	62	655	27	26	14	96	717

YEARLY POPULATION

YEAR	0-1	1-5	5-15	15 & ABOVE	SEX		DEATH	TOTAL POPULATION
					MALE	FEMALE		
1985	141	600	1395	6561	5147	3403	75	8197.
1986	167	657	1321	6396	5254	3636	87	8550
1987	103	593	1446	6166	5419	3664	74	9053.
1988	62	655	1577	6084	5786	3870	112	9658

Monthly Out Patient, In Patient & Refered Case

Month	1985 Out Patient	1985 In Patient	1985 Refeed	1986 Out Patient	1986 In Patient	1986 Refeed
Jan	3280	47	1	1,168	56	-
Feb	2496	52	--	1010	47	2
Mar	4448	56	--	1766	~~75~~	-
Apr	2544	55	2	2016	79	-
May	2032	60	--	2554	55	1
Jun	1672	50	2	1624	57	-
Jul	2024	55	-	2376	33	-
Aug	2368	53	--	2064	53	3
Sep	2216	49	3	1976	115	-
Oct	1440	38	1	2048	43	2
Nov	952 (Bodhgaya)	42	2	1504	50	-
Dec	488	25	--	1704	39	-
	25960	612	11			

Monthly Out Patient, In Patient & Refered Case

Month	1987 Out Patient	1987 In Patient	1987 Refer	1988 Out Patient	1988 In Patient	1988 Refer
Jan	2,288	64	1	1352	42	1
Feb	1944	67	–	1056	37	–
Mar	1746	76	–	1672	62	–
Apr	2040	62	–	1642	62	1
May	1696	48	–	1792	56	–
Jun	1639	47	–	1328	42	1
Jul	1520	57	–	1272	55	4
Aug	2991	54	–	1496	59	5
Sep	1192	35	–	1528	30	2
Oct	1208	40	1	1280	36	5
Nov	1352	37	2			
Dec	1920	44	–			
	21536	625				

(Covering letter)

Dear Dr Sadutsang

Greetings from the Community Health Cell. Enclosed herewith is a report of the findings of the CHC team that visited the Murdgod settlements along with your colleagues on _____. Also included are a series of recommendations and alternatives for further Community Health actions which have emerged from the participatory dialogue we have had with your colleagues as well as within our team.

We hope these ideas and suggestions will be of help to you in your efforts to strengthen the ~~Primary Health Care~~ Community Health dimension of Health activity in the Karnataka settlements. The CHC team and them

associates would be most willing to participate with you in the follow up of any of these suggestions through further interaction, and participatory dialogue

Please do convey to all your colleagues particularly the health teams of the settlements based in Ramanaka that they are most welcome to keep in touch with the CHC team, visit our centre whenever they are in Bangalore and explore any ideas and suggestions further -

Dear Gopi.

(1) Lalit's little brother was born on 17/12/88 at 6.46pm. The operation went off well. Both Thelma & baby are doing well.

(2) Just that morning I finished my contribution to the Tibetan Report – probably my last assignment for CHC for a few weeks. Please read through the suggested introduction etc. I have changed the summary a bit and added a covering letter to Dr Sadulsang. Copies of the report can be marked to Pasang & Ngodup. You make the final version & Shridi help & post it. There's no need to show me the final version before despatch.

(3) We need atleast 3 weeks complete break from CHC work/requests etc to get settled with the baby's routine and help Thelma to recover from the operation. So please take all initiative and handle everything you can. I shall ring you up when I feel I can.

You can send the salary cheques through John to be signed at the hospital before 24th.

(4) It was nice that we managed to settle things with Shirdi. You will have his support right through January in the afternoons.

Apart from discussing various ongoing projects with him you can follow up on any of the pending matters as well. You will just have to fix the meeting with the outsiders in the afternoon so that Shirdi can be around

Swanda Team can be given a date. Shirdi may also agree to ~~have~~ a full day session - gives adequate notice.

Sudarshan wants a preliminary discussion on Env. Education + Health component You, Shirdi + Mani can spend some time with him. Be in touch.

(5) Even if things settle earlier - I would like to get through some written assignments which are pending - before I rejoin as ~~Sec~~ 1st Feb. Till then tell everyone I shall be available only after 1st Feb and we would prefer if they did not bring the request home. They could discuss the matter with you + Shirdi + Mani

and you Force can take necessary action.

I plan to start on 4 assignments

a) Integration of Medicine _ Jointly ~ Dhruv article

b) Medical education anthology

c) PADI/CAPART Article

d) Chapter for VHAI Report.

The article by Dhruv is with you or Mani. Please send it to me.

I may call in to the CHC in early January after Lalit starts school - to collect some background papers for the writing assignments

(6) Please inform Fr Claude, Fr Tony Krishna about the Happy event.

(-) Some letters are enclosed. Booklets on Drug Abuse

Regarding the NIMHANS request - show the article to Shirdi & Mani and get their written comments/suggestions. If Gopal comes by show it to him as well. Send their comments to Dr. I. Ramakrishna. Send me a xerox copy of the article. I may work on comments after 1st week of January. In the library we have

a report box full of Health education materials from UK. You will find a detailed booklet on Drug Abuse/Alcohol etc. Guru may like to borrow it from us & show it to Dr Jayeshree. It will help them to plan their booklet. The material is on Laos only.

(8) Check & Br Appachen & send final lease document for signature when they are ready

(9) Fr Claude will probably acknowledge cheque/or letter from Mr Barker. we may also send a short/suitable Thank you

(10) Regarding sorting files/documents I have discussed some matter & John He will tell you & Nagaraju which we thought would be a good way of going about it The suggestions are on the list they prepare

So I will see meet. I am looking forward to 3 wks complete leave. We shall be sending all CHC mail which comes to 326 to you unopened for necessary action

Best wishes to you & team Ron

A Report of a Participatory Reflection on the Community Health dimension, ~~in the context~~ of the existing and ongoing Health programmes in the Tibetan settlements in Karnataka state particularly, the Doegu Ling settlement in Mundgod

Community Health Cell
46/1
Sr Marks Road
Bangalore - 560034

1. Preamble
2. ~~Introduction~~ Background
3. The Process
4. The Findings & action alternatives
5. ~~Some additional data~~
6. Summary
6. Appendices - Some data

At this initial session an outline of the existing Health services & Programmes in the Tibetan settlement was presented by the MO's ~~xxxx~~ . In addition, Mr ~~and~~ a ~~basic~~ explained about understanding of the Administrative structure and decision-making process in the Health Dept by Mr ~~_____~~ Various important socio-epidemiological issues relevant to the Tibetan settlements were then explored. These included the socio-cultural factors, the effects of migration, & a society in transition the socio-economic situation, the special importance of the Swedish settler phenomenon, the karma system, the interactions of the allopathic & Tibetan systems of medicine and the community/settlement organisation and process of governance & decision making. Some aspects of the important ~~urgent~~ public health problems of Tuberculosis and the problems encountered in its control were also discussed.

Dr SPT & Mr KG then visited Mundgod settlement for 3 days along with _____ and _____ and _____. During this visit they made certain observations on various aspects of Health services exploring available details through discussions with local team & community representatives and a perusal of records and documents

A report of their observations was then presented at a series of informal ~~dialogue~~ meetings with Drs _____ and _____ and Mr _____ and among the CHC team members themselves.

The Recommendations and possible options for action emerged through this dialogue process.

The entire process has been a very interesting and encouraging one and both the Tibetan Medical Team & the CHC have mutually benefitted from it. The enclosed report incorporates the observation of the CHC team that visited the settlement as well as the action alternatives that have emerged in the dialogue.

For purpose of meaningful communication these are presented ~~in~~ point by point in the enclosed format.

~~The CHC team hopes that the~~

We hope this dialogue report is a beginning of a process through which the Health Teams of the Tibetan settlements and their CHC colleagues can follow up on action alternatives through further interaction & di-logue.

COM H 18

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE ~~SOLUTIONS~~ ALTERNATIVES FOR ACTION
I. HOSPITAL	
A. General	
The Doeguling Tibetan Resettlement Hospital has 30 beds. Its average occupancy rate is 6-8 beds. It is well equipped with X-ray, Laboratory, ECG and other necessary equipment. The hospital has adequate facility for performing minor operations. It has specialist facility for eye problems with the help of a local opthalmologist. The hospital has acquired the necessary dental equipment for future use.	A well equipped library and current medical periodicals will help in updating of medical knowledge especially in the area of community health; it will also be useful to the para medical workers in strengthening the primary health care activities.
The hospital services are well utilised by nearby 5 villages and 2 lama camps. There seems to be under-utilization by 4 distant villages due to transport problems.	Administrative routine to include visit to these villages by competent staff on a regular schedule could be considered.

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
The hospital is self-sufficient for water and sanitation.	
There is a large out patient load with general and tuberculosis follow-up cases	Separate TB follow up clinics on specified days in addition to the already allotted Saturday afternoons could be considered.
Record keeping is up-to-date. It is adequate for the TB control programme only. The Hospital follows the National Tuberculosis Programme regime.	Adequate record keeping to reflect the amount of activitiy being undertaken in the areas of primary health care such as MCH, under-5 care etc., could be started.
A good referral system with the Medical College Hospital at Hubli for specialist services not available except on the personal liaison of the medical officer.	A formal arrangement with the Medical College Hospital, Hubli and the National Tuberculosis Institute, Bangalore, to be considered.

OBSERVATIONS	RECOMMENDATIONS/POSSIBLESOLUTIONS
B) Staff The medical officer is overloaded with preventive, curative and till recently administrative activities at the hospital level.	It may be a good idea to induct additional manpower support for community health activities.
An administrator has joined the health team recently.	
The two trained staff nurses are fully involved with hospital out-patient and in-patient activities and are unable to devote time to community health.	A trained community health nurse is required for better utilization of MCH and under-5 activities by the community.
C) Administration and funds The budget of the hospital is prepared by a Committee consisting of the Representative of the Settlement, Village Leaders and the Medical Officer.	

OBSERVATIONS

About 25% of the funds are met by the Health Tax, Bed Charges and OPD Charges at present. Free treatment is given to deserving patients.

It is proposed to collect further 25% from the same resources. This community participation will meet a major part of the health budget apart from TB Control programme.

Decisions are made with the participation of the community (represented by the leaders) with adequate flexibility for the medical officer's functioning in medical matters.

Could move to next page ④

The percentage of patients on second line Anti-tubercular treatment showed 35.0% in 1985; 32.1% in 1986; 36.2% in 1987 and 28.68% in 1988 (upto Nov)

RECOMMENDATIONS/POSSIBLE SOLUTIONS

1. Ensuring that all Tibetan Settlers approach their own health centres or the nearest District Tuberculosis Centre

OBSERVATIONS

The cause for this is the starting of second line treatment at private clinics and other centres which do not follow the National Tuberculosis Programme recommended regime. A standard treatment policy in all the settlements in accordance with the National Tuberculosis programme is being implemented.

From the statistics provided, it is noticed that more than 31% of the proposed budget for TB and Primary Health Care programme is earmarked for anti-tuberculosis drugs in view of the high proportion of cases being on costlier second line treatment, and the inability of the District Tuberculosis Centre to supply these drugs. This cost is despite the fact that all other health care

RECOMMENDATIONS/POSSIBLE SOLUTIONS

to enable the standard treatment policy to be followed.

2. Consider mobile health worker with first line drugs; even if the diagnosis is made by the private practitioners, treatment to be followed should be as per the National TB programme.

3. Links with local practitioners/organizations could be established for following the NTP regime.

4. Consider training of mobile sweater sellers for tuberculosis programme.

5. Employer of the sweater sellers may be requested to take action as in 1-3 above on detection of tuberculosis cases.

6. Check if second line drugs with CMS-I are cheaper, details of which are being sent

OBSERVATIONS

activities are being met by the community itself.

There is no definite staff development and continuing education programme as a policy in the South Indian settlements.

Detailed studies of disease incidence/ prevalence are not being done due to lack of funds for this activity.

RECOMMENDATIONS/POSSIBLE SOLUTIONS

to Doeguling Hospital.

7. A goal for eradicating / controlling the TB problem should be set. (↗ to National level)

Taking this up as a policy matterwill enhance the skills of the team in perfoming their work more effectively. In addition, regular monthly meetings of the staff, discussion of health and related problems, training of staff not individually but as a team, will further strengthen their team work towards providing primary health care.

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
II. COMMUNITY HEALTH	
A. Water supply and sanitation	
Adequate potable water is available from borewells within walking distance.	Overflow and sullage water can be utilised for kitchen gardens.
Collection and storage of water is unhygienic	Proper health education of the community in this area is needed.
Sanitary facilities for excreta and waste disposal are grossly inadequate.	Propagation of the concept of atleast community latrines to be considered.
B. General hygiene	
Concepts of general hygiene, especially oral and personal is poor.	Health education to alter the habits which were not harmful in their homeland of Tibet but are conducive to spread of diseases in the present circumstances is required.

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
C. Maternal and Child Health	
Immunization coverage is good.	
Breast feeding is promoted as part of the culture. Birth weight of newborns is above average.	
Pregnancy is usually diagnosed after 5-6 months. Hence the critical period of MCH care in the first and early second trimester are not availed of to a full extent	The services of a Community Health Nurse will help improve the situation.
Abortions are not reported and home deliveries are conducted by elders in the family who are untrained.	Awareness building programme (through community participation) to elders who conduct deliveries could be organized. Concepts of hygiene etc., could be included in the programme. Since prevalent cultural practices appear to

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
	be adequate in producing healthy children, maternal and child health needs deeper study especially antenatal practices in order to foster good traditional practices.
D. Health Workers The health workers are well trained, motivated, sincere and capable of handling responsibility, especially in TB control programme. They were given adequate on the spot training by the medical officer for TB control, MCH care and Health Education. They are occasionally utilized in hospital care in place of nurses in addition to above.	Health workerscan be trained to handle minor ailments and given some drugs for it thus reducing the hospital out-patient load.
There are 3 drop outs out of the original 8 health workers trained and the replacement workers are yet to be fully trained.	Additional work with more incentives to be considered for health workers to ensure committed primary health care. In order to ensure replacement of staff easily regular training programme for health workers could be organised. The services of part time health workers could

OBSERVATIONS

The younger unmarried health workers are not well accepted by the community yet.

RECOMMENDATIONS/POSSIBLE SOLUTIONS

be considered; they could be selected from amongst school teachers/staff of cooperative/ staff of handloom weaving centres etc., who are likely to be permanent residents of the settlements.

E. <u>Villages 1,2,3,5 and Lama Camps 1, 2</u>

Majority of TB cases are found in the mobile population of sweater sellers especially those coming from major cities. Many people affected by TB belongs to the age group 15-35 years, while in Lama Camp 1 under 20 years and above 55 years are affected. It is believed that the higher incidence rates in monastries is due to newcomers from Tibet.

Cases on second line treatment have been

OBSERVATIONS

RECOMMENDATIONS/POSSIBLE SOLUTIONS

initiated on treatment elsewhere.

Females show a lower incidence compared to males.

(observations pertaining to other aspects of health are as recorded in previous paragraphs.)

F. Nunnery

It has 25 residents and is clean and well maintained. Adequate water and sanitation facilities are provided to it. Since it is next to the hospital, the inmates utilise ~~its~~ health services well.

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
G. Homes for the old, infirm and destitute	
They have been provided with adequate water and sanitation facilities. However, general and personal hygiene in the general section is poor. It is better in the Lama section.	More community health worker's activity especially in the field of hygiene is required. Participation of community to be sought to take care of those who are unable to help themselves.
H. Tibetan Medicine and Astro Institute	
It aims at revival and popularisation of traditional system ofmedicine. According to the Medical Officer, its theoretical principles are similar to Ayurveda. Source of medicine is centralisedat its HQ in Dharmsala. No local/herbal/home remedies propagated which can be easily made at home.	Integration of activity with the allopathic system and more so in the direction of providing primary health care to be considered. Imparting some skills to health workers and utilising them would strengthen their efforts. It could play an important role in taking over of hospital over-load of out-patients wherever possible.

OBSERVATIONS

The institute is staffed by a senior doctor and two trainee doctors. They conduct home visits and treatment on request.

I. Representative of the Settlement

Mr G Choeden was very concerned about the mobile population of sweater sellers since

a. they constitute the younger generation;
b. they are unable to learn any skills; and
c. they are the major source of the tuberculosis problem.

RECOMMENDATIONS/POSSIBLE SOLUTIONS

Comparative clinical trials of treatment for chronic diseases using both allopathic and Tibetan systems can be initiated at the settlement levels.

Screening of settlers returning from their prolonged stay outside to spot TB cases could be considered.

(other suggestions regarding TB as in above).

It will be good to involve the health team to introduce health aspects in all the social/economic activities of the settlement.

more to next page (4)

OBSERVATIONS	RECOMMENDATIONS/POSSIBLE SOLUTIONS
Mr Choeden invited us to speak at a Seminar-cum-Workshop on INTEGRATED DEVELOPMENT PLAN FOR TIBETAN SETTLEMENT AT MUNDGOD. During the discussions here, it was noticed that "health" did not form a part at all of their "Human Resource Development". This was pointed out and stressed by a member of our team.	
J. Cultural and Social factors	
Community eating and drinking habits from common plates and glasses is prevalent.	Health education to create awareness of the adverse health effects in the present conditions to be organized.

OBSERVATIONS

A traditional barley brew is consumed by many though alcoholism does not seem to be a problem. Smoking and chewing of tobacco are not common while using of snuff is widely prevalent.

There are no organised health promotive activities like youth clubs, community reading rooms/libraries, play grounds, games etc.

RECOMMENDTIONS/POSSIBLE SOLUTIONS

Community participatory activities to be considered.

K. Schools and School Health

There are 3 central schools: one upto higher secondary (XI std) and two are primary schools. There is a high drop out rate ~~after~~ at middle school level.

There is no regular system of school check ups and health record maintenance.

The doctor has noticed a very high

The causes for high ~~school~~ rate of school drop-outs to be analysed and some action initiated to control it.

Regular school health check ups and recording could be undertaken.

Health and hygiene/sanitation to be made

OBSERVATIONS	Recommendations/possible solutions
incidence of Dental caries.	
There are 9 creches with under 5 children. Some of the personnel are trained in the Montessori system. Mid-day meals, supplementary nutrition and growth monitoring are done here.	a part of school curriculum. These places can be used for education of mothers in health, hygiene and nutrition aspects of children.
There are no regular formal/non-formal adult education classes.	Regular adult education classes to be considered.
The drop out rate at middle school level is very high.	

OBSERVATIONS

COMMENTS NOT COVERED ABOVE

RECOMMENDATIONS/POSSIBLE SOLUTIONS

From the available statistics, the following is noticed.

a. The Crude Birth Rate shows a decreasing trend in the settlement population.

A detailed study of these statistics from hospital and community records will help in formulating a more meaningful health programme for the future, especially since this settlement has a large monastic population and also an old age/destitute home which may account for the present interpretation of statistics.

b. The crude death rate is mainly due to old age and destitute home accounting for it.

c. The infant mortality, neonatal mortality, maternal mortality, and mortality by cause could not be calculated.

OBSERVATIONS

RECOMMENDATIONS/POSSIBLE SOLUTIONS

d. The high rate of BCG immunization is due to the fact that all settlers under 19 years of age were immunized in 1985 and more newcomers into the settlement.

e. The in-patient and out-patient attendance has decreased while the referrals have increased during October 1988 due to the absence of the medical officer.

AREAS OF STUDY

1. A thorough study of the trends and pattern of Tuberculosis in Tibetan settlements in Karnataka.
2. Comparative study of the relation and impact of agriculture, dairy farming and other socio-economic activities on health in the different settlements in Karnataka.
3. A study of the child bearing and child rearing practices of the Tibetan community.

4. A study of the training needs and training in areas of MCH/under fives and school health.

5. Study of utilization pattern and scope for integration in community health practices of the Tibetan system of medicine.

could be initiated as part of an ongoing Health Research Strategy. It would enable the evolution of a

THE ABOVE STUDIES, BY THE HEALTH TEAM THEMSELVES, ~~WILL ENABLE EVOLVING OF~~ A MORE APPROPRIATE AND EFFECTIVE STRATEGY FOR THE FUTURE OF THE SETTLERS. The studies can be of an action-research orientation.

SUMMARY (Rewritten) (Please type as a separate page)

and organised. Most aspects of Hospital Management are being looked into and alternatives explored by the Health Team themselves

(1) The Hospital is very well equipped, ~~while~~ staff development & continuing education ~~enrichment~~ programmes, however need more attention.

(2) ~~Though~~ The aspects of primary health care being implemented are not adequately projected ~~at the expense of a very well conducted~~ in spite of the commendable efforts mentioned above, the tuberculosis control programme, is very well conducted. All the same the prevalence being very high, a goal has to be fixed to eradicate or at least to bring it down to the Ind Natl avg

- The community participates in making ~~democratic~~ decisions and pays for most of the primary health needs apart from the tuberculosis programme. This dimension needs to be fur

- Considering the high cost of TB control programme, various avenues of better management have been

explored in the report. The suggested study will help in pointing out an appropriate course of action.

- Health education in addition to appropriate public health engineering works will help prevent many minor illnesses and promote primary health care.

- Good cultural, traditional practices in maternal and child health care can be fostered after an adequate study in this field.

- The health worker services are commendable in the tuberculosis control programme and can be extended ~~extended~~ to other areas of primary health care.

- The large mobile population appears to be the main source of disease especially tuberculosis. An appropriate administrative and medical approach is to be evolved to tackle this problem. A detailed study of RE phenomena and its epidemiological implication is an urgent first step

- Integration of Tibetan Medicine at all levels with the prevailing system will prevent duplication of health efforts.

- Health promotion practices to be introduced at pre-school, school and non-formal education levels including regular health check ups and record maintaining.

- Youth clubs / community oriented activities

- Involvement of Lamas in ~~the~~ Primary Health Care / Orientation towards Community Health.

Some additional data

Appendix

DEMOGRAPHIC DATA OF MUNDGOD SETTLEMENT

1. Total Population	9658
Males	5788 (includes Lamas - 2400)
Females	3870 (includes Nuns - 25)
2. Total Area of Settlement	3000 Acres
3. Number of Villages	9
4. Number of Lama Camps	2
5. Nunnery	1
6. Home for Aged	1
7. Number of Creches	9
8. Number of Schools	3 (1 High School, 2 Primary Schools run by the Central Government)
9. Cooperatives	1
10. Banks	2
11. Post office	1
12. Transport facility	2 Government Buses to Mundgod daily
13. Main Occupation	Agriculture
14. Seasonal Occupation (3 to 7 Months)	Sweater selling (more than 60% according to the Representative)
15. Other Occupations	Carpet Weaving/Handicrafts/ Dairy

Appendices

1. Demo.
2 Co

COMMUNITY STATISTICS

	1985	1986	1987	1988 (till Nov)
Crude Birth Rate (1981 - Indian- 33.2)	16.21	12.0	11.33	6.41
Crude Death Rate (1981 - Indian - 12.5)	8.62	9.78	8.14	4.34
Under - 5 Population	741	764	696	717
- as % of total population (Indian - 15%)	(8.52)	(8.59)	(7.66)	(7.42)
- 0-1 Population	141	107	103	62

IMMUNIZATION STATISTICS

		1985	1986	1987	1988 (till Nov)
B.C.G (Good Coverage, see comments)					
DPT & OPV	1st	20	108	93	81
	2nd	10	102	83	74
	3rd	4	106	69	55
Measles		46	82	113	115
Boosters	I	Nil	119	79	45
	II	Nil	91	21	43

56
32
88

110
22
22

88
24
64

HOSPITALS

	1985	1986	1987	1988 (till Nov)
Total Outpatients	25,960	21,862	21,536	14,418
Total Inpatients	612	696	625	484
Referrals	11	8	4	19
Average Stay in Hospital (Days)	9	9	9	9

MOTHER AND CHILD HEALTH

	1985	1986	1987	1988
Ante-natal Clinic attendance	1059	895	864	308
Hospital Delivery	36	39	24	30
Home Delivery	63	39	33	31
Outside Delivery	45	25	28	6

58
22
80
23
57

142
58
84

84
50
134

Summary

1. The Hospitals & Dispensaries are well equipped and organised Most aspects of Hospital Management are being looked into by the MOs themselves and alternatives being explored. Staff development and Continuing Education programmes need however much more attention

2. The Tuberculosis programme is well organised and conducted However since the prevalence is very high in spite of the commendable efforts, further intensification is required to bring down the prevalence to atleast the Indian National average

(3) Though a 'Primary Health Care orientation' is evident in the overall planning, the focus at the field level is

still very much oriented to TB. The infrastructure, health team functions & routines and activities geared to TB control can be used without much difficulty and a certain creative reorientation be focussed on a larger range of Primary Health care problems. Community based activity need to be further strengthened.

4. The Community participates in decision making, and pays for much of the health needs apart from the TB programmes. This dimension needs to be further strengthened and decentralised. Health Cooperatives / Health insurance schemes can be further explored

5. Considering the high cost of the TB control programme, various avenues of better management have been explored in the report. The suggested study will also help in pointing out an appropriate course of action

6. Health Education and appropriate Public Health Engineering will help further to prevent many of the minor illness and promote Primary Health Ca

7. Good cultural traditional practices in maternal and child health need to studied and fostered in the MCH programmes

8. The CHWs need to be supported in carrying out at the field level a wider range of health actions other than TB control activities

9. The large mobile population predominantly of Sweden sellers seem to be a major ~~source of~~ problem at ~~epidem~~ Health practice level. A detailed study of the phenomena and its epidemiological ~~app~~ implications is an urgent first step From the appropriate medical/administrative actions to tackle the problems could emerge

10. Integration of Tuberculosis Medicine at all levels ~~of~~ the health service will prevent duplication of efforts and promote a more wholistic planning. compartmentalization needs to be avoided.

11. 'Education for Health' is an area not adequately explored in the existing

Health planning. The school as a focus of Health activity health education needs to be explored more dynamically Preschool, non formal education efforts which include the health dimension need to organised. ~~Child to child Activities~~

12. Community involvement in health can be further strengthened by exploring the involvement of youth/youth clubs, ~~and the~~ women/women clubs and Re Iamas in Primary Health Care activities particularly preventive and promotive activities

---

Lama Camp V Pop - 1,200.

TB cases	I line	II line
26	19.	7

2 > 50 yrs.
1 - 10 yr

Rest 19 - 36 yrs age gp.

13 Nov 88 Arrival at Mundgod - 9:30am.

10:30 — 1:00 pm
- Visit Hospital
- Discussion ē Med. Offr / Administrator / Dep. Secy of Health.

2:00 — 5:30pm
- Visit to Village 1 & 2 on discussion ē A.W.
- Visit to Lama camp 2.
- Meeting ē Representative. Mr. Choedan.

14 Nov 88

8:30 — 1:30 pm
- Visit to Nunneny / Old age Home for destitutes & Lamas./
- Visit to Wksp / Carpet weaving on Handicrafts' centre.
- Visit TMAI
- Participation in Seminar-cum-Wksp on integrated Dev. plan for Tib. Sett. Mundgod.
  - a brief talk on health aspects of the settlers.

2:30 pm — 4:45pm
- Clinic.

Left for Bangalore 5:00 pm.

~~DEMOGRAPHIC DATA~~ ~~VITAL STATISTICS~~ OF MUNDGOD SETTLEMENT

General

1. Total population - 9658
   Males - 5788 (includes Lamas - 2400)
   Females - 3870 (includes nuns - 25)
2. Total area of settlement - 3000 acres.
3. No. of villages - 9
4. No. of Lama camps - 2
5. Nunnery - 1
6. Home for aged - 1.
7. No. of creches - 9.
8. No. of Schools - 3. (1 High school / 2 primary ~~camps~~ run by Central Govt.
9. Main occupation - Agriculture.
10. Seasonal occupation - Sweater-selling (>66% popln. acc. to Rep. 5 to 7 months).
11. Other occupations - Carpet weaving / Handicrafts / Dairy /
12. Cooperatives - 1
13. Banks - 2.
14. P.O. - 1.
15. Tpt. facility - 2 Govt. buses to Mundgod daily.

Comm Stats

	1985	1986	1987	1988 (Nov)
- CRUDE BIRTH RATE (1981 Indian - 33.2)	16.21	12.0	11.33	6.41
- CRUDE DEATH RATE (1981 - Indian - 12.5)	8.62	9.78	8.14	4.34
~~NEONATAL~~ ~~INFANT~~ INFANT / NEONATAL / MATERNAL MORTALITY RATES ~~5314~~				
- UNDER-5 POPULATION	741	764	696	717
- as % of total popnlx. (India 15%)	(8.52%)	(8.59)	(7.66)	(7.42)
- ~~Under~~ 0-1 popnlx.	141	107	103	62.

Immunization statistics

good coverage (see comments in comments)

		1985	1986	1987	1988
B.C.G.		90	108	93	81
DPT. & OPV	1st	10	102	83	74
	2nd	4	106.	69	55
~~DPT~~ Measles		46.	82	113	115
Boosters	I	Nil.	119	79	45
	II	Nil	91	21	43.

Hosp.

		1985	1986	1987	1988
Total	OP.	25,960	21,862	21,536	14,418
	IP.	612	696	625	484
	Referrals.	11	8	4	19.
	Avg. Stay in hosp			9 days.	

T.B Stats

	1985	1986	1987	1988
- Total New cases ~~Used~~	108	86	144	83
Avg. no. on Rx	116	94.25	89.41	93.0
% on 1st line	65.0	67.9	63.8	71.32
% on 2nd line	35.0	32.1	36.2	28.68
- Total Completed Rx	84.	111	80	76
Total Relapse	7	14	8	3
" Expired	8	-	-	-
Gland TB	3	-	-	2
Men.	1.	-	-	1
Joint	—	—	1	—

MCH Hosp Stats

		1985	1986	1987	1988
Total	A.N. Clinic attendances	1059 ~~88~~	895	864	308
	Hosp Delivery	36	39	24	30
	Home Delivery	63	39	33	31
	Outside "	45	25	28	6
Incidence of TB new case (India - 0.13%)		1.24%	0.96%	1.58%	0.85%

Gowri Malli
Clerk/Typist K.M.C. Office

M.D. Degree Certificate of
Dr. Prabhavish
passed 1984 - P.S.M. (M.D.)
Reg. no. 29

?
- Any forms
- Letter from College.
- refund. payment
  → Dr. Prabhavish will pay when he visits.

Hostel

Hubli - KSRTC canteen
Gyanagatti Kamats Hotel (Kalpana Kamat)
- Kalpana Lodge for accomdn.

3000 acres

Mundgod Pop: 10,000. 1967 (pop: 6000)

Hosp - 1969-70 Dr Passang 1978

CHWs - 1984 onwards

Staff - 8 CHWs - 10 villages
as periphery 2 Lama camps
Tot-24 1 aged home
9 creches / Central school.

1 CHW per 1000 popn.

TB Survey 1985 - 90 at present on ATT.

- sputum conversion imp. criterion
- many on 2nd line drugs.

3000 → nomads - selling sweaters & 6-7 months a year.

140 deliveries/yr 40 in hosp.
Rest outside.

Agriculture - cash cropping: Maize
Carpets weaving / Sweaters / Dairy / Poultry.

PER-CAPITA INCOME ?

CHWs → How were they trained ? SYLLABUS !

Monastery - how involved in health?
- how formed?
- how contributory to economy.
- do monks live in community?

- School health -
- Health Records -

(Evening 7:20pm Kirkland Express)

NEEDED:

1) Health data
2) Stratification of community
3) Traditional medicine
4) Religious orders - involvement in

Indicators of Health

I Mortality Indicators

a) Crude Death Rate - deaths/1000 pop.

b) Expectation of life.

c) Proportional mortality Ratio
deaths >50yrs / Total deaths

d) INFANT MORT. RATE - Infant deaths / 1000 live births.

e) Maternal Mort. rate

f) Mort by cause.

II Morbidity Indicators: Incidence / Prevalence.

III Disability Rates

Sullivan's index = Life expectancy minus disability-period

IV Health Care Delivery Indicators

a) Doctor - population Ratio

b) Doctor - nurse ratio

c) Population - bed ratio.

V Utilization Rates

a) % of children <2yrs immunized.

b) % of ♀ using antenatal services.

c) % of Deliveries by TBAs

d) Bed-occupancy rate
Avg. daily IP censuses / Avg. no. of beds

e) Avg. length of stay
Days of care rendered / Discharges.

f) Bed turn-over ratio:
Discharges / Avg. no. beds

VI Indicators of Social/Mental Health.
Homicides / Suicides / Drug abuse
Delinquency etc.

VII Indicators of Quality of life:

a) Nutrit. Status indicators
- 90% newborns > 2500 gms wt.

b) Water Supply & Sanitary.
% populty. ē safe drinking water within walking distance
% ē sanitary latrines.

c) Educn: % attending primary school.
+ Adult Literacy rate, ≥70%.

EVALUATION OF HEALTH SERVICES

a) Evaluation of structure.
b) Evaluation of processes of care.
c) Evaluation of outcome.

Elements of Assessment

a) Relevance
b) Accessibility.
c) Acceptability.
d) Effectiveness.
e) Efficiency.
f) Utilization and coverage
g) Medical Audit.
h) Satisfaction

SOCIAL ASPECTS

1) Families / types
2) Child rearing practices
3) Socialization & Social institutions

★ Social organisation
GOBIFF.
Weaning

CULTURAL FACTORS

1) Concepts of Etiology & Cure.
2) Environmental Sanitation
   a) Excreta disposal
   b) Waste disposal
   c) Water supply
   d) Housing
3) Food habits
4) M.C.H.
5) Personal hygiene
   - Oral
   - Bathing
   - Shaving
   - Smoking
   - Clothing
   - Foot wear
   - Circumcision etc.

6) Sex & Marriage:

Health Services

- Budget { Income / Exp.
- Liaison ie. { local / other vol. / Govt } Health services provided.
  + Extent of services utilized.
- Health - K.A.P.

General

- Percapita income.
- Savings/banking
- Pay/Paystructure who pays?
- Occupy. + Occupt-health.
- Economics
- Contribution to Health (Health tax)
- Cooperatives
- Health Decision-making
- Communications
- Transport / Radio-TV
- Language & Cultures

CHWS

- daily routine
- syllabus
- work load
- efficiency

Routine

2 ~~Villages~~

~~Monday~~ - → Home visit TB pts

1 Tuesday -

2 Wed → Nursery children.

3 Thu → Hosp. meeting

4 Fri → ANC + Hosp referral.

5 Sat → Wt. of children + visit + TB Sputum

6 Sun → Records

CHWs course

1) Community Health – 4 hrs
   RSM / sanitation / vaccine
   Disease / health concepts

2) Nutrition – 8 hrs
   Food / cooking / Malnutrition /
   Deficiencies / Breast feeding etc

3) Child Health – 20 hrs
   Normal / Vaccine / Hygiene etc

4) TB – 6 hrs

5) Skin – 6 hrs

6) First Aid – 6 hrs

7) Adult illnesses – 4 hrs

8) Obs & F.P. – 7 hrs

9) Drugs & uses – 5 hrs

10) Odd lectures – 4 hrs
    Teeth / Stats / Traditional Medicine

11) Practical Nursing Skills

- Mobile population - 50-60% for 2 months.
  - permission to leave camp needed
  - people do not report back.

- Per-capita income. (family) 2-8 members. } Loss of Rs. 2000 pa. - 3000

(Sweater-selling as labourer)
∴ few moneyed prosper.

Concern of Representative
→ NO SKILLS IN YOUNGSTERS
∴ Sticking on to sweater sellings.

		Pop	Cases of Dysp	II Clinic
Lama Camp		~~2400~~	9	7 + 2
	-2	1500		
Village I		700	~~8~~	~~7~~ + ~~1~~
Village II		500	4	2 + 2

Surrounding camp

- Majority - from mobile populx
  - from 15-35 age gp in Vill I & II
  - from <20 & >45
  - treated elsewhere to stomach with.

Total Lama populx. ~~2400~~

	Preg ♀	<5y children
VI	12 (4 clinic, ~~5~~ 3 sweaters selling, 2 delivered.)	106
VII	4	51

♀ △ - after 5-6 mo. ✓
- immunizx complete.

CHW – Village 3 & 5 (Rinzing Tsomo)

	Vill	Pop	TB cases	I line	II line
(4) new	3	780	7	6	1 (Relapse + Rx)
(5) new	5	565	4	4	—

Vill – III – 4 new cases ← 42 yrs ♂
28 yrs
3 → BCG given
24 yrs ♀

– Sweater sellers
3 yr old diagnosed at B'bay

Vill V – 2 new cases ← 52 ♂ – sweater seller
15 ♀ – TB gland. (from Ladakh)

Sweater selling Bombay / Kolhapur / Pune / Bangalore / Madras

---

From Bombay } cases
Nasik
Ahmednagar
Pradesh

Nil from Bangalore / Madras /

DTL → Mass survey (5 yrs back) – 2 cases detected
→ reports received by them.

	ANC	< 5yrs	Births	Deaths
III	2.	100	11	2 old age
V	1	54	7	1 accidents (child).

- Close to hospital.
- facilities well utilized.

CHWs were ~~previous~~ Prior to 1986 issuing drugs (basic) on ROR.

- Now, not able to.

Problems

- Night duties
- Low pay.

NO PREGNANT FEMALES WITH TB.

Tibetan Medicine Astro - Instt

40 - 70 pts a day

- 40% arthritis - 3 months Rx
- Hypertension 75% effective 6 mo
- Liver disease 20 pts.
- Gastric / Bronchitis / GE

Dietary } part of system
Moxa }

Ref. by Allopath - Jaundice

Pulse diagnosis
Astro diagnosis
Urine examn

Lanna Camp I Pop 1200

TB cases	I mine	II mine
26	19	7

2 > 50y
1 < 10y

Rest 19-36 ys age gp

9083
2400
~~9243~~
6683

103
6683 × 1000.

maize for commercial production only. In Mudgud paddy is produced and consumed.
dairy, sweater, carpet making.

- eating habits — relationship
- skin diseases
- tapeworm
- malnutrition
- school health

// Tibetan Medicine

CTSW works under the direction of the hospital

- water supply
- sanitation
- Referral facilities
- communication courses
- manpower
- autonomy (Separate Centres)

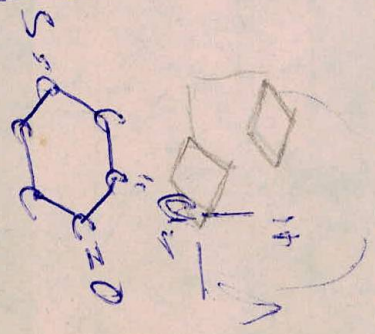
1
5
1 | | | | | | | |
1
1
1
1

7. Partim

10

- administrative constraints.
- decision making / participation
- Monastery (how they function, finance etc.)

CMS-I / Ramagiri to HS DS



9-11-88

1959
= 2 settlements in Balekundri 1960

Mungud Karwar 45 kms from Hubli
3000 acres now 10000 pop.
hospital 1969. — 24 staff
Parang 1978.
TB - quite a no. of patients 9/1000
'82 preventive aspects
'84 CHWs
9-10 villages
1 home for aged
1 central school, crèches,
'85 Dept of Health begins involvement
- each village 1000 pop one CHW
based in village - to meet needs 5
3000 pop. 7 months away from settlements
delivery - no data but there are
home deliveries.
1.5| +140 deliveries per year — 40 in hospital
their are landless people.

Kallyan started
3000 acres
1971 - 3500 {30 gunta
1987 - 4500 {22 gunta
Under 5 = 622

Contractors

(5) ~~Contractor of movement~~ of sw sellers to be made responsible for correct action in TB suspected TB cases. Since he is aware of their movements and should be done as part of the contract

- continuity of Rx of cases ~~can~~ to be done at any of ~~the~~ the settlements - ~~by admin~~

Nunnery - Well maint. / clean.
- Since near to hosp - export early for Rx.

Old age: - Lama section better maint.
- General hygiene to be taken care of as part of C.H. work.
Sanitary latrines are available for inmates

T.M.A.I - has a senior Dr. & 2 trainee Drs.
- treats Arthritis / BP / Liver / Gastric diseases
- ~~also~~ also conducting house visits and Rx on request.

Rec: - integration of activity - C.H. oriented
- utilization of H.Ws. by impartg trg in
- taking over load of Hosp. wherever possible.

Cultural / Social factors:
- Eating / drinking habits - + chang. / smuff.
- Marriage
- NO youth clubs / Health promotive activities.

Future possible involvement

(1) Thorough study of the trend of TB
(2) further trg. in MCH / under-5 / School health areas
(3) Study of child bearing / rearing practices.
(4) Comparative study of relation of Agriculture / Dairy and their effects on health in diff. settlements in Karnataka.

(5) Tibetan Medicine
(6) School Health

Administrators

- Health tax
- Bed charges.
- Opd charges / free Rx.
- New administrator to take over wk. load of Med. officer.
- Community participation in wider aspect than meeting a part of the expenditure.

Schools / School health.

DTC - not very helpful since they do not stock adequate
- takes reports from hosp. but not acting on the reports.

HOSPITAL (1) Obs: Doeguling T.B. Hospital is situated close to 5 villages & 2 Lama camps, while 4 other villages are distant (farthest 5 Kms) which reflects on the utilization of this facility - since the nearer ones show better utilize. rates. (HWs interview

Rec: Regular visit by doctor at least twice a week to far villages

(2) 30 bedded - 6-8 beds at any time used.

(3) Obs: - Well equipped for diagnosis. Xrays/ECG/Lab etc. + manpower tech. pow
- Well spaced-isolation / TB wards
- Well maintained.

(3) Obs: Self sufficient for water / sanitry.

(4) Obs: Inadequate staff. esp. nurses / Lab

(5) Obs: Large Out patient load.

(6) Obs: TB cases & general cases

Rec: Separate TB clinics in addition esp. follow up clinics

(7) Obs: → Gogti's book
Opkth / Dentistry / Referral

Med. Officer / Doctor → Overloaded fully involved with preventive / curative activities at hosp level. Protective in.

Requires additional manpower support for community health activities.

Trained HWs work. But due to drop outs from them is handicapped till he can train a few more.

HWs Obs: - well trained / motivated / sincere & capable of handling resp. esp in TB control since they were given on the spot adequate training / additionly are utilized in the hosp. work in lieu of nurses. This encouragement gives them more confidence in their work.

- are bi-utilized for other health work also, as they are already trained for MCH and under-5 care.

- Given only TB drugs. Can be utilized for minor ailment treatment & reduce OPD load. This requires additional incentives for them.

TB: Records/- following NTP regime properly - 731.00% of health budget is earmarked for ATT drugs - showing the magnitude of problem.
- Incidence of new cases 1.24/0.96/1.153/0.857% (India 0.13%) 85 86 87 88 till Oct.

Is line & costlier ∴ budget higher.

~~Staff~~ ~~Nursing / Techn~~

Record keeping is very good for TB program. The same may be adopted for other health activities esp MCH / under-5. ~~This will reduce the tendency for use of outside / home facilities for deliveries etc~~.

Separate specialised nursing staff in hosp-comm-field level will help in better utiliz. of MCH & under-5 facilities.

Staff development programme with regular meetings and discussion of health and related problems will enhance the team-work, and distribute the work load.

- Library / Med. periodicals could be improved.

Villages / Lama camps

(1) TB ~~problem~~ - majority cases from mobile (sweater-selling popn)
" from Bombay side.

General popn. of V I & II/III/V - age gp 15-35 yrs ~~- incidence very large in~~

Lama camp - less than 20 ys / over 45 yrs

Incidence of lesser than male + statistic

NO PREG ♀ ē TB.

Second line treatment cases have been started on Rx elsewhere at private clinics and have to be continued ~~from~~ in this hosp.

(2) Other health aspects ~~problems~~: - preg. Δsed after 5-6 mo.
∴ critical period of MCH care in the first & early second trimester are not available.
- Abortions etc. are not reported.
- Home deliveries are conducted by elders in the family who are untrained.

Rep: Choedan: (1) Very concerned about mobile popn (Sweater selling). Since they bring in TB (~~issues movement passes~~ → Will have to monitor re-entry into camp to spot TB cases.

(2) Invited for seminar - Stressed on health aspects during discussion on Human Resource development.

Suggest → (1) HW ē sweater sellers ē 1st line drugs
(2) SS. report to nearest D.T.C
(3) " " Tibetan settlement
(4) Standardisation of Rx at all Tibetan camps to avoid unnecessary start on 2nd line.

[illegible]

Age Wise Distribution Of T.B. Patient

Village	Male	Female	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75
Lama Camp D	11	-	-	-	-	1	3	1	-	1	-	2	1	1	-	-	1
" IV	26	-	-	1	1	6	4	8	1	3	-	2	-	-	-	-	-
Village No. D	6	1			1	1	2			1			1	1			
" II	2	2					1	1			1				1		
" III	2	5	1	1			2					1		1	-	-	1
" IV	6	6				3	1	3	1	1		2		1			
" V	1	3		1	1	-	-	-	-	1		-		1			
" VI	6	3			-	1	1	2	-	-	1	1	2				1
" VII	7	2			3	-	1	-	-	1	-	3		1			
" VIII	4	3				1	1	3	-	-	1	1					
" IX	3	1		1		-	-	1	-	1	1	-					
Old and Infirm	1	1				1	0	-	-	-	-	-					1
Total	75	27	1	4	6	14	16	19	2	9	4	12	4	6	1	-	4

PLANNERS' APPROACHES TO COMMUNITY PARTICIPATION IN HEALTH PROGRAMMES: THEORY AND REALITY

by Susan B. Rifkin *

Introduction

Concern with the people who receive health services rather than those who provide services has gained increasing importance over the last twenty years. By the mid-1970's, the experiences of the national health care programmes of countries like China and of many church and non-governmental organizations (NGOs) gave birth to the concept of Primary Health Care (PHC). Defined as "a practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation", PHC is the strategy propagated by the World Health Organization (WHO) as the means by which "health for all by the year 2000" is to be attained.

Community participation is seen as the key to PHC. It has reached a prominent place in health care strategies in many countries and programmes for a number of reasons. These include: 1) increasing evidence is being provided to show that medical technologies are less important for health improvements in large communities than what people do and can do for themselves; 2) economic planners increasingly are convinced that development is more a result of an investment in people (in their health and education) than in machinery, and efficient use of this investment is possible only with community involvement; 3) health care services are being misused and underused, a situation it is thought possible to rectify by involving clients in decisions about the development of these services; 4) the problems of injustice and maldistribution of health resources can be addressed as lay people, especially the poor, develop, maintain and control their own health programmes.

Community participation in health care has raised many assumptions and expectations among health planners. One is that community people are a great untapped resource potential which, if mobilized, can contribute to the scarce pool of existing health resources to actually reduce the cost of health care by providing additional manpower. Another is that communities are homogenous entities which are able to agree upon a course of action which would enable a more equitable distribution of existing resources. Also, planners expect that health is a priority for community people, who, thus, will be motivated to spend their precious time and energy, especially scarce among the poor, to improve services and care. Finally, it is expected that community people want to participate in their own health care because they wish to serve their communities and to have a part in decisions which affect their daily lives.

In the 1970's, the belief in and the rhetoric of community participation in health care mushroomed. Inspired by the alternative health care models and the increasing concerns of social justice, health care planners, particularly in the less developed countries, looked to community participation as the panacea for problems of scarce resources, unequal distribution of resources and medical domination of health policies. How real were these expectations?

The answers to these questions now are begin-

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Integration of Vertical Programmes in Multi-Function Health Services

Preconditions, Limits and Potential of Integration

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Introduction

The concept of integration has been the subject of differing interpretations. For example. during an international conference on the prevention of HIV and AIDS[1] the concept of integration was much discussed in the sense of the integration of services in the execution of a programme, or in the sense of greater collaboration, or indeed a *fusion,* between two programmes (for example a programme for the control of sexually transmissible diseases and a family planning programme). Little consideration was given to the integration of certain programme activities in the package of activities provided by a polyvalent (multi-function) service. There is a need, therefore, to clarify these problems.

This paper seeks to contribute to the debate by discussing the concept of integration and the operational implications of integration. For this purpose we base our discussion largely on the study and experience developed by the Public Health Department of the Institute of Tropical Medicine in Antwerp in the course of its history and on a review of the literature on the concept of integration.

The concept of integration which we propose to discuss in this chapter therefore concerns the activities included in programmes in multi-function health services. After clarifying the terminology and the conceptual framework in which we understand integration, we shall discuss the potential and the limits of integration. We shall then consider the problems encountered when the integration of certain activities involved in vertical programmes is decided on, and we shall attempt to formulate the preconditions of integration and the practical questions which must be answered if integration is to have a chance of succeeding.

Theoretical considerations

It is important to establish clearly the definitions of certain terms which will be used in this discussion of integration (Kegels, 1992).

Vertical structures

Vertical programme

A vertical programme consists of a coherent package of activities designed to deal with a single health problem or a group of linked health problems. The content of a programme (the package of activities and tasks aimed at dealing with a particular problem) is the result of a technical analysis based on a vertical approach. The creation of a programme is the result of a *political* decision which *ipso facto* recognises the importance (epidemiological, economic, social, cultural or political) of the health problem and thus justifies the establishment of a specific administrative structure to be responsible for the management of the programme.

[1] USAID Conference on Prevention of HIV/AIDS, Washington, August 1995.

Thus a vertical programme may be established to manage more effectively the control of a particular disease (for example leprosy or tuberculosis), to manage a group of linked health problems (diarrhoeas, acute respiratory infections), to manage the health problems of a particular population (problems associated with maternity), to structure existing activities (e.g. vaccinations) or new activities (in the AIDS context, for example), etc.

Vertical structure

A vertical structure is a health structure staffed by specialised (monovalent, "single-function") personnel highly qualified in a particular field[2] who are responsible for dealing with a single health problem (or a limited number of problems). Very frequently (but not always) a vertical structure operates on a periodic basis; it may remain centralised or may operate in a decentralised fashion (for example with mobile teams). The establishment of a vertical structure for the control of a particular health problem ought (at least in principle) to be the result of technical consideration and analysis.

Horizontal structures and integrated health care services

Horizontal structure

A horizontal structure is defined as a health structure in which a multi-function staff, responding to the needs felt by the community served, is responsible for dealing with a wide range of health problems. A horizontal structure is decentralised and operates on a permanent basis.

Integrated care

Integrated care means that the care provided in curative, preventive and health-promotional activities is offered by a single operational unit. (A distinction can be made between integration of care in time and integration in space[3]).

Integrated health system

An integrated health system is a system in which all the elements of which it is composed (basic health services, referral hospital, etc.) are organised and coordinated in such a way that they constitute a single entity with a common objective. For example in an integrated district health system the activities of the health centres and the referral consultations at the

[2] Though not necessarily with a formal specialist qualification.

[3] Integration in time means that all services are available at the same time, so that at each contact with the service a patient can have access to any type of care. Integration in space means that all services are provided by the same team but at different points in time (for example curative consultations in the morning and preventive consultations in the afternoon).

hospital are coordinated with the object of improving the health of a well defined population living within the administrative boundaries of the district.

Integration of the health activities of a given control programme

This is the result of a decision to have particular activities, decided on in the context of a programme, carried on by staff working in horizontal structures, accompanied by a transfer of responsibilities. *Integration* thus implies a decentralisation of both administrative and operational responsibilities (Mercenier and Prévot, 1983; De Brouwere and Pangu, 1989; Feenstra, 1993). We can thus talk of administrative (or structural) integration and operational (or functional) integration (Mills, 1983).

Relations between basic health services and vertical programmes

In a district health system multi-function health services are organised in a network of health centres associated with primary-level hospitals. Structures of this kind can be called horizontal. In many developing countries the running of a health centre is in the hands of a nurse or medical assistant heading a small team. In other developing countries and in most industrialised countries health centres are headed by generalist doctors.

The health policy option considered by the authors of this paper sees the health centre as the first point of access for patients to a formal health formation, lying at the very heart of the health system (Figure 1). The health centre has comprehensive responsibility for the patient, to which it gives effect by offering a minimum package of continuous, comprehensive and integrated care, covering curative, preventive and health-promotional activities. It is at this level that all relevant information concerning the patient is archived and brought together.

Figure 1: Operational structure of health services

The care provided by health centres is fundamentally characterised by its potential for developing the interaction of human and relational aspects between the service and the community it serves much more than by the technical level of the care provided. In other words the quality of care is defined not only by reference to technical performance but also in terms of its capacity for communication between health care staff and patients, the accessibility of the service, the degree of continuity of care offered, etc.

There is a dynamic equilibrium between the offer of integrated care and the "need" to structure certain forms of care through vertical programmes. It will depend on the emergence of new health problems, the level of resources available (in terms of the qualification of health personnel and of equipment and supplies) or on political preoccupations at national level.

- ***structuring of existing activities***

  A multi-function health service may decide at a particular point in time to structure all the various tasks which it offers for dealing with a particular health problem in a programme, with the object of improving its effectiveness and/or efficiency. For example it may decide to draw up a programme for structuring its measures for dealing with diabetes, high blood pressure or acute respiratory infections.

- ***Establishment of new activities under new programmes***

  New programmes may have been established because of the appearance of new problems, either on a national (AIDS) or a local scale. The basic health services are then alerted to the new problem and staff are trained for the complex of tasks which they will have to integrate into their activities in order to deal with the new problem.

- ***Transfer of activities from vertical structures to basic health services***

  At some point it may be decided, for good reasons or for bad, to dismantle a vertical structure and transfer its activities to basic health services. This was the case with tuberculosis after the dismantling, in some countries, of networks of specialised dispensaries. It is also regularly attempted in the arrangements for the treatment of lepers, when the activities run by vertical structure are transferred to basic health services.

- ***Transfer of integrated activities to vertical structures***

  Conversely, certain activities run by basic health services may on occasion be transferred to a vertical structure which is considered more appropriate.

The discussion on integration may thus be approached from two complementary points of view, each the mirror image of the other:

- on the one hand, from the point of view in which integration is considered the *normal state of affairs* and discussion centres on possible preconditions and reasons for de-integrating, that is to say removing a particular activity from the package of activities of a multi-function service of first contact and making it the responsibility of specialised personnel. The question

then becomes: when should de-integration take place? In what circumstances is the multi-function health worker, the generalist doctor, no longer the most suitable person to organise a particular activity?

- on the other hand, from the point of view in which discussion centres on the question: when should an activity not previously integrated be integrated?

Conceptually, the former point of view is more coherent, since it consistently sets the multi-function health service (for which the various health problems to be dealt with are on each occasion only relative priorities) at the heart of the health care system. From this point of view a multi-function service is, *until proof of the contrary,* the one best placed to run a particular activity. De-integration then becomes the exception for which a case must be made.

The second point of view, however, can claim to be more in line with reality as it frequently presents itself today; and this is broadly the point of view adopted in this chapter. This reality is the situation in which, whether we like it or not, many health activities are compartmentalised: that is, are not integrated. It is perhaps partly the consequence of a vision of health, still too fragmentary and selective, in which the relativity of each health problem is not realised. In this point of view discussion will centre on the arguments which would justify a transfer of activities previously carried on by vertical structures to multi-function health services.

Potential and limits of integration

In certain circumstances, and for certain activities in a particular programme for dealing with a health problem, the integration of that programme in multi-function health services may be an appropriate strategy for making the services offered more efficacious, more efficient and more equitable. This is not, however, always the case. Integration, therefore, is not an end in itself (Mills, 1983).

Integration is justified only when some benefit is to be expected: that is, when it is more advantageous for a particular health problem to be made the responsibility of multi-function health services. This benefit must, therefore, be spelt out and supported by argument. The justification for integration then becomes a crucial question. The answer must be based on *technical* and not on *ideological* grounds.

The rationale and motivation of integration must be of a positive nature: integration should be undertaken to bring about an improvement - for example because the handling of cases will benefit from a comprehensive and integrated approach, or to achieve early detection or the proper carrying out of treatment (Lehingue and Urtizberea, 1985; Walley and McDonald, 1991), or because integration will improve the accessibility of services (Dharmshaktu, 1992; Courtright and Lewallen,

1992), or because it will reduce any stigma that may be attached to some particular health problem, etc.

In reality, however, it is not uncommon to find that the underlying rationale of integration is not demonstrated (Dechef, 1994) and it is simply taken for granted that integration is better; nor to find that the rationale is of a *negative* order. As an example we may take the situation (regrettably very common) in which integration is decided on because of a lack of resources to maintain a vertical structure (Tonglet et al, 1990; Warndorff and Warndorff, 1990). In such a case integration is a makeshift solution, decided on unilaterally by the managers of the vertical programme, in which multi-function health services are manipulated rather than used to take advantage of their potentialities.

The problem is not to integrate programmes, but rather to integrate activities or even tasks in a programme (Figure 2). From this point of view integration is not a standard operation, carried out at constant speed and intensity whatever the context may be (Bainson, 1994). It may be more advantageous to integrate an activity in certain situations than in others. Integration is thus not an all-or-nothing question. And it does not mean that the vertical programme should disappear (Mercenier and Prévot, 1983), or that specialised personnel have no longer any part to play (Loretti, 1989; Tonglet et al, 1990; Feenstra, 1993): quite the contrary.

Figure 2: Integration of programmes versus integration of activities or tasks

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Problems encountered in the process of integration

Integration is a process which meets with considerable resistance from the staff concerned

The various members of staff concerned by integration may, in varying degree, oppose it (Feenstra and Tedla, 1988; Bainson, 1994). This resistance may be technical, conceptual or human (Mercenier and Prévot, 1983).

Resistance by specialists

Specialists may fear a decline in the technical quality of the health care provided. They may also be afraid of losing power or losing their control over the running of the vertical programme and its content (Huntington and Aplogan, 1994). For integration is more than a mere operational decentralisation of activities in space, from a specialised and centralised structure to a decentralised and multi-function structure. It involves a real transfer of responsibilities, rights and duties to the "horizontalists", the staff responsible for running multi-function health structures.

However a situation in which certain activities or tasks in a given vertical programme are always carried out by the central level of a system is not necessarily in contradiction with a policy of integration. Let us return to the example of the tuberculosis control programme in Figure 2: there is no contradiction between the fact that the diagnosis of tuberculosis is still made at the central, specialised level and the situation in which a decentralised multi-function health structure has overall responsibility for the care of patients. In this situation the multi-function health structure uses the specialised service in the same way as a generalist uses a laboratory to have his examinations carried out. The centre of decision remains at the point where arrangements for the comprehensive care of the patient are made.

Resistance by the providers of funds

If the management of resources is to become the responsibility of horizontal structures there is a real risk of problems in the supply of those resources; for very frequently the resources supplied by international fund providers are rigidly linked with budgetary items earmarked for financing precisely specified elements in vertical programmes. Their management by multi-function health services, for which this health problem is only one among many, makes it likely that some of those resources will be used for other activities which have little connection with the particular problem for which the resources were offered by these bodies.

The providers of funds are disinclined to support this kind of situation, not least because it could have a negative effect on the raising of funds; for funds are increasingly being raised through the media, for which it is necessary to have a single, simple - even simplistic - message, inevitably isolated from its context.

Moreover these strategies designed to generate funds make it necessary to offer those who give money tangible results in the short term which justify the use of the money given (in terms of health care coverage, for example, or the number of human lives saved); and this is evidently not a realistic objective, at least in the short term, for the integration of activities included in a vertical programme.

Resistance by the "horizontalists"

There may also be resistances within multi-function health services for social and cultural reasons. Integration may be rejected by the staff of a multi-function health service because social disapproval or the stigma attached to a particular health problem would lead the population to object to the mixing of patients with that problem and other patients. This perception is, of course, dynamic and will change with changing values in society.

Integration may also meet staff resistance because of the overload of work which it involves[4]. Integration can thus have an upsetting effect on the operation of multi-function health services (Unger, 1991).

Resistance by patients

The integration of arrangements for handling a health problem in multi-function services may also have implications for patients in terms of the loss of privileges: for example the loss of free treatment for their particular problem[5], or the loss of other advantages (e.g. gifts of food[6]), etc. Evidently these patients will take a poor view of this and will tend to oppose a process of integration which will make them "normal" patients just like the others.

Patients may also oppose integration if they see the multi-function service as a second-best to a specialised service.

There is a price to be paid for integration

There is a price to be paid for integration in terms of technical efficacy, resources (guides and instructions, basic and continuous training, equipment and recurrent costs) and in terms of organisational changes. The price to be paid is linked with the *relative* importance of the health problem for which integration is to take place among all the various problems of which people are conscious, about which they complain and which they bring to the multi-function health services (Table 1). For example when an immunisation programme is integrated there may in consequence be a fall in coverage.

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[4] A situation in which the frequency of a problem is (still) high, involving a substantial increase in work load for multi-function staff, could be a deterrent factor in the introduction of a process of integration of activities for dealing with that problem.

[5] In the Belgian Congo leprous patients sometimes objected to being offered the prospect of cure. A former leper then became an individual like any other patient and lost such privileges as free health care, exemption from taxes, free accommodation, etc. (personal communication from H. Van Balen).

[6] This is the case, for example, in Uganda with AIDS patients.

Table 1: Differences between the approaches of managers of vertical programmes and managers of horizontal services

One sacrifice which must be accepted is a fall in the technical quality of the services provided (at least in the short term). By definition, a health worker in a multi-function health service (for example a generalist doctor or a health centre nurse) will never have the technical competence of a specialist in a particular field. And of course if this were not so the specialists would have no *raison d'être*.

Integration is thus not always possible even if it is desirable. Techniques, instruments and tasks which are integrated should be designed in such a way that they can be used by multi-function staff. It is necessary, therefore, to prepare and circulate guides and standardised instructions suitable for multi-function staff, who will frequently have only limited qualifications.

Perhaps the most immediately visible cost of integration, at least in the short term, is the cost of the training programme for multi-function staff (Ross, 1982). The cost of an initial programme of specific training can of course vary very considerably between one problem and another. There are also the costs of the continuous training of multi-function staff (mainly the cost of supervision), particularly in the short term; for these costs can be very considerable during the first phase of integration, which makes more intensive supervision necessary.

Integration can also increase the recurrent costs of a multi-function health service (Brédo, 1991). Again, these costs will vary considerably between one problem and another, and it is difficult to quantify them. For example it might be necessary to buy specific drugs or additional equipment for multi-function services. It may also happen that the costs associated with the general logistics of multi-function health services increase because of integration, or that it becomes necessary to recruit additional staff to cope with the increased work load.

Some of these costs may, however, be recovered if the specialised vertical structures are discontinued.

Preconditions of integration

Basic health services must be functional

There is no point in integrating when multi-function health services are not operating properly. How can you integrate in something that isn't there?

How will integration work when the overall performance (both technical and relational) of multi-function health services is poor? Clearly the success of integration in these circumstances is very doubtful: a vertical structure may then be completely justified (Roos and Van Brakel, 1994).

However, if we are to be able to answer this question properly we must take account of the context:

- **What resources are consumed by the vertical structure?**

  Have the costs involved not become too high? The resources - or some of the resources - allocated to the vertical structure (which is concerned with only a single problem) could in actual fact be used to increase the functional level of the multi-function health services (which have to deal with a variety of problems) if it is really a lack of resources that is the principal cause of their dysfunction.

  In other words, the functional level of multi-function health services is a *variable* and not a *constant*.

  Integration may offer an opportunity to invest in the overall functioning of multi-function health services[7].

  Integration may be a means of enhancing the prestige of the service and thereby increasing the satisfaction and motivation of the staff of multi-function health services[8]. An interesting hypothesis to test would be to see whether a marginal benefit of integration is to trigger off the development of multi-function health services (even though this is not the principal objective of integration). It could improve the ability of multi-function health services to respond to the wide spectrum of problems presented by the population (Loretti, 1989).

- Is there advantage in having a monovalent (single-function) vertical structure concerned with a single problem in a context in which the functioning of multi-function health services is poor? This can be justified only insofar as such a health problem is so common and so

[7] For example resources for regular supervision may become available.

[8] For example the decision to equip health centres with microscopes under the tuberculosis control programme. The microscope can be used for purposes other than the diagnosis of tuberculosis. An improvement in the ability of multi-function health services to respond to problems with additional technical capacity can increase the confidence and the credibility of these services.

serious that its control can be felt by the population as a real improvement in their wellbeing (for example epidemics of very serious problems such as African trypanosomiasis: Kegels, 1992).

Integration should be decided on at an appropriate time

- ***Integration when the problem has become less common: too late***

  Frequently integration is decided on because the problem has become less common[9]. This is what we have called a "negative motivation". In a situation in which the frequency of a health problem is steadily falling the marginal cost of a specialised service becomes increasingly high: a stage of decreasing return has been reached.

  The managers of a vertical programme may then decide to integrate because the unduly high marginal costs of the specialised service become unacceptable to them (and to the providers of funds)[10]; *but not (necessarily) because the staff of the multi-function health services would really be offering a "plus", a significant improvement in the quality of care.*

In reality a situation of low prevalence may be a reason for *not integrating*, since:

- the specific work load of the multi-function health personnel could be so low that they would not see enough patients with this specific problem to maintain their technical competence in handling the problem. For example, how can (non-specialised) staff be expected to identify correctly a new case of leprosy if leprosy has become a very rare problem in the community? In the long term it is the credibility of the multi-function staff that is called in question, and there is then a risk that the community may lose confidence in their abilities. In such a context integration would have clearly negative repercussions and the managers of the vertical programme would have no difficulty in demonstrating that integration was a failure.

- a problem which has become rare may no longer be a need felt by the community[11]. As a result it will be difficult to secure their participation in the process.

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[9] Most of the literature on integration refers to the problem of leprosy. It is notable that for most authors the main argument for deciding to integrate is precisely an *epidemiological* one (i.e. a fall in prevalence).

[10] Very high marginal costs could in fact be justified in a situation in which the health problem could be eradicated: that is to say, a situation in which a permanent impact can be hoped for (as was the case with smallpox). They would be less justified in a context in which the very high costs have to be carried indefinitely. For example it will never be possible to "eradicate" the demand and the need for family planning services.

[11] This will depend, of course, on the type of problem and on the sub-groups of the population mainly affected by the problem. For example diabetes is a relatively rare health problem in many developing countries, but it affects older people, who are an influential group.

- the staff of multi-function health services will have little incentive to take a training course for a rarely occurring problem[12].

To integrate in a context of this kind may form a serious handicap for the staff of multi-function health services at the very beginning of the process of integration. This may also be the case when it is proposed to integrate the activities for dealing with a problem which has just emerged and is still relatively rare: it may then be too early to decide on integration.

- ***Integration in a situation of emergency: is there any benefit?***

  An emergency situation calls for a rapid response. Multi-function health services do not seem the most appropriate facilities for handling a situation of this kind.

  The rapidity of response will be determined by the load of routine work falling on these health formations and on the amount of work required to deal with the emergency. For example it will not always be possible or acceptable to stop all their routine activities in order that they may deal with the emergency. Moreover multi-function health services will often not have the appropriate means to do this work properly. And finally it would be necessary to evaluate - independently for each such situation - what additional benefit there is in using multi-function staff (rather than specialised staff) to deal with a particular emergency situation[13].

Integration involves a transfer of decision-making power to multi-function health services

Integration may involve the disappearance of specialised health care structures, but not the elimination of the programme and/or the specialised staff, at the most centralised levels of the health system. As noted above, the establishment and the existence of a vertical programme is a political decision reflecting the fact that a given problem calls for particular attention (even if the problem is not a need felt by the population[14]). A vertical programme, therefore, may not depend on specialised vertical structures: whether or not specialised vertical structures should be used, and at what level of the health system they should be operational, are questions the answers to which lie in the technical field.

Integration involves administrative and operational changes at the level of multi-function health services, since there is no point in integration unless the multi-function health services have been

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[12] World Health Organization. Report on a consultation on the operation of leprosy control in the context of primary health care. MOS/CDS/lep/86.3.

[13] For example, what would be the specific contribution and the benefit of having multi-function staff involved in dealing with cholera? In the case of cholera there is an urgent need of people skilled in such essential techniques as rehydration and intravenous perfusion. No other particular technical skill is required. A hospital auxiliary may very well be the most competent person.

[14] For example a decision to establish a vertical family planning programme may be founded on macro-economic or demographic motives.

given the means to deal adequately with the problem, taking account of the level of qualification and work load of their staff. Integration will necessitate - in varying degrees - supplementary training, appropriate instruction manuals, closer supervision, etc. This implies that the managers of the multi-function health services must have sufficient administrative authority and operational control: *it is very difficult to achieve successful operational integration unless there is concomitant administrative integration.*

A practical example which illustrates this point concerns supervision. Most of the work and studies on integration stress the importance of supervision. One important question, however, remains (Smith and Bryant, 1988): who should carry out the supervision? the specialist or the manager of basic health services? what are their respective roles?

If there is operational but not administrative integration, there is a danger that a situation like that shown in Figure 3 may arise, with various specialists visiting multi-function health formations to supervise activities carried on at that level under a specific vertical programme. There might thus be several specialised supervisors supervising different programmes, possibly leading to overlaps and contradictions which become a source of confusion for the staff being supervised. The main concern of specialised supervisors is to check that their particular programme is being properly carried out. There is then a real risk that the multi-function structure may be seen as an appropriate instrument for developing the activities of each programme in relation to their particular objectives and that the multi-function health care unit will be used to serve the purposes of various specific programmes.

Figure 3: Supervision in the context of operational integration without administrative integration

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Administrative integration means that the managers of multi-function health services are responsible for supervision; they will monitor the quality of health care in general and not merely the quality of the handling of a limited number of health problems (Mercenier and Prévot, 1983). A situation in which a multi-function supervisor follows the various activities carried on in a health centre is *not* in contradiction with the involvement of a more specialised supervisor at a particular time, provided that the multi-function supervisor is a person who appreciates when and why it may be appropriate to seek more specialised expertise and what particular expertise is needed (Figure 4). Not only is there no contradiction in having a specialist associated with the arrangements for supervision: it would be foolish not to use him when appropriate.

Figure 4: Supervision in the context of operational and administrative supervision

Integration calls for a remodelling of objectives

Integration entails a redefinition of the objectives of the programme. Instead of aiming at a relatively short-term epidemiological impact, the objective should be to offer an appropriate response to the suffering[15] of patients. The integration of control activities in multi-function health services can clearly form part of a policy whose objective is to have an epidemiological impact, for example in terms of reducing the incidence of the problem; but this should not, and cannot, be the prime objective of integration. Nor would it be right to impose an epidemiological impact as the objective to be achieved by integration (Criel, 1992).

The corollary is that the absence of impact on the frequency of the problem after integration does not (necessarily) mean that the policy of integration has failed.

The framework and the criteria for the evaluation of integration must therefore be adapted. The results expected from a policy of integration must be clarified from the very outset and must be clearly formulated. Multi-function health services cannot be expected to achieve results which it is impossible for them to achieve; moreover it is fundamental that the specific characteristics of the potential contribution to be made by multi-function health services to the control of a given health problem should also be recognised and developed.

Conclusion

Integration cannot succeed without a dialogue between specialised staff and the staff of basic health services.

A dialogue between specialised and multi-function personnel is necessary from the very beginning, so as to promote the best possible mutual understanding between two different logics:

- The logic of the system of multi-function health services is to respond in an appropriate manner and in a dynamic perspective to the needs of the population[16] without the imposition of any specific target from outside[17].

[15] We consider this suffering expressed by patients as a demand.
[16] Where the health problem in question has only relative priority.
[17] Since the achievement of any such target may interfere with locally defined priorities or even be opposed to them.

- The logic of the system of specialised services is to achieve quantified and relatively well defined objectives in the control of a particular health problem[18].

A dialogue is also necessary to appreciate the specific characteristics of the other partner's potential contribution. A rational discussion on the sharing of activities and tasks between specialised and multi-function staff can then take place.

Even if the two logics differ it is undeniable that there are sufficient overlaps between the two systems in terms of objectives: both of them desire to improve the care provided to patients. Sufficient common ground exists to initiate the dialogue. The starting-point should be what is common to the two systems and not what distinguishes them from one another. Both systems should benefit from integration: if this were not so, integration would yield little result or would have negative effects on multi-function health services, or both.

As has been shown above, it is important to organise a discussion between specialised and multi-function services on a technical basis and not on an ideological basis or on the basis of institutional arguments. In that case there would be a real risk that each partner would cling to its own positions, and the result would be a service of poor quality of which the patient would be the first victim.

Before contemplating the integration of the activities of a programme in the basic health services it is essential that every health service manager should ask himself the following three questions: Is it advantageous to integrate? Is this the right time to integrate? Is it possible to integrate?

[18] Once the vertical programme has been established its sole function is to deal with a given problem. The idea of priority, therefore, has no relevance.

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Tables and Figures

Table 1: Differences between the approaches of managers of vertical programmes and managers of horizontal services

Manager of a vertical programme	Manager of horizontal services
an approach by health problem: a vertical logic	an approach by service: a horizontal approach
an epidemiological objective	a social objective
methodology: a rational approach, top-down	methodology: a response to needs felt by the population
the problem has a character of absolute priority	the problem has a character of relative priority
evaluation centres on a reduction in frequency of the given health problem	evaluation centres on a reduction in human and social suffering created by health problems in general
tendency towards maximalisation	tendency towards optimalisation

Figure 1: Operational structure of health services

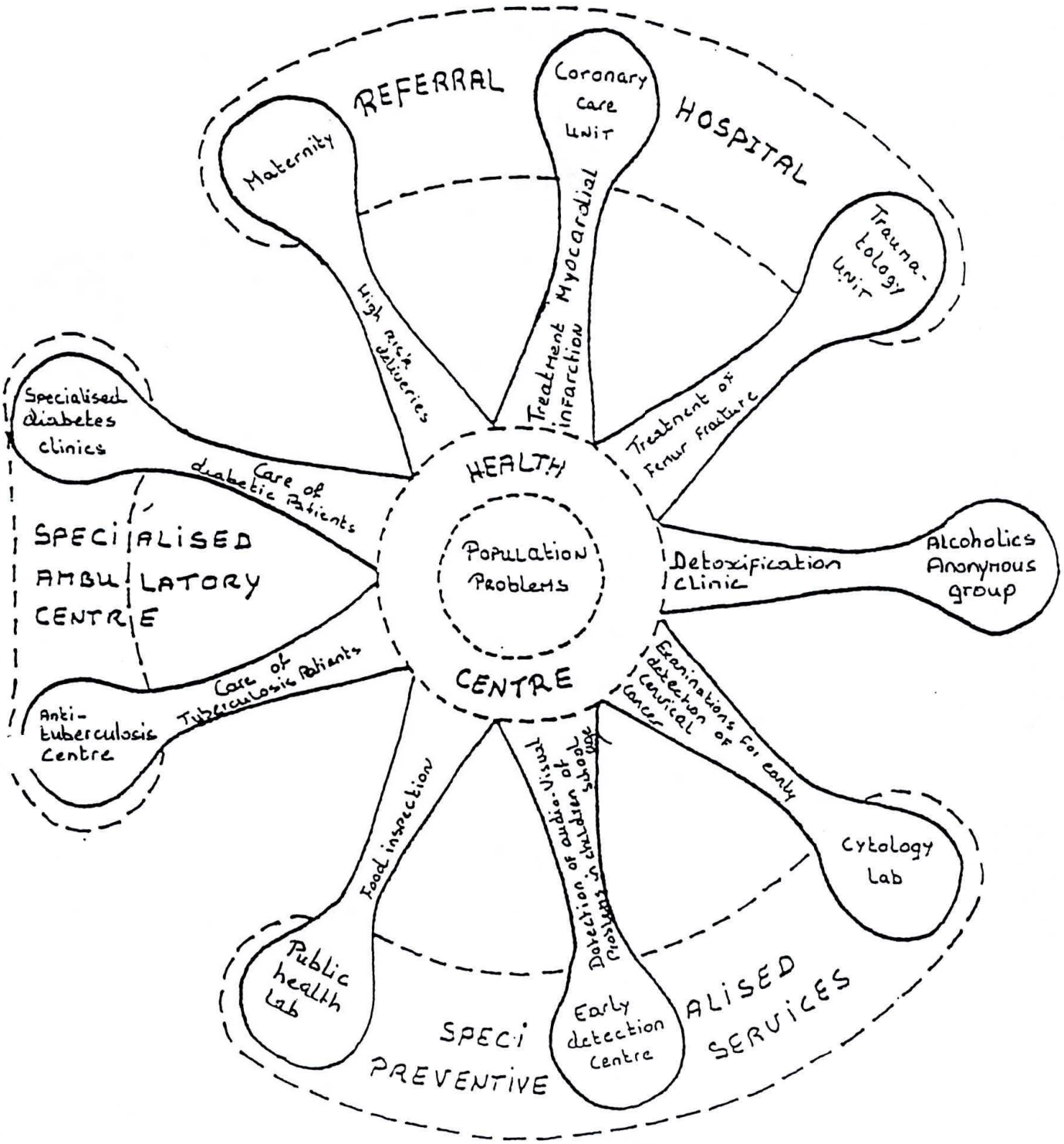
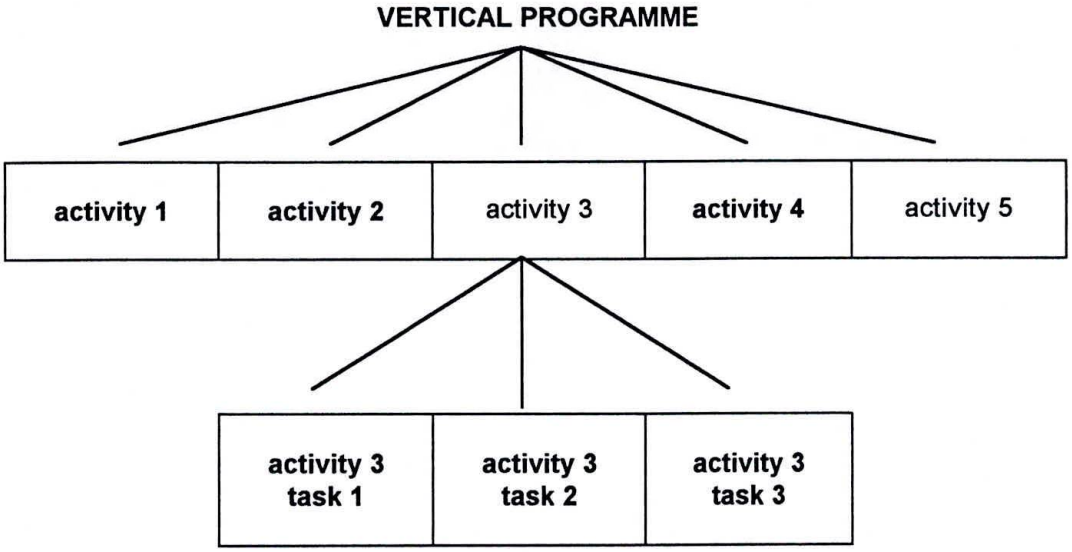


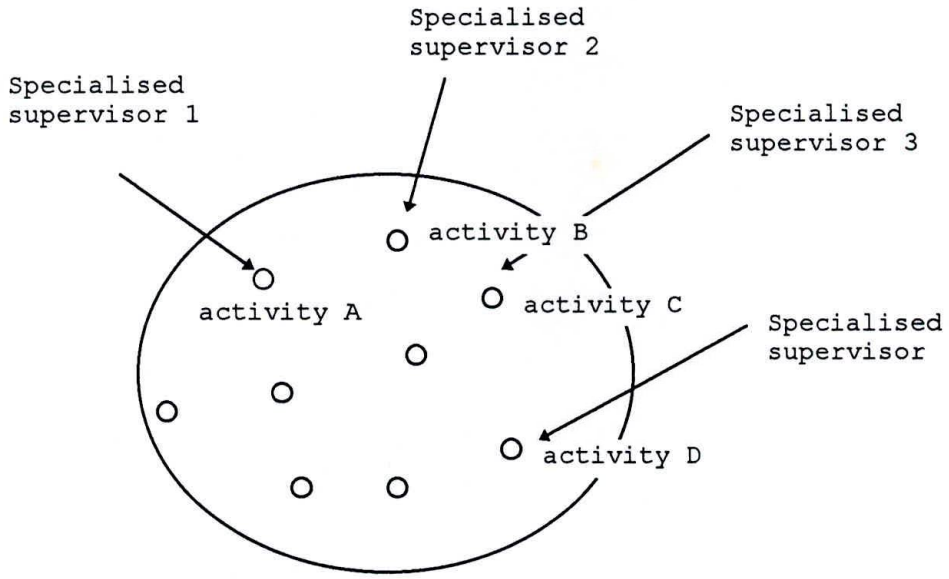
Figure 2: Integration of programmes versus integration of activities or tasks



A programme is made up of a a group of activities; an activity consists of a series of tasks.
In the above diagram activities and tasks in bold type are integrated; the others are not.
Activity 3 may be taken as an example. In the vertical programme of tuberculosis control one of the activities is the passive detection and treatment of cases. It may be decided to integrate the detection of suspects in multi-function health services (task 1), and also the treatment and follow-up of patients diagnosed as tuberculous (task 3), but not the diagnosis (task 2). One of the reasons for not integrating this task might be that there are not sufficient resources: for example no resources for the purchase of a microscope in the multi-function health services. The diagnosis could then be made by a specialised service, and the patient could return to the health centre for treatment and follow-up.

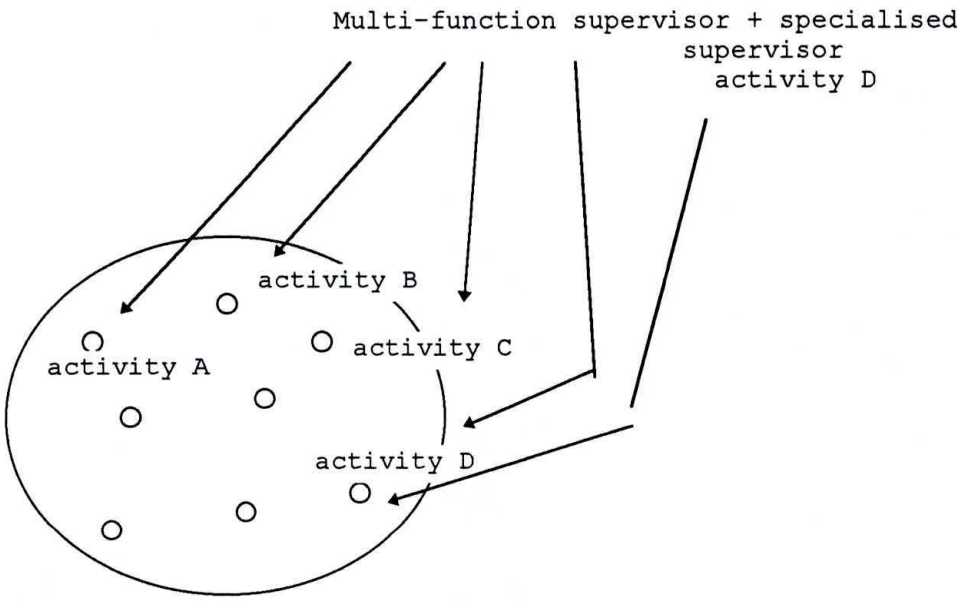
Certain activities in a programme should not be integrated unless there are solid reasons for doing so: for example quality control, epidemiological surveillance, fundamental research. etc. These activities also require the involvement of specialised personnel.

Figure 3: Supervision in the context of operational integration without administrative integration



Multi-function health structure

Figure 4: Supervision in the context of operational and administrative supervision



Multi-function health structure

HEALTH POLICY AND PLANNING; 12(3): 193–198

Viewpoint: Public versus private health care delivery: beyond the slogans

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In most settings, a 'public' health service refers to a service which belongs to the state. The term 'private' is used when health care is delivered by individuals and/or institutions not administered by the state. In this paper it is argued that such a distinction, which is based on the institutional or administrative identity of the health care provider, is not adequate because it takes for granted that the nature of this identity automatically determines the nature of the service delivered to the population. A different frame of classification between public and private health services is proposed: one which is based on the purpose the health service pursues and on the outputs it yields. A set of five operational criteria to distinguish between health services guided by a public or private purpose is presented. This alternative classification is discussed in relation to a variety of existing situations in sub-Saharan Africa (Mali, Uganda, Zimbabwe). It is hoped that it can be used as a tool in the hands of the health planner in order to bring more rationality in the current altercation between the public and the private health care sector.

Introduction

There is a growing interest in increasing and improving co-operation between the public and private sectors in the field of health care delivery, particularly in the developing world. A range of different explanations for this boost in interest can readily be identified. For a start, the already scarce resources for health care are dwindling yet further and linkages with the private sector may raise additional resources. There also is the gradual acknowledgement of the need to develop a *systemic* approach to health care delivery. The private sector is an important actor in this system, and can, under certain circumstances, substantially contribute to a consistent development of health systems.

Our field experience in sub-Saharan Africa confronted us with the rigidity, and even the strong emotions, that often tend to colour this debate on co-operation between the public and private sectors. The relative lack of rationality and objectivity in these discussions has contributed to a state of affairs where the concerned interlocutors clutch at their respective positions. It is common, and even natural, to notice a certain diffidence among civil servants and public health managers towards matters outside their control. The private health sector has often grown independently from the public health sector and is rarely taken into account in health planning scenarios. This has been the case in Uganda where the non-governmental sector, which generally has been in the forefront of the development of primary health care initiatives and which accounts for about 65% of the current primary health care delivery in the country, is rarely taken into account by the District Health Teams in their planning exercises. On the other hand, there is often in the private sector an excessive jealousy for its own independence, with a disregard of policy guidelines, aversion to evaluation, and hostility towards regulative measures.

It is increasingly evident that co-operation between the public and private sectors is a must in a systemic view of health service provision and in order to avoid expensive and useless duplications. In this perspective, it becomes important to move towards an ever progressive integration into the health system of all elements accepting a 'public' rationale of operation. But the definition of 'public' is, at present, somewhat hazy and needs focusing. The purpose of this paper

is to contribute to a proper definition and understanding of the terminology. We acknowledge the limitation of this paper to the specific context of sub-Saharan Africa. We intended it to be this way, since we believe the misconception to be stronger in that part of the world than elsewhere.

The confusion: what is the meaning of *public* and *private*?

In our view, one of the major stumbling-blocks in the process of understanding is the lack of consistent use and interpretation of the terminology public and private, be it conscious or not. We think attempts merely to answer the questions 'what is a public health service?' or 'what is a private health service?' would reveal the heterogeneity of views on the matter. The purpose of this paper is precisely to present some thoughts on *how* these very words 'public' and 'private' are used and to attempt to clarify *what* content they should refer to. We think that the development of a more coherent vocabulary is a necessary step in the broader process of co-operation between public and private sectors in the field of health care, or in any other social field for that matter.

In the majority of situations, the definition – both implicit and explicit – of a *public* health service refers to health care institutions *belonging* to the state. In sub-Saharan Africa, health care delivery is often supplied by private individuals and/or institutions whose ownership and/or administrative guardianship is *not* the state. In that case, the term *private* is used. It is generally understood that the public health sector should be supported by public money and protected by a series of privileges regulated by law, while the private health sector should operate on private funding, obtained through fees, donations or other means in the arena of a market oriented provision of service and of competition. This understanding is based on the assumption that the private sector is homogeneous and financially self-sustaining whereas, in reality, a remarkable heterogeneity exists in the private/non-government sector (DeJong 1991; Green 1992; Zwarenstein and Price 1990; Smith 1989).

Generally, when the service is rendered without lucrative purposes the specification 'not-for-profit' is added. The term 'non-governmental' is used to indicate organizations offering services without profit-making purposes, and whose ownership and/or administrative guardianship is not the state. We think that a distinction between public and private based on the institutional or administrative identity is not always adequate in dealing properly with the variety of existing situations.

The limits of this classification can be exemplified by the mushrooming number of non-governmental organizations operating for outright or hidden lucrative purposes. At the same time, there are public services which operate, to varying extent, on a lucrative basis, even if the intensity and the sometimes radical character of this shift in rationale within public facilities has not necessarily been the result of the planned choice of policy-makers. Examples of such shifts are the situations of some government hospitals in Zimbabwe and Uganda. In both countries, m l officers are allowed to develop private practice in tandem with their responsibilities and tasks in the hospitals. In the case of Zimbabwe, this measure is part of a broader effort aiming to attract national medical officers into the public sector in a context of massive brain-drain to neighbouring countries or to the private sector. In the case of Uganda, it grew out of a legitimate concern to increase the revenue of national doctors beyond the extremely low level of government salaries. In both countries, government officers are allowed to use the hospital infrastructure and hospital resources for treatment of private patients who pay them a fee, but without recompense to the hospital.

The gloomy prospect is one of governments ending up subsidizing – with tax-payer money – a private lucrative sector where basic measures of quality control are lacking and with a poor accessibility for lower income population groups. A 'two speed' health care system becomes a real threat – the same government would instead deny subsidies to private institutions striving, but finding it increasingly difficult, to r financially accessible services, often at lower s than those observed in public institutions.

The core of the matter really is that the adjectives private and public refer to the institutional or administrative identity of a given health service, taking for granted that the nature of this *administrative identity* automatically determines the nature of the *service* that is actually offered to people. In a time of reform of many health systems, with decentralization as a key element, this assumption can no longer be justified. If a distinction between public and private needs to be made, we think it cannot be based exclusively on the institutional set-up of a given service, but rather on the objectives and the output of that service.

Maintaining a distinction between public and private on the grounds of the administrative identity will only perpetuate confusion, prejudices and discrimination (positive or negative but, in either case, inadequate to the changing context). In Uganda for instance, the non-government sector (mainly Church-related not-for-profit organizations) has been able to achieve acceptable levels of health care delivery in some very remote and insecure areas of the country and in environments characterized by important social and political unrest with a *de facto* absence of the state. Nevertheless, the posting of national doctors to these institutions has become very difficult because of uncertain career and training perspectives for those who c[illegible]e to work in them; nurses trained in NGO s[illegible]s, which are formally recognized by the national Nursing Council and the final examinations of which are supervised by government officials, can make their way to the government service only with great difficulty; no or very little government subsidies are being allocated to NGO facilities which are considered by District Health Teams as falling outside their scope of responsibility, even when their importance for the system is openly recognized. The (private) status of these NGO not-for-profit hospitals, and the consequent refusal of support for them from government sources, clearly has hindered long-term development efforts, both for the NGO and for the state.

Such a distinction will hinder the dialogue between the different components of the health system at a time when each one's contribution and co-operation is necessary. Indeed, in the light of decentralization policies implemented in many developing countries, the institutional set-up of many decentralized 'public' health services is far less clear-cut. In the past all public health services, with few exceptions, belonged to and were financed by the state, represented by the Ministry o[illegible]lth. Today, there is a trend towards decentralized ownership and management by local communities, co-operatives, administrative districts etc.

Such a trend can be exemplified by the case of the network of community health centres ('centres de santé communautaires') gradually put in place in Bamako (Mali) from 1989 on. Former rural community-based experiences in the public sector served as an inspirational basis for young medical doctors who could not be hired by the government and who remained, jobless, in the capital of the country. With some initial external help, three or four health centres were organized so as to offer basic curative, preventive and promotional services. The owners of the facilities were members of community associations created for the purpose and the aim of these health centres was to provide health care to the subscribing members through a system of cost-recovery. Later, a 'second' generation of centres was put in place with virtually no external help other than small in-kind loans by existing centres. These new centres built up their revolving drug fund through the initial voluntary work of their employees. Several of them acquired grants from different donors, but only at a later stage.

The government played a promotional and regulatory role by considering these centres as active partners in its health development efforts. The existing centres constituted the starting point for geographical health coverage maps drawn up by the urban district teams. They also received small subsidies in kind from the government, especially for immunizations and family planning services. Their revenue was tax exempted and they were granted a special license to sell generic essential drugs. This support was provided in the understanding that the health centres themselves would not generate profits.

The debate on the status of these institutions is still ongoing. Legal texts have defined both the government's and the health centres' responsibilities, but the way the centres were put in place and the pressure from unemployed health workers in Bamako indicate that some of the attention has been diverted from the equitable provision of health care to the raising of revenue, mainly to hire additional staff.

An alternative classification?

What really matters to the health planner *and* to the public, are the contents, the quality and the costs of the package of services offered. For planning and evaluation purposes, and for the allocation of the meagre resources available, it is important that a clear and explicit *declaration of intent*, or mission statement, of the health care institution exists, so that the output and accessibility of these services can be evaluated. In an era of rapid change, it is also necessary to evaluate over time how, and to what extent, the performance of each health care institution fits the mission statement. Hence, we propose a different frame for the classification of health services based on their declared objectives and on their outputs. From thereon, a dichotomous classification in health services with respectively a public or private *purpose* can be proposed. More specifically, we propose a set of

purpose the health service pursues \ *administrative guardianship and/or institutional identity of the health service*	public	private
public	**a**	**b**
private	**c**	**d**

Figure 1. Classification of health services according to their purpose and their administrative status

criteria for the classification of a health institution in the category of 'public':

- A social perspective: a concern to enhance people's well-being and autonomy in a perspective of human promotion. In the case of health services this more specifically means contributing to people's realization of a socially productive life, in a climate of dialogue between all implicated partners and in harmony with the prevailing overall socioeconomic development.

- Non-discrimination: a concern to offer people accessible and quality health care without discrimination whatsoever with regard to race, sex, religion, political affiliation, social status, income level etc. This is not in contradiction with a positive discrimination of specified population groups, deemed to be in particular need of health care (e.g. women, children, disabled people etc), or with a focus on specific health problems in the frame of vertically organized health programmes (e.g. trypanosomiasias control programme, family planning services etc).

- Population-based: a concern to take responsibility for, and to be accountable to, a well-defined population for its health care delivery. This accountability could be based on a contract with the population, specifying the mission statement of the service or institution.

- Government policy guided: a concern to comply with government health policies for the level of care provided and to fit in a broader masterplan. Should any different views arise with regard to official policy, then it is necessary that they be argued, discussed and, when possible, formalized in official agreements between the health institution and the national health authorities.

- Non-lucrative goals: a concern not to reduce the purpose of the service to profit making. This does not, of course, mean that good working and living conditions would not be a right for staff, nor that the service must be run at a loss. On the contrary, it is desirable that any service be self-sustained (this is not always possible; it is even virtually impossible in the case of district hospitals) and that its staff can work in acceptable conditions. In any event, in order to preserve the public purpose of the service, profits made should be reinvested in the same service or in other activities of social interest in agreement with the concerned population.

These criteria, which are currently being tested in the context of district health care delivery in Uganda, do not exhaust the variety of possible criteria identifiable in other contexts. Nonetheless, they provide an instrumental framework which could be used to assess the purpose of health services rather than the administrative/institutional set-up only. Both perspectives can be represented in a simple two by two table (Figure 1).

The four cells of this table can be exemplified as follows: **a** corresponds to National Health Service (NHS) hospitals in the United Kingdom (although the current reforms of the NHS represent a gradual shift from **a** to **b**); **b** corresponds to most church-related

hospitals in Uganda: a shift from **a** to **c** is taking place in many government hospitals in Uganda and in some government hospitals in Zimbabwe; and **d** corresponds to the situation of many hospitals in the USA. The relative strengths of the actors involved in the environment of the health centre of Bamako will determine whether these centres end up in categories **b** or **d**, or remain somewhere in between.

It is clear that the variable 'purpose' does not completely fit the nature of a dichotomous variable: indeed it covers a range of intermediate situations in the wide spectrum from public to private. The same comment holds for the administrative guardianship as well. Figure 1 is thus an oversimplification of reality. We nevertheless think that it is useful to illustrate our point. If governments agree and accept the rationale of this classification according to the very purpose of the service, then it would allow them to achieve more accuracy in targeting their support to health care institutions and organizations – both government and non-government – who serve a public purpose. The case of designated district hospitals in Tanzania or Ghana illustrates that it is possible to define consistent policies. In the case of Uganda, it appears that many (but by no means all) of the non-governmental and church-related organizations would sufficiently fit the criteria defining a 'public' service. This classification could also be helpful to distinguish organizations in the present mushrooming of private practices throughout the developing world: it may help to separate the corn from the wheat. A consistent policy would then be to support those organizations and individuals that pursue a public mission, and not only those that fit a given administrative status.

Conclusion

We have argued that a distinction between private and public based on the institutional set-up of a given service is not always adequate in defining the very nature of the service offered, the latter being of paramount importance to the health planner at any level of the health system. For example, many private hospitals and health centres in developing countries operate according to a rationale which could be defined as public; at the same time, lucrative goals are being introduced into public health services which, eventually, endanger their adequacy, relevancy and accessibility. An operational definition of what could be considered to be a public health service is still lacking. This is not without consequence at a time when, on the one hand, most governments are (or have become) unable to respond in a satisfactory way to the health needs of people, and where, on the other hand, the contribution of the private sector is called upon more and more.

This paper attempts to identify some operational criteria which would enable services to be distinguished according to their public or private rationale. These criteria do not necessarily fit each situation, but they can open up debate among health planners aiming to bring more rationality into the current altercation between public and private. They may also bring the various actors beyond the slogans and to a constructive dialogue.

What could this classification be used for? In operational settings public administrations could use these criteria to identify elements in the health system which need to fit the rationale of public-oriented health service provision. It should not be impossible to develop from these criteria some simple indicators, both quantitative and qualitative. In Uganda, for example, the criteria 'population based' and 'non-lucrative goals' are progressively being used to identify those elements of the health system eligible for integration and, sometimes, for partial financial support. But there is definitely a need for further research: the set of criteria need to be tested in a variety of different situations and precise indicators need to be designed so as to render the whole process less of a theoretical exercise.

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Biographies

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SECTION E

CULTURAL INFLUENCES IN COMMUNITY PARTICIPATION IN HEALTH

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Abstract—The adoption of Primary Health Care in developing countries brought a new interest in the influence of cultural factors in community health programs. This paper traces the changes in the way that the role of culture has been analyzed in relation to community health issues and in particular with respect to 'community participation'. A look at recent perspectives shows that the fate of community health programs has come to be seen as relying more on structural factors in health care systems than on cultural factors within local communities. There has also been an increasing emphasis on political factors or power relationships within and between health agencies, governments, and various levels of national health care systems. These perspectives raise new questions for community health programs and the strategy of community participation.

Key words—community participation, Primary Health Care, culture

Beginning in the 1970's, the widespread adoption of Primary Health Care (PHC) policies among developing nations spurred a new interest in the role of cultural factors in health development. PHC was, after all, designed as a way to deliver at least minimal health care to poorer, more remote rural segments of a nation, to people whose lifestyles and modes of thought were considerably different from those of Western outsiders or educated, urban elites working in national health planning and administration. In these rural areas, PHC sought not merely to introduce a new health technology but to bring about substantial changes in the health behavior of local people. Even more significantly, PHC was to adopt the strategy of 'community participation' whereby communities identify their own health needs and assume responsibility for their own health development. For the effective introduction of PHC, knowledge of and sensitivity to the cultures of these 'recipient' communities came to be seen as essential.

In the 20 years since these ideas were being formulated, there have been innumerable efforts to discover how and in what ways cultural factors influence the creation of and participation in community health programs in developing countries. Although much interesting and potentially useful knowledge on this topic has accumulated, even more striking is that over the past decades, the professional definition of the role of culture in community health development has changed and continues to do in ways that tell us as much about the 'culture' of health 'developers', and how this culture influences health programs, as about the cultures of the Third World communities that PHC advocates seek to transform. This impression is itself the outcome of certain recent trends in the thinking about the relationship between culture and health development. In accounting for successes or failures in community health programs, these trends include (1) greater emphasis on structural factors in health programs than on community cultural variables, and (2) increasing emphasis on political factors or power relationships.

This paper outlines what I see as the major phases in the definition of the role of culture in health development, with particular attention to 'community participation'. This is followed by a discussion of some new questions and challenges for community health development raised by recent perspectives on the role of culture.

CULTURE AND HEALTH DEVELOPMENT: CHANGING PERSPECTIVES

An early period, from roughly the 1940's to the early 1950's, was an optimistic era in which development, including health development, was defined as a set of problems easily overcome with the introduction of Western knowledge and technology. Local culture, if considered at all, was considered irrelevant to the development process. Peoples in Third World countries would naturally accept and adopt 'superior' knowledge and technology. This is what Foster [1] referred to as the 'silver platter model' of technical assistance, which as he pointed out, was not only ethnocentric but failed in fact to work. Yet, as naive and ethnocentric as this approach may have been, it did hold to an image of Third World rural persons as, like 'us', rational. Like us, they would naturally opt for better health care and so would accept what we knew to be the means toward this end.

Recognition of the failure of this approach, and increasing knowledge of the complexities of international development, eventually led to a whole new era of development thinking, marked by new phrases such as 'basic needs', 'new directions', 'felt needs' and reaching the 'poorest of the poor'. This period appears to have reached its peak in the late 1970's. It was considerably favored by new policies of particular donor countries and international agencies, such as the New Directions Legislation in the United States Foreign Assistance Act, and the World Bank's new 'Poverty Oriented' programs. The PHC movement itself was officially endorsed by the World Health Organization (WHO) in this period [2]. The whole thrust of this new movement appears to have been increasing concern with all aspects of the lives of the truly poor and needy people of developing countries who were to be the beneficiaries of development efforts. Their voice was to be heard and their health programs were to be 'culturally appropriate' [2, p. 23]. Moreover, community participation, an idea that had been around much earlier, now loomed as an essential development strategy. In order for this to be realized, or stimulated by outsiders, knowledge of local social structure and leadership patterns was mandatory.

With regard to health development and PHC in particular, there were in fact two somewhat different views of the role of culture during this period. One view, held primarily by planners and health project personnel, saw culture as a set of 'beliefs' and 'customs' which were potential 'obstacles' to the introduction of new health measures and ideas [1]. A second view, sponsored primarily but not exclusively by social scientists, saw 'culture' in the realm of health as 'local knowledge' (indigenous medicine) on the one hand, and local 'strategies' for securing health care on the other. Both groups, however, tended to regard local culture as fairly static.

These two views carried different implications for health interventions and for the notion of community participation. The first, 'culture-as-obstacle' view stressed that a particular culture needed to be understood so that a health program could be designed in such a way that local people would be more likely to accept it. The inherent truth and superiority of modern medicine and modern health education were central to this view; the problem was to get the medicine and the messages 'out there' and accepted. The local Third World peasant was no longer seen as rational and eager for change but as 'ignorant' and 'tradition-bound'. Local beliefs were seen as largely 'wrong' by the yardstick of scientific medicine and public health. Some way would have to be found to discourage these 'wrong' beliefs and practices, but to do so, one should at least know about them.

The second view of culture which focused on local knowledge and health care strategies saw 'culture' as a much broader ideological and behavioral *context* within which the old and new of health care should be *integrated*. In this perspective, 'culture', far from being seen as an obstacle, was viewed more relatively and more positively as a potential resource for health development. Perhaps the clearest expression of this view came in the many programs around the world which attempted to recruit local mid-wives and other types of indigenous healers into PHC programs. This attempt was also automatically seen as promoting community participation.

In some cases the tension between these two points of view was felt within health programs. Coreil [3] reported a Haitian program where traditional healers were already dispensing modern Oral Rehydration Therapy. The healers sought active cooperation with the public health officials, but the latter, who saw traditional healers as themselves a problem and a source of national embarrassment, did not want to cooperate with or legitimize the work of local healers.

While these two views of the role of culture in health development were being expressed during this period, a considerable amount of research in local communities of developing countries was taking place. The results of this research have by now stimulated new thinking about the role and power of culture in both health programs and community participation. Before outlining these recent perspectives, I will discuss what I see as the major findings of research on culture and community health in developing countries. They involve the relationship between traditional and modern medicine, the issue of the cultural relevancy of PHC to local communities, community participation, and the problem of assessing program success.

The relationship between traditional and modern medicine

With regard to traditional medicine, WHO [4] adopted an 'integrationist' perspective, supporting the inclusion of traditional medical practitioners and the use of local remedies in PHC. Some reports of the use of traditional practitioners in new health programs, especially the use of local mid-wives [5], have been very positive. However Velimirovic [6], who is highly critical of integration, claims that a genuine integration of traditional and modern medicine has not taken place anywhere in the world, and that even WHO has retreated from encouraging it. Another report, although concurring that a real integration has not occurred, claims that international health agencies show a "cautious but increasing value accorded to traditional healers" [7, p. 1027].

Some anthropologists have been skeptical of the use in PHC of traditional practitioners [8], though less so for use of traditional birth attendants or for traditional treatments of mental illness [9]. Meanwhile, Foster [9, 10], claimed that the debates over the use of traditional curers may never need to be resolved since truly 'traditional' medical practice is so

...ger being taken up by new generations in sufficient ...mbers.

Regarding indigenous medicine, another concern, ...pecially to the 'culture-as-obstacle' viewpoint, has ...en that traditional medical beliefs and practices ...ould discourage the adoption of modern medicine. ...ut more and more social scientists have come to ...gard people of rural communities in the developing ...orld as in the end pragmatic with regard to medicine ...nd medical options [11]. Foster summed it up best ...ith his statement in 1977:

> ...I am increasingly convinced that *economic and social ...orts* are more important in determining the use or nonuse ...of scientific medicine than is the belief-conflict between ...raditional and modern medicine [9, p. 529].

Where modern curative services are accessible, affordable and effective, they are used. Many studies have shown that even in areas where, from an external point of view, the theory and principles of modern and indigenous medicine do conflict, local people find ways of making their own cognitive adjustments and their own ways of 'integrating' their resort to both traditional and modern options. Welsch's study of traditional and modern medical options in Papua New Guinea [12], for example, showed how the Ningerum people have interpreted Western medicine in a way that brings it in line with a single indigenous theory of disease.

All of this is not to suggest however that cultural factors, in medicine or other areas of life, are no longer regarded as important to health programs. Traditional medical 'beliefs' may no longer be seen as the obstacles they once were; at the same time, the success or failure of health interventions is today regarded as clearly dependent on the extent to which planners and administrators have considered cultural factors [1]. To cite one example among many, Justice [13] has shown how disregard of fairly simple and widely known cultural expectations concerning women's roles resulted in the failure of Nepal's Assistant Nurse-Midwife Program. In this case, urban women were trained to deliver maternal and child health services in remote rural communities. Yet since in Nepal it is socially and culturally unacceptable for women to travel and live alone, these women were not well received in rural areas and were themselves very unhappy with their assignments.

The cultural relevancy of PHC in local communities

Although cultural factors, and particularly indigenous beliefs about illness and curing, need not be seen as obstructing the introduction of modern medicines, a far more serious issue arises when we consider the relationship between local cultural context and what PHC largely has to offer, namely health education and preventive services. Theoretically, PHC was to include some curative services—very simple ones at the lowest levels, using community health workers, with access to more sophisticated services through a system of referrals linking health workers, clinics and hospitals. But in practice, what most poor people of developing countries actually encounter in PHC is health education and preventive services.

Nearly every observer has recognized that rural people of developing countries, like people everywhere, are overridingly interested in good quality curative services and are not very interested in receiving health education or preventive medical advice [7, 8, 10, 14]. It is further not just potential clients who are focused on curative services but community health workers and others delivering PHC, since they realize that their own credibility, status and prestige rest directly on their ability to dispense medicines and offer cures. At the same time PHC is founded on the idea that modern health education messages (covering environmental sanitation, oral rehydration, nutrition, family planning etc.) would, if followed, be far more effective in raising health standards than would curative services. In addition, the whole PHC movement in part grew out of the concern that extension of good quality curative services equitably throughout an entire nation would be far too expensive for developing country governments.

But this raises a serious contradiction for PHC: it is supposed to foster community participation and wherever possible assist local communities to *define their own health needs* and initiate ways of meeting them. At the same time PHC has already set its own parameters around both the needs of the people and the range of possible means of meeting them. Thus the essence of PHC can contradict the whole spirit of a genuine, grassroots community participation [7, 8].

Health planners may assume that even if local communities are *more* interested in curative services they will *still* be responsive to health education. Yet it is not just that health education merely has a low priority, but that local people may see it as frankly irrelevant to their health needs and concerns. In one case in Nepal, village people expressed disappointment and even anger when they saw that their new village health workers would only be giving them health advice [8].

This problem is further compounded by the manner in which educational activities are implemented. In many programs the new health messages are delivered as flat statements whose medical truth is somehow beyond question, with no attempt to integrate the content of the messages with indigenous knowledge or concepts [8, 15]. Nicher [16] and others have argued for a more creative use of 'appropriate analogy', or using cultural metaphors and analogies to effect a closer 'fit' between local health concepts and modern health messages. Though not widely used as yet, this approach has met with positive results in health education efforts [17, 18].

The problem of relevancy is well illustrated in Nabarro and Chinnock's [19] discussion of the PHC promotion of growth monitoring of children. Although outsiders recognize this as a low-cost and

'appropriate technology' for monitoring the health status of children, parents in rural communities are quick to realize its limitations: "Growth monitoring is not useful if those who identify growth faltering cannot do anything about it" [19, p. 945]. This study also points out that growth monitoring has been intensely promoted even though little is actually known about the impact of different interventions on children who have lost weight. The study further concludes that the promotion of growth monitoring has not encouraged peoples' participation in health care.

Community participation

Perhaps no other development concept has been more thoroughly, consistently, and fervently advocated than that of 'community participation'. Problems with participation are widely recognized, but this idea, unlike other development fads, has stuck, primarily for three reasons. First, local governments see it as more cost-effective than alternative approaches that would draw more heavily on scarce state resources [20, 21]. Second, both common sense and innumerable field experiences [22] tell us that those development projects in which local people themselves are somehow actively involved are, other things being equal, going to be more successful. Third, the concept is morally consistent with the principles of equality and self-reliance that have guided international development philosophy over the last decade. It is little wonder that community participation quickly came to be seen as a cornerstone of the PHC movement.

But just what community participation should mean and how it should work have remained problematical. In actual projects around the world, anything from semi-forced local contributions of money to revolutionary seizing of power has been discussed in terms of ideals of 'participation'. Rifkin [23], borrowing from the Cornell University Rural Participation Project [24], has recently helped clarify what participation can mean in the field of health care by distinguishing different 'levels' of participation. Minimally, and most passively, people can participate in the benefits of a health project, by, for example, receiving health services or education. At a second and deeper level local people may participate in program activities. Examples would be local contributions of land, labor or money for a health facility or local individuals assuming roles as rural health workers. A third level involves implementation, where local people assume managerial responsibilities in a program and decide how certain activities are to be conducted. A fourth level concerns program monitoring and evaluation. But in all these levels so far, local people are still not involved in program planning or in translating their own felt needs and interests into a true 'grassroots' development. Only a fifth and final level specifies that

> ... people from the community ... actually decide what health programs they think should be undertaken and ask health staff, agencies and/or the government to provide the expert knowledge and/or resources to enable the activities to be pursued [23, p. 14].

As Rifkin notes this is often the ideal of health programs, but in fact this level of participation is very rarely achieved. Her point, however, is that projects need to specify, realistically, the level of participation they are aiming for rather than to phrase program objectives in terms of vague concepts and ideals.

Whatever enthusiasm initially surrounded the incorporation of community participation into PHC, most investigations by social scientists have in the last decade suggested reserve and caution. Many investigators have pointed out, for one thing, the naive fallacy of assuming a rural 'community' to be a homogeneous entity, full of persons sharing common interests and oriented toward mutual cooperation [20, 25, 26]. In some cases efforts to structure community involvement in health programs (through local health committees, community health workers, etc.) became enmeshed in local politics and power struggles between factionalized and competitive interest groups [27, 28].

Others are concerned that the rhetoric of community participation can be used as a substitute for government responsibility in public health [20] or as a mask that shields national and international inequalities of wealth and power, which are the real causes of poverty and ill-health in the Third World [29, 30]. In this sense community participation can be seen as a double-edged sword. On the one hand it can be phrased in such a way that it calls for empowerment of the poor [31]. But on the other hand, the concept of community participation can too easily be manipulated to deflect responsibility away from those who truly have power, ending up as yet another slogan which, however ironically, promotes current political and economic structures of inequality.

Other researchers have questioned the local relevancy of the concept of community participation. In an early survey of health programs in Hong Kong, Indonesia and the Philippines, Rifkin concluded that

> Community people who are involved in community health activities tend to see the programs as extensions of medical services and tend to want responsibility to remain in the hands of the medical profession [32, p. 1494].

Similarly Brownlea [33] pointed out that not all cultures value local participation in decision-making for health activities. My study of a participatory development project in Nepal [26] suggested that the current focus on community participation appears to be an attempt to promote the Western cultural values of equality and self-reliance (values not shared by the local population), while ignoring alternative values and perceptions of how development might work in rural, non-Western societies of developing countries.

A final issue concerning participation was articulated by Madan, who wrote, "participating

communities are 'made', they are not 'born' " [20, p. 619]. Madan argued that it is unrealistic to assume that local people in developing communities will have the resources, organization, expertise or power to take the kinds of actions outsiders want to see in the name of community participation. Brownlea [33] likewise wrote that participation has to be 'resourced' (with power, knowledge, and skills) in order for it to be more than mere tokenism.

At this point perhaps even more caution is in order. We have heard that community participation is vital to community development. Now we hear that the community must be rather profoundly transformed before even participation can realistically begin. But according to whose values should this transformation be encouraged (or in whose image should a community be 'made'?). Madan raises a similar concern with his comment that community involvement can be

> ... employed to describe euphemistically the manipulation of people by politicians, bureaucrats and technocrats for purposes which are believed to be for the people's good—and may well be so—but which are conceived by these others in a manner that objectifies an infantalizes people [20, p. 619].

Assessing program success

It is easy to find faults and failures in community health programs. Discussing success is more difficult. Some general impressions of the success of PHC, as measured against the goal of "Health for All by the Year 2000" [2] are pessimistic [1, 7]. But reliable measures of the health impact of PHC programs is very rare [34]. Berman's studies of village health worker programs in Indonesia [35] and other countries [36] indicates success in terms of coverage and cost-effectiveness but poor performance in terms of quality of health care and health interventions.

What are more often reported in the literature are examples of specific successful strategies used within programs. Thus, to give a few examples beyond some already mentioned, Griffiths [37] described the difference that use of ethnographic methods and information made to the success of a nutrition education program in Indonesia. Loevinsohn [38] showed how the use of food incentives improved PHC coverage in Nicaragua. Nicher [39] described how a 'participatory research' strategy fostered community participation in a PHC program in India.

Where health programs are analyzed within broader health systems, there does appear to be wide agreement on the importance of a number of factors—such as national political will, government support to community health worker training and supplies, administrative decentralization of decision-making, and, of course, community participation—in determining program success [21]. At this level, the question is not, ideally, 'what works?' but rather, how can a multiplicity of agencies be made to coordinate their resources and activities in the interest of community health? Some particular problems within this issue are discussed in the next section.

CULTURE AND HEALTH DEVELOPMENT: RECENT PERSPECTIVES

As a result of research and field experiences a new mode of thinking about the relationship between culture and community health had emerged by the 1980's and has continued to the present. Among the factors that influence the success or failure of PHC in general and community participation in particular, this mode places primary emphasis on *political* relationships and processes [40]. Local beliefs and practices regarding illness and curing, are in this mode seen as flexible, changing, and, in and of themselves, not very powerful as 'obstacles' to adoption of new ideas and practices. What now loom in the foreground are local cultural ideas and institutions which govern the acquisition and manipulation of status, power, and wealth. This perspective thus focuses on structural factors of health systems and the ways in which these interface with local social and political structures. The idea of 'cultural' influences on health programs shifts away from an exclusive focus on the local culture of village peoples to a much broader concept which includes the 'culture' of health organizations and health bureaucracies, or even of 'international development' itself.

This new emphasis on power and politics carries two important implications for the understanding of the relationship between culture and community health programs. First, it encourages an encompassing framework within which all levels of a health system can be simultaneously incorporated. International relationships between developed and developing countries can be included as can relationships between agencies such as WHO and local governments, internal relationships between governments and health ministries, and so on down to the levels of health centers, community health workers, rural communities and finally to the 'poorest of the poor'. At each level there are struggles for power, status and access to resources, all of which influence how community health activities and services are planned, delivered and utilized and how and to what extent local 'participation' is actualized.

One example of a report which incorporates an analysis of the relationships between agencies and institutions at different levels is Welsch's study of PHC in Papua New Guinea [41]. He shows how, despite the rhetoric of 'self-reliance' in PHC, the administrative culture of health care supports a top-down flow of policy and information throughout the bureaucratic levels of the system. Each higher level sees itself as superior to and more knowledgeable than lower levels. Thus,

> ... WHO sees itself as the knowledgeable partner in its relationship to member countries in the developing world,

a pattern that replicates the relationship between central planners and village communities [41, p. 106].

In more general terms Van der Geest *et al.* [7] have used a multi-level or 'linkages' perspective to discuss how current problems with PHC are related to the fact that it is perceived and implemented very differently at different levels of social organization. They cover the levels of international organizations, the state, health workers, and the local population, showing how each level redefines PHC in accordance with its own interests and political position.

A second implication of this new focus on power and politics is that if offers a beginning in the breakdown of a conceptual barrier between local village peoples and outside developers. Previously, even with the best of intentions and a true spirit of equality inherent in the PHC movement, discussions and reports on health programs implicitly divided off local villagers as an alien category of persons, who, if not outright 'ignorant' then at least in need of all kinds of outside education, advice and guidance, and, with respect to community participation, 'stimulation'. All this was to be provided by another amorphous category of well-meaning but patronizing outsiders who had already defined local peoples' 'rights and duties' for them with regard to health. The new perspective, by contrast, sees the world of PCH as one filled with a myriad of diverse groups, each admittedly constrained by self-interest and by political realities. This perspective, in short, encourages all of us to look inwardly at ourselves, our own affiliations, our own institutions, and our own professional subcultures, as potential obstacles to global health development.

One of the first to promote this new perspective was George Foster. After claiming a general agreement today that cultural knowledge of recipient groups is essential in the planning and implementation of health programs, Foster wrote:

> Less widely appreciated is the fact that the structural and dynamic characteristics of health agencies profoundly influences the strategies, planning and mode of operations of international health programs [1, p. 1039].

Foster encouraged the study of the cultures of these health agencies to understand how bureaucratic behavior and bureaucratic imperatives influence the viability of health programs. His own work [1, 42] went a long way toward showing how rural health policy and planning could be adversely affected by built-in bureaucratic constraints, such as an agency's needs to justify budgets and validate itself, and individuals' needs to promote certain activities so that they can demonstrate or justify their own professional skills.

Foster warned that social science research geared toward the probing and exposing of these kinds of bureaucratic and professional foibles would be unpopular and perceived as threatening to health agencies. Undoubtedly for this reason we have seen few such studies. Aside from Welsch's study already referred to, a study conducted by Justice [43] stands out as a clear demonstration of how PHC programs in Nepal and other South and Southeast Asian countries were ineffective because they were designed to meet the needs of various health bureaucracies rather than the needs of local villagers. For Nepal, the officials who attended meetings in Geneva, extending their country's commitment to PHC, were not the persons responsible for implementing PHC back home. For these latter officials

> . . . primary health care appeared as an array of demands to be met in exchange for certain resources. The pressing question for them was how to meet these demands with their limited resources and without dislocating the existing health care system too severely [43, p. 1303].

Another expression of the political perspective in the study of culture and community health comes in a series of articles on PHC by anthropologists, published in the journal, *Human Organization* in 1986. In the introduction to this series [44], the authors noted that one of the reasons for this new focus on the political dimensions of health care was the relative success of rural health programs in socialist countries. Discussing the positive changes in the quality of health in the populations of these countries, they wrote

> . . . we came to the conclusion that the changes were not due solely to measures taken in health promotion . . . In each instance, health care was placed in the context of broader revolutionary changes in the political economy which facilitated a more equitable reallocation of already existing natural resources. We began to analyze the effect on health of greater access of people to power and wealth [44, p. 95].

Along these lines, Donahue [45] showed how the decentralization of decision-making during the Sandinista revolution in Nicaragua led to an ascendency of meaningful kinds of popular participation in health over a previous professional dominance of the health care system. Another kind of connection between politics and health care is seen in Stebbins' [46] study of how local people in a region of Oaxaca, Mexico supported a new health clinic because it served as a powerful symbol of political strength in their power struggle with another municipo. In this case community 'participation' to maintain the clinic was undertaken even though the clinic was poorly stocked, ill-managed and perceived by villagers to bring few medical or health benefits.

Many observers have confirmed the importance of national political will in bringing about more equitable health and successful PHC initiatives. However the extent to which this is necessarily tied to a socialist political ideology is not certain. Young's [47] study of PHC in Tanzania concluded that a socialist transformation is neither necessary nor sufficient for PHC to succeed. And New [48] has shown how the equity and other benefits of China's PCH system have not been maintained under the country's new economic policies.

Mark Nicher's study [49] of PHC in South India and Sri Lanka takes a close look at political realities affecting the health care system from the point of view of health center staff. This study details the professional interests of various levels of staff, showing how the promotion and guarding of these interests and the power struggles between levels brings about decisions and actions antithetical to community participation and other ideals of PHC. He concludes that

> health programs which do not pay credence to the professional identity and social status of health staff may well end up in promoting conflict in the name of team-work and community participation [48, p. 347].

Thus, for example, in South India, Nicher describes how medical officers severely restricted the dispensing of even the simplest curative drugs by nurse–midwife field staff in order to protect their own power and prestige and maintain a 'mystique' around their own claims to special medical knowledge. In turn, health center field staff felt threatened by the introduction of a new level of health worker, the village health guides, and sought to keep strict administrative control over their activities. In Sri Lanka, a power struggle between two levels of health workers, family health workers and public health nurses, was expressed in the nurses giving little credence to letters of referral that the family health workers were handing out to clients to encourage them to go to the health center.

In this recent perspective, which emphasizes how health systems and programs are structured and how power struggles are played out, the image of the poor changes once again. The poor rural person, far from being tradition-bound or constrained by culture, is now seen as constrained by lack of power. He/she is also seen as rational and pragmatic, as in the early post-War period. Moreover, the poor rural person is seen less as an exotic 'other' in need of guidance and enlightenment, but more as an end point of a long and complicated hierarchy of health care within which all units and levels act to secure power and status and promote their own social and economic self-interests.

One may be tempted to see this image of the rural poor as an improvement over that of previous eras. Or it may be yet another illusory projection. One could argue that international development is a whole arbitrary and relative world within which we all continually struggle to define our own realities and articulate our own identities. Escobar [50] suggests that the whole 'development paradigm' is inherently ethnocentric, rooted in patterns of political domination and perpetuation of a certain world economic order [51]. He points out how, within this paradigm, the local 'realities' of Third World peasants must be transformed with labels, such as 'small farmers', 'beneficiaries' and 'illiterate peasants', so that they are recognizable to development institutions. Third World poor are defined as 'problems' and these problems are further "defined in such a way that some development program has to be accepted as a legitimate solution" [50, p. 667]. A particular kind of internationally managed 'development' is, in this paradigm, uncritically accepted as a historical necessity.

The poor of developing countries are in turn reconstructing their own realities as their world is penetrated by the forces of international development. A recent study in Nepal by Pigg [52] discusses how people of a rural Nepalese hill community are now defining as 'undeveloped' what they used to perceive as locally varied ways of life. Her work shows how in particular local discussions and debates about the roles of doctors as opposed to shamans is a symbolic expression of these peoples' concern to formulate new identities for themselves and others in their rapidly changing world.

DISCUSSION

Over the years, international health professionals have increasingly stressed the importance of understanding the perspectives of the poor themselves. This is all the more the case whenever community participation is invoked. At the same time, these professionals have, in the very nature of things, worked as 'outsiders' who, as Robert Chambers wrote nearly 10 years ago, "are people concerned with rural development who are themselves neither rural nor poor" [53, p. 2]. Throughout all the community health development efforts, through all the fads, slogans, debates and expressions of genuine concern, one senses that outsiders are forever defining poor peoples' problems and solutions for them. Even community participation, designed to bring about the opposite, is an external idea rooted in particular cultural values. The inevitable ethnocentrism and paternalism which all this produces may be unavoidable. On the other hand, one positive change I see in international health discussions, is a new awareness of the intellectual constraints and limitations of outsiders. At least conceptually, if not in program planning, new notes of self-criticism and realism are being heard.

Meanwhile, some international organizations have recently shifted their own policies. These favor 'selective' (vertical) approaches and tactics such as 'social marketing'. Community participation is still emphasized, but perhaps less is being demanded in the way of 'self-reliance' [7].

This current mood of realism and political awareness raises new questions and challenges for community participation in health. Perhaps the time has come to see participation as a common-sense development strategy, but not as a goal in itself, nor as a powerful tool of democratic reform, since in these latter cases the concept always seems to carry more significance for outsiders than for the poor. But if the concept is going to be kept at all, the real challenge

will be (and always was) how to remodel PHC to fit the perceived needs and concerns of the poor (themselves diverse). Finally, if power relationships, conflicting self-interests, and entrenched political and economic inequalities are the true stumbling blocks to "Health for All by the Year 2000", who can legitimately ask whom to compromise power in the interest of global health?

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The Role of Non-Governmental Organizations and the Private Sector in the Provision of Health Care in Developing Countries

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SUMMARY

A major component of total health care in many developing countries is that provided by organizations outside the state sector. Analysis of the relationships between the state and non-state sectors and explicit government policies towards the non-state sector have, however, often been neglected. Within many developing countries, there is heterogeneity rather than homogeneity within the non-state sector, making the task of developing consistent and workable policies difficult. In order for such policies to be developed, a clear understanding of the characteristics and roles of the various non-governmental and private health care providers is needed. This, in turn, requires the development of analytical tools and evaluative criteria. This article outlines and discusses issues requiring consideration in the formulation of policies, and sets a preliminary agenda for research action.

KEY WORDS: Non-governmental organizations; Private sector; Health planning; Health system research; Health policy

INTRODUCTION

For many developing countries, health care provided by organizations outside the state sector is a major constituent in the total sum of health care provision. Indeed, in many countries, such non-state health care accounts for the majority of all health care. Paradoxically, however, until recently there has been markedly little attention paid to the role of this sector by the governments of many of these countries, by international agencies, or by academic researchers.

This situation is now changing, with greater recognition and interest in this area by governments and some international agencies, particularly the Christian Medical Commission, the World Health Organization (WHO) at its assembly in 1986, and the World Bank. There are various reasons for this increased awareness, but two stand out as being of particular importance. Firstly, the emergence of the philosophy of primary health care, which, *inter alia*, stresses the need for multi-sectoral and multi-agency collaboration. Secondly, the recent and continuing global recession, and its effects on the public financing of social, and in particular health, services, has prompted interest in alternative funding arrangements. Linked to this second point has been increased interest in the development of methodologies to determine the nature, sources and scale of existing health care finance.

However, the burgeoning recognition of the size, and hence potential effects (whether helpful or harmful) of the non-state sector, has not, in general, led

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to concomitant policy action on the part of the sector itself, governments, nor international development agencies. This paper attempts to set out the major issues that require exploration and research, in order that such policies can be more fully formulated.

The paper, firstly, examines the characteristics that distinguish and differentiate non-governmental organizations (NGOs) and the private sector, from each other and from state-provided services. For analysis to be made of their relative roles, it is important that their prime distinguishing characteristics be identified.

The next section then looks briefly at the existing evidence on the role and importance of NGOs in the field of health care. What little literature there is, is often characterized by either underplaying the extent of both NGOs and the private sector, or by gross generalizations about their actual or potential role. Such generalizations, it is argued, are both inaccurate and unhelpful, in a field where heterogeneity, rather than homogeneity, is the order of the day. Various criteria are then suggested as both descriptive and analytical tools, and which highlight this heterogeneity.

The arguments surrounding the public/private mix for health care are then addressed, noting that: (a) even the most ardent 'marketeers' have accepted the need for some public sector provision, and that hence the debate focuses on the *optimal* extent of this provision; (b) the theoretical debate has not yet been, and indeed may never be, concluded; (c) even in the more industrial countries of the West, where the debate has existed as a mainstream activity in the fields of health planning and economics, there are wide differences of opinion as to the optimum mix, and equally wide sources of contradictory evidence.

The final section looks at the area of policy formulation and the optimal strategy for any government in the mix of service provision and regulatory controls. The article concludes by urging that urgent research attention should be focused on tools and criteria that can be used to formulate appropriate policies.

NGOs, THE PRIVATE SECTOR AND THE STATE

Analysis of the respective roles of, and comparative advantages between, the state, NGOs and the private sector requires a prior definition of these three terms. Presently, literature uses a variety of terms to describe health care organizations, including: government, state, public sector, social security, voluntary, non-governmental, charity, mission, private-non-profit, and private-for-profit.

For the purpose of this article, a working definition is chosen which accords with common usage. This definition uses two criteria—whether an organization is directly managed by and accountable to the state; and, whether its stated aims are explicitly in pursuit of profit maximization. Under such criteria, NGOs are defined as non-profit-making organization, outside direct state control, and the private sector is defined as profit-maximizing non-state activites.

Though such a definition is adequate for present purposes, in practice the demarcation is more ambiguous. Three examples illustrate this diversity. Firstly,

organizations such as district designated hospitals in Tanzania, managed by the church, but heavily subsidized and controlled by the state, occupy an uneasy position between being an NGO and being part of the state sector. Secondly, the term 'private' is often used to denote the opposite to 'public' rather than profit-maximizing. Thus, for example, the Private Hospital Association of Malawi is made up largely of church organizations. Thirdly, the term *state* is deliberately chosen in many countries to include, in addition to ministry of health (central government) activities, health services managed by local authorities, or other ministries and quasi-governmental activities, such as the large social insurance organizations typical of Latin America. However, several of these display organizational characteristics (for example, a degree of autonomy) similar to NGOs.

The development of tools by which one can describe, categorize and analyse the different health organizational forms, is of much more than academic interest. The development of policy guidelines is dependent upon the ability to describe and delineate such organizations, for which further research is required. Such research would be able to draw upon the experience of health sectors within developed countries and non-health sectors in the developing world (such as education) where policies in this area may be further advanced.

THE IMPORTANCE OF NGOS AND THE PRIVATE SECTOR IN HEALTH AND HOSPITAL CARE IN DEVELOPING COUNTRIES

Until recently the role in terms of both size and nature of the non-state sector within the health field, was not given due recognition by governments or international agencies. Government development plans were often characterized by a failure to mention, let alone take account of, in anything more than a cursory fashion, the existence and role of such organizations. Similarly, international aid agencies concentrated their efforts on the government sector. (To some degree this was due to a failure to differentiate sufficiently between the dual role of government health agencies as responsible both for national health policy, and for major service provision and funding.) Furthermore, where recognition *was* given, there was often little distinction made between NGOs and the private sector. The World Bank *Health Sector Policy Paper* of 1975, for example, makes no such distinction (World Bank, 1975).

This situation is, however, for many countries, now changing with a more explicit recognition of the extent and importance (wheher negative or positive) of the non-state sector. At least two explanations can be identified. Firstly, the acceptance of the philosophy of primary health care has, to varying degrees, forced upon governments and others involved in health care, a recognition of the need to appraise critically the workings of *all* health care providers, through its stress on multi-agency collaboration, appropriate health care and equity. Closely allied to this has been a push in many countries to a more decentralized system of health care, placing greater emphasis on a planning, management and coordinating role at the local (district) level.

Secondly, the financial crisis, in part the result of a global recession, which has been evident in many developing countries over the last decade, has forced a closer look at means of expanding (or in some cases maintaining) health care provision with minimal implications for government expenditure. This has led to greater interest in the non-state sector as one possible way of achieving this strategy. Financing surveys, whose importance in providing planning information is gradually being recognized, have been an important source of comprehensive information on the overall size of the different sectors. For instance, comparative information has been compiled (de Ferranti, 1985) on the level of total private expenditure in 37 developing countries, showing a range, as a percentage of total health expenditure, of between 12% for Lesotho to 87% for Bangladesh and Korea.

The evidence that is readily available (Cumper, 1986; Abel-Smith, 1985) would appear to show that: between countries there is a wide variation in the size and composition of the non-state sector; and, that there are methodological difficulties in making comparative estimates compounded by the lack of a single survey/accounting system.

TYPES AND CHARACTERISTICS OF THE NGO/PRIVATE SECTOR

Analysis of both NGOs and the private sector suffers from broad generalizations. NGOs have been described variously as being autonomous, flexible, innovative and cost-effective; or, alternatively, as failing to meet national health needs, unplanned, duplicative or inefficient (WHO, 1985). Whilst any of these descriptions may be justifiable when applied to particular NGOs, they are inaccurate and unhelpful when applied to the sector as a whole. Similarly, the debate on the role of the private sector has often polarized (Roemer *et al*, 1984). For the development of policy, it is first essential that a clear understanding be developed of both the *types* and the *characteristics* of individual NGOs in a country.

Main NGO/Private sector types

Seven broad groupings of non-state organizations involved in the health field can be identified:

Religious Organizations. Possibly the longest established organizations are those which are church-related. They are often major providers of health care alongside other social development services including, most commonly, education. Whilst their connection with the church has always implied a religious motive for this work, this has manifested itself in different ways with different religious and denominations, some seeing health services as a vehicle for proselytization, and others seeing them as an end in themselves.

The motivations of any particular church-based health service have implications for both its approach to health care and its desire to work with other NGOs and with government. To some degree a gradual overall shift away from a proselytizing motive can be discerned, resulting perhaps from the reduced availability of external funding, and from a parallel localization of church-related activities. However, wide variations still exist. Church-related health services are often multi-dimensional, and involve hospital-based services with outreach satellite clinics, of either a mobile or permanent nature. The church has also often been associated with particular disease programmes of a vertical nature — such as leprosy. Many church-related services have had extensive involvement in training staff, usually in the first instance for their own purposes, but often for government and other sectors as well. Attitudes to government vary from organizations that are committed to working within the government structure and which may see their long-term future as part of government, to those anxious to maintain their autonomy.

International (social welfare) NGOs. Various international NGOs, usually based in developed countries, are involved in the provision of health care. The relationship between the central office and the country-based office varies, with some being seen as outreach branches carrying out central policy (e.g. Oxfam) to those who have an affiliated relationship (e.g. Red Cross and Red Crescent Societies). The scope of activities of such NGOs varies. Although originally an explicit and well-defined target listed (e.g. Red Cross — disaster/emergency relief; Save the Children — children's welfare; International Planned Parenthood Federation — family planning), this has, depending on the periphery-to-centre relationship, commonly broadened out. Thus the Red Cross, for example, is, in many countries, increasingly active in the primary health care field. The degree of decentralization of such NGOs depends largely on the dependence of local branches on central funding. One specific subgroup of international NGOs are the service clubs such as Lions and Rotary, which have commonly shared international aims, but local organization. They differ from other international NGOs in that they are primarily involved in fund-raising activities rather than direct service provision.

Locally based (social welfare) NGOs. In contrast to the international NGOs there are a variety of locally based NGOs operating within the social welfare field. Two subgroups are identifiable — NGOs dealing with broad community development issues, and often geographically focused, and NGOs which are more issue specific.

Within the first group fall traditional social groupings and women's groups. The second group focuses on specific issues and may have as much a pressure group role as a service delivery role. The impact of both such groups is extremely variable. Their restricted funding base implies that the majority are unlikely to be involved in the direct provision and management of health and, in particular hospital, care; but, through their pressure group activities, they may be highly influential in general policy formulation.

Unions and trade and professional associations. A fourth group comprises organizations whose primary motive is the protection and promotion of their constituents, including trade unions and trade associations. Whilst their present role within the field of health activities is limited, there is a potential, particularly on the demand-side, for an expansion of their role. The present extent and strength of such groups is still generally small, though within Latin America the role of union activity in this field has been recognized for some time. Professional health-related associations are, of course, important for specific reasons on the supply-side.

Other non-profit making organizations. A fifth group of non-government organizations comprises services provided outside the public sector, but with access limited to certain groups or individuals on non-financial grounds. Occupational health services, for example, often have a substantive input to the overall health sector, and may be regarded as non-profit making in themselves.

Non-profit making (but pre-paid) health care. This sector, comprising organizations modelled on American group health care, such as Health Maintenance Organizations (HMOs), is still relatively rare in many developing countries, requiring a minimum concentrated population base of adequate income. However, it is likely that this sector will grow. One example of this is Latin America, where urban concentrations of skilled labour have led to a growth in this sector. ISAPRES in Chile, for example, perform similar roles to HMOs in the USA; in 1984 the 17 ISAPRES had a total of over 852 000 enrollees out of a total population of approximately 11.2 million (Scarpaci, 1985).

Private sector The last group comprises the for-profit organizations, which may be locally based, or part of a wider international corporate structure. Though this sector as a whole is presently a major element in the total health care system of many developing countries, the main emphasis lies in the area of individual private medical and nursing practices, and the provision of drugs, rather than in the organization of hospital care. Of considerable importance in many developing countries, however, is the use of public facilities, in a *private, profit-seeking manner*, by either state-employed physicians or private practitioners. Such use may or may not be officially condoned or used as a fringe benefit to government medical employees.

Characterists

A number of characteristics can be examined which further demonstrate the diversity in the nature of the non-state sector, and are important in analysing the role of such institutions within the health sector. These major characteristics are outlined, and their importance discussed, below.

Motivational. The influence of an organization's objectives on its performance is a field that is fraught with difficulty. Studies relating to hospitals within

industrialized countries have looked at a variety of variables within both the for-profit and not-for-profit sectors, to explain performance; such variables coming from both economic schools of thought (via the theory of the firm) and from behavioural schools of though (McGuire, 1985). Despite the depth of debate, no clear view on which are the key determining variables has emerged. In part this is the result of the difficulty in analysing the role within organizations of health professionals and, in particular, doctors. It has been argued (Majone, 1984), for example, that there is a convergence of interests between non-profit-making organizations and professionals, and that as such NGOs are highly suitable organizations for the delivery of health care. However, though in specific instances this may be the case, it cannot be held, *a priori*, that *all* NGOs are more suited, either in comparison to the private sector or to the state sector. Furthermore, it is by no means clear that the interests of health professionals converge with the health care needs of the community.

Proselytization was originally an important motive for many religious health services, and such motives may have led to an unduly curative bias, as a means of attracting patients. Whilst proselytization as the *sole* motive is now rare, the religious culture of some church health services can on occasion be a source of tension between them and other organizations, and in particular government health services. An example of an often contentious area can be found in the field of family planning (and most particularly abortions), where strong attitudinal differences may exist. A more general problem may be found in the area of personnel management. Where staff are expected to identify themselves with the organization's religious motive, this may be *positive* resulting in higher commitment; or, *negative*, when for example schemes to allow staff transfers between government and NGOs are arranged or training is carried out for government staff by NGOs. Motivation is often cited as a cause for perceived quality differences between government, NGOs and the private sector; however, even where such quality differences can be demonstrated, it is difficult to single out motivation as the prime variable.

A second tension may exist between those NGOs that are issue specific, or those that are primarily involved in fund-raising, where different views of priorities may exist. This may be particularly difficult where the NGO has a pressure group role, within a system where lobbying balances between uses of resources are weak.

Between the NGOs themselves there may be sufficient differences in philosophy leading to an atmosphere of competition rather than collaboration. For example, many religious NGOs are located in close proximity to each other as a result of earlier competitive proselytization. Whilst there are some circumstances where competition may be regarded as healthy, situations are still common where there is unnecessary duplication of facilities, or where inefficient and possibly dangerous dualistic supervisory or referral mechanisms exist within an area served by two NGOs, or an NGO and government.

The interests of other than religious NGOs are again different. Organizations involved in the provision of employment-related health care, are primarily motivated to demonstrate that such services affect profits or productivity through either decreasing employee absenteeism, increasing worker productivity, or enhancing the payment package in fields of skill shortage. The

last of these may give rise to an unduly curative approach, with expensive, high-technology health care as a conspicuous end in itself.

The effect of profit-maximization as an organizational objective, on the type of health care provided, has been well documented in the literature on industrialized countries and is unlikely to be very different in shape in developing countries. Of crucial importance on the scale and type of health care is the means of financing (and particularly fee-for-service and insurance) and the degree and type of regulation. Also of great importance to the for-profit sector, though its importance is not confined to this sector, is the form of payment to the doctor (Glazer, 1970).

Types of health service. Within the non-state sector, there is a wide diversity, as has already been shown, of types of activities within the health field including fund-raising, lobbying, and service provision. Even within these activities, wide variations are possible. Examination of just one of these activities — the provision of hospital care, illustrates wide variations in (a) *location*: many NGOs (though certainly not all, as is sometimes urgued) are rurally based; whereas private hospitals are almost entirely based in the larger towns and cities, as are industrial health services (though some mines/plantation/agro-business-related hospitals may be rural); (b) *activity*: differences exist as to the type of hospital care — whether specialist or general — and the degree of identification with primary health care through, for example, referral mechanisms, preventive activities, or community development activities. Private hospitals, for example, are likely to cater for short-term, acute cases, as being the most profitable; (c) *form of provision of service*: even between similar activities, differences often exist as to the way in which services are provided, as a result of the technology used, including staffing mix, equipment, form of buildings, and plant, and the degree of innovation.

Internal organizational characteristics. The characteristics of the organizational structure of non-state sector organizations differ tremendously. They can be contrasted with the state sector which usually has, within any one country, similar organizational structures between institutions of the same type, such as hospitals. Differences are likely to emerge, as a result of a number of factors including: (a) *motivational differences*. Firstly, NGOs that have a strong proselytizing tradition may be heavily influenced by either the local or international church. Secondly, within industrial health care the decision-making process is likely to reflect the management style of the industry it services. Lastly, the degree of divergence between the professionals and the profit recipients in a for-profit institution will influence the relative strengths of the medical profession *vis-a-vis* the adminstrative cadres; (b) *size*, both in terms of the hospital itself, and (where applicable) in terms of its size in relation to its parent organization; (c) *accountability* — the degree to which formal structures of accountability have been set up and are adhered to; (d) *strength of the medical and nursing professions* generally within the country, and their ability to exploit this within the context of a specific administrative framework; (e)

staffing policies — the extent to which the particular organization is staffed and run by expatriates, and the degree of participation in management by the workforce.

External relationships. The relationships that NGOs/private health services have with other agencies are extremely varied, and are documented in Figure 1. Examples of factors that influence the relationship are given in the body of the matrix, and include: historical antecedents; motivational considerations; considerations of trust, often as a result of information sharing; legal/bureaucratic barriers; existing service patterns throughout the country; and, lastly, the degree of government or external financing.

FACTORS AFFECTING RELATIONSHIP WITH OTHER INSTITUTION IN AREAS OF:

<table>
<tr><th>RELATIONS WITH:</th><th>Policy/Planning/ information sharing</th><th>Medical referrals/ policies and supervision</th><th>Shared support services including training and supplies</th></tr>
<tr><td>Other institutions run by the same parent body</td><td colspan="3">Degree of centralization of parent body
Location of facilities</td></tr>
<tr><td>Other non-state sector services</td><td colspan="3">Existence/effectiveness of central coordinating body[1]
Historical factors
Perceptions of competition vs complementarity</td></tr>
<tr><td>Government services</td><td>Representation on government bodies and vice versa; degree of formal integration of NGOs[2]</td><td>Complementarity of types and location of services</td><td>Degree of national training/manpower planning;
size of central procurement system</td></tr>
<tr><td></td><td colspan="2">Funding arrangement
Legal framework</td><td></td></tr>
</table>

[1] Such as the Voluntary Health Association of India; Private Hospital Association of Lesotho.
[2] Varying as between subvention provision to formal designation as district hospitals (as in Tanzania).

Figure 1
The combination of relationships possible between an NGO/private health service with other agencies.

The nature of such relationships is key to the future development of efficient health care. Whilst there may be a place for different organizational types within any country's health system, the ability of such a network to work efficiently is greatly constrained by the lack of clear, open relationships *within* the network; coordinating mechanisms may either exist; in the first instance, outside of government, with government then collaborating with non-state institutions *through* an intermediary body; or may exist within government, with itself then providing the coordinating mechanism. There would appear to be no clear evidence as to which model is likely, *a priori*, to be most effective.

Funding base. The means of financing the non-state sector again varies tremendously from country to country. Figure 2 shows the possible permutations that are possible.

During the 1970s a major form of NGO health care — the religious/charity sector — began increasingly to face financial difficulties. This can be traced, in general, to three factors. Firstly, a reduction in overseas recurrent cost support. In part this may be a result of a declining interest in, and priority given by many denominations to, mission work. In common with official government

FORMS OF FUNDING SOURCE

PROVIDER	User charges	Voluntary insurance	Employment related	Compulsory insurance	Tax revenue	Donations/ grant/aid
State	x			x	x	Community, international aid
NGO	x	x			As grants/ subsidy	Community, international aid
Occupational health	x		x		As subsidy	
Private sector for profit	x	x			As subsidy	

Figure 2. Major forms of funding of different health care providers.

aid (bilateral or multilateral), international NGO aid has often been directed at capital expenditures — thereby worsening the financing situation, through incurring greater future recurrent commitments. Other factors are, secondly, the impact of world inflation, particularly in the area of pharmaceuticals; and, lastly, an increasing divergence in fee levels between comparable government agencies and NGOs.

An many cases the situation has become critical, particularly where government policies had been to restain or freeze their own user charges. In such situations, the NGOs that relied on user charges (which can often be as high as 70% (Kolobe and Pekeohe, 1980)) as a source of finance fell back onto a strategy of increasing them, often to a point where utilization rates began to decline, as users either could not afford services or chose to travel to the nearest government facility. Such a strategy often compounded the problem. In some countries this situation led to demands for (increased) government subventions, prompting the Ministry of Health to review policies towards NGOs. Alongside such government policy reviews, the NGOs themselves, faced with a common problem, recognized in a number of countries the need for a common policy and formed coordinating mechanisms. To the extent that governments have accepted a need to increase subventions, this has carried the potential (not always exploited) for closer integration of such NGOs into the state sector. The extent of overseas funding and hidden subsidies is often unknown, so that withdrawal of overseas support creates unexpected difficulties. Examples of this include donations in kind (for example, of drugs) and the deployment of volunteer staff.

Government-explicit subsidies may take a variety of forms, ranging from: a straight annual grant (in some cases linked to factors such as the operating size or budget); to payment for particular services (such as treatment for communicable disease); or, reimbursement for particular items of expenditure (such as salaries or drugs).

Elements of the non-state sector that relied on health insurance as a main source of funding appear to have been less affected by the global economic recession, which may have hit higher income groups and hence their clients less severely. Within the NGO sector, there is, in some cases, the development of 'private' facilities, charging commercial rates, which are provided alongside their usual services, and are used to cross-subsidize such services.

One area that is of clear importance for the development of government policy is the degree to which both NGOs and the private sector receive hidden subsidies from government in the form of, amongst others, tax relief, training, access to cheaper or even free medical supplies, and the use of government facilities either directly or indirectly (Segall, 1983). Information of such hidden subsidies is rarely carried in conventional accounting systems, and yet is essential to obtain a comprehensive picture of the funding characteristics of the non-state sector.

Manpower training and usage. Manpower may include both externally recruited expatriates and citizens trained either within the particular employing organization or outside. There are a number of major issues to be addressed

here, involving the relationship between government and the non-state sector, as regards training and employment policies. These include: (a) *Standardization and coordination of training*: individual NGOs may provide a variety of different training programmes mainly devised for their own needs. This is most obvious in auxiliary training programmes where national licensing and curriculum standards are relatively undeveloped. Where such training *is* nationally recognized, NGOs have often had a lead role in determining national curricula. The general relevance of such curricula then depends of the degree to which the training organization is effectively integrated with or collaborates with government. The private sector is rarely involved in training, with resultant hidden subsidies for this sector. (b) *Staff transferability and deployment*: as a result of either different training levels of bureaucratic barriers (such as the non-recognition of experience) transferability of staff between institutions within the non-state sector, or between the non-state sector and government, may be difficult. Furthermore, pay-scale differentials between the private sector and the state sector are often a cause of staff movement between sectors, or of pressure within the state sector to move towards unrealistic private sector levels of pay. Conversely, the NGO sector may be unable to meet even state sector pay levels, leading to recruitment difficulties (McGilvray, 1974). In a number of countries, the government has responded either through coercive policies such as bonding, or by incentive policies such as allowing state doctors to practise privately, in some cases using government facilities, thereby effectively increasing their real income. Further major differences between NGOs and government agencies stem from their ability to attract volunteers and to employ part-time staff. The motivational differences between government and NGOs, and the often wide activity base of NGOs, appear to give them a substantial comparative advantage over the use of volunteers (Rankin, 1985). Even where government agencies have made deliberate efforts to involve communities in the planning of local services, and as resources to provide the services, their success rate would appear to have been low compared to NGOs. This seeming advantage can, however, on occasion, become a sourse of tension, where volunteers are being used as substitutes for paid staff. (c) *Appropriate manpower mixes*: utilization of different types of staff would appear to vary between organizations, having implications for their cost-effectiveness. This can either be relative (for example ratio of doctors to nurses) or absolute (for example doctors per head). An example of the latter is given by Gish (1971), who compares a 100-bedded women's wing in a public hospital in Tehran, with a 30-bedded private hospital. The former has four part-time and one full-time doctors, the latter has six part-time and four full-time doctors. (d) *Localization policies*: the ability of some NGOs to recruit expatriates at subsidized rates may be a deterrent to localization policies. One example of where this may be difficult is the not uncommon situation of expatriate spouses holding unpaid positions, thereby reducing local employment opportunities. (e) *Manpower planning*: all the above have implications for the ability of government to perform effectively manpower planning, which is often further constrained by the lack of *information* on both the demand for, and supply of manpower from the non-state sector, and in particular the private sector.

Degree of innovation. One argument that is frequently put forward in favour of NGOs, and to a lesser extent the private sector, relates to their apparent innovativeness. Innovation may in this context occur either in the form of technology adopted, or the form of organization. Within the private sector, the former may manifest itself in a replication of the latest high-technology medical care practised in the more industrialized countries. In addition, in some countries, the private sector has introduced new forms of organization. (Scarpaci, 1985). Many NGOs pride themselves on the use of more appropriate technology and on their degree of innovation in service delivery. The degree to which this is generally true merits investigation, though certainly NGOs have been involved in path-breaking work such as the Flying Doctor Service in East Africa by AMREF. The ability and need to innovate is generated, it is suggested, through an historically lower funding rate, motivational differences and a flexibility of operation. Whilst many governments recognize the usefulness of NGOs in this respect, and indeed may use them to circumvent their own organizational constraints, such individualistic, unplanned and often unevaluated innovation can result in extremely heterogenious services whose prime characteristic is not necessarily *better* health care, but *different* health care, with implications for planning and coordination.

EVALUATING THE NON-STATE SECTOR

The preceding section outlined a number of characteristics that differentiate NGOs and the private sector from government, and between themselves. As a result of certain of these differing characteristics, arguments are employed that purport to demonstrate the comparative advantage of one sector over another, and hence the need for policies to encourage or discourage parts of all of the sector. This section accepts as a premise, the provision by the state of certain forms of (particularly public) health care. Such as assumption is commonly accepted, with the debate focusing rather on *how* comprehensive such state provision should be. Figure 3 outlines the arguments which are now discussed in greater detail in the test below. The arguments, though often interlinked, are grouped into five sets of issues:

—Does the existence of the non-state sector lead to *additional net resources*?
—Are organizations within the non-state sector more or less *efficient* at providing (certain types of) health care?
—Are there differences in *quality* between the state and non-state health care?
—Does the existence of a variety of organizations within the non-state sector alongside a state sector, have implications for the *planning and coordination* of health services, and ultimately for the efficiency of the health sector as a whole?
—What are the *equity* implications of the existence of difference sectors?

Resource mobilization.

One of the central issues surrounding the non-state sector is whether or not the existence of this sector increases the total share of resources available for

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Resource mobilization.

One of the central issues surrounding the non-state sector is whether or not the existence of this sector increases the total share of resources available for

Arguments for NGOs/private sector	*Arguments against NGOs/private sector*
Resource mobilization	
Can tap additional sources of funds. Can release public sector resources by syphoning off demand.	Use of user charges creates inequities. The extent of additional real resources is less than apparent, due to: (a) hidden subsidies; (b) less efficient use of resources.
Efficiency	
More efficient in use of resources due to motivation/management structure	Less efficient due to inabilities to exploit economies of scale. Duplicates service provision.
Service quality	
Provides high quality of service.	Creates unrealistic expectations in the public sector. Lack of regulatory mechanisms may reduce quality of service below acceptable minimum.
Planning/coordination	
Is autonomous, innovative, 'loyal opposition'.	Duplicates services. Is unplanned in national terms.
Equity	
NGOs locate services in rural areas. Existence of alternative provision provides freedom of choice. More responsive to consumers through market mechanism.	Private sector located in urban areas. Access to health care dependent on financial status of patient. Less responsive to community needs. Not democratically controlled.

Figure 3. Summary of the main arguments for/against the non-state sector.

health care, from either internal or external sources. External resources may be available through tapping different aid channels such as international NGOs, in which case it is particularly useful as a source of foreign exchange. Internal resources may be seemingly generated by shifting the demand of certain groups from the public sector to the private/NGO sector, thereby releasing public sector resources for other purposes.

Counter arguments focus on two themes. Firstly, that the level of additional *real* resources generated may, in net terms, be less than is at first sight apparent—either because subsidies of various kinds are borne centrally, or becuase it results in a less efficient use of overall resources. A second argument is that expressed in terms of equity. It is argued that for demand for private services to exist alongside the public sector, there must be a (perceived at least) difference between either the coverage or quality of service provision of the public sector and the private sector, which may be a result of either the hotel aspects of the service, or of the treatment itself. To the degree to which fees charged in the private sector are prohibitive for a large section of the population, this is a continuing source of inequity.

Efficiency

A second set of arguments focuses on whether resources are likely to be used more efficiently in the state or the non-state sector. Arguments for the

non-state sector are based on neo-classical economic arguments that competition will (under certain circumstances) achieve an optimal allocation of resources. Though such proponents recognize that in the field of health care, such perfect conditions do not pertain, they argue that effort should be directed to creating such conditions or substitutes for such conditions, rather than providing alternative publicly operated systems. However, it is worth noting that the basic premise for competitive markets — profit maximization — not only does not apply to the not-for-profit sector, including NGOs, but may also not apply to the for-profit sector, where research has suggested a number of other maximands, rather than profit (McGuire, 1985).

Arguments as to the comparative advantage of the NGO sector, the state sector, or the private sector are complex and, to a large degree, untested, with perceptions being largely based on anecdotal evidence (Brown and Tenn, 1985). Inefficient or unnecessary medical practice in terms of the treatment used, may occur in private practice where consumer information may be limited (this may be a particular problem in developing countries) as a result of profit motivation and fee-for-service payment systems; flexible management *may* be the hallmark of some NGOs/private organizations, free from government bureaucratic encumberances; conversely, poor management may occur in other NGOs or private health care, where specialist management training is unavailable or where medical interests dominate. The potential for exploiting economies of scale in areas such as drug purchasing, which are open to large public sector purchasers, may not be available (though through group purchasing could be) to individual non-state organizations acting alone.

In addition to the above questions, which clearly need empirical investigatin, and which are primarily concerned with the technical efficiency of individual organizations, are arguments that relate to the non-state sector and its effect on the overall efficiency of the health sector. Some of these arguments relate to the present uncoordinated nature of the health sector in many countries, with the inefficient duplication of resources and activities. Other arguments are concerned with allocative efficiency and the use to which resources are put. Thus, scarce health resources may be used (albeit with technical efficiency) by the private sector on services which are not regarded in community health terms as of high priority. Such inefficiency is often compounded by its ability to raise unrealistic expectations/public pressure for similar provision by the state. Such issues are further explored below.

It is clear that research into general indicators of efficiency, and the relative cost-effectiveness of various organizational modes, is a vital pre-requisite of policy formulation. It is important to note, however, that because of the multiplicity of factors that impinge on the efficiency of a particular organization, much of this research will be country-specific; it is possible that only the research methodology itself will be more widely applicable.

Quality of service.

Clearly linked to the last point is the set of arguments that concern the relative quality of services provided by the state and non-state sectors. There are two main issues — the first related to the provision of 'over-high quality'

care, and the second to ensuring provision of minimum standards of care. One perception of NGOs is their ability to provide a higher quality of health care. Within developing countries this has rarely been tested: partly due to methodological difficulties in finding institutions whose ownership or management can be compared; and, partly due to difficulties in measuring quality itself, particularly in developing countries (Eldar, 1983). Such perceptions may arise through observation of the lower occupancy rates prevailing in NGO and private sector hospitals. However, the opportunity cost of this particular indicator of quality is likely to be a reduction in accessibility or coverage.

To the extent that service provision in NGOs, and more particularly the private sector, is determined by clinicians, it is reasonable to hypothesize that policies regarding resource allocation may be biased towards individualistic clinical viewpoints, at the expense of the wider community health. Such phenomena are well-reported and are the cause of tension in many health organizations (Majone, 1984). At the other end of the spectrum is the inability or unwillingness of the state, in many developing countries, to devote scarce resources to the regulation and inspection of non-state services to ensure that *minimum* standards are maintained.

Planning and coordination role in primary health care.

In terms of the planned provision of care, arguments for the non-state sector range from the viewpoint that the market is the best planner, or that NGOs are as a result of their community links, or that the private sector is as a result of its responsiveness to demand, to a viewpoint that a regulatory form of government planning and/or government funding of services is possible without necessarily the involvement of the state in the actual *provision* of services. Emerging interest in the decentralization of health care management is also used as an argument for the non-state sector. Arguments against focus on *efficiency* criteria, as discussed above, with, for example, the claim that the absence of planning leads to: a duplication of services (Schulpen, 1975); and the lack of referral mechanisms or standardization of medical practice; and, on *equity*, to the belief that planning is a mechanism for determining needs-based services, rather than demand-responsive services.

Private health care based on a medical model, it has been argued earlier, is less likely to be concerned with wider issues of community health or primary health care, and as such, where its existence is permitted at all, requires close regulation. NGOs, on the other hand, have, in many instances, been at the forefront of innovative primary health care activities, particularly those with links into other sectors or activities, such as broader community development. Governments may, in addition, welcome the existence of NGOs, not just as potential innovative pilots, but as agencies providing specific services whose importance the government recognizes but which are politically too sensitive for it to provide; for example family planning services. In some countries NGOs may also act as a 'ginger group' or as loyal opposition; they may also be used by ministries of health to bypass their own government bureaucratic constraints, through contracting-out service provision. Acceptance of the need for state

planned health care does not necessarily imply or require state *provision* of health care. However, it does imply the need for knowledge of the particular activities of non-state health care, their strengths and weaknesses, and the ability, where necessary, to regulate them. Such information and regulatory mechanisms are at present conspicuous by their absence in many developing countries; research in this area would clearly be beneficial.

Equity/social justice.

Health care may be viewed as either an investment or a consumption good. In the former case, its allocation is not related to issues of equity but rather to those of productivity. Proponents of this view of health care argue that health care should be targeted at certain groups; and that equity losses in the short-term are worth such overall development gains. Roemer, arguing for social insurance, has made this point strongly (Roemer, *et al*, 1984); the same could be argued for occupational health care and its subsidization by the state. Proponents of the consumption good view of health care are concerned rather that health care is available in relation to need and not on any other criteria. As such it is difficult to reconcile the two views.

Arguments couched in terms of equity and social justice are of four types, the first two concerned with access to services. Firstly, those concerned with the location of facilities point, on the one hand, to the concentration of private hospital care in urban areas, and on the other to the location of many NGO facilities in rural areas. Secondly, where access is restricted through financing mechanisms, namely reliance on user charges, or high insurance premiums/co-payment charges, there are clear implications for equity in terms of utilization of services in relation to need. Thirdly, there are arguments which relate to the degree of subsidization of private services by public monies. Lastly, there is the libertarian view that argues for freedom of choice. How such arguments are assessed and concluded will depend on a government's understanding of, and commitment to, equity; and, hence, on the ideological standpoint of the government.

For many countries, other than those with a clear socialist ideology, an evaluation of the non-state sector as a whole is unlikely to lead to unambiguous answers: value judgements will be required as to the trade-off between equity and resource mobilization. The two research questions that need answering are:

—Do organizations within the non-state sector release or tap additional resources (either through efficiency or resource mobilization)?
—If so, do any equity losses outweigh any benefits gained from the additional resources?

IMPLICATIONS FOR POLICY

Preceding sections have examined the size and characteristics of the non-state sector, and argued that, in many countries, it is a significant force in the health

care field. The last section concluded that, for many countries with a non-Socialist ideology, it is not possible to make generalized evaluative comments about the non-state sector. Rather, country-specific and organization-specific evaluations are needed, as a precursor to policy formation.

Perhpas because of the very real difficulties in making such assessments, health care policy formulation for many countries appears to have avoided looking too closely at this sector. Yet, as a significant component within the health sector, it is clear that such a situation cannot continue. Indeed, increasingly, governments are being forced, often through their own financial crises, or those of the NGO sector, to formulate policies in this field; however, this is often in the absence of a workable policy-making framework that asks the right questions and provides the methodology to find the answers.

This concluding section, therefore, suggests a range of policy options open to governments in this area and identifies areas of research that are needed to improve policy selection.

The state has two potential roles within the field of health care — as a *provider* and as a *regulator*. Policy development within this area needs to disentangle these two functions, if the full range of options available are to be adequately assessed. Figure 4 shows the possible range of positions open, in broad terms, to governments. Any country can be represented by a position on the diagram which shows the particular mix of service provision and regulatory controls prevailing.

The optimal strategy for any particular country at a certain time and under particular circumstances may change, as external circumstances or political assumptions and social values change. In addition, policies may be markedly different towards the different organizations, or towards NGOs compared to the private sector. It has been argued, for example (de Ferranti, 1985), that it may be more sensible in the long term for governments to support private insurance than employer-based health care for firms. Similarly, it would be perfectly consistent for governments to contract-out and fund certain types of service provision to certain NGOs, and yet withdraw all subsidies from the private sector. What is required is a means of continuously assessing the options

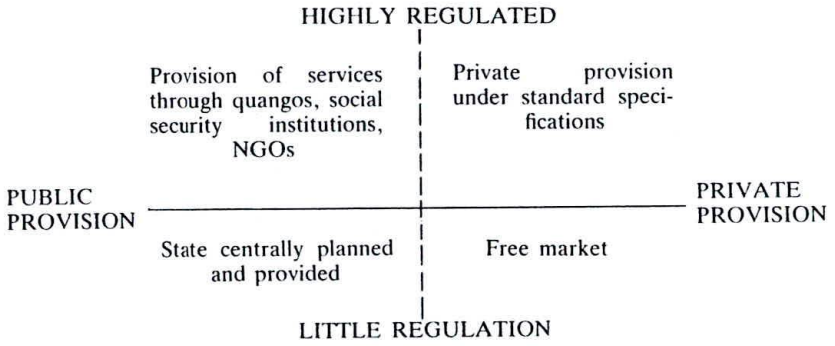

Figure 4. Mix of service provision and regulatory controls.

available, and determining the best route of attaining the chosen position. Figure 5 sets out a variety of such options.

For the development of coherent government policies towards the non-state health sector, research is required that will assist governments: (a) in determining their long-term goals in terms of a public/private mix, through identification of the specific implications and effects of different systems; (b) to determine and analyse their own present country position, and, in the absence of specific policy interventions, its likely future course; (c) to identify and assess feasible short- and medium-term options to attain their long-term goals.

Similarly, NGOs themselves need to determine their long-term role and strategy. The Christian Medical Council of the World Council of Churches has, in a number of countries, provided support and advice in such deliberations. For many church-related NGOs, such reviews provide the impetus to rethink the rationale and hence character of their work. Some, as a result of such reviews, have concluded that their involvement should be terminated and the health facility handed over to government; others have looked towards strategies for working more closely with government whilst maintaining a separate identity; some have taken the opportunity to increase *local* control of church policy.

Industrial health services fall into a different category, in that their future is likely to be as strong or as tenuous as the industry to which they are linked. However, their wider role in the health care system does need a similar review.

In order to assist organizations to carry out such reviews, which should form an important input into the formulation of government policy, research is needed which assists NGOs to: identify their preferred long-term and medium-term role within the health sector (this may differ from their present role); determine the true costs of current operations; identify areas of inefficient operation (both within and between organizations); identify medium- and long-term strategies; and, identify means to improve efficiency. Furthermore, research is required that results in evaluative techniques, and indicators of output and efficiency, which can be *easily* used by NGOs.

CONCLUSION

A number of themes have run through this article. Firstly, the heterogeneity of organizations operating in the health sector (both *between* countries and *within* them); secondly, the present and potential impact of the non-state sector; thirdly, the present incomplete state of the art relating to the economics of the public/private mix; fourthly, the different social objectives between countries on which policy is made; and lastly, the lack, in many countries, of a clear framework for policy formulation in this field. On that last point, however, there would appear to be little justification for global blanket policies about NGOs, in the absence of specific country analysis, and an understanding of each particular NGO. There may be more justification for broad policies towards the private-for-profit sector where more homogeneity is exhibited, and where the negative effects are apparent.

MEASURE	RESOURCE IMPLICATIONS	DEGREE OF REGULATION/ CONTROL
Nationalization — the take-over and continual operation, with or with out compensation, of facilities	Major resource implications	Would allow complete integration into national system
Increase or decrease in subsidy/subvention — either on a general basis, or specific to certain items or functions	Resource implications either positive or negative	Provides an opportunity for closer coordination of services without total integration; can be used to encourage provision of certain services
Designation of hospitals as government agents	May require funding, through subventions or through agreed fees for service	Allows integration into the government planning system, without total management responsibilities
Fiscal Policy	Revenue earner/loser	Can be linked to specific factors
Direct regulatory action	Minimal funding requirements other than regulatory mechanism and inspectorate	May be difficult to enforce; can be applied on costs or quality (including type of technology adopted)
Encourage collaborative	Minimal	Reciprocal participation on decision-making bodies; encouragement of central coordinating bodies, etc
Foreign exchange controls	May have positive economic benefits	Can be used to control drugs, and importation of equipment
Manpower controls	Minimal direct implications	Through bonding, licensing, licensing etc
Central drug supply controls	Minimal	Central drug policies
Legislative prohibition of certain categories of health care	May require funding to provide replacement services	May drive such activities as private care underground

Figure 5. Selected policy options open to government.

MEASURE	RESOURCE IMPLICATIONS	DEGREE OF REGULATION/ CONTROL
Provide seed money for initiatives (through subventions, grants or fiscal incentives)	Resource requirements in short term	May be used to underwrite new, innovatory forms of organization
Legislative requirement for industrial health care	Minimal government; may affect industrial profits	Problems of implementation

Figure 5. (continued)

Three main types of institution are involved in policy formulation in this field — the national governments in developing countries, NGOs and the private sector institutions themselves, and aid agencies. Whilst each of these is likely to have different policy objectives, they share much common ground in their need for information and analytical tools on which to formulate their policy actions, and it is in this area — the development not of policies themselves, but rather of tools and criteria that can be used to formulate policies, that, it is argued, urgent research attention should be focused. The following summarizes the main questions which need to be addressed in each country in order for robust and relevant policies to be formulated.

Firstly, basic question that needs to be answered for each country concerns the present size of the non-state health sector, both in aggregate terms (by facility, resource and expenditure) and by type. Where financing or comprehensive sector reviews surveys have been carried out, this information may be available; in other countries, research may be required to determine this basic picture. Some further attention also needs to be given to develop definitions that describe accurately the different types of organization.

Secondly, not only is country-specific information required as to the current size of the non-state sector, but information is needed that describes past trends, and projects into the future, in the absence of policy changes, the future size of the sector. Thirdly, a number of possible characteristics on non-state sector hospitals have been set out in this article, the precise configuration of which will vary as a result of the country or organization context. Tools need to be developed to allow the analysis of such characteristics.

Finally, this article has reviewed a series of issues that relate to the effects that the non-state sector have on the availability and utilization of resources. These issues have been identified as a series of questions, for the answer to which evaluative tools need developing. The size and potential impact of the non-state sector upon health care and upon health itself strongly suggest that policy development and, hence, research in this area should be seen as a priority.

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SHORT COMMUNICATION

SPECIALLY DISADVANTAGED GROUPS: A CHALLENGE FOR HEALTH SERVICES

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1985 saw the publication, by the World Health Organization, Regional Office for Europe, of a text that is intended to set out the fundamental requirements for people to be healthy, to define the improvements in health that can be achieved by the year 2000 for the peoples of the European Region of WHO, and to propose action to secure those improvements (WHO, 1985a). The strategy in that book also calls for the formulation of specific regional targets to support its implementation. This short communication spells out the main elements in that overall commitment by the European Member States, and focuses directly on the health needs of those most disadvantaged.

As the WHO text states clearly, if health for all is to be reached in Europe by the year 2000 (HFA 2000), two basic issues must be tackled: first, to reduce health inequalities among countries and among groups within countries; and, second, to strengthen health as much as to reduce disease and its consequences. Thus, health for all in Europe has four dimensions as regards health outcomes, involving action to:

— *ensure equity in health*, by reducing the present gap in health status between countries and between different population groups within countries;

— *add life to years*, by ensuring the full development and use of people's integral or residual physical and mental capacity to derive full benefit from and to cope with their life situation in a healthy way;

— *add health to life*, by increasing the number of years people live free from major diseases and disabilities;

— *add years to life*, by reducing the number of premature deaths, and thereby increasing life expectancy at birth.

Here, the HFA strategy will be judged in years to come to the extent that it achieves these four aims, the key being the manner in which individual countries come to grips with the basic issues identified.

A number of the targets in the strategy deal with the concern (WHO, 1985a) to reduce inequity in health, and with the disadvantaged. Indeed, the very first target of the European HFA strategy reads:

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HEALTH

A PRECIOUS ASSET

Accelerating follow-up to the
World Summit for Social Development

Proposals by the
World Health Organization

Contents

HEALTH: A PRECIOUS ASSET

Foreword

The world has committed to halving the number of people living in extreme poverty by 2015, and a set of concrete targets has been set. Many of them focus on health – on child and maternal health and access to primary and reproductive health care. To me it is clear that we must strengthen our focus on the pathway that leads from health to poverty reduction and sustainable development.

Until recently, many development professionals have argued that the health sector, itself, is only a minor player in efforts to improve the overall health of populations. And the overwhelming majority of finance officials and economists have believed that health is relatively unimportant as a development goal or as an instrument for poverty reduction. Health was seen as a consumption rather than an investment cost.

But this is changing. We are standing on the threshold of a major shift in thinking. Health is increasingly being seen as a crucially important asset of poor people. From this perspective protecting and improving health are central to the entire process of poverty eradication and human development. It is the purpose of this report to share WHO's views on health in development.

I believe that the Special Session of the UN General Assembly in Geneva in June 2000 offers a timely opportunity for international endorsement of a more robust, multidimensional approach to human development and its social components, particularly health.

Gro Harlem Brundtland
Director General
World Health Organization

Health as an asset

"The wealth of poor people is their capabilities and their "assets". Of these, health is the most precious and important. Health allows poor people the opportunity to participate in the labour market or in the production of goods. It is a key to productivity. Having a fit, strong body is an asset to anyone: a sick, weak and disabled body is a liability, both to the persons affected and to those who must support them. When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household. The family faces not only a loss of income and care but also needs to find the money to cover medical care costs as well. Health calamities are a common cause of impoverishment.

If health is an asset and ill-health a liability for poor people, protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors - economic, environmental and social."

Introduction

"We commit ourselves to the goal of eradicating extreme poverty in the world, through decisive national actions and international cooperation, as an ethical, social, political and economic imperative of humankind."
Copenhagen Declaration, World Summit for Social Development, 1995

Five years after the commitments were made at the World Summit for Social Development (WSSD) in Copenhagen, progress in achieving the targets has failed to match expectations. Whereas the Summit aimed for substantial reductions in the number of people living in extreme poverty, the number has actually grown. Nor has much progress been made in the objective of achieving universal health care. In some countries access has deteriorated, particularly for the poorest populations.

Nevertheless, the international consensus on what constitutes the essential elements of human development has progressed. Belief in economic liberalization has given way to a global social concern. There is a greater understanding that effective human development policy must allow a better integration of economic, social and environmental concerns.

The centrality of health has been recognized. Health is seen as both a critical input to development and as an outcome of development, as well as a fundamental human right with a value in and of itself. Herein lies the opportunity which must be seized in "Copenhagen Plus Five", the five-year follow-up meeting. It takes place in Geneva, 26-30 June 2000, as the Special Session of the United Nations General Assembly on the Implementation of the Outcome of the World Summit for Social Development and Further Initiatives.

Health as an asset

The wealth of poor people is their capabilities and their "assets". Of these, health is the most precious and important. Health allows poor people the opportunity to participate in the labour market or the production of goods. It is a key to productivity. Having a fit, strong body is an asset to anyone: a sick, weak and disabled body is a liability, both to the persons affected and to those who must support them. When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household. The family faces not only a loss of income and care but also needs to find the money to cover medical care costs as well. Health calamities are a common cause of impoverishment.

If health is an asset and ill-health a liability for poor people, protecting and promoting health are central to the entire process of poverty eradication and human development. As such they should be goals of development policy shared by all sectors – economic, environmental and social.

Health improvements are disproportionately beneficial to the poor because they are wholly dependent on their labour power.

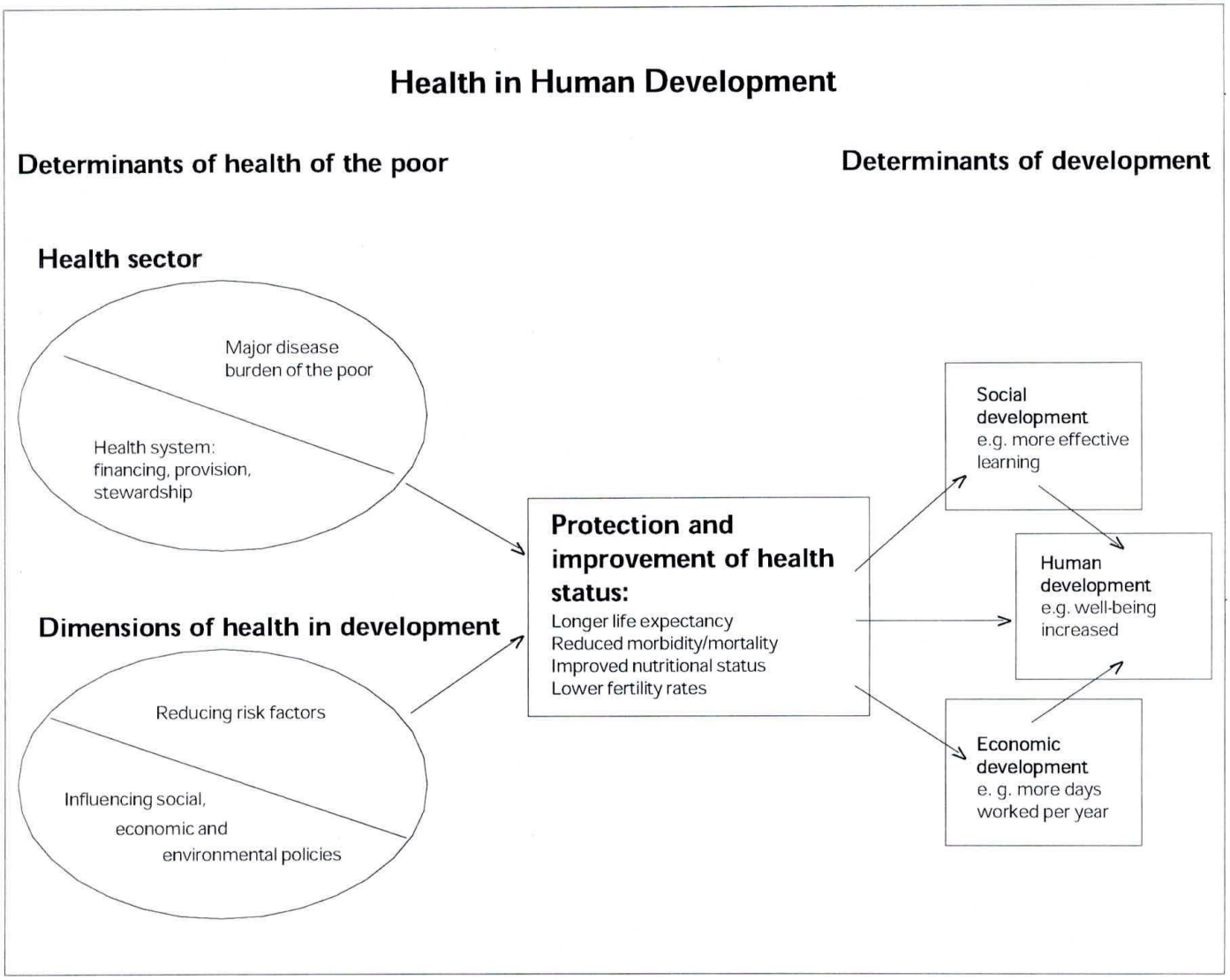
A multisectoral vision

The Copenhagen Declaration and Programme of Action accorded responsibility for health to basic health services. This narrow perception of health undervalues the contribution of improved health status to development. At the same time, it does not recognize the potential of many sectors to foster the health of poor people in the interests of furthering human wellbeing. Any positive contribution to human and social capital is the result of the improved health status of populations, and not merely the output of health service industry. Better health contributes to sustainable livelihoods and human development.

Universal access to health services *is* important. But if health is to fulfil its potential in human development, the services required need to have the capacity to improve health status *and* to reduce the inequities in health. Health inequities are in themselves contributors to ill health.

The World Health Organization believes that the Special Session of the UN General Assembly in Geneva in June 2000 offers an extremely timely opportunity to build on the commitments of the Copenhagen Summit by obtaining an endorsement for a more robust, multidimensional approach to human

"When breadwinners die or experience episodes of ill-health or long-term disability, the results can be disastrous for the entire household."



Source: WHO/HSD

Poverty eradication as part of the overall development goal

In societies with clear policies on equality and democracy, and where the overall goal of equity is the improvement of the health status of the entire population, the chances of health development for the poorest people is higher. Experiences from countries with a historical commitment to health as a social goal, and to equality as a political goal, confirm this. Costa Rica, Sri Lanka and the state of Kerala in India have achieved considerable improvements in the health status of their populations by a series of political, social and economic interventions in society as a whole, actively involving communities in the process. In Costa Rica, where health is considered an "investment in the nation, a necessity for social vitality and economic progress," progressive health policies have increased the income of the poorest 10% of the population by more than 65%. Source: *"Poverty and health: Who lives, who dies, who cares?"* Macroeconomics, Health and Development Series, No. 28 by Margareta Sköld, Department of Health in Sustainable Development (HSD), WHO/ICO/MESD.28

development with strengthened social components, particularly relating to health.

Further information

This report is necessarily brief and selective. It responds to the request of the preparatory committee for the Special Session of the UN General Assembly for information on progress in achieving universal access to primary health services.

The report begins with a summarized global update on the main diseases and conditions which disproportionately affect the poor. It also describes current problems in health services. The second section sets out a number of proposals for action, within the Copenhagen framework, which the World Health Organization believes can make health a significant force for poverty reduction.

The information in this document will be supplemented by the World Health Report 2000.

Five years after the Copenhagen Summit

THE HEALTH REVOLUTION THAT LEFT OUT A BILLION PEOPLE

The 20th century has seen a global transformation in human health unmatched in human history. Over the past three decades, overall improvements in health and human development can be illustrated as follows:

- Infant mortality rates have fallen from 104 per 1000 live births in 1970-75 to 59 in 1996. On average, life expectancy has risen by four months each year since 1970.
- Per capita income growth in developing countries has averaged about 1.3 percent a year, bringing relief from poverty for millions of people.
- Governments report rapid progress in primary school enrolment. Adult literacy has risen, from 46 to 70 percent.[1]

We can soon expect a world without poliomyelitis, with no new cases of leprosy, and with no more deaths from guinea worm.

But over one billion people – one in six of the world's population – will enter the 21st century without having benefited from the health and human development revolution. The lives of these people are difficult and short, and scarred by a ruthless disease called "extreme poverty". Extreme poverty is categorized as a disease under code Z59.5 in WHO's International Classification of Diseases.

Growing disparities

Unacceptable and growing disparities in the health of rich and poor countries, rich and poor people, and between men and women, are important characteristics of human kind at the start of this new millennium. It is only if the health problems of the poor can be reduced that human assets can be liberated for social development.

It is hard to give a detailed, up-to-the-minute account of trends in the health of poor and vulnerable populations since 1995. We must frankly acknowledge that the poor quality or, in some instances the absence, of data is a significant obstacle to tracking the health status of the poor.

However, it is now generally recognized that the many dimensions of poverty including lack of basic education, inadequate housing, social exclusion, lack of employment or opportunities, environmental degradation, and low income all pose a threat to health. On every health indicator studied by the World Health Organization, the poor fare worse than the better off in any given society. Specifically, compared to fellow citizens, those living in absolute poverty are:

- Five times more likely to die before reaching the age of 5 years
- Two and a half times more likely to die between the ages of 15 and 59 years.

Potentially deadly infections, such as HIV/AIDS, malaria, tuberculosis and diarrhoeal diseases, disproportionately affect poor people producing devastating effects on households and national economies. As a result, the World Health Organization accords high priority to controlling these diseases – a task made especially difficult by the evolution of drug-resistant microbes. Major current health problems such as malnutrition and maternal mortality also have a greater prevalence among the poor.

"One in six of the world's population will enter the 21st century without having benefited from the health and human development revolution."

Health status of the poor versus the non-poor in selected countries, around 1990

Country	Percentage of population in absolute poverty	Probability of dying per 1000 between birth and age 5, females		Probability of dying per 1000 between ages 15 and 59, females		Prevalence of tuberculosis	
		Non-poor	Poor:non-poor ratio	Non-poor	Poor:non-poor ratio	Non-poor	Poor:non-poor ratio
Aggregate		38	4.8	92	4.3	23	2.6
Chile	15	7	8.3	34	12.3	2	8.0
China	22	28	6.6	35	11.0	13	3.8
Ecuador	8	45	4.9	107	4.4	25	1.8
India	53	40	4.3	84	3.7	28	2.5
Kenya	50	41	3.8	131	3.8	20	2.6
Malaysia	6	10	15.0	99	5.1	13	3.2

Poverty is defined as income per capita of less than or equal to $1 per day, expressed in dollars adjusted for purchasing power.
Source: *World Health Report 1999, Making a difference.*

MAJOR HEALTH PROBLEMS OF THE POOR

HIV/AIDS[2]

The prevalence of HIV/AIDS is associated with poverty:

- More than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years.
- The economic effect of HIV/AIDS on households is devastating. From household surveys in Africa and Asia we know that families living with HIV/AIDS have an income reduction of 40-60%. The inevitable response is the spending of savings, borrowing, and reductions in consumption.[3]
- HIV/AIDS illustrates the effect of multidimensional poverty on health. The socioeconomic factors contributing to the spread of HIV/AIDS include: illiteracy related to income poverty; gender inequality; increased mobility of populations within and between countries; and, rapid industrialization involving the movement of workers from villages to cities, with consequent breakdown of traditional values.[4]
- HIV/AIDS also illustrates the global equity gap. Successful public health measures have stabilized the epidemic in most developed countries, but the same is true only of some developing countries. Developing countries have 95% of cases, and many poor countries are experiencing exponential growth of HIV/AIDS cases. Yet, developing countries only receive about 12% of global spending on HIV/AIDS care.[5]

"Developing countries have 95% of cases... Yet, developing countries only receive about 12% of global spending on HIV/AIDS care."

Malaria[6]

Malaria hits hard on the poor and the vulnerable:

- Over one million people die of malaria each year of which almost 90% occur in sub-Saharan Africa.
- Malaria is directly responsible for one in five childhood deaths in Africa. Indirectly, it contributes to illness and deaths from respiratory infections, diarrhoeal disease and malnutrition.
- For reasons which are not fully understood, women are more susceptible to malaria during pregnancy. This is particularly so during the first pregnancy. Fetal growth, and the survival of the new-born, may be seriously compromised.[7]

Malaria flourishes in situations of social and environmental crisis, such as mass migration, military conflict and social unrest, where health systems are weak and communities disadvantaged.

The severity and urgency of the problem has led to the formation of global partnerships to control malaria. **Roll Back Malaria,** a World Health Organization initiative, is a coalition involving the United Nations Development Programme (UNDP), UNICEF, WHO and the World Bank. Roll Back Malaria assists health systems to deliver the cost effective interventions that exist to control malaria. The initiative harnesses the support of the private and public sector in developing new malaria drugs and vaccines.

Tuberculosis[8]

Tuberculosis and poverty are closely linked. Both the probability of becoming infected, and the probability of developing clinical disease are associated with factors which are associated with poverty. These factors include malnutrition, overcrowding, poor air circulation and inadequate sanitation. Given the often crowded conditions in which poor populations live, they are more likely to contract tuberculosis. At the same time, those who contract the disease are more likely to become poor given the economic consequences of the disease. Ninety-five per cent of cases and deaths occur in developing countries.

Tuberculosis is a growing problem in many regions of the world. It is on the rise in developing and transition economies due to a combination of economic decline, insufficient application of control measures, and the HIV/AIDS epidemic. People whose immune defences are weakened by HIV infection become an easy prey for other microbes, including the bacillus that causes tuberculosis. The resulting infections (along with some cancers) are responsible for the recurring illnesses which in their late stages are called "AIDS", and which ultimately lead to death.[9]

- Between 1993 and 1996 there was a 13% increase in estimated tuberculosis cases world-wide, one third of which can be attributed to HIV.[10]

Global distribution of death by main causes

Communicable diseases, such as tuberculosis and respiratory infections as well as maternal, perinatal and neonatal causes account for about 20 million, or 40% of global deaths. Ninety-nine per cent of these deaths occur in developing countries.
Source: *"Bridging the gaps"*, World Health Report 1995.

- Around 30% of all AIDS deaths result directly from tuberculosis.[11]
- WHO estimates that by the end of the century, HIV infection will cause an additional 1.5 million cases of tuberculosis annually.[12]

Concerted efforts to end social apathy towards TB; to expand the global coalition of partners involved in TB control; and, to advocate for TB to be placed high on the international agenda are currently being mounted through the **STOP TB Initiative** based at the World Health Organization. The initiative is creating a social and political movement against TB by promoting the use of the cost effective Directly Observed Treatment Short-course (DOTS).

Malnutrition[13]

Nearly 30% of humanity is currently suffering from one or more of the multiple forms of malnutrition. Protein-energy malnutrition and iron deficiency anaemia are major sources of concern, iodine deficiency is the greatest single preventable cause of brain-damage and mental retardation (affecting 740 million people or 13% of the world's population) and Vitamin A deficiency (VAD) remains the single greatest cause of preventable childhood blindness. Overall, malnutrition accounts for 15.9% of the global burden of disease.[14]

Each year some 49% of the 10 million deaths taking place among children under five in the developing world are associated with malnutrition. Currently, 26.7% of the world's children under five years are malnourished when measured in terms of weight for age.

Recent achievements:

- Remarkable progress has been made in controlling iodine deficiency disorders (IDD) in the last decade. More than two-thirds of households living in IDD-affected countries now consume iodized salt, and 20 countries have reached the goal of universal salt iodization (USI) defined as more than 90% of households consuming iodized salt.
- There has been progress since 1990 in combating VAD. In 1997, it was estimated that in about 30 countries, 50% of children were either given vitamin A supplements or had access to fortified food.

However, progress in reducing protein-energy malnutrition (PEM) among infants and young children is exceedingly slow, and little progress has been made in reducing the prevalence of anaemia over the past two decades.

Maternal mortality

The death of a mother is a catastrophe in any family. In many developing countries, it deprives a household of a vital income as well as love and affection. When a mother dies in a poor families, the loss is such that it may also spell death for her children.

Every year 585 000 poor women die from the complications of pregnancy and childbirth. In developing countries, maternal mortality and morbidity is by far the greatest cause of premature death and disability amongst women aged 15 to 44 years. Women in Northern Europe have a one in 4000 risk of dying from pregnancy–related causes. For women in Africa, the ratio is one in 16. There could hardly be a more striking disparity between North and South than this.

The target of the International Conference on Population and Development (ICPD) in 1994 was to reduce 1990 levels of maternal mortality by half by the year 2000 – a target which will not be met – and by a further half by the year 2015.[15] New targets were agreed in the five-year review of the ICPD in 1999. They are that at least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should rise to 50% and 85% respectively by 2010; and to 60% and 90% by 2015.[16]

In October 1999, WHO, the United Nations Population Fund (UNFPA), UNICEF and the World Bank combined forces in a joint commitment to fight maternal mortality more effectively.

Water-borne diseases[17]

Diarrhoeal diseases, largely preventable through access to adequate clean water and sanitation, claim nearly two million lives a year and account for 1.5 billion bouts of illness each year in the under-five age group. Diarrhoeal diseases impose a heavy burden on developing countries. The World Health Organization estimates that diarrhoeal diseases accounted for 73 million disability adjusted life years (DALYs)[18] lost in 1998.[19]

Out of the total global population of six billion:

- More than 1 billion people are highly vulnerable to diarrhoeal diseases because they do not have ready access to an adequate and safe water supply.
- Approximately 3 billion people are vulnerable because of they lack access to any form of improved excreta disposal services.

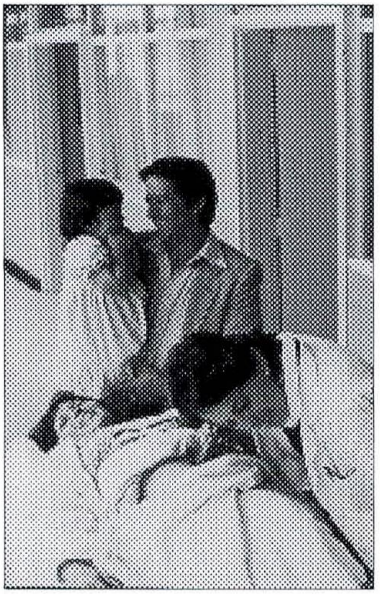
Respiratory infections

In 1998, acute respiratory infections (ARIs) were responsible for approximately 3.5 million deaths among people of all ages world-wide. Almost 2 million of these deaths were in children under the age of five years. Pneumonia kills more children than any other infectious disease, and 99% of these deaths occur in developing countries.

The World Health Organization estimates that acute respiratory infections accounted for 83 million DALYs lost in 1998.[20] An over-

"Currently, 26.7% of the world's children under five years of age are malnourished."

Trained childbirth assistance drastically reduces the risk involved in becoming a mother.



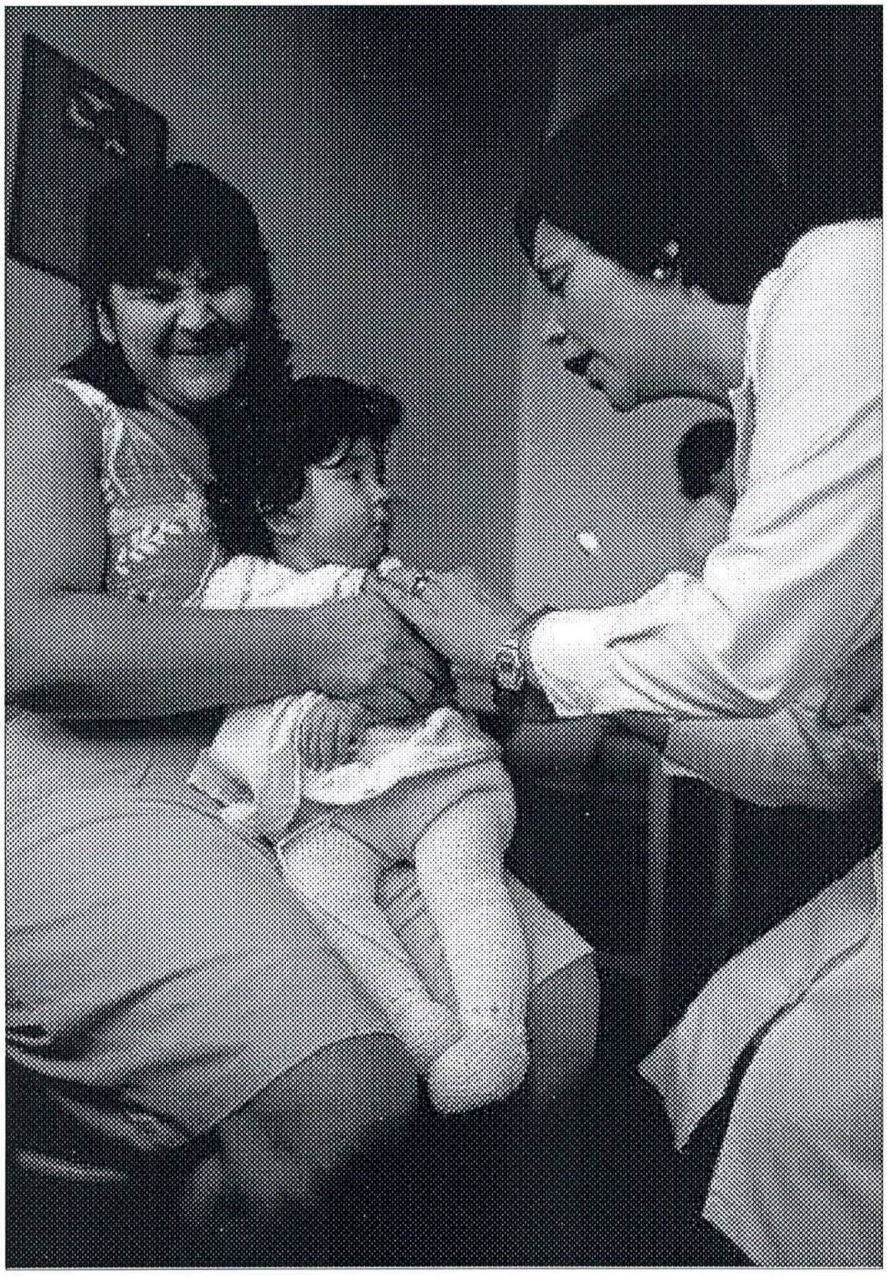
whelming proportion of this burden of disease is attributable to environmental factors. Children the world over die of respiratory infections associated with poverty and poor housing.

Mothers are also vulnerable to respiratory infections. Hundreds of millions of adult women in developing countries are exposed to extremely high levels of airborne particles when cooking with biomass fuels. Studies in India and Nepal have shown that chronic obstructive lung disease and *cor pulmonale* are common, and develop at an early age, in women exposed to high levels of indoor smoke.[21]

Childhood immunization

Globally, immunization coverage has continued to increase slowly. Yet, one in five children is not fully immunized against the six major killer diseases: diphtheria, whooping cough, tetanus, polio, measles and tuberculosis.[22]

On 31 January 2000, the new Global Alliance for Vaccines and Immunization (GAVI) was formally announced at the World Economic Forum in Davos, Switzerland. It represents a commitment by the World Health Organization, UNICEF, the World Bank, industry, philanthropic foundations and public sector agencies to work in partnership towards the protection of all children against major vaccine-preventable diseases.



Four out of five children are fully immunized against six major killer diseases.

HEALTH SERVICES IN CRISIS

In the 25 years since the Alma-Ata Declaration was signed, the rapid and sustained progress towards "Health for All" that was hoped for has not been realized. Figures which give reliable, comparable and recent estimates on health care coverage and access to care are not always available. However, the picture which does emerge is profoundly disturbing. In too many countries health systems are ill-equipped to cope with present demands – let alone those they will face in future. Certainly the call for universal access to basic health services made five years ago at Copenhagen has not been heeded.

The inequities in health are striking, both between countries and within them.

Inequities between countries

The differences between developed and developing countries in terms of access to services can be illustrated as follows:

- In developed countries there may be one nurse for every 130 people and one pharmacist for every 2000 to 3000 people. A course of antibiotics to cure pneumonia can be bought for the equivalent of 2 to 3 hours' wages. A one-year treatment for HIV infection costs the equivalent of 4 to 6 months' salary. And the majority of drug costs are reimbursed.
- In developing countries there may be only one nurse for every 5000 people and one pharmacist for 1 million people. A full course of antibiotics for pneumonia may cost one month's wages. In many poorer countries, a one year HIV treatment costs the equivalent of 30 years' income. And the majority of households must buy medicines with money from their own pockets.

Total government expenditure on health services is too low in poor countries. This is true despite the fact that social services may comprise 20% of government spending. A serious, aggravating factor has been the low level of international aid during the past decade. On current trends, the absolute levels of resource transfers required to help the poorest countries attain the international development goals will not be achieved.

Inequities within countries

Within countries, the distribution and delivery of health care is often anti-poor. In most countries of the world the distribution of services remains highly skewed in favour of the better-off.

Recent studies have underlined patterns of resource allocation, both human and financial, that are *de facto* anti-poor. For example, the majority of health personnel is found in urban areas, while the great majority of the poor live in rural areas. Financial resources favour hospital-based curative care whereas the poor need accessible and affordable primary health care. Allocations also favour personal medical care when the poor benefit most from broad public health measures such as clean water and sanitation.

Anti-poor delivery of services

The delivery of health care itself is often profoundly anti-poor. There is rarely, if ever, a focus on the risk factors that are the root causes of the ill health of the poor. And services are rarely designed with the poor in mind. For the poor, time is truly money and opportunity lost. This is reflected in how far they have to go to obtain a service, how long it takes them to travel there, how much the transport costs, whether only one service (or several services) is available in any given session, and how much waiting time there will be. Any of these factors may be financial barriers to the services – in addition to official and non-official hospital, laboratory and medication charges.

"Within countries, the distribution and delivery of health care is often anti-poor."

Women face particular constraints of time and mobility, and with regard to the decisions they can make about their own health and that of their children. For them, these barriers in access to care represent a clear obstacle to health.[23]

Another obstacle is the way poor people are received in hospitals. A number of studies have brought to light the lack of dignity and respect shown by health personnel. One study in a primary health care centre serving a primarily poor population in a developing country highlighted that an average of only 54 seconds was given to each patient.[24] No time for dialogue, no time for explanation, barely time for any human contact.

In times of sickness, those without assets do not even attempt to seek treatment. Those who do have some assets may sell them to raise money for care, or may use them as security to borrow from moneylenders at high rates of interest. Herein lies the route from sickness, or injury, to poverty and destitution. With assets disappearing, especially if it is the breadwinner who has fallen ill, the loss of the precious income-earning asset makes the situation particularly desperate.

Voices of the poor

"We watch our children die because we cannot pay the high hospital bills." – Ghana 1995

Source: *"Voices of the Poor, Can anyone hear us?"* Oxford University Press for World Bank, 2000.

"Spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met."

Decline of the government health sector

Unfettered market intervention in health care is anti-poor. A recent review of health services in one country concluded: "Due to the prevailing situation in the government sector, there has been an unprecedented growth of the private sector, in both primary and secondary health care all over the country. Given the current ethical standards of the medical profession and totally free market technology-driven operational principles, the private sector generally does not provide quality health care at reasonable cost. Before this sector becomes a public menace, it is necessary to introduce participatory regulatory norms."[25]

A clear historical lesson emerges from health systems development in the 20th century: spontaneous, unmanaged growth in any country's health system cannot be relied upon to ensure that the greatest health needs are met. In any country, the greatest burden of ill-health and the biggest risk of avoidable morbidity or mortality are borne by the poor. Public intervention is necessary to achieve universal access. While the equity arguments for universal public finance are widely accepted, the fact that this approach also achieves greater efficiency is less well known.[26]

WHO's Proposals for Action

MAKING HEALTH A FORCE FOR POVERTY REDUCTION

The ultimate objective of development is improvement in the human condition – of which enjoyment of good health is an essential part. However, while improving health status is an essential objective of the development process, the capacity to develop is itself dependent on good health.

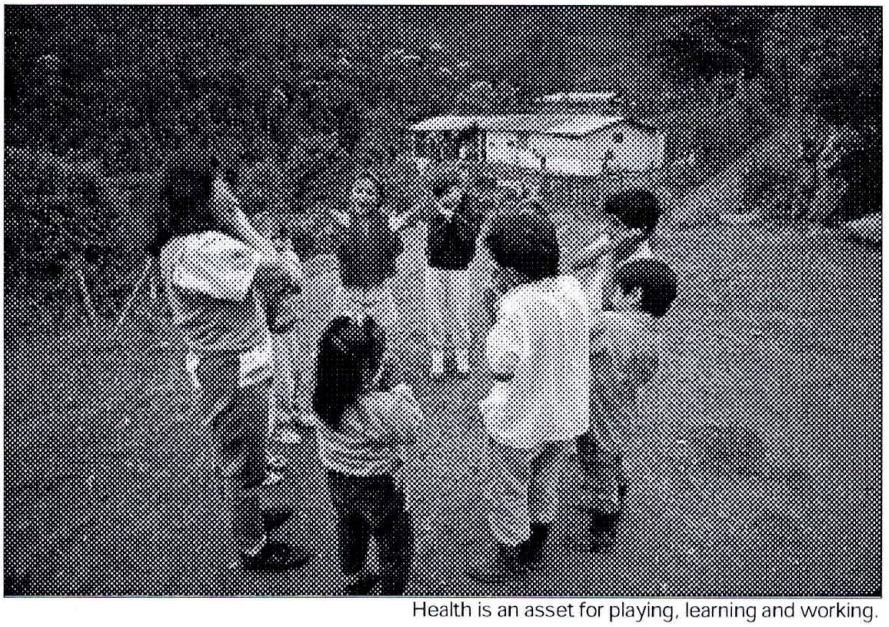
If health interventions are to ensure a maximum contribution to development, they should be planned and implemented within an integrated development framework. Today, the health components of poverty reduction programmes remain largely absent or marginal. On the one hand, health authorities limit their responsibility to the production of publicly funded health services. On the other, the architects of poverty reduction policies neglect the human and social capital contributions of health to sustainable livelihoods.

Universal access to basic health services **is** important, and achieving that goal in a way which will make a significant input to poverty reduction will require a massive international effort. However, the fact remains that leaving health to the health sector alone will not work. The major determinants of health, including poverty itself, are beyond the control of health services.

Copenhagen Plus Five can set future development policy on a new and more effective track by recognising the value of good health status as one of the most important assets of the poor. On that basis, the Copenhagen Plus Five meeting should recommend that the protection and improvement of the health status of poor and vulnerable populations be adopted as a core international development strategy. It should be shared by all actors in the development process – social, economic and environmental.

Strategy areas for follow-up

As its particular contribution to this new strategy, the World Health Organization proposes the following three areas of action as integral components of the follow-up to Copenhagen Plus Five.



Health is an asset for playing, learning and working.

- **Strengthening global policy for social development**
- **Integrating health dimensions into social and economic policy**
- **Developing health systems which can meet the needs of poor and vulnerable populations**

Partnerships

These initiatives will require action at global, regional and country levels in close collaboration with a range of partners, including the World Bank and IMF. In addition, it is suggested that some activities should take place under the auspices of the UN Economic and Social Commissions. This would be in view of the need both to ensure holistic and integrated approaches to poverty reduction, and to take account of significant differences in health issues between regions. **The Economic Commission for Africa (ECA)** and the **Economic and Social Commission for Asia and the Pacific (ESCAP)** would be particularly important partners since their responsibilities span the regions with the greatest concentra-

"The Copenhagen Plus Five meeting should recommend that the protection and improvement of the health status of poor and vulnerable populations be adopted as a core international development strategy."

Health and development

Conventional wisdom holds that income growth results in improved health, but that is only part of the health-income story. The remainder concerns the role of health as an instrument of self-sustaining economic growth and human progress. Poor health is more than just a consequence of low income; it is also one of its fundamental causes. To be sure, health and demography are not the only influences on economic growth, but they certainly appear to be among the most potent.

Source: *The health and wealth of nations*, David Bloom and David Canning, *Science* Vol. 287, 18 February 2000.

tion of the extreme poor. Both ECA and ESCAP could also serve as fora to bring together representatives of national social and economic ministries and sectors.

STRENGTHENING GLOBAL POLICY FOR SOCIAL DEVELOPMENT

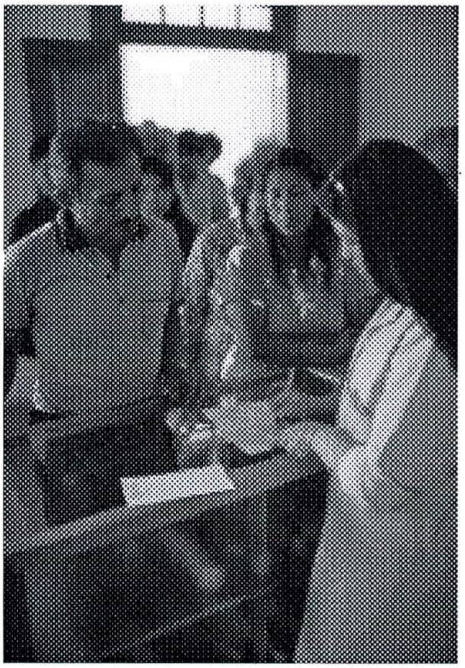
"Reducing the striking health inequities ... requires determined international action to turn globalization to the full advantage of poor and marginalized populations."

The international concern for accelerated social development that was initiated at the Copenhagen summit is continuing to grow. It has given rise to still-early-steps towards defining the principles of future global policy for social development. Much work still remains to be done to bridge the gap between growing social concerns and current global practice, particularly in global trade and international relations.

Reducing the striking health inequities between and within countries requires determined international action. The benefits of globalization need to be turned to the full advantage of poor and marginalized populations. The concepts, content and strategies for a global social development policy require further development. Thinking needs to move beyond traditional concepts of provision of basic social services towards defining an explicit pathway to the creation of social wellbeing, social capabilities, livelihoods and human development.

The World Health Organization proposes to engage in the UN-wide initiative to help take forward the process of global policy development. WHO's particular contributions will include:

- **building country capacities to assess the impact and design responses to economic, technological, cultural and political aspects of globalization on helth equity and the health status of poor and vulnerable populations**
- **building a global knowledge base on social development with regard to health and good practices in protecting and improving health status of poor and vulnerable populations**
- **strengthening governance for social development through development and advocacy of health protection norms and standards for the guidance of the international and national business sectors.**



Global governance for health

There is an urgent need for a public health involvement in key discussions about the future structure of the global political economy and the development and implementation of much needed governance to manage the rapidly growing spectrum of global activities. These discussions include: the promotion of a fairer trading system; debt relief; a global code of best practice of social policy; new practices in international cooperation to secure the provision of adequate public services for all, and contributing towards a more reliable supply of and access to global public goods (such as global health). WHO is currently working with the UN, the Bretton Woods institutions, the World Trade Organization (WTO) and leading non-governmental and academic institutions worldwide to place better health on these agendas and to promote the production, supply of and access to health as a global public good. We need to analyse and monitor how new international agreements can support public health. Making trade work to improve health is a major part of our agenda in our ongoing technical discussions with WTO.
Source: *"Making globalization work better for health"* by Tomris Türmen in "Responses to globalization: Rethinking health and equity", *Development* Vol. 42 No. 4 December 1999.

INTEGRATING HEALTH DIMENSIONS INTO SOCIAL AND ECONOMIC POLICY

Macroeconomic policy has a major impact on countries' abilities to protect and improve the health status of their citizens, particularly the poor and vulnerable. Human migration, rapid urbanization and increased road traffic are both the results of economic policy and, through their effects on the environment and on human health, also the cause of massive drains on public expenditure. For example, road traffic accidents are predicted to become the second major global cause of injury and ill health by the year 2020.

Recent econometric studies and the experiences of the East Asian countries have brought out the important role of good health status in stimulating economic as well as social development. Good health is also known to be crucial to effective learning and, for example, improving the effectiveness of microcredit programmes.

Maximizing the positive opportunities of globalization whilst minimizing the negative impacts poses particular challenges. Policy makers need to ask themselves questions such as what opportunities exist for identifying new sources of revenue for health services, or for regulating the trade of goods and services in the interests of health equity? New tools such as health impact assessment analysis need to be developed to help countries to achieve the maximum contributions of good health to economic, social, environmental and development policies.

Health in macroeconomic policy

Considerable international support now exists for the inclusion of greater investment in social determinants of development within macroeconomic policy. The well documented experiences of the East Asian economies have contributed to this new awareness. The nature of investments will vary according to need. In sub-Saharan Africa and South Asia both health and education are important priorities.

With regard to health, countries require considerable guidance on the specific mix of investments across a range of sectors to ensure optimum health impact on poverty reduction. The World Health Organization has established an international Commission on Macroeconomics and Health to advise WHO and the international development community on how health relates to macroeconomic and development issues. The Commission's main areas of analysis will include: the economics of investment in protecting and improving health status; public policies to stimulate development of drugs and vaccines for the poor; health in the international economy; and, health in international development assistance.

The World Health Organization proposes to provide the evidence for elaborating technical options and costs as the basis for more informed macroeconomic decision-making to improve the health of the poor by 2015 by governments, the World Bank, the International Monetary Fund (IMF), and Regional Development Banks.

"Considerable international support now exists for the inclusion of greater investment in social determinants of development"

Trade in health goods and services

Increasing trade in drugs, biotechnology and health services, including private health insurance, have important implications for health equity. The international agreement on the trade-related aspects of intellectual property rights (TRIPS) could result in the development of new drugs and vaccines for treating the diseases of the poor. But it could also worsen access by poor people through price rises.

Trade in health services includes foreign direct investment, the movement of consumers and providers across borders to receive and supply health care, and the emerging areas of e-commerce and telemedicine. In principle, increased trade in health services could bring needed technology and management exper-

The East Asian experience

In East Asia, the working-age population grew several times faster than the dependent population between 1965 and 1990. The whole process seems to have been triggered by declining child and infant mortality, itself prompted by the development of antibiotics and anti-microbials (such as penicillin, sulfa drugs, streptomycin, bacitracin, chloroquine and tetracycline, all of which were discovered and introduced in the 1920s, 1930s and 1940s), the use of DDT (which became available in 1943), and classic public health improvements related to safe water and sanitation. Health improvements can therefore be seen to be one of the major pillars upon which East Asia's phenomenal economic achievements were based, with the demographic dividend accounting for perhaps one-third of its "economic miracle".

Source: *The health and wealth of nations*, David Bloom and David Canning, *Science* Vol. 287, 18 February 2000.

Without health, people cannot contribute to development. Policies such as free health care contribute to the health status of the poor by reducing a major cause of poverty.

"Improving and protecting the health status of poor and vulnerable people ... (is) one means of improving their employability and access to livelihoods"

tise and, for some countries, increased export earnings. But it could also deepen current inequities in access to services and promote the migration of skilled health professionals from already underserviced areas to private-sector jobs in wealthy, urban communities.

The new openness to trade in health goods and services presents a need to ensure that trade agreements improve access to good quality services particularly for poor and vulnerable populations.

The World Health Organization proposes to build upon its collaboration with the World Trade Organization (WTO) and other agencies to help strengthen the capacities of less developed countries to analyse the consequences of agreements on trade in health services for health equity and for meeting the health needs of the poor. WHO also intends to help develop policies and collective negotiating strategies to ensure the promotion and protection of public health.

Health and the promotion of full employment

Copenhagen Plus Five will focus particular attention on promoting full employment, including self employment and employment in the informal sector. The health dimensions of this policy are significant. People need to be fit in order to work, and to continue to work effectively, their health needs to be protected. If the person is the sole breadwinner, the health of their dependants also needs to be considered.

First, millions of people are unable to access livelihoods or compete for employment due to chronic ill health, undernutrition and disability. Second, for those who are employed, particularly in the informal sector, lack of occupational health and safety protection can lead to death, permanent disability and destitution. The International Labour Organization (ILO) estimates that some 250 million workers suffer accidents at work and over 300 000 are killed every year. The annual death toll rises to more than 1 million when deaths due to occupational disease are taken into account.

The World Health Organization proposes to work with ILO and other agencies to promote health protection measures in future international and national policies for full and productive employment. These measures will include:

- **Improving and protecting the health status of poor and vulnerable people, including the disabled, as one means of improving their employability and access to livelihoods**
- **Promoting safe and healthy settings for work, particularly for women in informal employment**
- **Promoting social insurance and solidarity mechanisms, formal and informal, to protect households from the burden of health care costs arising from occupational causes, including in the informal sector**
- **Promoting the employability of women by creating community-based health and social services for sick and dependent family members.**

Surviving in the informal sector

The majority of the poor work in the informal sector with no social security or social protection from any source. Innovative micro-insurance schemes are needed to protect poor workers. Over 90% of the labour force in India is estimated to be in the informal sector, and the share is believed to be extremely high in many other countries as well. Most informal sector workers are causal workers with no direct access to government provided social security. The Self-Employed Women's Association (SEWA) has developed the largest and most comprehensive contributory social security scheme in India at the present time. It presently insures over 32 000 female workers and may offer a promising model for bringing urgently needed health, life and asset insurance to the informal sector.

Source: *"Voices of the poor, Can anyone hear us?"* OUP for World Bank, 2000.

DEVELOPING HEALTH SYSTEMS WHICH TARGET HEALTH PROBLEMS AFFECTING POOR AND VULNERABLE POPULATIONS

"Pro-poor" health systems are needed which effectively target resources on the most critical health problems affecting the poor and which are financed and organized to address the determinants of health among the poor and vulnerable populations.

Many countries have fallen short of providing basic health services which are universally accessible. The majority of resources go to expensive curative care. Basic health services are not provided for free or low-cost to the poorest people. Public health programmes often ignore the health needs of household breadwinners. And national health systems generally fail to effectively manage private sector providers from whom the poor receive much of their care.

To halve the number of people in extreme poverty by 2015, health systems must be more effective in achieving greater equality of health outcomes and greater equity in health financing between rich and poor. Thus, renewed efforts must be made to build sustainable health systems for the poor that:

- aggressively prevent illness and protect health,
- protect the poor and near-poor from impoverishing health costs,
- direct more resources to improving and maintaining the health of household breadwinners, and
- marshal the efforts of private providers towards improved health of the poor.

The World Health Report 2000 will address in greater depth what policy makers and programme managers can do to create more equitable and effective health systems based on evidence about alternative ways to deliver, finance and "steward", or "responsibly manage", the health care system.

Based on what is known already about what works to improve the health of the poor, the World Health Organization urges the international community to join forces to develop sustainable, pro-poor health systems by focusing on the following three areas:

Substantial reductions in the major diseases affecting the poor

A large proportion of the excess burden of disease among the poor can be attributed to a limited number of health problems – particularly communicable diseases such as HIV/AIDS, malaria, measles, and TB – as well as diarrhoeal diseases, respiratory infections, and complications from pregnancy and childbirth. For nearly all of these diseases or conditions, a set of cost-effective interventions exist.

Four things must happen if these health interventions are to have a greater impact in improving the health of the poor.

- First, prevention and treatment resources must be redirected to focus on cost-effective interventions for the diseases and conditions that disproportionately affect the poor. These "pro-poor" interventions include the Expanded Programme on Immunization, the Integrated Management of Childhood Illness, the Adult Lung Health Initiative, the Integrated Management of Pregnancy and Childbirth, and targeted interventions for HIV/AIDS and malaria – many of which have been jointly developed and implemented by the World Health Organization in collaboration with UNICEF.
- Second, health systems must better target the poor and vulnerable by directing funds, staff and supplies to facilities located in areas near where disadvantaged people work, live and learn. The benefits can also be enhanced by designing systems to protect the poor from out-of-pocket costs (see page 20) and by linking the delivery of these services with other poverty reduction programmes, such as microcredit and employment training.
- Third, more resources must be mobilized for the purchase of cost-effective medicines and supplies, such as mosquito nets, anti-TB and anti-malaria drugs, treatments for

"Protect the poor and near-poor from impoverishing health costs"

Countries need equitable, pre-payment health financing which subsidizes the poor.

sexually transmitted diseases, vaccines and oral rehydration therapy. These can be considered "global public goods" to the extent that they are directed to low-income countries contributing most to the spread of communicable disease.

- Fourth, significant investment should be made in the development of new and improved tools for the control of health problems which disproportionately affect the poor. On the one hand, there is a serious lack of efficient tools due to "market failure" issues; on the other, some of the drugs now in use are rapidly losing their efficacy due to increasing drug resistance.

"WHO endorses several key principles of health system financing."

Equitable health financing systems

Achieving greater fairness in health financing is not just a laudable goal of the health system. It is also key to protecting the income of the poor and insulating them from economic shocks. One of the major factors leading to poverty is illness, which prevents people from working and earning income, and in some cases leads to high health spending that depletes household savings or assets.

To increase financial risk protection of the poor, the World Health Organization endorses several key principles of health system financing to increase financial risk protection of the poor.

First, countries must seek to increase the level of pre-payment for health care via general taxation or mandated social health insurance contributions. This approach allows costs to be spread in accordance with ability to pay and helps to reduce dependence on out-of-pocket financing. Direct payments systems restrict health care access to those who can afford it and tend to exclude the poor from health services.

Second, efforts should be made to subsidize the poor by expanding the pool of contributors widely so that the rich are not able to "opt-out".

Third, progressive taxes or contributory rates are recommended. While multiple pools may be organized for particular groups of contributors, subsidies across the pools should be used to ensure fair financing.

Many low-income countries have institutional constraints – high levels of informal work and weak revenue collection systems – that make it difficult to develop pre-payment systems (based on taxes or social insurance). In the short-term, community-based pre-payment schemes can be promoted by the World Health Organization, the International Labour Organization and other UN agencies. But, in the long-term, health officials must work closely with other sectors in developing the financial infrastructure to promote greater social solidarity in health financing.

Source of funds	Private	More private than public	More public than private	Public
Form of payment	Out-of-pocket insurance	Private insurance	Social	General revenues
Locus of cost burden	Individual	Increasingly pooled risk →		Whole population
Coverage	Poorest excluded	Increasingly equitable →		Universal
Current example	Most low income countries	USA	Middle income and some OECD countries	Other OECD countries

Health system financing

This figure shows how risk pooling in health, and the share of public spending in total, increase as countries move away from out-of-pocket payment methods. Various institutional alternatives exist for achieving universal coverage. Recent comparative research, measuring equity in both the financing burden and the use of services by different income groups in countries, shows that the least organized and most inequitable way of paying for health care is on an out-of-pocket basis; people pay for their medical care when they need and use it. The financing burden falls disproportionately on the poorest (who face higher health care costs than the better-off), and the financial barrier means that use of services is lower among the lower income groups, in spite of their need being typically higher.
Source: *"Making a difference"*, World Health Report 1999.

Promotion of responsible health stewardship

Health systems of the 20th century have grown to encompass multiple actors, agencies, and institutions. As a result, they have become more fragmented and narrow, self-interested goals are often pursued at the expense of overall health objectives.

The new context has made it critical for states to ensure that the key *functions* of the health system - raising and pooling funds, purchasing health services, and providing care – work in harmony to achieve overall health system goals. This role can be called stewardship – the responsible management of the functions and interactions among a health system's multiple actors and interests to achieve societal goals.

Responsible health stewardship implies two key attributes:

The first is **oversight of all components of the health system.** Rather than a focus on publicly-provided services, Ministries of Health need to make efforts to engage the resources of the private sector. The provisions of the private sector are especially important for the poor given the high reliance on the private market for health care in many low-income countries. A combination of approaches can be employed to harness the resources of the private sector including financial incentives, use of purchasing power via contracts with private providers, consumer information and government regulations. Government oversight and intervention in sub-sectors of the private market for example insurance, pharmaceuticals, and human resource production, are necessary to ensure that these industries are contributing to the overall goals of the health system.

To carry out these stewardship responsibilities implies a fundamental shift in the focus of Ministries of Health. It means a shift from directly providing health services to broad oversight, advocacy, strategic purchasing, setting rules for financing and delivering health care by multiple actors, and assessing overall system performance. This shift – from rowing to steering – must be accelerated through training and technical cooperation to build the skills needed to carry out these functions.

Ministries of Health must be better at consensus-building, negotiation and mediation among all relevant actors – within and outside government – in order to create stronger partnerships and coalitions across diverse interests and sectors. They must be able to hold all actors accountable for country performance on agreed-upon national and international health goals. This requires stronger systems for monitoring which provide not only average trends in health status, health care use, and health care spending, but also socio-economic trends in these indicators.

The second attribute of responsible health stewardship is a **duty to engage in cross-sectoral advocacy** to influence policy on the wider determinants of health of the poor.

When the policies and practices of other sectors of the economy present both risks and opportunities for improving health, it is not enough for Ministries of Health to concern themselves only with the delivery of publicly-provided health services. Thus, for example, the Ministry of Health should become a strong advocate for better nutrition by participating in policy discussions regarding access to land, crop subsidies and other agricultural issues. Likewise, health ministries should support efforts to raise the level of female education and advocate for more equal distribution of incomes. Compelling evidence exists that both are positively related to better health outcomes.

The World Health Organization believes that this vision of strengthened health stewardship must be realized for health to fulfil its potential contribution to poverty reduction and human development. It is particularly needed in those countries where health governance is weak.

Fulfilling this vision of strengthened health stewardship will require strong international political, financial and technical support, especially in sub-Saharan Africa and South Asia.

"Responsible health stewardship implies ... oversight of all components of the health system."

Health Mnistries should support effort to raise the level of female education.

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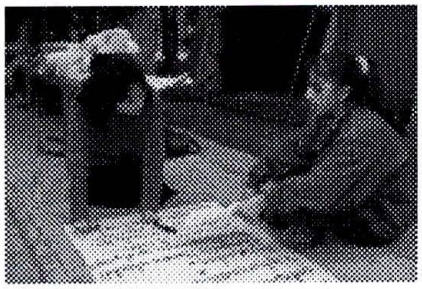

HEALTH

A PRECIOUS ASSET

Accelerating follow-up to the
World Summit for Social Development

Proposals by the
World Health Organization

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COMHI.

Caring Touch Makes the Difference

It is now widely recognized that the demographic trends of the past decades in many developing countries, and particularly those in Asia, are leading to unprecedented increases not only in the absolute numbers of older persons but also in the relative share of the population that belong to the elderly age groups. At the same time, rapid social and economic changes are underway that are widely assumed to have profound implications for the circumstances under which the future elderly will live. These changes include declines in the number of children couples have, greater longevity, increased involvement of women (the predominant providers of care) in economic activities outside the home, physical separation of parents and adult children associated with urbanization and age-selective rural-to-urban migration.

In Asian countries, the family is the traditional social institution for the care of the elderly who live and work with their children. Even when the children are all adults, elderly parents often continue to make valuable contributions in the form of services, such as child care, house-keeping, cooking and house minding, many of which are facilitated by co-residence.

Ref: Social and Economic Support Systems for the Elderly in Asia: An Introduction By John Knodel and Nibhon Debavalya

Problems faced by elderly women are likely to be especially acute and may require special policies to deal with them.

People need care because of disability, disease, long illness, mental incapacity, or ageing. The care may be in the form of:

- eating, drinking, or preparing food or drinks
- taking clothes on or off
- taking a bath or shower
- getting to the toilet
- helping controlling urine or bowels
- shopping
- washing or drying clothes and linen, or
- cleaning, housework, and garden tasks
- standing or walking
- getting onto or off of chairs, toilets, or the bed
- bending or picking things up from the floor or lifting or carrying things
- likely to fall or slip
- physical or mental conditions, illnesses, or disabilities cannot live without help from others
- help of others if they cannot leave their home without the

Strain of caring for the elderly can be killing: Study finds the greater risk of dying for caregivers under stress - Elderly people under stress because of caring for their ailing spouses were 63 percent more likely to die during the period of a four-year study than their non-caregiving counterparts

Under extreme circumstances, it may be right to relieve a vulnerable older person from caregiving by finding an alternative caregiver or institutionalizing the ailing spouse.

There are only four kinds of people in this world: Those who have been caregivers. Those who currently are caregivers. Those who will be caregivers. Those who will need caregivers."

Training Caregivers

Taught by registered nurses and occupational therapists, classes run three hours twice a week for about eight weeks. Classes cover such topics as age-related emotional and mental health changes, vital signs, body mechanics, environmental safety, injury prevention, personal care, nutrition, first aid, home management, dementia, caregiver stress and interviewing and job-hunting. Students wear clouded eyeglasses so they can identify with visually impaired clients. It's more important that caregivers have compassion and that they understand the clients they're caring for as opposed to making a bed 100 percent," she says.

"Our hands-on activities range from how to read a mercury thermometer correctly to how to give a bed bath. In one class the students learn how to change bed linens around a person still in the bed by practicing with linens on the classroom tables".

Students are taken to hospital's rehabilitation unit where they learn firsthand how to move clients from a wheelchair to an armchair, bed, car or commode--and how to prevent their own injury when lifting and moving clients. And they can observe the many types of special walkers, canes, bathtub grab bars and other equipment available to ease the lives of both the elderly and their care-givers.

During class faculty describes age-related changes to the brain, bone degeneration and skin changes, how to properly note vital signs like heart and respiration rates and details the many hazards present in each home, like slippery throw rugs, troublesome stairs, gas stoves and various electrical appliances.

Students discuss nutrition and learn a brand of first aid different from the standard Red Cross offering. They practice dealing with cuts and nosebleeds, distinguishing heart pain from gastric pain, noting real heart attack signs, understanding various allergic reactions and learning what to do if they suspect broken bones or head injuries.

The class learns how to properly clean dentures, administer bed baths and shampoos, help clients in and out of showers and tubs and work with bedpans and urinals.

Guest speakers teach home management, including correct housekeeping, kitchen cleanliness and proper chemical and food storage. Another discusses dementia, memory change, Alzheimer's disease and care-giver stress.

- Lesson One: Nursing assistant Quiz Lesson Two: Basic nursing care Quiz Lesson Three: Basic Nutrition Quiz Lesson Four: Basic communication and interpersonal skills Quiz Lesson Five: Prevention of infection Quiz Lesson Six: Simple body mechanics Quiz Lesson Seven: Introduction to basic terminology Quiz Lesson Eight: Basic Human Anatomy Quiz Syllabus is subject to change.

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HEALTH AND BEHAVIOUR

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Health is a state of complete physical, mental, and social well being, and not merely the absence of disease and infirmity. (World Health Organization (WHO) 1947) Started health professionals and general public thinking about health as a state of well-being. Health status is measured Still measure our nation's health status by 1) Morbidity (disease rates) and 2) Mortality (death rates). The Linguistics of health care can be understood with reference to disease insurance and sick days; part of a disease/sick care system and not a health care system. One major indicator of health is infant mortality and % of deaths within the first year of life per 1,000 live births The years of potential life lost can be determined from the deaths alone are not an adequate measure of the health status of the country and begun to calculate the Years of Potential Life Lost (YPLL). It considers the age at which deaths occur and also the cost to society in terms of the loss of human potential and productivity. Also refers to unintentional and intentional injuries - especially for young people carry a high cost of YPLL.

The goals of the Health care system is mainly intended to prevent the disease and this includes 1) Primary prevention (involves activities that prevent a disease from ever occurring e.g. cutting down on saturated fats reduction in some cancers 2) Secondary prevention refers to detecting conditions early so that the duration and severity of the disease can be shortened e.g. women who have regular Pap smears or mammograms for early detection of cervical cancer or breast cancer 3) Tertiary prevention activities used to rehabilitate someone from a particular disease e.g. cardiac rehab program. The goal is to help the individual to achieve the highest level of functioning possible following the disease or health problem.

Health is determined by four main elements viz., Environment, Heredity, Health-care services and Behaviour. Most disease and injury risk factors fit under one of these elements.

The Environmental factor begins with the fetal environment and is the fetus exposed to drugs or chemicals – does a fetus receive adequate nutrition and expand outward to include our physical surroundings – air, water, social interactions, level of education, type of job we have,

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The Heredity factor describes one area of health risk over which we have little control e.g. Down's syndrome, Sickle cell anemia but also includes such things as heredity of heart disease, high blood pressure

Behaviour factor is one of the major determinants of health and is often referred to as lifestyle factor such as foods you choose to consume, abuse of drugs and alcohol, exercise habits and stress management etc.,
The estimated role of each determinant confirms according to Centers for Disease Control and Prevention (CDC, Atlanta, USA) using an environmental model of health, it is estimated that 43% of the leading causes of death in the U.S.A are related to LIFESTYLE FACTORS (Behaviour). *Hence current disease prevention programs aim at these known behavioural and environmental risk factors.*

The Wellness concept emphasizes a process involving a Zest For Living and a self designed style of living that allows you to live your life to the fullest The wellness is determined by three criteria viz., 1) direction and program – not a static state – a movement toward ever-higher potentials of functioning 2) the total individual (Physical, Mental (Intellectural), emotional (feeling), social, and spiritual dimensions and 3) functioning (able to function during daily living and during times of challenge)
A panel of health professionals who reviewed wellness models and components defines contemporary model of wellness. This includes the belief – while individual's initiative and is an important dimension of wellness and it is not the key to wellness. It is equally important to the sense of community, sense of community being aware of your role and responsibility within your own community relating to thoughtfully about the environment, having a wellness mentor; building reinforcements into your wellness lifestyle

The present lecture thus attempts to focus the interrelationships of Health and Behaviour with reference to selected diseases and analyses the intrinsic relationships between the selected diseases associated with life style (behaviour) and health. The contemporary world is facing many of the diseases mostly associated with the risk factors concurrently determined by human behaviour and hence the study emphasized its importance a total behavioural change in the community to prevent most of our diseases to aim for a sustainable health.

Behavioural medicine or mind/body medicine (a subspecialty of behavioural medicine) is a newly developed area that responds to the psychosocial component of disease. In this field, mental and emotional factors, the ways in which we think and behave, are recognized for the significant role they play in our health. Such factors have a fundamental impact on our ability to withstand and recover from illness and injury. Mind/body medicine recognizes the strong interconnection of mind and body, believing it is only through a deeper understanding of this relationship that we can truly understand health and disease. The power that made the body can heal the body; in this way, it shares a strong similarity with chiropractic philosophy.

Thus the present study throws light in analyzing conceptual links on the following in relation to Health, behaviour and disease:

Health-related behaviour - death and illness attributable to alcohol

Health-related behaviour - death and illness attributable to smoking

Cigarette smoking contributes to many causes of death and illness, including cancers of the lung, larynx, mouth and cervix, coronary heart disease, stroke, chronic lung disease, sudden infant death syndrome and low birth-weight (English et al. 1995 cited in CHO Report, 2000).

Attributable burden of behavioural risk factors:

A variety of factors determine the prevalence, onset and course of mental and behavioural disorders. These include social and economic factors, demographic factors such as sex and age, serious threats such as conflicts and disasters, the presence of major physical diseases, and the family environment, which are briefly described here to illustrate their impact on mental disorders.

Poverty and associated conditions of unemployment, low educational level, deprivation and homelessness are not only widespread in poor countries, but also affect a sizeable minority of rich countries. Data from cross-national surveys in Brazil, Chile, India and Zimbabwe show that common mental disorders are about twice as frequent among the poor as among the rich (Patel et al. 1999). In the United States, children from the poorest families were found to be at increased risk of disorders in the ratio of 2:1 for behavioural disorders and 3:1 for co morbid conditions (Costello et al. 1996). A review of 15 studies found the median ratio for overall prevalence of mental disorders between the lowest and the highest socioeconomic categories was 2.1:1 for one year and 1.4:1 for lifetime prevalence (Kohn et al. 1998). Similar results have been reported from recent studies carried out in North America, Latin America and Europe (WHO International Consortium of Psychiatric Epidemiology 2000). Figure shows that depression is more common among the poor than the rich.

There is also evidence that the course of disorders is determined by the socioeconomic status of the individual (Kessler et al. 1994; Saraceno & Barbui 1997). This may be a result of service-related variables, including barriers to accessing care. Poor countries have few resources for mental health care and these resources are often unavailable to the poorer segments of society. Even in rich countries, poverty and associated factors such as lack of insurance coverage, lower levels of education, unemployment, and racial, ethnic and language minority status create insurmountable barriers to care. The treatment gap for most mental disorders is large, but for the poor population it is massive.

In addition, poor people often raise mental health concerns when seeking treatment for physical problems.

The relationship between mental and behavioural disorders, including those related to alcohol use, and the economic development of communities and countries has not been explored in a systematic way. It appears, however, that the vicious cycle of poverty and mental disorders at the family level may well be operative at the community and country levels.

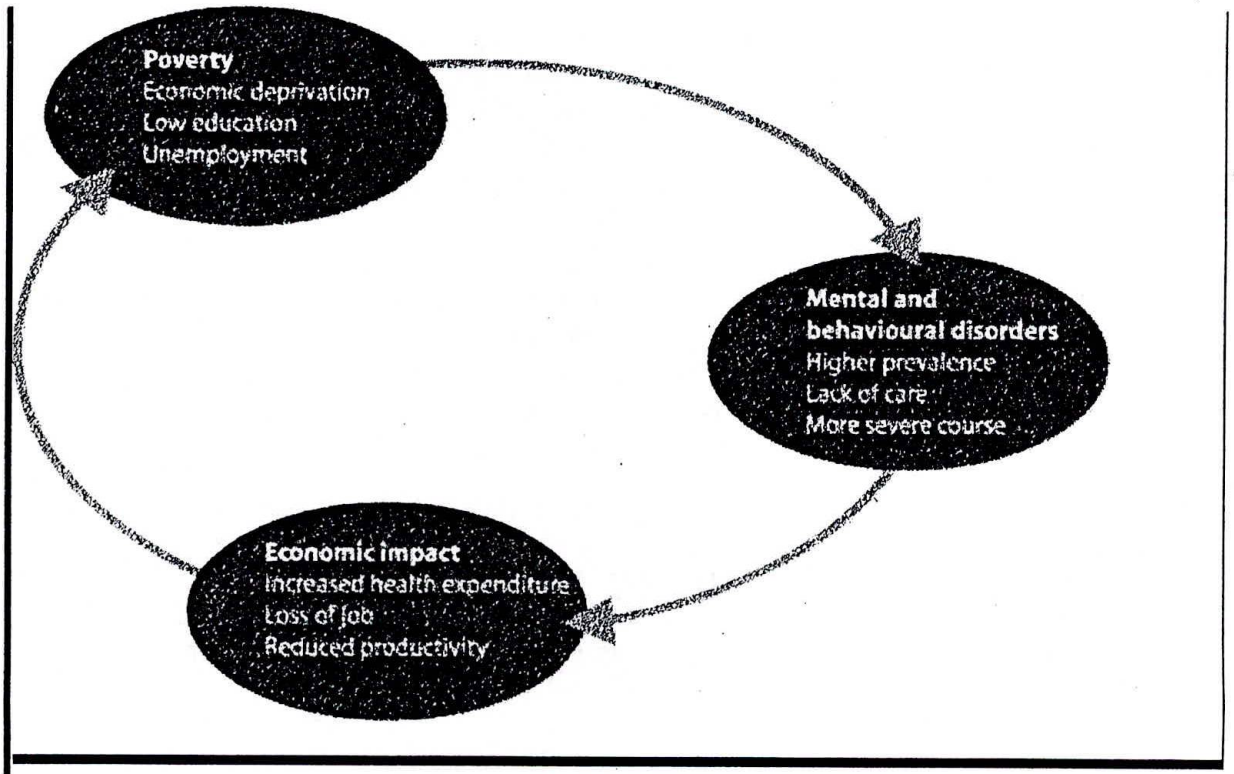
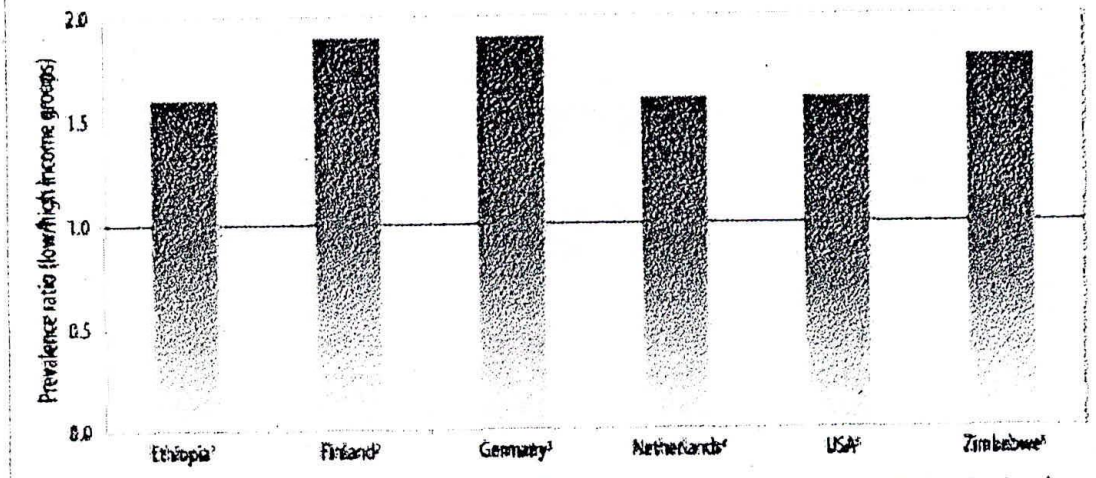


Figure 2.6 Prevalence of depression in low versus high income groups, selected countries



Note: The horizontal bold line at 1.0 indicates where the ratio of prevalence of depression in low income groups is equal to that of high income groups. Above this line people with a low income have a higher prevalence of depression.

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[3] Wittchen HU et al. (1998). Prevalence of mental disorders and psychosocial impairments in adolescents and young adults. *Psychological Medicine*, 28: 109–126.

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[5] Kessler RC et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51: 8–19.

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When questioned about their health, poor people mention a broad range of injuries and illnesses: broken limbs, burns, poisoning from chemicals and pollution, diabetes, pneumonia, bronchitis, tuberculosis, HIV/AIDS, asthma, diarrhoea, typhoid, malaria, parasitic diseases from contaminated water, skin infections, and other debilitating diseases. Mental health problems are often raised jointly with physical concerns, and hardships associated with drug and alcohol abuse are also frequently discussed. Stress, anxiety, depression, lack of self-esteem and suicide are among the effects of poverty and ill-health commonly identified by discussion groups. A recurring theme is the stress of not being able to provide for one's family. People associate many forms of sickness with stress, anguish and being ill at ease, but often pick out three for special mention: HIV/AIDS, alcoholism and drugs.

HIV/AIDS has a marked impact: in Zambia a youth group made a causal link between poverty and prostitution, AIDS and, finally, death. Group discussions in Argentina, Ghana, Jamaica, Thailand, Viet Nam, and several other countries also mention HIV/AIDS and related diseases as problems that affect their livelihoods and strain the extended family.

People regard drug use and alcoholism as causes of violence, insecurity and theft, and see money spent on alcohol or other drugs, male drunkenness, and

domestic violence as syndromes of poverty. Many discussion groups from all regions report problems of physical abuse of women when husbands come home drunk, and several groups find that beer-drinking leads to promiscuity and disease. Alcoholism is especially prevalent among men. In both urban and rural Africa, poor people mention it more frequently than drugs

Drug abuse is mentioned frequently in urban areas, especially in Latin America, Thailand and Viet Nam. It is also raised in parts of Bulgaria, Kyrgyzstan, the Russian Federation and Uzbekistan. People addicted to drugs are miserable, and so are their families.

Age is an important determinant of mental disorders. Mental disorders during childhood and adolescence have been briefly described above. A high prevalence of disorders is also seen in old age. Besides Alzheimer's disease, discussed above, elderly people also suffer from a number of other mental and behavioural disorders. Overall, the prevalence of some disorders tends to rise with age. Predominant among these is depression. Depressive disorder is common among elderly people: studies show that 820% being cared for in the community and 37% being cared for at the primary level are suffering from depression. A recent study on a community sample of people over 65 years of age found depression among 11.2% of this population (Newman et al. 1998). Another recent study, however, found the point prevalence of depressive disorders to be 4.4% for women and 2.7% for men, although the corresponding figures for lifetime prevalence were 20.4% and 9.6%. Depression is more common among older people with physically disabling disorders (Katona & Livingston 2000). The presence of depression further increases the disability among this population. Depressive disorders among elderly people go undetected even more often than among younger adults because they are often mistakenly considered a part of the.conflicts, including wars and civil strife, and disasters affect a large number of people and result in mental problems. It is estimated that globally about 50 million people are refugees or are internally displaced. In addition, millions are affected by natural disasters including earthquakes, floods, typhoons, hurricanes and studies on victims of natural disasters have also shown a high rate of mental disorders. A recent study from China found a high rate of psychological symptoms and a poor quality of life among earthquake survivors. The study also showed that post-disaster support was effective in the improvement of well being (Wang et al. 2000). Similar large-scale calamities (IFRC 2000). Such situations take a heavy toll on the mental health of the people involved, most of who live in developing countries, where capacity to take care of these problems is extremely limited. Between a third and half of all the affected persons suffer from mental distress. The most frequent diagnosis made is post-traumatic stress disorder (PTSD), often along with depressive or anxiety disorders. In addition, most individuals report psychological symptoms that do not amount to disorders. PTSD arises after a stressful event of an exceptionally threatening or catastrophic nature and is characterized by intrusive memories, avoidance of circumstances associated with the stressor, sleep disturbances, irritability an d anger, lack of concentration and excessive

vigilance. The point prevalence of PTSD in the general population, according to GBD 2000, is 0.37%. The specific diagnosis of PTSD has been questioned as being culture-specific and also as being made too often. Indeed, PTSD has been called a diagnostic category that has been invented based on sociopolitical needs (Summerfield 2001). Even if the suitability of this specific diagnosis is uncertain, the overall significance of mental morbidity among individuals exposed to severe trauma is generally accepted.

The presence of major physical diseases affects the mental health of individuals as well as of entire families. Most of the seriously disabling or life-threatening diseases, including cancers in both men and women, have this impact. The case of HIV/AIDS is described here as an illustration of this effect.

HIV is spreading very rapidly in many parts of the world. At the end of 2000, a total of 36.1 million people were living with HIV/AIDS and 21.8 million had already died (UNAIDS 2000). Of the 5.3 million new infections in 2000, 1 in 10 occurred in children and almost half among women. In 16 countries of sub-Saharan Africa more than 10% of the population of reproductive age is now infected with HIV. The HIV/AIDS epidemics has lowered economic growth and is reducing life expectancy by up to 50% in the hardest hit countries. In many countries HIV/AIDS is now considered a threat to national security. With neither cure nor vaccine, prevention of transmission remains the principal response, with care and support for those infected with HIV offering a critical entry point.

The mental health consequences of this epidemic are substantial. A proportion of individuals suffer psychological consequences (disorders as well as problems) as a result of their infection. The effects of intense stigma and discrimination against people with HIV/AIDS also play a major role in psychological stress. Disorders range from anxiety or depressive disorders to adjustment disorder (Maj et al. 1994a). Cognitive deficits are also detected if looked for specifically (Maj et al. 1994b; Starace et al. 1998). In addition, family members also suffer the consequences of stigma and, later, of the premature deaths of their infected family members. The psychological effects on members of families broken and on children orphaned by AIDS have not been studied in any detail, but are likely to be substantial.

These complex situations, where a physical condition leads to psychosocial consequences at individual, family and community levels, require comprehensive assessment in order to determine their full impact on mental health. There is a need for further research in this area. The lack of physical activity is a major cause of death, disease, and disability. Preliminary data from a WHO study on risk factors suggest that inactivity or sedentary life style is one of the 10 leading global causes of death and disability. Low- and middle-income countries suffer the greatest impact from these and other communicable diseases-77% of total number of deaths caused by non-communicable diseases occurs in developing countries. These diseases are on the rise

CARDIOVASCULAR RISKS

India has an estimated 1.5 million to 2 million cases of cancer, with 500,000 new cases added each year. Annual deaths from cancer total around 300,000. The most common malignancies are cancer of the oral cavity (mostly relating to tobacco use and pan chewing--about 35 percent of all cases), cervix, and breast. Cardiovascular diseases are a major health problem; men and women suffer from them in almost equal numbers (14 million versus 13 million in FY 1990).

- Current projections suggest that by the year 2020 India will have the largest cardiovascular disease burden in the world.
- One fifth of the deaths in India are from coronary heart disease. By the year 2020, it will account for one third of all deaths. Sadly, many of these Indians will be dying young.
- Heart disease in India occurs 10 to 15 years earlier than in the west.
- There are an estimated 45 million patients of coronary artery disease in India. An increasing number of young Indians are falling prey to coronary artery disease. With millions hooked to a roller-coaster lifestyle, the future looks even grimmer. .
- There are at least 20 million diabetics in India, which is the highest ever reported number from anywhere in the world. The prevalence of diabetes varies between 6-8% in urban and 2-3% in rural adults.
- Indians tend to be diabetic at a relatively young age of 45 years which is about 10 years earlier than in West
- The prevalence of diabetes varies between 6-8% in urban and 2-3% in rural adults.
- There appears to be a steady increase in hypertension prevalence over the last 50 years, more in urban than in rural areas. Hypertension is 25-30% in urban and 10-15% in rural subjects.

Sedentary lifestyle is a major cause of death, disease and disability. Physical inactivity increases all causes of mortality, doubles the risk of cardiovascular disease, type II diabetes and obesity. It also increases the risk of colon and breast cancer, high blood pressure, lipid disorders and anxiety.

Dr VK Bahl, Professor of Cardiology, All India Institute of Medical Sciences stresses on, "re-emphasizing the importance of a balanced vegetarian diet, increasing the levels of physical activity and cessation of smoking would be crucial in containing the rise of risk factors and Coronary Artery Disease prevalence induced by urbanization and industrialization"

Developing countries like India are struggling to manage the impact of infectious diseases simultaneously with the growing burden on society and health systems caused by non-communicable diseases. Physical activity in addition to healthy diet and a smoke free life style is an efficient, cost effective and sustainable way for promoting public health in low and middle-income countries.

Physical activity can be done almost anywhere and requires no equipment. Walking, perhaps the most practiced and most highly recommended physical

activity is absolutely free.
At least thirty minutes of moderate physical activity every day are recommended to improve and maintain your health. Even if you are very busy-you can still work in thirty minutes of activity in your daily routine.
Patterns of physical activity acquired during childhood and adolescence are more likely to be maintained throughout the life span, thus providing a basis for an active and healthy life.
Physical activity can improve quality of life in many ways for people of all ages.
Benefits of physical activity can be enjoyed even if regular practice starts late in life.

Acquired Immune Deficiency Syndrome

The incidence of AIDS cases in India is steadily rising amidst concerns that the nation faces the prospect of an AIDS epidemic. By June 1991, out of a total of more than 900,000 screened, some 5,130 people tested positive for the human immunodeficiency virus (HIV). However, the total number infected with HIV in 1992 was estimated by a New Delhi-based official of the World Health Organization (WHO) at 500,000, and more pessimistic estimates by the World Bank in 1995 suggested a figure of 2 million, the highest in Asia. Confirmed cases of AIDS numbered only 102 by 1991 but had jumped to 885 by 1994, the second highest reported number in Asia after Thailand. Suspected AIDS cases, according to WHO and the Indian government, may be in the area of 80,000 in 1995.

The main factors cited in the spread of the virus are heterosexual transmission, primarily by urban prostitutes and migrant workers, such as long-distance truck drivers; the use of unsterilized needles and syringes by physicians and intravenous drug users; and transfusions of blood from infected donors. Based on the HIV infection rate in 1991, and India's position as the second most populated country in the world, it was projected that by 1995 India would have more HIV and AIDS cases than any other country in the world. This prediction appeared true. By mid-1995 India had been labeled by the media as "ground zero" in the global AIDS epidemic and new predictions for 2000 were that India would have 1 million AIDS cases and 5 million HIV-positive.

In 1987 the newly formed National AIDS Control Program began limited screening of the blood supply and monitoring of high-risk groups. A national education program aimed at AIDS prevention and control began in 1990. The first AIDS prevention television campaign began in 1991. By the mid-1990s, AIDS awareness signs on public streets, condoms for sale near brothels, and media announcements were more in evidence. There was very negative publicity as well. Posters with the names and photographs of known HIV-positive persons have been seen in New Delhi, and there have been reports of HIV patients chained in medical facilities and deprived of treatment.

Fear and ignorance have continued to compound the difficulty of controlling the spread of the virus, and discrimination against AIDS sufferers has surfaced. For example, in 1990 the All-India Institute of Medical Sciences, New Delhi's leading medical facility, reportedly turned away two people infected with HIV because its staff were too scared to treat them.

A new program to control the spread of AIDS was launched in 1991 by the Indian Council of Medical Research. The council looked to ancient scriptures and religious books for traditional messages that preach moderation in sex and describe prostitution as a sin. The council considered that the great extent to which Indian life-styles are shaped by religion rather than by science would cause many people to be confused by foreign-modeled educational campaigns relying on television and printed booklets.

The severity of the growing AIDS crisis in India is clear, according to statistics compiled during the mid-1990s. In Bombay, a city of 12.6 million inhabitants in 1991, the HIV infection rate among the estimated 80,000 prostitutes jumped from 1 percent in 1987 to 30 percent in 1991 to 53 percent in 1993. Migrant workers engaging in promiscuous and unprotected sexual relations in the big city carry the infection to other sexual partners on the road and then to their homes and families.

India's blood supply, despite official blood screening efforts, continues to become infected. In 1991 donated blood was screened for HIV in only four major cities: New Delhi, Calcutta, Madras, and Bombay. One of the leading factors in the contamination of the blood supply is that 30 percent of the blood required comes from private, profit-making banks whose practices are difficult to regulate. Furthermore, professional donors are an integral part of the Indian blood supply network, providing about 30 percent of the annual requirement nationally. These donors are generally poor and tend to engage in high-risk sex and use intravenous drugs more than the general population. Professional donors also tend to donate frequently at different centers and, in many cases, under different names. Reuse of improperly sterilized needles in health care and blood-collection facilities also is a factor. India's minister of health and family welfare reported in 1992 that only 138 out of 608 blood banks were equipped for HIV screening. A 1992 study conducted by the Indian Health Organization revealed that 86 percent of commercial blood donors surveyed were HIV-positive.

Conclusion:

The study thus emphasized its significance in bringing out the significance of the behavioural factors and its role in determining the human health in a larger perspective. Since the human behaviour is a complex one and also based on the individual's behaviour, it is really a very difficult task to bring out the behavioural change among the individuals and community in large.

Pradhan Mantri Swasthya Suraksha Yojana

Five components of a major new pro-poor programme prepared by the Ministry of Health:

1. Six new hospitals on the pattern of AIIMS, New Delhi
2. Upgrading one medical college in each State to the level of AIIMS
3. 'Sanjivani' Task Force for emergency medical services
4. Janani Suraksha Yojana for safe delivery. The mother will get Rs. 500 for a male child and Rs. 1,000 for female
5. Universal Health Insurance Scheme for the poor

HEALTH: CLEAR GOALS, DETERMINED APPROACH

- A NationalHealth Policy has been approved,with stronger governmental commitment to primary health care and greater encouragement for private sector participation in secondary and tertiary health care. Health sector expenditure increased to 6 per cent of GDP.
- The new National AIDS Policy has achieved final form. Its aimisto achieve zero level of infectivity by 2007.
- National Population Policy (NPP) 2000 has been unveiled. A National Commission on Population has been set up to monitor implementation of the policy. Also, a Community Incentive Scheme has been introduced to encourage involvement of village communities in the national effort to stabilise population.
- The Government has approved the setting up of the National Population Stabilisation Fund - Rashtriya Jansankhya Kosh - as an autonomous body with a seed capital of Rs. 100 crore. The Fund willmobilise resourcesfromthe privatesectorand charitableorganisationsforundertaking activities and programmes aimed at achieving a stable population.
- A Bill proposing death penalty for persons producing and distributing spurious drugs has been introduced in the Lok Sabha during winter session.
- The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 has been enacted by Parliament in Apri12003.
- Incidence of malaria has reduced from 2.28 million cases in 1999 to 2.03 million in 2001. Focused attention to malaria-prone areas led to more than 50 per centdeclinein malaria cases in 2001 as compared to 1997 in 32 predominantly tribal districts in seven States.
- Population coverage under the Revised NationalTB Control Programme has increased from less than 20 million in 1999 to 800 million at present. Nearly 60 million persons were covered under RNTCP in the second and third quarters of 2003. Entire population of the country to be covered by 2005.

Com H-1.

Universal Health Insurance for the Poor

For a large majority of our poor citizens, easy access to good health services is just not there. In order to correct this, public sector general insurance companies wi 11 offer a community-based universal health insurance scheme. A premium of Rs. 1 per day for an individual, Rs. 1.50 for a family of five, and Rs. 2 for a family of seven, will entitle eligibility to get reimbursement of medical expenses up to Rs. 30,000 towards hospitalisation, a cover for death due to accident for Rs. 25,000, and compensation due to loss of earning at the rate of Rs. 50 per day up to a maximum of 15 days. To make the scheme affordable to BPL families, the Government will contribute Rs. 100 per year towards their annual premium.

- Leprosy prevalence rate in the country has been brought down from 5.3 per 10,000 population in March 1999 to 3.36 per 10,000 population in September 2002. Leprosy has now been eliminated from 14 states.

- Prevalence of blindness, which was 1.49 per cent during 1996-99 has been reduced to 1.1 per cent in 1999-2002. The number of cataract operations performed, especially for the poor, has increased from about 9 million during 1996-99 to about 11 million during 1999-2002.

- The Safe Motherhood Programme was launched by the Prime Minister in April 1998. The slogan of the campaign, 'Pregnancy is Precious, Let Us Make It Safe', powerfully expressed one of the most crying imperatives of the social sector. The campaign sought to recognise the role of traditional&is and train them in new, hygienic and safe methods of delivery.

- Sixty districts have been provided equipment to upgrade neonatal care facilities.

- Efforts for eradication of polio have been stepped up and the number of polio cases has come down to 194 between January-November 2003 as against 1500 during 2002. Six rounds of pulse polio vaccination will be taken up this year and will be continued till the eradication of polio by 2005.

- National Blood Policy has been approved.

- Guidelines for bio-medical research framed.

- Central Government Health Scheme (CGHS) rules simplified to provide creditfacilitiesto patients at recognised private hospitals in case of emergency.

- A premier postgraduate Medical institute at Shillong (NEIGRIMS) costing Rs. 422.60 crore approved.

- Code of ethics forallopathic doctors - regulations of professional conduct, ethics and etiquette - approved.

Health for All

- Allocation to health sector increased to six per cent of GDP
- Increased number of sub-centres in remote areas and villages
- Decreased prevalence of leprosy and malaria
- Incidence of polio reduced, to be eradicated by 2005
- RNTCP to cover entire country by 2005
- Free Anti-Retro Viral Drugs to AIDS infected patients by April 2004
- Boost to traditional systems of medicines
- Death penalty to producers of spurious drugs envisaged

- Pilot project for testing the feasibility of introducing Hepatitis-B vaccine immunisation programme in slums launched.
- The Government has given a big boost to Ayurveda, other Indian Systems of Medicine and Homeopathy by more than quadrupling the budget of this Department in five years.
- The Essential Drug Lists for Ayurveda, Unani and Homeopathy medicines issued for the first time. Also, a Traditional Knowledge Digital Library documenting 35,000 Ayurvedic formulations has been launched.
- A National Medicinal Plants Board has been established to give a specialthrustto Indian systems of medicine and realise India's huge potential in the production of standardised herbal products for domestic use and for exports.
- For the first time a comprehensive programme to provide free Anti-Retro Viral Drugs to certain categories of HIV/AIDS patients like children under the age of 15 years and mothers with HIV/AIDS who approach public hospitals has been formulated. It will come in effect from lst Apri1 2004. About one lakh patients are expected to be covered at a cost of about Rs. 130 crores.
- An Integrated National Vector Borne Diseases Control Programme incorporating the components of Dengue/DHF, Malaria, Filaria, Kala-azar and Japanese Encephalitis has been cleared by the Cabinet and will come into operation from Apri12004.
- New international norms for pesticide residues for bottled water were notified to take effect from 1st January 2004.
- Joint Parliamentary Committee has been constituted to look into the controversy related to pesticide residues in cola drinks.
- An additional 8,669 sub centres will be set up under Primary Health Centres in underserved states to provide better health services at grassroots level.

RATIONAL HEALTH CARE

***Health** is a personal and social state of balance and well-being in which a woman feels strong, active, creative, wise and worthwhile; where her body's vital power of functioning and healing is intact; where her diverse capacities and rhythms are valued; where she may decide and choose, express herself and move about freely.*
Health as defined above is thus a state which a person has or wishes to reach.
***Rational health care**, would be care that seeks to promote the above state of health, either through preventing diseases by leading a healthy lifestyle, or healing illness by choosing the best possible of the options available. It must be noted here that access and affordability are major deterrents to care for a vast majority of women in our country.*
***Health care services** are organised systems that provide information or skills or methods to enable people to move towards a state of health.*

In today's world, it becomes very difficult to make choices which are the best for ones own health for a number of different reasons. To start with the number of choices possible appear to be many but in reality many of them are beyond the average woman's control.
Let us start with the presumption that most people including women do not wish to suffer from ill health. Here ill-health may be taken to mean 'dis-ease' or any condition that disturbs the balance of well being and causes suffering. In order to enjoy a state of positive health (see defn in the box) she and her family must have certain basic necessities or the means to generate these needs of food, shelter and clothing. Following this, she should be respected in the family and society as a useful contributing member with individual, creative talents; her lifestyle can only then foster positive health. As can be seen from this background, there are very few women in our country today who enjoy these conditions that favour a healthy life. To the huge numbers of women who struggle to survive with the minimum number of calories every day after feeding their families; illness is an inevitable part of life. To those lucky to escape this battle, there is another set of bridges to cross, a patriarchal society that puts such little value on its women, denying her needs, potential and limiting her freedom.
In such a situation, women probably need more than ever to be aware of the possibilities of therapy when she or other members of her family fall ill.
Health care is broadly provided by two groups of people

- **The organised sector :**

This group of people form part of the medical system that provides curative care to people all over our country. This will include the government health care delivery system, the primary health centres and their subcentres, the taluk hospitals and the district hospitals. In addition to this, there are private practitioners who practice different systems of medicine such as allopathy, ayurveda or homeopathy.

- **The unorganised sector** :

This group which is available to most people is family or extended family. Traditionally this sector was very strong and women formed the backbone of this group as either grandmother, mother or daughter. However as more families turn nuclear, this is less common today, especially in the cities.
It is important to understand the different levels of the health system and the way it is meant to function so that women can access the most appropriate level of care. Most women in India use a combination of traditional remedies and modern 'allopathic ' medicine to treat a number of simple ailments. However, in some areas there may be very reliable traditional healers and practitioners of ayurveda, siddha and homeopathy. It is a worthwhile exercise to explore all the possible caregivers known locally with the women's groups you are involved in. In many cases, the cure for simple ailments is available at home, but for some problems, a woman may need to seek medical advice. It is also well known that patients often use a number of healers to treat the same

illnesses especially if they do not meet success in treatment. Unfortunately, as most healers trained in different systems are unaware of each others strengths and weaknesses, and are often in competition with each other, patients do not fully disclose past or even co- existing treatments taken. Thus, the issue of rational health care becomes even more complicated. Add to this scenario the unfortunate but often real dimension of the greed of the medical professionals, who wish to extract maximum gains from the consultation and the real predicament of the poor woman who is 'dis-eased' is evident

What is quality health care?

There are a number of attributes that could be looked for in good health care. Some of these are seen through the eyes of the patient, others through the eyes of the care- giver, and yet others through the eyes of people who make decisions about our health system like the officials in our governments. It is important that all these groups of people understand what is quality care in order that quality can improve. The groups of women participants can try to contribute to improving the care available in their communities by asking the following questions and seeking answers. In brief, these are

1. **Is the care efficacious**? Can the treatment bring about an improvement in health and well being, given the best possible chance?
2. **Is the care efficient**? Does the treatment bring about an improvement in health and well being under the day- to day realities many of our women live in?
3. **Is the care effective or in other words cost- efficient**? Given a choice of two equally effective treatments, is this the less expensive of the two?
4. **Is the health care optimal use of resources**? This means in the long run does it still make sense to use this treatment/ care or do the costs outweigh the benefits?
5. **Is the care acceptable**? This important criterion includes:

(a) Is the care accessible in terms of time, distance and money?
(b) Does the care- giver have a good, mutually respectful relationship with the patient?
(c) Is the setting in which the care is given, convenient, comfortable and pleasing? Is account taken of the fact that she will require privacy for some aspects of the care?
(d) Are the patient's preferences as to the costs and effects of treatment heard and taken into account?

6. **Is the care equitable**? In other words, can most other people in society access the health care or treatment choice that is available to you?

You will notice that the first two of these questions will be best answered by the doctor/ healer who is giving the treatment. The second two questions are best answered by people who are managing the health care system- whether at local level the panchayat or elders, or at national level the government administration. The fifth question with all its various aspects is obviously best answered by the patients themselves, and the sixth question is one to which all members of society are answerable. You will also notice that most patients use these criteria all the time to assess the quality of a health service and the services that fulfill these criteria are those that are flourishing.

Life- styles that promote health

Our ancient science of Ayurveda, says that the purpose of life is four-fold, to achieve *dharma* (virtue), *artha* (wealth), *kama* (enjoyment) and *moksha (*salvation). In order to attain success in this four-fold purpose of life, it is essential to maintain life not only in a disease-free state but also in a positive state of body, mind and spirit. With this emphasis on the promotion of positive health, it prescribes a regime of Swastha Vrutta (healthy conduct) and Sad Vrutta (ethical conduct). The following advice by Charaka sums up the whole concept beautifully.

Nityam Hitaharavihara Sevee, Samishyakari Vishayetwasakthah
Datha, Samah, Satyaparah, Kshmawan, Aptopasevee Bhavet Arogah

"She alone can remain healthy, who takes regulated diet and exercise, who deliberates all her actions, who controls her sensual pleasures, who is generous, just, truthful and forgiving, and who can get along with her kinsfolk."

Unfortunately, conditions in today's world often do not allow for even the first of these requirements, namely diet or nutrition. It is vital for good health to have a daily diet that is complete in calories (meaning that it provides enough energy to do the day's work) as well as balanced in proteins, fats, vitamins and minerals. In many places, women who are in poorer families do not have enough to eat (See hand out on a balanced diet) and certainly, a majority of women suffer from anemia. This is an illness where there is not enough iron in the body and as women have greater needs due to pregnancy and menstruation, they often lack the necessary stores. As the discrimination in the diet starts from early childhood, the young girl- child is already at a disadvantage, and this deficiency grows worse as each pregnancy takes it's toll with the symptoms of listlessness and chronic fatigue appearing very soon. At present, 85% of women during pregnancy are known to be anaemic; and one-fifth of mothers who die during childbirth die due to anemia- related causes. It is a simple matter to eat plenty of green leafy vegetables, and certainly avail of the iron tablets that are given free during the antenatal check-up at the subcentres by the nurses. You must urge the women leaders to insist that this simple tablet is available at the primary health centre, it is one of the most cost-effective methods to improve women's health.

The other very important part of the diet is water, clean drinking water which has also become a luxury in so many poor households. Poor environmental sanitation and unsafe drinking water together account for almost 60-80% of infections that occur in our country. One of the basic steps to improve rural sanitation is by the proper and safe disposal of human excreta. Otherwise, this pollutes the soil, ponds, canals, rivers and wells. This results in more people falling ill from diseases like typhoid, dysentry, jaundice, cholera and diarrhoea. It is worthwhile discussing in your women's groups both the problems of water and sanitation (see the handout on low-cost sanitary latrines) and exchanging notes on water management within the home.

As women are often the prime care givers within the family, it is important that she is aware of the basic rules of diet, and the good health promotive practices, such as exercise and avoidance of addictive habits such as tobacco and alcohol. In addition she should be aware of threats to her own body and peace of mind and try to avoid allowing these to surface in her life. An important message of Ayurveda is that health, instead of being 'provided ' or 'delivered' has to be practiced by Swasth Vrutta and Sad Vrutta. As individuals, all of us have the power and responsibility to keep our body and mind healthy by observing a number of simple rules of conduct and behaviour in relation to food, exercise, sleep, personal cleanliness and by rules of ethical and moral conduct.

Fact sheet 1- Rational therapy and essential drugs

Rational drug therapy means the practice of scientifically sound medicine that is relevant concerned and takes into account the socioeconomic context of the patient. It recognises that in some diseases, drugs do not have a role, in others and alternative therapies are required,

Irrational prescriptions raise the cost of medical care; they waste available resources, delay treatment and/or worsen the conditions of ill- health. They also change the way we spend our hard- earned money in our families, as our health culture changes to a philosophy of "a pill for every ill". Finally, they widen the existing gaps between rich and poor, as debt incurred from ill-health makes health -care even more inaccessible to the poorest among us.

What is an irrational prescription? One that contains:

- Banned or bannable drugs
- Multiple drugs for the same effect
- Irrational and unnecessary combinations
- Drugs that are costly because of fancy wrapping
- Underdosage or over-dosage
- Wrong indications
- Injections instead of oral preparations

Who could the irrational prescriber be?

- A doctor
- A specialist
- A nurse
- A health worker
- A compounder or a pharmacist
- An unregistered medical practitioner
- A folk healer
- A practitioner in indigenous systems of medicine
- A family elder/ contact
- The patient herself

What can you as a patient do in order not to fall into this trap?
When telling the doctor your problem ***always mention previous treatments***, show the prescriptions if possible. This will prevent you from wasting time and money on a repeat treatment. It may also help the doctor to correctly diagnose your condition.

You must have the courage to ask the following questions
Do I really need all the drugs in this prescription? Many doctors in particular, are known to respond " Are you the doctor or am I?" Don't be cowed down by this response, you can explain that you have exactly 20/100 or whatever rupees in hand so could he/she please check how much the prescription will cost and reduce it to the essential drugs.

What is the effect of the drugs on my body? If the response is " Are you going to become a doctor?" you can laughingly respond, "No, but I am going to take the medicines." However, insist on an answer. Here you may expect to hear about side- effects that some drugs may have.

After receiving the prescription, when you go to the drug store to buy the drugs,
Ask specifically that the medicines are not "expired"- that means they are old and may not be effective.

You may also ask here for the least expensive drug from a reputed company. Every drug is prepared by a number of different companies and there is at times a significant difference in prices.
Most drugs are cheapest in the tablet form as compared to a suspension or 'liquid' form. Avoid injectables as far as possible. A needle that is not clean may give you an additional disease like AIDS! Remember that an injection is needed only if the medication cannot be absorbed through the stomach, or if the condition is so serious that the drug levels must be kept at a high level with six hourly or eight hourly injections (for a patient admitted in hospital).
These guidelines are mainly with regard to the western system or allopathic system of medicine. With traditional remedies made from locally available herbs/ ingredients these problems do not arise, so maybe you should reconsider going to the doctor in the first place!

Are there any other ways in which this problem can be treated?
This question may inspire the doctor to think about alternative solutions to your problem, and occasionally he or she may refer you to someone they trust who they feel may be able to help you. Always remember, if in doubt, you are entitled to a second opinion, although routinely 'doctor-shopping' or going from doctor to doctor without faith or intent to take the therapy completely is bound to fail.

Is it a complete cure or will the problem recur?
This is a very important question to be asked, especially since the doctor's idea of 'cure' and yours expectations may be different. Ask specifically if the drugs need to be taken for a longer time, or until a repeat check-up is advised. If it appears to be a long term treatment that you will find difficult to follow because it is not affordable, be open and you could explore the possibilities of less expensive alternatives together.

Why did I fall ill and how can I prevent doing it in the future?
Rational health care means paying equal attention to cure and prevention. Although the cure is preventing the disease from progressing, it is important to prevent a recurrence or relapse, which might be both more difficult and expensive to treat. It is important to note that in different systems of medicine the causes of diseases are very differently understood, however in all the systems, the doctors or practitioners will be able to give you guideline to follow in answer to this question.

You may find that your doctor or nurse finds it difficult or expresses irritation at having to answer your questions. They are not in the practice of giving information, are often busy, and may not take the time to answer your questions. Be respectful and patient with them but firm. They should be able to make you understand.

PATIENT'S RIGHTS

- All patients have a right to health care. This is regardless of how much money she has, what her status in society is, what community she comes from, or what health problem she has.
- The patient has a right to considerate and respectful care at all times and under all circumstances, with recognition of her personal dignity. Care should be taken that she feels as comfortable as possible.
- The patient has a right to privacy and confidentiality at all times. This includes during the history taking and examination, and with reference to her medical records.
- The patient has a right to safety at all times.
- The patient has a right to know the complete information concerning her diagnosis, treatment and possibilities for cure. This information must be communicated in terms she can reasonably understand. If possible, the means to prevent the same illness from recurring must be clearly explained.
- The patient has a right to ' informed consent' that means no procedure can be done on her without her voluntary and understanding consent after understanding the risks involved.
- The patient has a right to a second opinion, as also to refuse care.
- The patent has a right to ask for an explanation of all medical costs incurred by her.

OBJECTIVES OF THIS MODULE

1. Trainers understand a concept of women's health, which is holistic, and encompasses aspects of her body, mind and spirit.
2. Trainers are well informed on what constitutes good care (considering all aspects) and can look for these elements in the care available. As care includes the issues of life-styles, this would also include water, sanitation and nutrition as part of the subject matter.
3. Trainers are familiar with the different groups of health care providers available to communities and particularly women in these communities. They can share this information and then help women to choose from these options available, the best choice to prevent illness and/or treat the illness early, in the most rational way.
4. Trainers know about patient's rights and can impart this to the women's groups also discussing possible ways in which these can be demanded or negotiated.
5. Trainers know about essential drugs (in the allopathic system of medicine) and can make maximum use of a consultation and a prescription for drugs.

Duration of session	Content of session	Methods that can be used	Materials required
30 min	Discussion on 'dis –ease' and health	Question and answers Sharing experiences	
60 min	The importance of prevention- nutrition and life-styles	Discussion and sharing	
30 min	Health care providers	Resource persons from different groups and self introductions	
30 min	Quality care- what does it mean to you?	Brainstorming with the group	
60 min	Patients rights and how to ensure them	Role- plays	
60 min	Essential drugs and a prescription scrutiny	Role- plays Exercise with three prescriptions	List of the essential drugs Three prepared prescriptions

Note to the trainer: If you feel that the majority of your participants give you a feedback of non-utilisation of the allopathic providers, do not waste time on the last topic. Use that hour instead to strengthen traditional practices that move towards the positive state of health.

SOURCES;
Essential drug list (As prepared by CHC along Who recommendations)
Seven pillars of the Quality of care (1987) A.Donabedian
Ayurveda and modern medicine (1986) Dr. R.D. Lele

COMMUNITY PARTICIPATION IN MCH/FW PROGRAMMES.

Com H-1.

Chapter 1

Community participation in health care: a brief history

The growth of primary health care

Interest in community participation in health care is not new; there was community support for healers in past centuries and it is still a feature of traditional cultures today. It was recognized in the nineteenth century as a fundamental factor in the public health movements that swept Europe—particularly the United Kingdom—and North America during that period. Today, many international organizations and agencies, including UNICEF and WHO, emphasize the importance of community involvement in health care as a basis for improving health throughout the world.

The stress now laid on community participation has resulted from two trends that emerged after the Second World War. The first was increasing disillusionment with the ability of the "Western" medical system to improve the health of the majority of the world's people. That system, which had developed in the industrial countries, stressed curative, hospital-based treatment and one-to-one doctor/patient relationships, and was transferred to their colonies by those same countries. With the advent of decolonization, the inadequacies of the system were dramatically exposed. New nations had neither a suitable infrastructure to sustain it nor the money to support its high costs. Moreover, since it was based mainly in the urban areas and available principally to those with the money to pay for its services, it denied care to the majority of the people, who lived in rural areas where they had little access to any type of health care.

To deal with the health crisis that began to develop as a consequence, it was proposed that a logical step would be to shift the emphasis away from this type of medical service and new technologies towards preventive, decentralized, community care based on epidemiological priorities. Health service delivery was seen in terms of social policy rather than technological development. Planners believed that providing people with knowledge, through health

education, would greatly improv- health. However, the policy gradually degenerated into the me provision of knowledge, generally handed down from experts to lay people and resulting in only limited improvements in health. As a result, new approaches to health care delivery were adopted which rejected health policies handed down from "the top" and health education concerned merely with the provision of knowledge. It began to be apparent to many that it was necessary to involve in the planning of health services those who most needed them.

Put succinctly, it was increasingly recognized that the differences that exist between urban and rural societies, ethnic and regional groups, and people with different lifestyles and values, make it essential that the consumer—the community — influences the nature of the health service available to it. Thus, if any noticeable improvement in health status is to be effected, communities must be involved in decisions concerning health services.

The second trend to emerge in the post-war period was the recognition that public health policy was not only concerned with curing disease but formed an integral part of a country's general development policies. In line with the arguments of the Swedish economist Myrdal, health was increasingly recognized as an "investment in man" (Myrdal & King, 1972). As a result, health services were no longer the preserve of the medical profession but became an integral part of all economic development planning. Thus the debates about "basic needs", "social justice", and "people's participation" began to involve health care.

The development of these two trends resulted in the concept of primary health care. As defined in Alma-Ata in 1978 by WHO and UNICEF, primary health care is "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford" (WHO, 1978). Among the most important aspects of primary health care are the following:

(1) Health is not the responsibility of the health sector alone, but is also affected by development activities in other sectors such as education, housing, agriculture. Hence a need exists to integrate all such development activities.

(2) The development of self-reliance and social awareness through continuing community participation is a key factor in improving health.

(3) If hea care is to be improved it is essential that the community should define its needs and suggest ways of meeting them.

(4) Decentralization is necessary if community needs are to be met and problems solved.

(5) Community resources, financial and human, can make an important contribution to health and development activities.

Community participation is seen as the key to primary health care, which is concerned not with advanced medical technology but rather with applying tried and tested health care procedures to the health problems of the poor and underprivileged, most of whom live in rural areas of the developing countries. It is believed that only if those who most need health care participate in its delivery will there be any impact on the diseases afflicting them, and that only community involvement can ensure that culturally acceptable care is available to those who are at present underserved.

WHO and UNICEF have not confined themseleves to mere advocacy of primary health care based on community participation but have also pursued activities designed to promote its practical application. In developing a strategy for "health for all by the year 2000", WHO has focused on examining the role of members of the community in the delivery of health services. For example, it has promoted exchange of experience among countries in which community health workers have been utilized and has supported research to assess the extent to which community participation in health services has led to an improvement in health status. It has also sought to integrate community participation into several specialized health care activities. Those concerned with the control of communicable diseases have examined methods of involving members of the community in their efforts and have incorporated community participation components in their training modules.

UNICEF has adopted a more integrated approach, in which community participation is developed through a number of community development activities (discussed in the next section) in addition to health services, including food production, nutrition, water and sanitation, education, and income generation. UNICEF's experience of this approach to community participation has contributed much to an understanding of how people in the community can be motivated and involved in improving their own health. It has also helped give a broader meaning to "health" in primary health care, expanding the definition beyond health service activities alone.

Primary health care and community development

In approaching the integration of health into development planning by promoting primary health care, the history of community participation in development programmes in general is relevant. The interest in community participation in development programmes in the Third World is not new, nor did it begin with development of the primary health care concept. In the 1950s, the United Nations was instrumental in promoting what has been called the community development movement, which advocated that people in the community should play a major role in their own development programmes. Used originally in various parts of Africa as a mass education activity for the rural poor, it gradually gained wide acceptance throughout the world. It was defined at the 1948 Cambridge Summer Conference on African Administration, called to discuss the social policies of colonial administrations; in part, the definition read "Community development . . . . embraces all forms of betterment. It includes the whole range of activities in the district, whether they are undertaken by government or unofficial bodies" (quoted in Brokensha & Hodge, 1969). The definition was later expanded by the United Nations Department of Social and Economic Affairs to stress the *processes* in which communities and government joined together to improve the economic, social and cultural conditions of the community (UN Department of Social and Economic Affairs, 1971).

Community development, it has been suggested, can be seen as a method, as a movement, as a programme and as a concept (Sanders, 1970). As a method, it is very similar, but on a community scale, to the techniques used by social workers with individual clients, such as gaining the trust of the client, using that trust to find out the client's view of the problem (felt needs) and its causes (real needs), encouraging the client to discover what he or she can do to help improve the situation, and supporting any efforts to find and use the resources necessary for such improvement (self-help). When programmes are implemented, this method develops the following characteristics (Mezirow, 1963):

— concern for ensuring the integrated development of the whole of community life, involving the integration or coordination of technical specialities;

— planning based on the "felt needs" of the people;

— emphasis on self-help;

— concentration on singling out, enouraging and training local leaders;

— provision of technical assistance in the form of personnel, equipment, materials and/or money.

Foster (1982) has compared the conceptual similarities between community development and primary health care. He notes that both concepts:

— emphasize multipurpose activities;

— presuppose that the provision of basic services and material gains are essential to development;

— recognize to a greater (community development) or lesser (primary health care) degree that the processes by which the goals are achieved (local initiatives, self-confidence, self-reliance and cooperation) are more important than the goals themselves (achievement of concrete objectives).

In addition, both concepts stress the need for planners to base their plans on a community's felt needs and to utilize community resources, including its people, to carry out programme tasks.

Foster also discusses a number of false assumptions that plagued the community development movement and that, in his view, had to be corrected if primary health care was to be successfully developed. They include the following:

(1) "Communities are homogeneous." In fact, communities are mostly not homogeneous, nor do they usually see reasons for always cooperating "for the common good". Experience shows that individual concerns often override community goals, particularly in areas of poverty. Only when people rise above the level of extreme poverty and lack of resources does cooperation become feasible.

(2) "Knowledge will automatically create desired changes in behaviour." In reality, communities do not change their types of behaviour because new practices are taught by community development workers. Time and experience have proved not only that new knowledge does not automatically induce change but also that traditional practices often have some value. Behavioural change — for better or worse — takes a long time.

(3) "Community leaders act in the best interests of their people." The actions of community leaders do not always benefit the entire community. People singled out by community workers

as having influence often use the opportunity to enrich themselves and their families. Thus, a programme designed for the poor has often benefited only those who were already better off.

(4) "Government and community workers share the same goals for community development." This is often not the case. Government workers want to mobilize local resources in order to free capital for other national programmes; community workers want to inculcate confidence and self-reliance in the members of the community. This conflict of interest has sometimes inhibited community development programmes.

(5) "Community development activities do not create conflicts for planners." In fact, the management of community programmes may pose several problems for planners. For example, the need to show results may conflict with the need to allow members of the community sufficient time to become active in programmes with new orientations; professionals may define the community's needs on the basis of their own training and their capacity to provide for those needs, whereas the community may wish to give priority to other needs which its own experience shows to be more important; the wish of personnel to "serve the people" may conflict with their own career goals; and personnel may wish to promote their own sector's interests rather than cooperate with other ministries.

These problems have actually been encountered in many programmes but tended to be forgotten or ignored when planners in both health and development programmes were searching for a definition of community participation that could be used as a basis for implementation.

Community participation and MCH/FP activities

While literature analysing the necessity for community participation in primary health care has proliferated over the past decade, few case study reports have dealt specifically with the relationship of community participation to MCH/FP activities. Rather, the reports tended to explore the role for members of the community in a whole range of health activities, of which MCH/FP programmes are usually considered a part. For the purposes of this publication, however, it seems useful to review briefly the reason for concentrating on those sections of the community — mothers and children — that derive direct and immediate benefit from MCH/FP activities

and on the potential and limitations of their involvement in improving health conditions and health care.

The factors that either constrain or favour the involvement of women in community health activities were treated at length in a recent WHO book *Women as providers of health care* (Pizurki et al., 1987). The book points out the following factors, *inter alia*, as reasons for involving women in health activities, particularly those designed to improve the health care they themselves receive.

First, women have a traditional and natural role in providing health care. They are the principal providers of health care both within the family and in communities. Moreover, as role-models for children and younger people, they can do much to encourage health-sustaining attitudes and behaviour. Women also provide the greater part of care delivered by formal health systems, within which they work as doctors, nurses, modern and traditional midwives, and paramedical and voluntary workers.

Second, the opportunities provided for communicating with other women during the course of normal domestic tasks—water-collecting, shopping, etc.—ensure that much valuable information is passed on. Communication and mutual support within this informal "network" often supplements the work of formal health providers.

Third, women frequently have stronger community roots, especially in developing societies where men may migrate to urban areas in search of better-paid work. In volunteering to become village or community health workers, or becoming active in other areas of community life, they provide a continuity that is essential in rural development and health programmes.

Many of the traditional activities of women, such as the collection of water, the provision and preparation of food, the rearing of children, reflect aspects of the intersectoral approach to improving health. Where they strive for basic levels of sanitation, clean water supplies, improved food safety, etc., women can have a positive influence on health status; the promotion of health will then come to be seen as a community activity rather than solely a task for the health services.

Finally, the women's organizations that already exist in many communities provide a ready-made structure for the participation of women in health-promoting activities. Such organizations include child-care groups, community centres and, to an extent, schools, where the majority of teachers are usually women; they are experienced in mobilizing resources for the common good and are therefore able to put their experience to good use in promoting the improvement of health.

The book also discusses the constraints that limit the participation of women in community activities in general and health in particular. Perhaps the most significant of these is the relatively low social and economic status of women in many rural and developing societies, combined with the frequent lack of educational opportunities, as a result of which their personal and material contributions to their traditional role as health providers are rarely understood by planners. Government policy-makers in particular give little credit or support to women or women's organizations in this area, with the result that women are rarely consulted on health issues and frequently lack training opportunities and funding.

Women are also hampered by cultural traditions that relegate them to menial tasks in the community. In a male-dominated society there is likely to be entrenched opposition to any radical change in the status or role of women that is seen as giving them greater authority.

In many developing countries, women in poor rural areas are often overburdened with domestic responsibilities and prone to ill health, which leaves them little time or energy for activities outside the home. When they are able to participate in other work this is likely to be in an undertaking that will bring immediate economic benefit rather than long-term advantage; health or sanitation programmes may well be seen as the responsibility of the government rather than the community.

These factors apply to the involvement of women in community development generally and in health activities specifically and must be taken into account in analysing community participation in MCH/FP programmes.

Chapter 2

What does "community participation" mean?

Reviewing the history of interest in community participation in health programmes provides a basis for determining what factors influence community participation in MCH/FP programmes. As a first step it is important to attempt to define the term "community participation".

Some interpretations

A variety of different interpretations have been placed on the term "community participation", each of which can give rise to a different form of practice. The following are quoted as examples by Oakley (1989):

> Participation means ... in its broadest sense, to *sensitize* people and thus to increase the receptivity and ability of rural people to *respond* to development programmes, as well as to encourage local initiatives.

> With regard to development ... participation includes people's involvement in *decision-making* processes, *implementing programmes* ... their sharing in the *benefits* of development programmes, and their involvement in efforts to *evaluate* such programmes.

> Participation involves ... organized efforts to increase *control* over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control.

These interpretations do not answer the question of whether community participation is a means or an end, or give any idea of what is meant in practice by such terms as a community's

"involvement", "ability to respond to development programmes" and "control over resources" or of how they could be measured. Moreover, they do not discuss the conflicts that inevitably arise as a result of any serious proposal that may lead to shifts in power or changes in resource allocations.

A functional meaning

In order to develop a better understanding of community participation, the Rural Participation Project at Cornell University has looked into the concept. In a subsequent analysis of this work, it was suggested that participation can best be defined by asking questions about its concrete components. If the same approach is taken to participation in MCH/FP programmes, some of the factors that help or hinder its achievements can be determined. The following three questions seem most pertinent. They are not asked as a basis for judging the value of programmes; their purpose is rather to try to define MCH/FP programme objectives in terms of community participation. This is not an easy task since objectives are all too often defined in terms of concepts and ideals, so that it is not clear who in the community should undertake what actions for what purpose.

Why participation?

WHO and UNICEF documentation and materials from non-governmental groups such as the Christian Medical Commission put forward many cogent arguments for community participation in health care programmes. The most important can be summarized as follows:

(1) There is increasing evidence that medical technology is less effective in improving health in large communities than what people can do for themselves. In developing countries, particularly in rural areas where the majority of the people still live, health patterns can be more radically improved by preventive than by curative measures. If, therefore, rural communities can adopt healthier habits in regard to sanitation, environmental hygiene and food consumption, a more rapid improvement in health will be achieved than by increasing investment in services alone.

(2) Health care services are being misused and underused. If those who need the services are involved in planning their development and application, the services will be better able to meet

their needs. Thus, discussion between the community and planners and agencies would enable more appropriate services to be provided. In addition, people would be more likely to use services that they had helped to develop.

(3) Communities possess untapped resources that could be used to make health care more accessible and acceptable, particularly to the poor and underprivileged. It is for the community to decide on the best ways of mobilizing those resources, which include materials, money and personnel, to satisfy community priorities, particularly by providing better care for more people.

(4) People have both the right and the duty to be involved in decisions about activities that affect their daily lives. Such involvement provides a basis for increasing self-confidence and self-reliance, which are sorely lacking among the poor and underprivileged. It gives practical force to the idea of health as a human right and an element in social justice issues. In addition, if it enables even the very poorest sections of the community to take part in improving the health services available to them, it will thereby create a precedent for their participation in yet wider community activities.

Who participates?

Since primary health care is concerned with using scarce resources in a way that will bring the greatest possible health benefits to the greatest possible number of people, its success will obviously depend on persuading as many members of the community as possible to participate in planning and providing it. Determination of the numbers doing so will help to measure the extent of participation. As already mentioned, however, communities are composed of various economic and social groups, and the participation of particular groups may be essential for the attainment of particular programme objectives. In such cases, the extent to which the support of these specific groups has been enlisted in practice will be the measure of success of community participation in the programmes concerned.

How do people participate?

Five different levels can be distinguished in a community's participation in programmes with an important health services component:

People participate in the benefits of the programmes. Members of the community receive services and education provided by planners and agencies, such as curative services, preventive immunizations, antenatal care, improved water supply and sanitation facilities, and health information. In many cases, obtaining these benefits involves only attendance at a clinic or payment of a small fee for the services, maintenance or materials provided by health staff and/or the government. In such instances community participation may be considered as passive. In all health programmes that are community-oriented rather than individual-oriented, communities do receive benefits and many passively accept the health services that are provided.

Many nongovernmental organizations operating in the United Republic of Tanzania have realized that the hospital services they provide do not meet the health needs of the rural population, who do not come to the base hospital. Several have therefore started mobile maternal and child health clinics that make rounds in various districts in an attempt to provide services that actually reach the mothers and children who need them. The women and children "participate" by using the services. While the programme planners consider this as community participation, many dispute that view, especially the overseas donors, who regard these activities merely as an increasingly expensive way of providing services.

People participate in programme activities. In addition to the above, members of the community contribute land, labour and money to health programmes. They may help construct a clinic or distribute contraceptives, or pay for drugs and other medical supplies for the programme. They may become community health workers and provide mothers and children with simple services and education. This can be considered as active participation, but those concerned do not participate in the choice of activities to be undertaken or in decisions as to how they will be carried out, which remain the prerogative of health planners, agencies or the government. The members of the community simply agree to carry out the activities laid down by the planners.

Examples of this kind of participation abound in the community-based contraceptive distribution schemes that were developed in several countries in Africa and Asia in the early 1970s. Members of the community were recruited to sell contraceptive devices and give some family planning information; they were usually provided with some economic incentives for their work. In the early stages they were basically employees and had virtually no say in decisions about the launching or development of programmes.

People participate in implementing health programmes. In addition to participating in benefits and activities, members of the community may choose the site of a clinic, run drug-purchasing schemes, organize infant welfare and nutrition clinics, etc. At this level, those involved have some managerial responsibilities, since they make decisions about how these activities are to be run. However, the activities to be undertaken and the programme objectives to which they contribute are decided by planners to whom the members of the community have to refer for advice, supervision and approval. It is therefore the planners rather than the community who are the focal points for these activities.

Examples of this type of participation are found in the many programmes that set up village health committees, choose community health workers and/or institute community health insurance schemes in response to suggestions by those who administer the community health programmes. A study undertaken by the American Public Health Association (1977) on the delivery of low-cost health services in 150 projects showed that, in the early stage of project development, most community participation that involved community choice occurred at this level.

People participate in monitoring and evaluating programmes. In addition to the above, members of the community help planners to judge whether the programme objectives have been met—and if not, why not. At this level they are involved in deciding how to measure

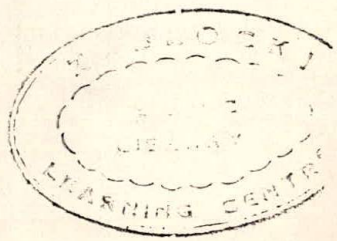
objectives and in systematically mo ...ring activities. They are in a position to modify programme objectives but not to determine those objectives themselves, a task which is still the prerogative of the planners. This level of participation is perhaps the one of which there is least experience. This is partly because, in many programmes, only lip service is paid to monitoring and evaluation and partly because programme objectives, particularly as regards community participation, are often not clearly stated and therefore cannot be measured.

There have been cases in which members of the community have been involved in monitoring and evaluation activities such as conducting surveys, determining what should be evaluated, discussing the findings of monitoring and evaluation, and deciding the future policies of the programme. A study by the American Public Health Association (1983) cites the pilot project undertaken by the Research Department of the Ministry of Health in Colombia as an example of a very thorough system for community involvement in evaluation. In that project, the community health committees carry out community surveys, then analyse them jointly with the local health team. The evaluation is done by the committee members, who are trained to use a simple form with questions to which heads of households in their villages respond. It is designed to cover the structure, activities and impact of the health services as well as the participatory process itself.

People participate in planning programmes. In addition to participating in the ways described in the four preceding sections, people from the community (usually leaders and key members such as teachers, etc.) actually decide what health programmes they think should be undertaken and ask health staff, agencies and/or the government to provide the expert knowledge and/or resources to enable the activities to be pursued. Members of the community decide upon and manage a health programme that includes services and provides the necessary resources to achieve their objectives. This is the level at which community participation is the broadest, in both range and depth. It involves members of the community in receiving benefits, in joining in activities, in implementing projects, in evaluating and monitoring programmes, and in making decisions

about, and taking responsibility for, programme policy and management. It is the ideal towards which many programmes strive.

WHO received a request for a small amount of money to fund supplies for a project in Peru that involved a community health programme and had developed the organization necessary for implementation and management and begun to undertake activities. There are few reports of such programmes. In the 1977 study by the American Public Health Association, of 150 projects surveyed only 8% claimed to have attained this level of participation. (The study did not seek to verify this figure.)



Chapter 3

Factors and features of programmes: a framework for analysis

Types of programme

On the basis of the five levels of participation described in the preceding section, an attempt can be made to categorize the various types of MCH/FP programme and define the factors that determine whether and in what ways they can attain their community participation objectives.

The programmes chosen all have health services, mainly MCH/FP services, as an important component and are all designed to achieve, *inter alia*, the following goals:

— improving the health status of large and mainly impoverished groups of people;

— developing long-term, self-sustaining programmes through community contribution in management, money and human resources.

Descriptive factors

The effectiveness of community participation in helping planners and agencies achieve their goals in MCH/FP programmes depends on two distinct groups of factors (see Table 1). The first may be called "descriptive factors". Many of these were highlighted in a WHO/UNICEF study (1977); they describe the local and national context in which a programme develops, and may be cultural, economic, social and political, or historical, or they may reflect:

— the degree to which national policy responds to local aspirations and needs;

— the degree to which the civil service has been decentralized;

— the degree of organization at local level;

— the degree to which communication takes place between the centre and the periphery at both local and national levels.

In developing a programme, planners and agencies can have little impact on these factors. Through advocacy they may succeed to some extent in changing government attitudes or removing specific bureaucratic obstacles, but they will certainly have little influence on cultural and historical factors. Case studies show that, for the most part, planners have accepted these factors and recognized their importance in developing and defining programme objectives. However, since few details have been given in the literature and because these factors are specific to each programme, they will not be discussed in detail here.

Table 1. Factors in programme formation

Descriptive factors	Action factors
Cultural	Assessment of needs
Economic, social and political	Community organization
Historical	Programme management
Government policy	Resource mobilization
Decentralization	Leadership development
Local level organization	Attention to the needs of the poor
Core/periphery communication	

Action factors

The second set of factors that influence the success of a programme may be called "action factors". They can be acted upon by programme planners in order to achieve the objectives set. A review of the programmes covered by the case studies suggests that action factors are of special importance in determining to what extent short-term and long-term objectives in respect of health services and community participation in them are being achieved in the programme under review. These action factors reflect:

— how community needs are assessed

— how community organizations are developed

— how programmes are managed

— how financial and human resources are mobilized

— how leadership is developed

— how the problems of the poor, especially the very poor, are dealt with.

The following paragraphs deal in more detail with these factors and discuss some of the conditions under which they may favour or hinder effective community participation in MCH/FP programmes.

Assessment of needs

As already stated, one way of bringing about community participation is to find out what members of the community see as their major problems and then work with them to define some possible solutions. As members of the health or other professions, planners make their own judgements about both problems and solutions in the community, but may be bewildered to find that asking the community to do the same produces a number of different ideas. In such cases, which are common, planners can react in various ways. They can adhere to their own judgements in the belief that they will provide the most efficient and effective solution. They can attempt to explain their professional views to the community in an effort to get its agreement. They can try to reconcile the different opinions by discussion, building up community awareness and self-reliance. This dilemma is particularly acute for health planners who are often only willing to look at disease-related problems and to take action in respect of health or medical services: when they ask questions about community problems they are actually concerned about health problems.

If planners and agencies regard the improvement of health through the improvement of health services as their major objective, they achieve success only when the community sets the solution of health problems as its own priority. This creates broad possibilities for planners to promote community participation by discussing what should be done and then undertaking it. There are also further advantages to the community identifying health improvement as a priority. One is that health sector planners are then able to use their professional skills to undertake specific tasks and to educate community members about the health topics in which they have expressed interest. Planners can also define other development activities in terms that they understand, using people from other sectors as resources rather than as managers. Moreover, political questions can be set aside, allowing planners to define health in purely technical terms and concentrate on providing an efficient service with wide coverage.

In Costa Rica, in response to an ever-increasing demand for hospital services, a programme for community care was developed in the early 1970s. Described as a programme for a "hospital without walls", it focused on integrating the services of the Ministry of Health, the Social Security Fund, local hospital boards and other community organizations, and medical and social service professionals with a view to improving health in the rural areas of the country. It established regional structures for community involvement that included health committees and community health workers. The committees have built, equipped and supervised over 44 community health posts, established nutrition centres and water-supply systems, organized school gardens and food distribution and implemented various other health-related projects. They provide much-needed and highly appreciated support for the Ministry of Health's plans for the rapid improvement of rural health services, a need defined both by the government and by the rural population.

There are many programmes in which planners have already decided that health care, particularly services, is a community need. By devising a programme without consulting the community, they have denied a role to members of the community in deciding what is best for the community. They have thus, intentionally or unintentionally, limited community participation to receiving benefits or possibly being involved in programme activities. As a result, planners have lessened the opportunity to involve the community in decision-making because they have already defined the problem and also, by implication, the range of possible solutions.

A hospital programme in Hong Kong began an innovative attempt to improve health and health care among the large, mainly refugee, population in one of the growing "new towns" by setting a goal of "having the community take responsibility for its own health care". However, the planners decided that the health problems of this diverse community could be best met by providing improved services. They therefore developed, without consulting the community, three community clinics and a health insurance scheme under which mothers and children, workers, and old people could avail themselves of basic curative, preventive and health education services on

payment of a small fee. The result was that the members of the community, who had not participated in developing the programme, saw it as a hospital project without a role for themselves in forming policy or activities. They participated in the programme only by accepting the services it provided, not by contributing resources or ideas to it.

In other programmes, the planners and agencies have advocated not only improved health service delivery but also integrated development on the grounds that wider community participation, which is necessary to bring about health improvements, depends not only on health services but also on programmes for agriculture, education, housing, and income generation. Planners who hold this view believe that successful assessment of needs depends on a community *not* identifying health as a priority; though they may well use health as a focal point for their activities, they will rely on personnel from other sectors to deal with more pressing community needs. A team of people from various professions working with a community in this way will afford any programme the greatest chance of success.

In Indonesia, a rural doctor persuaded members of a community to participate in a health insurance scheme and to provide community health workers for front-line health care. However, the people did not participate in any decisions about the programme. When the doctor began to discuss the community's problems with the people, it became apparent that health care was not considered to be a priority need. He therefore encouraged community leaders to develop their own programmes, using the established health insurance and community health worker activities as a basis for housing, sanitation and income-generation schemes. He also asked people from community development and government agriculture and rural development organizations to assist the community in developing programmes. This wider approach to health problems became a model for the entire province and provided a basis for intersectoral cooperation.

For those who want to use participation as a means of inculcating a spirit of initiative and self-reliance in the poor as the first

step towards achieving wider community development objectives, the problem is one not merely of finding out what the poor want but of gaining their confidence, so that they will discuss problems with people from outside their communities. Case studies in which this has been a clearly stated aim have shown that planners and agencies have been able to use maternal and child health services (curative and preventive) as a means of gaining the confidence of the poor. Maternal and child health services have thus provided a basis for gradually determining community needs. In this way, outsiders have also been able to work in areas designated by governments as politically unstable, since the provision of health services is regarded as an apolitical activity.

When an attempt by a group of university students in India to improve the very poor socioeconomic conditions of tribespeople in their vicinity by beginning a dairy scheme had failed, they decided instead to provide simple curative medicine, concentrating on the prevalent diseases of tuberculosis and malaria and on maternal and child health. Simple education about these problems led to the establishment of a village health committee and the training of village health workers. In this way the tribespeople were given the confidence not only to undertake wider development schemes but also to demonstrate resistance to a group of people who had exploited them economically for years. The support of the students enabled these very poor tribespeople to discover, and do something about, some of the underlying causes of their poverty.

Community organization

If members of the community are to participate by taking an active part in programmes, and not merely receiving health benefits, there is a need for community organizations that will initiate, support and maintain the activities concerned. The importance of such organizations was well demonstrated by the 1977 APHA study. Of 150 projects studied, two-thirds were based on established or newly created community organizations, which were quoted as being responsible for the successes achieved. Conversely, lack of success in those projects considered as failures was blamed on the absence of organizations to support their activities (APHA, 1977).

Ideally, any organization through which a community participates in MCH/FP programmes or in health programmes in general should be created by members of the community to deal with a health problem they themselves have identified as being of prime importance. When such an organization exists, it provides planners and agencies with a structure that has already attracted community support and can become the basis for active collaboration. An example of a programme of this type in Costa Rica has already been mentioned. However, programmes that have developed in this way are very rare. Planners and agencies therefore need to search for other approaches if they are to meet their programme objectives.

Where no health-related organization exists, use can be made of established organizations in other fields to promote health activities. In many communities such organizations have been set up to meet other development needs and thus have the structure and experience to handle community involvement in a range of activities.

The Mothers' Clubs of the Republic of Korea are often cited as examples of MCH/FP activities being successfully introduced into existing programmes. Women's organizations had long existed in Korean villages as a counterpart to all-male organizations. In the 1960s some were transformed into mothers' groups of the National Reconstruction Movement at which many topics of national importance, including health care and family planning practices, were discussed. These discussions proved to be so successful that the Korean Family Planning Association, with the help of USAID, later decided to revive the mothers' clubs. Although they were initially concerned with family planning activities, the clubs expanded in later years to include other community development projects. In the 1970s, established clubs sent members to help set up family planning education in the most remote parts of the country. They have also undertaken work in the urban slums.

Another possibility, and one that is particularly common in programmes designed to improve health services, is to create an organization from scratch, often in the form of a community health committee. A number of case studies have recorded experiences in developing this type of organization. An initial step that has proved

effective in some programmes has been to call a community assembly and ask it to authorize the establishment of a health committee. Other programmes have formed health committees on the basis of strong community leaders and the authority of existing community administrative groups. From case studies it seems that health committees established under the auspices of outside planners and agencies need careful supervision, help in identifying tasks, and, in many cases, funds. In addition it is necessary to find ways of ensuring that the community at large is involved in committee decisions. Otherwise there is a danger of the committee's work being dominated by staff, strong community leaders and/or community elites, thus limiting the part played by larger groups and the support they will give.

In Cameroon, an American university and a central African organization decided to establish village health committees with a view to giving villagers experience in finding their own solutions to health problems and to applying that experience to the solution of wider development problems. After a slow initial process, involving surveys, discussions with the community and reciprocal education between the outside agency workers and the community leaders, village health committees were established. Specific health problems, such as disease control and making maternal and child health services more accessible, were put on the agenda. These committees were carefully planned and supported, both the outside agency and the Ministry spending time and effort to ensure success. Although the Ministry decided to extend this approach to the whole country, only one out of the four pilot villages succeeded in achieving the original goal of extrapolating experience in health promotion to broader development activities. In other villages, lack of interest, cultural and historical divisions, and traditional beliefs about disease made it difficult to attain even the health objectives.

Other problems of which planners must be aware may also arise. In some programmes, for instance, particularly those aimed at improving health services, planners have organized health committees only to find that later, when other community development problems had also to be covered, the committees were too inflexible to cope with the new tasks that faced them.

In a programme in Tunisia, local family health workers were trained to promote maternal and child health care and family planning by persuading women in isolated rural areas to use the existing health services and, in the long term, encouraging self-help projects among the female population. In the training, stress was laid on ways of improving the utilization of the health services. An evaluation of the project found that little success had been achieved in the development of self-help activities. These had been swamped by efforts to improve the health services—the programme's main objective—and more planning, support and resources would have been required to achieve any noticeable improvement.

In other programmes, especially those concerned with encouraging self-reliance and initiative among the poor, the creation of health committees has provided an elementary organizational basis for a whole range of development activities. Since health workers from outside have an opportunity to gain the confidence of the community, promote its activities and build up awareness of its potential through their work in the health services, health committees can serve as organizational starting points for efforts to solve wider community problems. Planners and agencies have therefore come to regard health activities as a means of encouraging the poor to tackle economic, social and political problems. In so doing, they have had to face up to the conflicts that arise as a result of resistance by those in power to change in existing community structures which they consider to be against their interests. In such circumstances, every aspect of power and control may be brought into question. This type of situation is well illustrated in the programme in India described in the section on assessment of needs.

Programme management

One of the major objectives of many programmes is that the community should manage the programme, i.e. play a decisive role in its planning, implementation and evaluation. Achievement of this objective would represent the highest degree of participation. Unfortunately, in this respect there has been far too much wishful thinking. There is evidence to suggest that, despite statements to the contrary in many programmes, management is in the hands of professionals who are from outside the community and/or have

come from outside agencies. The 1977 APHA study found that most projects limited community management to consultation by the planners and agencies. Members of the community could, for instance, express opinions on the opening hours of clinics, what drugs should be purchased and sold, and how money should be allocated to projects. In fewer than 20% of the projects studied were community members allowed policy and administrative control. Of these projects, 16% allowed the community to decide where the health centre should be sited; a far lower percentage allowed the community to participate in decisions on other matters (APHA, 1977).

It is mostly in programmes established by the community itself, and in which it has set its own priorities, that a community has a say in decisions. In such cases, very few of which have been recorded, professionals and planners from outside are sometimes asked for some support, usually financial.

It is far more common for planners and professionals to dominate programme developments. One reason for this is that programmes in which improving MCH/FP services is a major objective tend to stress the more technical aspects of the work to be done. For example, the 1983 APHA study found that, although community workers are theoretically responsible to the community, they in fact see themselves as accountable to the health staff, who are responsible for supervision and evaluation. Failure to define community health workers' tasks clearly and the lack of trained supervisors also hinder the development of community management in this area (APHA, 1983).

In a community in Thailand in which a health committee had been established to choose and support community health workers, the committee lapsed into inactivity after selecting them because its specific functions and responsibilities had not been made clear (APHA, 1983). Although it is also desirable that members of the community should play a bigger part in evaluation, the APHA study again found that only about 25% of the programmes studied gave the community some role (undefined) in programme evaluation. In a further 40% the community's role was limited to answering questions in surveys. In 35%, the community was assigned no role at all in evaluation.

All the above evidence suggests that giving members of a community an important role in taking decisions about programmes

is a much more complicated matter than the literature would indicate. While most programmes pay lip service to the idea of developing the management potential of the community, planners and agencies find that it is in fact very difficult to do so. Involving members of the community in decision-making processes appears to need a clear statement of the tasks involved and strong support from professionals, planners and agencies. It needs a concerted effort by professionals to share information about new technologies and new approaches to programme planning and implementation. Lay people need time to gain confidence and experience in an unfamiliar field. In some programmes, members of the community have gained experience in managing activities such as water supply and sanitation before going on to manage health activities. In other programmes, which have started with health services and tried to promote community management, members of the community have relinquished the more technical aspects of the programme to the professionals and moved into management of broader community projects such as water supply, nutrition and income-generating schemes.

In Kenya, a rural community in an arid area defined water supply as its most urgent need and provided the resources, planning and infrastructure to develop a strong water project. After its primary goal had been achieved, it used this experience and the organizational framework that had been created to provide access to health services. In Indonesia, a community initiated a community health programme with a health insurance scheme and community health workers, but after some time the programme became less concerned with service delivery and concentrated on other more essential community development activities.

A few cases have been described in which planners have attempted to use health services as a basis for persuading members of the community, particularly the poor, to assume responsibility for wider community concerns. In these instances, planners have usually aimed at enabling the poor to become self-reliant and to show initiative, and have regarded health services, because of their apolitical nature and the rapidity with which they produce results, as a means of achieving that aim. In the early stages of such schemes,

however, planners have encountered the same barriers of community expectations and professional dominance as those found in programmes aimed solely at improving the health services. Here again, the gap between vision and reality forces planners to recognize that achieving their declared goals will be a long-term process.

In a national community health programme launched by a non-governmental organization in the Philippines, the planners believed that education of the community—explaining the reasons for its poverty—would spur it to take action to change the exisiting situation. In the early stages of the programme emphasis was therefore laid on community organization rather than on the provision of services. The community, however, had looked upon the programme as a health programme and, when they were not provided with the services they had expected, lost interest in the organizational and educational activities. As a result, it proved necessary to develop the health aspect of the programme and use it to gain the confidence of the community, building up awareness of the need for change and of the community's ability to bring that change about.

Resource mobilization

One of the reasons already given for community participation in MCH/FP programmes is to provide more resources for activities that are needed continuously. Community participation will also enable communities to become self-reliant and reduce their dependence on outside planners and agencies for money and advice. Nearly all programmes with community participation as an objective accept this as one of the reasons for their work. The literature on the potential contribution of communities is too extensive to mention in detail here, but some general observations will show how community contributions influence effective community participation in MCH/FP programmes.

The resources generally provided by communities have tended to fall into three categories:

— labour for building and maintaining facilities

— people to serve as community health workers

— funds to pay for minor forms of treatment and medicaments.

These contributions are often cited as evidence that community participation is taking place. Review of a wide range of case studies, however, suggests that participation tends to be limited to participation in benefits and activities. The decisions taken by the community are limited to choosing people to serve as community health workers and determining how to raise money for the activities that planners have decided upon.

This situation arises particularly in programmes concerned principally with health services, when planners tend to assess the budget implications of programmes and then ask members of the community to contribute to the planned activities. A 1982 APHA study on community financing covered over 100 programmes and concluded that the decisions to train community health workers, to finance the procurement of medicaments, and to provide labour for building health facilities were generally dependent on national budgetary constraints rather than on the community's willingness and ability to pay. Community financing would be more viable if planners began by studying demand (APHA, 1982).

In programmes in which the improvement of health has been singled out as a priority, or which comprise a wider range of development activities, there appears to be more scope for the community to decide how to mobilize resources. In both cases, however, it is the better-off members of the community who tend to be involved both in decisions and in contributions (either as an act of charity or for reasons of self-advancement). In such cases, participation is confined to a limited group of people, usually acting against the interests of the poor. Sometimes, although resource mobilization is a result of community rather than outside decision, it is actually a minority in the community that makes the decision. There is also evidence to suggest that wide participation of the poorer segments of the community does not guarantee a more equitable distribution of the benefits. Unless planners make special efforts to direct benefits to the poor, their greater participation may serve only to supplement the comforts of those who are already better off (Carino et al., 1982).

In this respect the experience of programmes that have self-reliance as one of their objectives is also of interest. A review of case studies suggests that self-reliance is very difficult to achieve. Experience has shown that, when a health programme based on community participation is launched, outside assistance is initially needed to help mobilize resources, ensure discussion and communication, provide technical and management back-up where necessary and make up temporary budget deficits (APHA, 1982). In programmes destined to help the very poor, the situation is more complex in that such people rarely have any resources to contribute. To date there is

little evidence to suggest that mobilizing community resources will make a health programme self-reliant. This is a field in which research might be very useful.

Leadership development

Planners who choose programme objectives that include community participation most often select a completely new way of dealing with health problems. Acceptance or rejection of this new approach, which emphasizes that people who need health care should play a part in ensuring that it is provided, depends on who introduces it. In most communities, leadership patterns are historically and culturally determined. If these patterns are not recognized or are deliberately or unwittingly ignored, experience suggests that programmes have little chance of being accepted or utilized at any level in the community.

Programmes that have had some success in achieving their stated objective of providing health services on the basis of community participation have mostly had the support of local leaders. This leadership may be either structural or personal. If it is provided by community organizations created to support community development programmes, there is a fairly good chance that a new programme, accepted by this leadership, can be institutionalized and maintained. Programmes to which community officials are committed enjoy influential support and have ready access to resources.

Personal leadership has also played an important role in the development of many programmes. Programmes that have received the most publicity and have been put forward as models are often those in which personal leadership, usually by a charismatic leader, has been most influential. Such programmes are often based on the vision of one person rather than on concerns shared by all members of the community. Unfortunately there is a risk that, once that leader is no longer there, too few of the visionary objectives will have been institutionalized to enable the programme to continue.

The idea of primary health care arose, in part, as a result of action by nongovernmental organizations in which committed and highly respected people developed an alternative health care system in rural areas where there was great deprivation and need. Their experiences have been recorded in the WHO publication *Health by the people* (Newell, 1975), as well as in various publications of the Christian Medical Commission and other bodies. They showed that, in very difficult conditions, new approaches based on a high degree of community involvement in both benefits and activities

improved health status and health conditions. However, there is still nothing to prove that equally impressive results could be achieved elsewhere on a larger scale without the guidance of the planners.

The structure of community leadership and the types of people who provide it will also determine, to some extent, whether participation will be narrow and represent only community elites or whether it will continually broaden so that all socioeconomic groups become involved. There is evidence that programmes in which it is wished to ensure community participation succeed more often when they do not rely solely on leadership that supports the views of the elite. This is particularly true in maternal and child health programmes, since the elite in most communities is male and does not represent women's interests or needs. In addition, a more representative leadership will not be paternalistic or dictatorial, but will tend to be democratic and more flexible in responding to the various needs and demands of the community.

> In a pilot programme run by the Department of Community Medicine of a university in the Islamic Republic of Iran, the traditional village structures of authoritarian leadership and male domination militated against broad and sustained community participation. The programme failed for a number of reasons, among which was the lack of effective utilization of community health workers from the vicinity. In the end, the majority of primary level workers were brought in from outside the pilot areas in an attempt by the planners to remove them from the control of the village authorities (elites) and to reduce their involvement in political and family disputes.

The nature of community leadership must in some respects be classified as a "descriptive" factor, which planners and agencies cannot change without assuming an openly political role. On the other hand, they can encourage leaders to take certain actions that will promote achievement of programme objectives and also support leaders who wish to encourage wide community involvement in health promotion. Experience shows that leadership plays a vital role in every programme but that its features will depend on the conditions present in each specific case and on the correlations between them.

Concentrating on the needs of the poor

All the programmes described in the case studies under review include some form of community participation on the grounds that past health care systems have not been accessible or acceptable to the poor. When planners and agencies see improved health services or wider community development as their objectives, the poor become the "target" group. The literature suggests, however, that it is difficult to get the poor to participate in MCH/FP programmes, or indeed in any type of service programme, beyond the level of receiving benefits. This appears to be true whether a programme is concerned mainly with improving health services or with wider community development. There are several possible reasons for this.

First, the social and economic structures in most communities give the poor virtually no access to resources. This is partly because those who have the knowledge and skill to gain access to resources also gain control of them and, in most cases, have little inclination to share them with others. The poor, lacking the knowledge and skill to gain such access, remain poor.

Second, the poor have neither the time nor the energy to change this situation. They live from hand to mouth and have to concentrate their efforts on surviving rather than on obtaining benefits. They have virtually nothing to contribute to programmes which in the longer term might provide them with a better standard of living.

Third, their lack of the necessary knowledge and skill confirms them in their feeling that they cannot improve their lot. As a result, they tend neither to respond to new programmes nor to attempt to gain access to services and activities to improve their lives. This barrier seems to be the most difficult to overcome.

For these reasons programmes have encountered difficulties in persuading the poor to participate. Concentrating on the needs of the poor raises two problems, of which the first is political. Planners and agencies must be seen as attempting to solve a problem in an even-handed manner. MCH/FP programmes are designed to meet community needs. Discrimination in favour of the poor may well lead the better-off to protest that they too need help in solving their problems.

A cognate problem arises when agencies and planners support groups outside the existing power structure, thus running a serious risk of alienating the existing elites. If common ground is not found and compromise achieved, confrontation may develop. There have been instances in which lives have been lost because of the polarization brought about by a programme.

In one Asian country, a community health programme originally concerned with hospital services expanded its activities to include the training of female community health workers (a novelty in this traditionally male-dominated society) and wider community development activities. Gradually, as the programme began to give the poorer and more oppressed members of the community additional income and more political leverage, the groups previously holding the reins of power—mainly land-owners—began to feel threatened. One evening, one of the most active and respected male health workers failed to return home. He was later found decapitated at the side of the road. Subsequent investigations by the programme personnel indicated that he had been killed by persons hired by the local landlords. Unfortunately, there was insufficient evidence to bring any of the suspects to trial.

The second problem is economic. Studies on how to improve the lives of the very poor have concluded that, if their needs are to be met, planners and agencies must devote a large amount of time, money and effort to the task (Coombs, 1980; Carino et al., 1982). If they do so, the resources in question are unavailable for programmes that might bring more immediate benefits to a larger group of people. As a result, in many programmes with the declared objective of participation by the poor in health services or community development, actual participation is limited to receiving benefits. Although planners and agencies realize the importance of trying to meet the needs of the poor and often list it as one of their major aims, experience suggests that the matter is more complicated than had been imagined.

Chapter 4

Conclusion: what the analysis revealed and failed to reveal

Summary

On the basis of the data reviewed in the preceding chapters of this book, a framework has been suggested for analysing the types of MCH/FP programmes that include community participation. Two sets of factors, "descriptive" and "action", are described, which determine the progress made by a programme and assess its future prospects in relation to the degree of community participation.

Limitations

The analysis does not make it possible to draw generally applicable conclusions as to what factors, under what conditions, produce the kind of participation planners and agencies have listed among their programme objectives. There are several reasons for this.

As already stated, very few of the case studies deal in detail with "descriptive" factors. Although they are recognized as important, very little is said about why they are important in a specific context and how, specifically, they affect participation. It is therefore difficult to understand their effect on policy and programme implementation.

Second, although a wide range of case studies from a large number of organizations was reviewed, there is no guarantee that they are representative of all MCH/FP programmes in which community participation plays a major part. In fact, there is a possible bias, in that the cases presented are those that have outside funding, while those that have utilized their own resources are not represented in the documents forming the basis of this study. The data base is thus not reliable.

Third, as already mentioned, the case studies vary in length and in quality. By far the most numerous are those that are basically

programme descriptions and fail to inquire into the manner in which community participation develops. They do not offer any clearcut definitions of community participation and pass over important topics such as differences of opinion between planners and members of the community, the degree to which community support has been enlisted, and the power structure in the community. In addition, programmes are often described in terms designed to promote funding and/or acceptance by international bodies, important issues being either omitted or glossed over. For instance, in the case of programmes designed to encourage more initiative and self-reliance among underprivileged groups, stress may be laid instead on the provision of improved health services, an objective more likely to attract support from government or outside agencies. Few of the documented studies succeed in advancing understanding of the subject.

In addition, relatively few of the documents analyse problems and failures. Most are positive statements about the value of community participation and the possibility of developing it. Those obstacles that are mentioned are either those that planners managed to overcome or those that can be attributed to "descriptive" factors such as culture or history. Thus it is often not possible to find answers to questions about the process of community decision-making, the cost-effectiveness of the community approach, or the possibility of replication elsewhere.

Finally, there has been little field research. Since communities are composed of people, it is essential to ascertain their views of the value of community participation as an approach to health care. Few of the studies reviewed have investigated with any thoroughness the views of members of the community. Moreover, few have asked the questions essential to understanding how effective community participation can be achieved. Thus, the analysis may well have omitted important factors that field research would have revealed.

Potentials

The analysis does make it possible to suggest some ways in which planners and agencies might obtain the kind of community participation in MCH/FP programmes that would promote their programme objectives. For instance, they might be better able to clarify their objectives by asking why there should be participation, who should participate, and how they should participate. This would provide a practical basis for action instead of the platitudes commonly encountered.

When broad community participation is one of the stated objectives of a programme, members of the community must be offered a wide range of options and activities. In a comprehensive analysis of nine Asian community-based projects, most of which were concerned with some aspect of health, Coombs rightly states:

> "A programme that subscribes to the values and ethics of a community-based service has to subordinate its immediate and narrow objectives—be it the acceptance of contraceptives and/or the treatment of parasites, or vaccination against preventable diseases—to the ultimate needs and interests of the community people. These needs and interests of the community as perceived by the community can be the only basis for an authentic community-based service programme" (Coombs, 1980).

In a review of 35 projects, the American Public Health Association struck the same note:

> "Project experience shows a correlation between high participation and an integrated approach open to community priorities and not strictly related to health care" (APHA, 1983).

Those who regard community participation as a means of making MCH/FP programmes more cost-effective must study experience gained in various programmes. This suggests that, in the short term, particularly in programmes that focus on the needs of the poor and contain a health service component, financial requirements are considerable. In addition, community participation tends to be limited to receiving benefits and being involved in activities. Participation in decision-making and resource mobilization appears to need a long time to develop.

Planners and agencies should study their own experience and the experience of others to find answers to a number of questions. Among the more important are the following:

(1) What effect has the programme had on the health status of the population and how has community participation affected health status?

(2) What effect has community participation, as defined by the programme, had on service utilization in the view of both planners and members of the community and why?

(3) What broader improvements in health has community participation brought about and how have those improvements been manifested?

(4) How have programme planners and agencies defined and dealt with the inevitable problems of political control when broad participation has challenged the power of the existing elites?

Answers to these questions will lead to a better understanding of the dynamics of community participation and of some of the conditions under which it does or does not help meet programme objectives.

As has been seen, the concept and implementation of community participation are very complex. Although the literature, in relation both to health programmes and to other development programmes, continues to grow, little is yet understood about the dynamics and impact of community participation. If its possibilities are to be realized, more thorough and critical analysis of experience in programmes is needed.

Com H-1.

WHO/CSI/2001/DP2

Understanding Civil Society: Issues for WHO

CIVIL SOCIETY INITIATIVE

External Relations and Governing Bodies

World Health Organization

Discussion Paper No. 2
CSI/2001/DP2

Understanding Civil Society:

Issues for WHO

February 2002

Civil Society Initiative

External Relations and Governing Bodies

WORLD HEALTH ORGANIZATION

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Introduction

We live in a world of shrinking borders and burgeoning needs, where people faced by rapid social, economic and political change are seeking new ways of controlling their lives and the future of their communities. Armed with more access to information than ever before, and backed by new technologies, people are banding together to find new means of articulating their needs and to ensure that government and business policies protect and promote their interests.

Along with governments, the United Nations (UN) system, which believes that development must rest on people's needs, has not been immune to this unleashing of people power. The UN as an institution has a history of opening its doors to organizations and institutions that represent the diverse interests of people. In recent years, the UN family has made a special effort to broaden its collaboration and consultation with such organizations.

The World Health Organization's (WHO) Constitution encourages interaction, consultation and co-operation with nongovernmental organizations (NGOs) while a number of World Health Assembly, Executive Board and Regional Committee resolutions have strengthened this collaboration.

In recent years, there has been an unprecedented growth in the activity and influence of civil society actors in the area of public health. They have engaged with WHO to implement WHO programmes at country level, made outreach to remote areas and populations possible, advocated WHO issues to a broad audience, addressed sensitive issues that WHO cannot for political reasons and worked in alliance with WHO to raise funds more effectively.

The increasing role of civil society in public health and the mutual benefits involved in expanding partnerships have placed new demands upon WHO. The Civil Society Initiative (CSI) was established in June 2001 in order to ensure that the changing roles and expectations of civil society are more adequately reflected within WHO. The mandate of this new initiative is to initiate a policy discussion on the role of civil society in public health and to guide WHO policy on ways to strengthen relationships with civil society organizations (CSOs)

This paper is part of a series produced by CSI to help promote a wider understanding of civil society and the various ways in which it is involved in health. It introduces some basic concepts and issues to assist WHO in its development of policies and interactions with civil society. It has been edited by CSI based on a background contribution written by Dr Rene Loewenson, TARSC, Zimbabwe.

Exploring the definitions

Civil society has its roots in the word 'civics', which comes from the Latin word 'civis', meaning citizen. Both the Romans and Greeks had equivalent terms meaning 'political society'[1] where citizens active in the political life of the state helped shape its institutions and policies.

Today, there is no universally accepted definition of civil society or organizations formed to represent civil society. Even within Member States and the family of the UN, the definition and classification of civil society actors seems to vary. Many use the term NGOs synonymously with CSOs.

The common understanding is that civil society embraces the general public at large, representing the social domain that is not part of the State or the market. Lacking the coercive or regulatory power of the State and the economic power of market actors, civil society provides the social power of its networks of people. Its ideas, information, services and expertise are used to advance the interests of people by seeking to influence the State and the market. It is a sphere where people combine for their collective interests to engage in activities with public consequence.

The increasingly accepted understanding of the term CSOs is that of *non-state, not-for-profit, voluntary organizations* formed by people within the social sphere of civil society. These organizations draw from community, neighbourhood, work, social and other connections. CSOs have become an increasingly common channel through which people seek to exercise citizenship and contribute to social and economic change They cover a variety of organizational interests and forms, ranging from formal organizations registered with authorities to informal social movements coming together around a common cause.

The term NGO is also commonly used to describe non-state, not-for-profit, voluntary organizations. However, NGOs usually have a formal structure and are, in most cases, registered with national authorities. WHO and other UN agencies use the term NGO in their formal and official language and policies. ***The term CSOs is used in this paper to indicate a wide range of civil society actors including NGOs.***

The fuzzy boundaries between State, market and civil society

In theory, the State can be strictly separated from non-state actors. Non-state actors refer to both the market and civil society. While the market refers to the private for-profit sector, civil society actors are known by their not-for-profit operations.

In practice, however, this categorization between state and non-state, profit and not-for-profit is far from being clear cut. The boundaries between the market, civil society

[1] In Latin ' societas civilis' and in Greek 'politke koinona'

and the State are not always clear, nor are the interests of those in civil society always divorced from the State or market. The interests that motivate people to form associations may reinforce State or market interests or they may challenge them.

There are some not-for-profit organizations that by virtue of their area of operation, governance mechanism, or funding may be closer to or involved in the market. These include, for example, chambers of commerce or trade unions. Other organizations may be more linked to the State. Many CSOs are dependent on public or government funds, including aid from international sources. This has given rise to categories such as Government Organised NGOs (GONGOs) or Business Organised NGOs (BONGOs) and Business Interest NGOs (BINGOs).

As far as WHO's public health mandate is concerned, the importance of differentiating between non-state actors with commercial or market interests and those without such interests is considered important. Some market interests may be in direct conflict with health outcomes, such as the marketing of hazardous products like tobacco or alcohol, while other markets may need to be regulated to protect consumers or ensure equitable distribution of health care resources. Given the possibility of real or perceived conflicts of interest between market motives and public health goals, it is important that market links or interests be transparent to WHO, particularly in the organization's normative and policy role.

Differences within civil society

The world of civil society is not uniform. The role of CSOs in promoting "public" interests may not always be clear. The interests that motivate people to form associations may be public, but they may also be personal. Associations may be formed to support kinship or narrow group interests that have little to do with wider public concerns. Civil society interests provide an important channel for understanding and reaching out to particular social groups but need not be oriented towards wider public good. CSOs may reflect social, political and economic inequalities based on factors such as wealth, geography, religion, and gender.

The wide range of interests, combined with the possible existence of market or State links in civil society organizations, implies that even **within** civil society there may be competition and conflict over different values and interests. Such debate and conflict, if they are open and transparent, are essential for the development and implementation of socially acceptable and equitable policies. Such contention can be constructive, especially when it is used to open channels of communication and negotiation around areas of real conflict, find mutually acceptable ways of resolving conflict and build social harmony.
Far from shying away from or fearing such conflict, international agencies such as WHO have a constructive role to play in encouraging this open public debate, encouraging the expression of all points of view and bringing in new actors and perspectives in the search for constructive policy solutions.

WHO's primary interest is in working with CSOs that share its values and offer the greatest opportunities and synergies for improving health outcomes. Achieving this

calls for 'due diligence' in understanding the nature and interests of the organizations within civil society. Given the number, scale and diversity of such organisations this is a challenging but essential task for WHO if it is to ensure the relevance and integrity of its work. The values, agendas and interests of CSOs and communities that 'talk through' them may be clear and easily assessed against WHO and UN values and goals. Hence, for example, organizations that are involved in promoting interests directly in conflict with health such as arms, tobacco, or alcohol or in conflict with UN values – such as promoting racism – may not form the best partners for WHO.

Making an informed choice

The opportunities of partnerships carry with them the challenge of informed choice—who to engage with and how, who to listen to, whose capacity to build and who to involve in joint actions. WHO needs to be able to sort through and evaluate the wide range of CSOs in operation.

Since there is no single classification system, those wishing to work with CSOs may start by identifying some basic premises on the role the CSO is expected to fulfil. For instance:

- Will the organization contribute to WHO's role as a *global* health institution responsible for developing and advocating norms, goals and policies in public health?

- Will the organization contribute to WHO's role as a *technical* agency contributing to the knowledge base for the development of health policies, systems and programmes?

- Will the organization contribute to WHO's role as *institutional* support at country level for the development of national health systems?

Once clarity on the broad role of the organization has been achieved, judgements on the suitability of CSO need to be made. Three features—constitutional, functional and scale—could form the basis of the information needed to form these judgements.

Constitution and composition

For any representative, normative or policy work it is important to know how the CSO is constituted, who it represents, who funds it and to whom it is accountable.

Some of the key constitutional features that locate the representativeness and interests of CSOs in policy and normative issues are:

- whether the CSO is accountable to a membership and if so
  what is the membership , its relevance and interests in any health issue.

Membership-based CSOs are governed in a manner that makes them accountable to a common interest membership, whether organised on grounds of professional, religious, welfare, social or other special interests. In contrast, non-membership CSOs are governed by a trust, board of directors or other shareholder mechanism. They include direct service providers, research institutes, technical, training and funding agencies.

- the composition, scale and organization of the groups represented; and whether the CSO has a constitutional mandate for the policy issues under debate.

Knowing how the CSO is composed, and who it represents, will provide WHO a starting point for evaluating the reach, activities, and potential influence of a CSO. The composition of CSOs can cover a wide range. One can have community-based organizations with direct membership from community members (such as home-based care groups); organizations with members drawn from representatives at national level (such as national patient rights organizations); formally organised networks formed by a number of civil society organizations (such as country AIDS networks); and informally organised social movements coming together around a common cause.

- the various funding sources of a CSO; and composition of its governing board members, including transparency of individual board members' related interests.

Knowledge regarding the funding sources, the executive or governing body membership and the affiliations of this membership is also very important for WHO. Without access to this information WHO will not be able to assess potential or real conflict of interest risks when entering into relationships with NGOs and CSOs. Transparency in providing this information is critical for WHO.

Functions and capacities

For all areas of WHO's operation whether it be policy, technical, or health system-related, it is important to know the primary functions, capacities and resources of the CSO.

CSO functions of relevance to WHO include:

- Action, research and training in service provision, outreach, technical and research inputs in specific areas;
- Advocacy, lobbying and information sharing through existing networks and, building wider alliances for health goals and sharing information;
- Policy dialogue and development, policy strategy research and analysis
- Monitoring and 'watchdog' roles and protection of consumer interests.
- Fundraising, resource mobilisation and financial contributions;

The capacities that a CSO brings to its work with WHO include its technical, human, financial and institutional resources. It is also important to build an understanding of the processes and methods used by CSOs to strengthen joint actions on health. This includes processes used to obtain and share information, build networks of support,

obtain mandates, generate alliances, provide services and advocate and negotiate interests.

Scale and outreach

Given the global nature of WHO and its regional and country offices, it is important to know the scale of operation—local, national, regional, international— and north/south location of the CSO and its branch offices. Depending on the issue and strategy under discussion, WHO may wish to work with organizations having a specific reach and range.

Knowing where an organization is located is also important for equity issues. There is concern that many international CSOs have their headquarters based in northern, high-income Member States and that this may lead to an under-representation of developing country interests. Thus it is important for WHO to receive information on the composition and location of the governing body and branch offices of international CSOs

Conclusion

There has been an explosion of civil society actors in recent years. Competing interests and rapid change have created a more complex environment but have also contributed positively to improving human health and development.

Harnessing the energy of these diverse voices to improve public health is both a challenge and an opportunity for an international agency such as WHO.

This paper has outlined some features of civil society relevant to WHO's work and that can be used to help WHO staff to begin assessing which CSOs they want to work with. The manner in which WHO draws civil society into its health policy development will be vital to the relevance of its future public health policies. A better understanding of civil society puts the organization in a clearer and more strategic position to build more inclusive alliances for global and local public health goals.

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May 2003

Civil Society Initiative

World Health Organization

Annotated bibliography of selected research on civil society and health

Civil society actors have become visible, active and influential within health and health systems. Understanding their role, the factors influencing them and the health outcomes they produce is important for anyone aiming to improve public health.

The Civil Society Initiative has produced an annotated bibliography of research on civil society and health with the assistance of Training and Research Support Centre (TARSC), Zimbabwe.

The research is divided into three theme areas:

- Civil society-state interactions within national health systems
- Civil society contributions to pro-poor, health equity policies
- Civil society influence on global health policy

The bibliography can be found at:

http://www.tarsc.org/WHOCSI/index.php

At this web site you can:

- View and download **a general overview paper** on the major findings and research issues from the three theme areas.
- View and download **highlights of research findings** and issues arising from the literature within each of the three theme areas.
- View and search a **database of the annotated bibliography** of research covering all three theme areas.

NGO FORUM FOR HEALTH

- Partnering to make health a reality -
Promoting equity and justice in health care

The NGO Forum for Health is pleased to invite you to its annual symposium, conducted in association with the HIV/AIDS Department of the WHO:

Making the difference:

3/5 initiative and the Civil Society's response

Wednesday, May 19, 2004, 14:30 – 17:30

room XVI

Agenda:

- **Presentation of the 3/5 initiative**
  Jim Yong Kim, Director, Department of HIV/AIDS

Facets of experience of the civil society in relation to the 3/5 Initiative

- **Advocacy**
  - The role of regional networks in mobilizing support for care and treatment. The PHM dialogue and action with the 3 by 5 initiative: Thelma Narayan & Mwajuma Masaiganah *Peoples Health Movement*
  - Global networks – advocating local action- the experience of mobilizing resources for treatment globally: Albert Peterson, *Ecumenical Advocacy Alliance*
  - Building on Good Practice NGOs: Julia Cabassi, *NGO Code of Practice Project*
- **HIV Treatment Access and Primary Health Care**
  - Forging a Common Advocacy Agenda: Subha Raghavan, *Solidarity and Action Against the HIV Infection in India*

- **Access to drugs- the civil society contribution and challenges.**
  - The role of Civil Society in the procurement and supply of drugs: Eva Ombakka, *Ecumenical Pharmaceutical Network*
  - Access of Antirectoviral to rural areas of the Bagamoyo district Tanzania: Dr. Abdalla Omar Dihenga, *Bagamoyo Medical Hospital*

- **Infrastructure & Health Systems** in the implementation of 3/5 programme
  - Strengthening Health care for 3by5 delivery: Alan Leather, *Public Services International*
  - Improving prevention and improving care in the era of ARV care: Nance Upham, *The International Health Care and HIV Working Group, and PHM*

- **Resource mobilisation** that assist the implementation of 3/5
  - The role of the Global Fund: Christoph Benn, *Global Fund to fight AIDS, T.B, Malaria*
  - The role of Civil society: Milton Amayoun, *World Vision*

WHO/CSI/2001/DP1

Strategic alliances: The role of Civil Society in health

CIVIL SOCIETY INITIATIVE

External Relations and Governing Bodies

World Health Organization

Discussion Paper No. 1
CSI/2001/DP1

Strategic alliances:

The role of civil society in health

December 2001

Civil Society Initiative

External Relations and Governing Bodies

WORLD HEALTH ORGANIZATION

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Introduction

"We are dealing with the prime public health concerns of our time. We are focusing on conditions with a major impact on the poor and disadvantaged [...] and we are working alongside a broad range of partners, maximizing what we can achieve together"

Dr Gro Harlem Brundtland, WHO Director-General

Civil society and non-state organisations have been contributing to public health for centuries. In more recent years, however, they have grown in scale and influence and are having profound impacts on health.

People, as part of the civil society, form the core of health systems. They use health services, contribute finances, are care givers and have a role in developing health policies and in shaping health systems. In all these respects, there is growing pressure for public accountability and increased response to inputs from civil society. The manner in which the state responds to these changes, and the extent to which civil society actors are recognized and included in health policies and programmes, are some of the critical factors determining the course of public health today.

This paper is part of a series produced by the WHO Civil Society Initiative (CSI) to help promote a wider understanding of civil society. It provides a brief overview of civil society trends in development and health, along with a brief discussion of the risks and benefits arising out of future strategic alliances between the state and civil society to improve health. It has been edited by CSI based on a background contribution written by Dr Rene Loewenson, TARSC, Zimbabwe.

Terminology

In the absence of common understanding or definition, civil society is usually understood as the social arena that exists between the state and the individual or household. Civil society lacks the coercive or regulatory power of the state and the economic power of the market but provides the social power or influence of ordinary people.

Within this social domain, individuals and groups organize themselves into civil society organizations (CSOs) to pursue their collective interests and engage in activities of public importance. CSOs draw from community, neighbourhood, work, social and other connections and provide institutional vehicles, beyond the ties of immediate family, to collectively relate to the state or market.

CSOs are broadly understood to be non-state, not-for-profit, voluntary organizations. In reality, however, there may be state or market links to CSOs that blur the borders between the non-state and not-for-profit aspects of these organizations. States or the private for-profit sector may play a key role in the establishment of some CSOs or provide significant funding, calling into question their independence from the state and private sectors. The interests that motivate people to associate may be public but they may also be personal. Associations may form to support kinships or narrow

group interests that have little to do with wider public concerns. Non-governmental organizations (NGOs) are considered part of civil society and the term is often used interchangeably with the term CSOs, particularly the health sector. ***The term CSOs is used in this paper to indicate a wide range of civil society actors including NGOs.***

The expanding role of civil society organizations

In recent years, CSOs have become more prominent, more visible and more diverse all over the world. One of the factors influencing the growth of CSOs has been the increased challenge to imbalances of power between state and its structures on the one hand and civil society on the other. This has been driven by many forces such as reactions to centralized authority in state structures; dissatisfaction with state performance on public services; and dissatisfaction with policy positions taken by the state in international arenas.

Civil society activity has also increased as a response to the perceived weakening of the nation states' authority under globalisation and increasing strength of transnational corporations. CSO networks have been formed within and across countries to promote a wider and more 'transnational' support of public interests on global policy issues such as human rights, environment, debt, development and health. Meetings of the World Trade Organization, Jubilee 2000 on debt relief, civil society lobbies on drug access and pricing, and the many civic lobbies around World Bank /IMF programmes, for instance, have come to dominate global headlines.

Increased public concern over the right to participate in policies and processes that affect people's lives and the growing demand for improved public accountability and responsiveness to citizen inputs at the local, national and global levels has made the work of CSOs more prominent. Their visibility has also been enhanced as CSOs become increasingly widely connected and organised into national and global networks, supported by expanded access to information. Electronic communication through email and the Internet has opened opportunities for communication and association within and across national boundaries.

Civil society organizations in development processes

The growing role of civil society in development processes is not simply a response to political lobbies or to an increased scale of Organization. It also emerges from a shift in the understanding of development processes. When people and human dimensions are defined as the core of development, then social exclusion itself becomes a facet of under-development and social networking a development asset. Under these terms, the fulfilment of human development will require concerted efforts of the State together with citizens and their Organization.

As there has been a shift towards a more rights based approach to development, more prominence has been given to civil society roles in raising, advancing and claiming the entitlements of different social groups. This gives CSOs a vital role as participants, legitimizers, and watchdogs of policy as well as collaborators in national development.

The complexity of development needs, declining resources, declining aid and various structural adjustment policies and global political changes at large, have also contributed to declining service provision by the state. This gap has been increasingly filled by CSOs adding to their importance as development agents within countries. Analysts have noted that these capabilities have had a positive impact on development outcomes and on government accountability and performance.

The increased channelling of bilateral and private financing, in this context, to international CSOs has reinforced the prominence of CSOs and drawn the attention to their potential role in new modalities and strategic alliances for health in development cooperation.

These trends at local, national and global level reflect the changing relationship between the state and the civil society. There are growing demands on governments for democracy, accountability, participation and compliance with human rights. Demands on the state to alleviate economic and social inequalities, provide public services to poor populations, and conform to a liberalised global market has led to a range of state relations with civil society—co-operation, confrontation and, in some cases, repression.

The growing presence and importance of CSOs at global and national levels has also motivated both national governments and global institutions to establish more formal mechanisms for listening to and responding to claims made from within civil society. Mechanisms for judging how representative CSOs are and evaluating the mandate of the civil society actors have also taken on added value.

The role of civil society organizations in the health sector

Civil society has a long history of involvement in public health. Early public health actions to clean up American cities in the 1800s, for example, were led by well known public figures supported by women's' groups. However, the recognition of civil society's contribution to health has varied over time. One of the most significant developments in the recent past has been the 1978 Alma Ata declaration, which is considered a landmark for recognising people's participation in health systems as central to Primary Health Care and for recognising the role that organised social action plays in securing health gains.

Health reforms in the 1990s, however, de-emphasised the welfare state and community participation and gave greater profile to the market. Social values were given less attention than the technical, economic and management factors in health systems. The state's role was 'downsized', either by deliberate policy measures such as Structural Adjustment Programmes, by reduced public spending or by the declining quality of public services. In low-income countries, coverage of the lowest income social groups fell, leaving many people cut off from effective services and dependant on self-help. These trends motivated many CSOs to new actions including health service delivery and renewed advocacy for basic health rights and access to health resources.

As the attainment of health goals has become more evidently influenced by political, legal, investment, trade, employment, and social factors, civil society involvement in health has also widened to include organizations whose main mandate lies outside the health sector. Hence, for example, youth organizations not specifically set up to deal with health issues have been an important contributor to adolescent reproductive health promotion, or groups dealing with economic and trade issues like trade unions have played an important role in essential drug lobbies.

The following sections outline some of the contributions that CSOs have made to various aspects of health:

Health systems

CSOs contributes to a range of health system functions, summarised in Table 1 below.

TABLE 1: HEALTH SYSTEMS AND CIVIL SOCIETY ROLES

Health system function	**Examples of roles of CSOs**
Health services	Service provision; Facilitating community interactions with services; Distributing health resources such as condoms, bed nets, or cement for toilets; and Building health worker moral and support.
Health promotion and information exchange	Obtaining and disseminating health information; Building informed public choice on health; Implementing and using health research; Helping to shift social attitudes; and Mobilising and organizing for health.
Policy setting	Representing public and community interests in policy; Promoting equity and pro-poor policies; Negotiating public health standards and approaches; Building policy consensus, disseminating policy positions; and Enhancing public support for policies.
Resource mobilisation and allocation	Financing health services; Raising community preferences in resource allocation; Mobilising and organising community co-financing of services; Promoting pro-poor and equity concerns in resource allocation; and Building public accountability and transparency in raising, allocating and managing resources.
Monitoring quality of care and responsiveness	Monitoring responsiveness and quality of health services; Giving voice to marginalised groups, promoting equity; Representing patient rights in quality of care issues; and Channelling and negotiating patient complaints and claims.

Health service delivery

CSOs play a major role in the delivery of health services. Religious organizations have had a long history of service provision while other organisations have become more involved in recent years. In Asia and Latin America, CSOs have been involved in mobilising effective demand for services, building awareness of community needs and experimenting in innovative approaches to service delivery that were later replicated by the state sector. In Africa, among other tasks, CSOs have assisted in working with the state to integrate evidence led health planning and community preferences.

These CSO health services may or may not be contracted by the state. In many cases, CSOs provide cover to groups otherwise disadvantaged in health service access or assist governments in major treatment campaigns and disease control programmes, in drug distribution, in reaching vulnerable communities, and in fostering innovative approaches to disease control.

CSOs contribute to enhanced health care by providing services in response to community needs and adapted to local conditions; they lobby for equity and pro-poor health policies, often acting as an intermediary between communities and government; reach remote areas poorly served by government facilities; and provide services that may be less expensive and more efficient. CSOs also provide technical skills on a range of issues from planning to delivery to services. They innovate and disseminate good practices to other NGOs or the state sector. CSOs contribute to public understanding and enhance public information. This can build more effective interaction between services and clients and enhancing community control over health interventions.

There is, however, significant variability in the quality and scope of non-state services. Some CSOs may not be responsive to the population they serve and may in fact be more accountable to the international agencies that fund them. Many national CSOs struggle with issues of how to access their own national public resources; their capacities to manage and sustain programmes; negative attitudes and non participation of health workers; poverty and other social problems; and how to build strong and active links with their own members.

Analysts have pointed out that CSOs have a long-term and sustained comparative advantage when they can access resources not available to government, or where they can meet a need not currently met such as in improving coverage.

Advocacy, policy and standard-setting

In addition to service provision, CSO make other important inputs to health such as transforming public understanding and attitudes about health; promoting healthy public choices; building more effective interactions between health services and clients; and enhancing community control over and commitment to health interventions.

The recent recognition of health as an outcome of economic, social and political inputs and actions call for participation from a wide diversity of state and non-state

actors. Many developments oriented CSOs are active in political areas such as monitoring of the impact of global agreements on public health, fuelling demand for more effective public health safeguards. CSOs have participated in global policy areas such as trade agreements and health, prices of and access to drugs, international conventions and treaties on health related subjects such as landmines, environment, breast milk substitutes and tobacco and in debates around policies and public health standards.

Many global CSOs promote and use the increasing profile given to human rights instruments and actions in health. They monitor health and human rights issues such as patients rights, women's and children's health rights, reproductive health rights and occupational health risks. Increased CSO activity reflects public discontent over socially unacceptable inequalities in health or access to health care or over falling coverage of public health services, both in terms of increased advocacy for health or in terms of private not for profit service efforts to fill gaps in health care coverage. CSOs have also become more visible and important as primary health care policies have placed emphasis on participation of communities.

These developments within health systems at local, national and global level signal that CSOs are an important channel for public involvement in health systems. They bring human resources, technical expertise and new knowledge to health and provide a powerful additional pressure for the recognition of public interests within the health sector.

State and civil society interactions: benefits and risks

These trends have led to a call for greater 'stewardship' from governments in health, that is for governments to better facilitate the range of stakeholders, relations and inputs needed for health gains, and to balance links with the private for profit sector with stronger links with the public interest organizations in civil society

Clearly the interaction between civil society and state is not without both benefits and risks for both state and non-state agents. Some of these are summarised below

Benefits for the state

Interaction with CSOs can bring to the state:

- Support for national / global values, for state regulation of commercial interests adverse to health, for public policy goals and enhancing public information and legitimacy of state work.

- Introduction of new perspectives, technical expertise, capacities and human resources, networks and informed leadership on health.

- Increased service provision and implementation of public programmes, particularly among marginal communities and in remote areas, and increased financial contributions to health programmes.

Benefits for civil society

Interaction with the state confers on CSOs:

- Increased possibilities of influencing health policy by incorporation of CSO issues in policy processes including counterbalancing of commercial interests and consensus building on health priorities.

- Provision of legal authority for public participation and enhanced legitimacy of CSO work. Enhanced linkages and transparency of interaction with the state and technical inputs to CSO work from the state.

- Enhanced prospects for civic education, participation and building of social capital thus strengthening CSO capacities. Improved options for access to health services. Expanded opportunities for greater involvement in health programmes.

Risks for the state

Interaction with CSOs carry certain risks including:

- CSO representativeness cannot be assumed, pseudo NGOS may be a hidden channel for corporate interests and potential conflicts of interests between the state and CSO interests. For the state, it is important to assess the representativeness, authenticity, interests and capacities of the CSOs it works with.

- Crosscutting and multiple roles among CSOs leading to great diversity in views and numbers can be difficult to manage. CSOs clearly do not speak with one voice, and there are asymmetries in the capabilities and numbers between the North and South.

- CSOs have varying levels of accountability to the communities they speak for. These features may weaken the legitimacy of CSO positions within national and international platforms.

- CSO's political roles and polemic approaches on issues such as human rights, consumer protection, or ethical issues may generate tension with governments.

- Risk of government staff leaving to join CSOs, leaving the state weaker in technical expertise and capacity.

Risks for civil society

Interaction with the state carries with it risks for CSOs, including:

- State links may distort CSO voices and representation by giving privilege to a few interlocutors. If this bias is towards CSOs representing more affluent or Northern Hemisphere interests, then perspectives and access of more marginal, Southern Hemisphere groups can be weakened.

- Dependence on the state for access or resources may compromise the autonomy, accountability or self-determination of CSOs and make CSOs reluctant to criticise the state. Work on government programme or funding priorities could distort CSO priorities.

- Risk of CSO staff leaving to join government units, leaving CSOs weaker in technical expertise and capacity.

Conclusions

There is great potential for improving public health through systematic collaboration between governments and civil society. This document is a first attempt to summarize and provide an overview of the role of CSOs in health. The conclusions at this stage can therefore only be of a very general nature.

What is sure is that there is a need to collect more systematic evidence on the role of CSOs in health, to improve our knowledge and to give visibility to good practice and to the contribution of CSOs in health. As described in this paper, the interfaces are complex and there are many aspects, risks and benefits to be taken into account.

The public health sector must understand CSOs and CSOs must better adapt to the needs of the health sector and better organize themselves as a group. States need to work with civil society to organise the social dimensions of health actions, to build wider constituencies for health rights and goals, and to strengthen public accountability and responsiveness within health systems. As regards CSOs, they clearly do not speak with one voice and their perspectives differ between different interest groups. There are also asymmetries in capabilities and numbers between the North and the South, and CSO have varying levels of accountability to the communities they speak for. All these features may weaken the legitimacy of CSO positions within national and international platforms, and therefore need to be addressed in order to maximize the benefits of the collaboration.

The overall impression and conclusion however, is, that the benefits of collaboration for both the State and CSOs outweigh the risks of possible tensions in CSO-state interactions. Strategic alliances offer opportunities for enhancing the legitimacy of health policies and programmes, improving public outreach, advocacy of health goals, information exchange and increasing resource inputs to health programmes.

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SOCIAL DEVELOPMENT INITIATIVES IN PAKISTAN

BY

THE AGA KHAN UNIVERSITY

DEPT. OF COMMUNITY HEALTH SCIENCES

Govt. largest health care provider however, utilization is as low as 20%

Over crowded tertiary hospital and underutilized PHC facilities

Most of the TBAs are untrained

Practice in health sector is clinically driven

Around 4000 medical graduates and 600 specialists are produced annually

Over all doctor to population ratio is 1:2200 and may be as high as 1:700 in urban areas.

Only 55 % of the population has any access to health services

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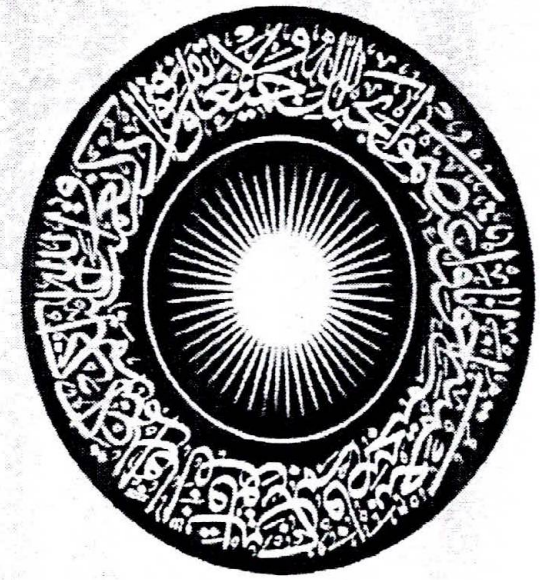
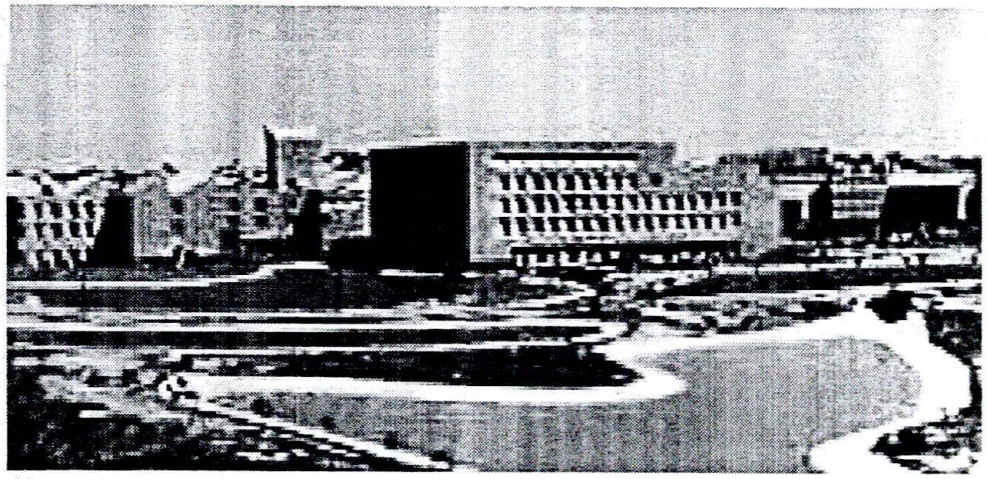


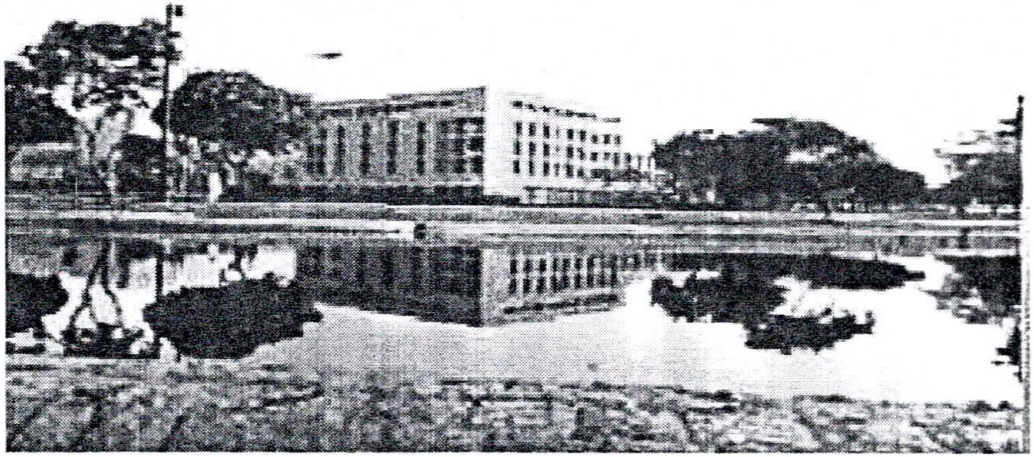
The Aga Khan University
Karachi, Pakistan

The Aga Khan University



- First private International University in Pakistan, Chartered in 1983
- Committed to Excellence in Education and Health Services
- Prioritizing higher education and research relevant to Pakistan and developing countries
- Pivotal position in social development activities of Aga Khan Development Network
- Empowerment of Women

Present Faculties



Faculty of Health Sciences

Medical Collage Teaching Hospital

School of Nursing

Institute of Educational Development

Professional Development Centre

COMMUNITY HEALTH SCIENCES (CHS) DEPARTMENT

EDUCATION

To educate health personnel for leadership in dealing with health and development problems, particularly those of the more deprived and dis-advantaged community in Pakistan and developing countries

RESEARCH

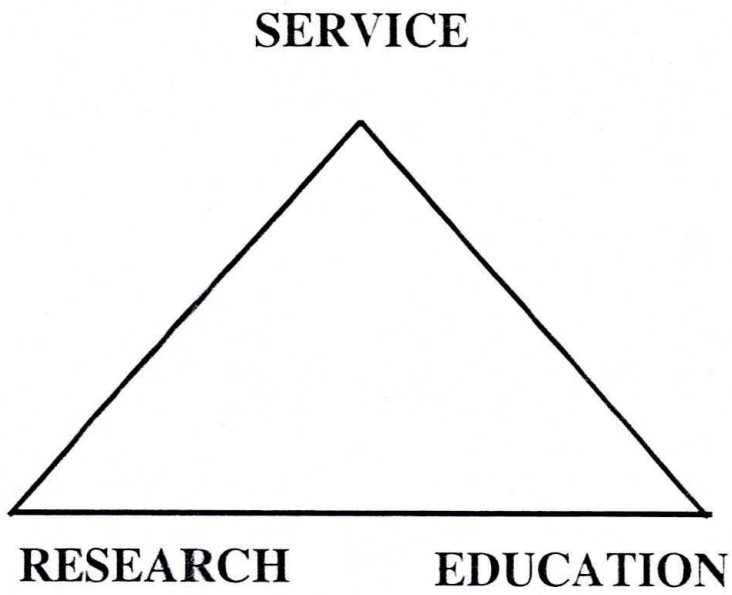
To strengthen the development of Health Systems in Pakistan through RESEARCH with emphasis on the development and implementation of health system prototypes in collaboration with local and national authorities.

SERVICES

To promote development of equitable and sustainable health care system, that embraces the basic needs of underprivileged and under-served segments of the population in partnership i.e. communities, government and non-government organizations.

Research areas include:

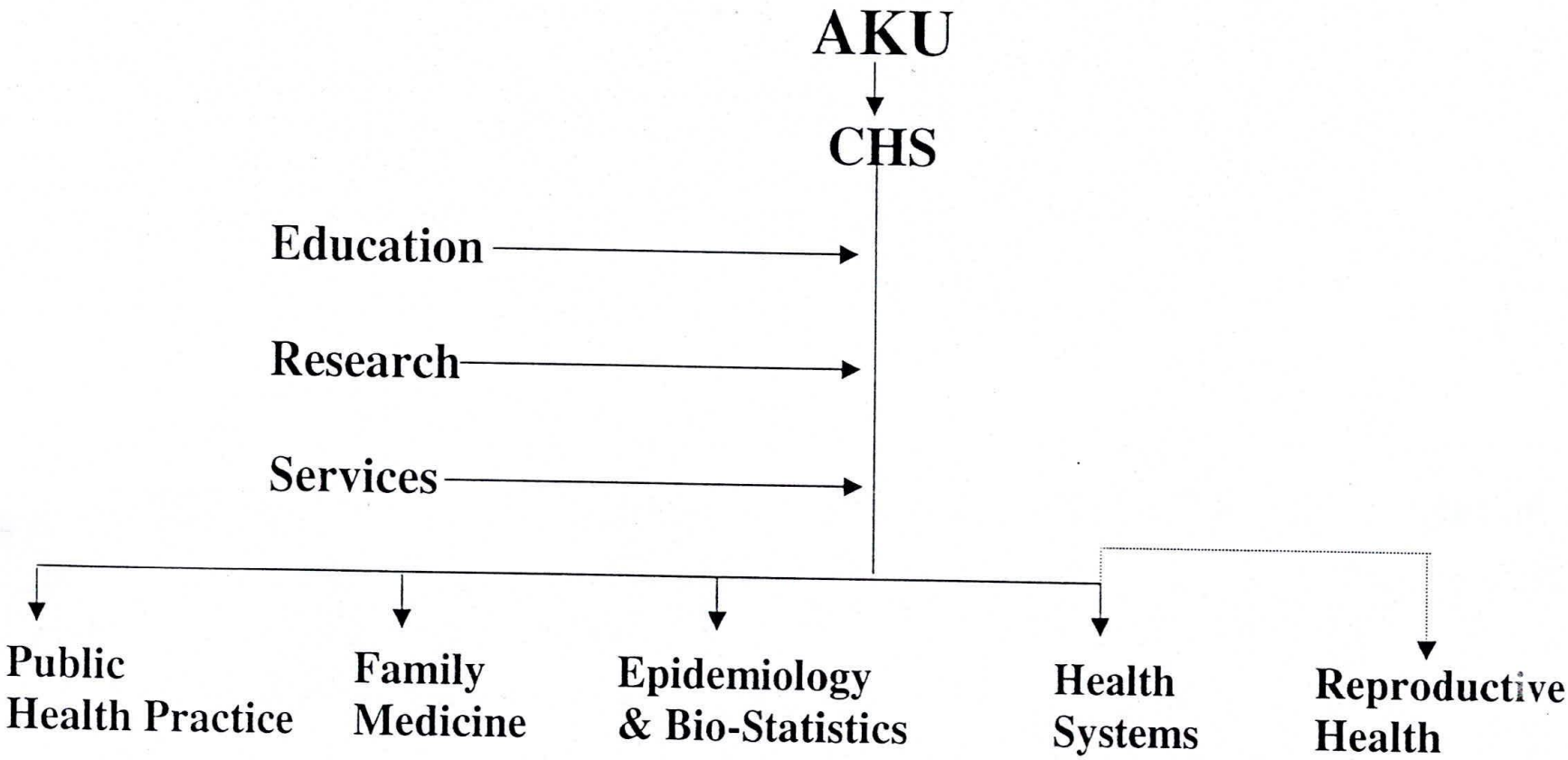
- PHC prototype models
- Community empowerment
- Gender and reproductive health
- Health systems research
- Epidemiological research
- Health Management Information System


SERVICE
RESEARCH
EDUCATION

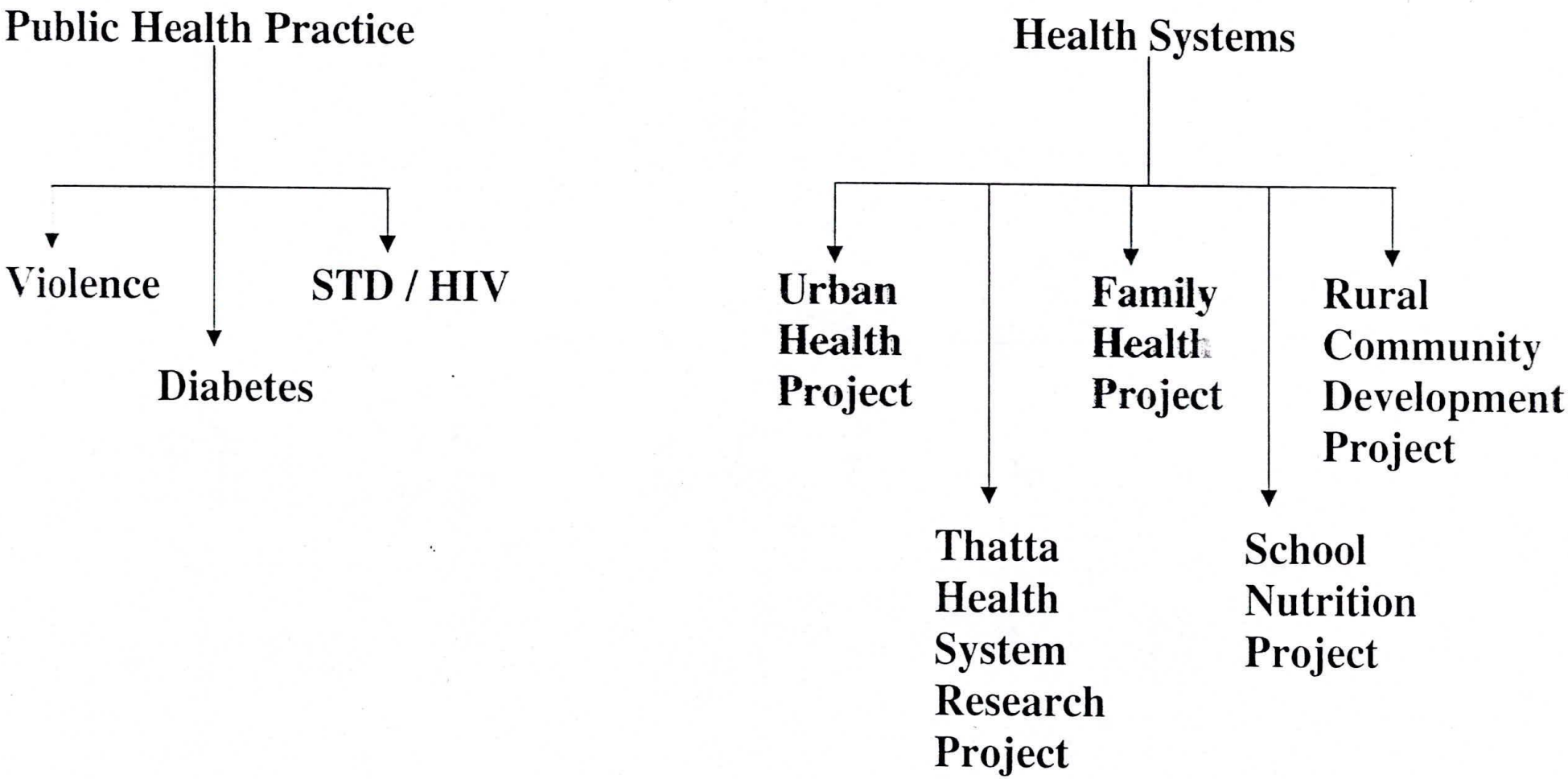
SERVICES

PRINCIPLES

- PARTNERSHIP
- CAPACITY BUILDING
- PARTICIPATORY APPROACH
- EQUITY
- SUSTAINABILITY


AKU
CHS
Education
Research
Services
Public Health Practice
Family Medicine
Epidemiology & Bio-Statistics
Health Systems
Reproductive Health

CHS
Research Projects



Thatta Health System Research Project (1985) :

Operation Research Project of AKU in collaboration with Dept. of Health.

Aim was to strengthen the district health system towards improving the health of the population.

Lessons learnt:

District and Village Level :

THSRP provided opportunity to both AKU and Govt. for better understanding of health system issues and on the basis of studies done, two projects came into existence.

PHC level : **Improved utilization of health facilities.**

Family Health Project:

Started in 1991, with the collaboration of Health Department.

Aims:

- **Improve the health of the population in the project area**
- **Increase the effectiveness of health care network**
- **Develop the institutional capacity**

Initiatives:

- **Established in each district a permanent cader of staff, at district health development centers.**
- **To acquire the skills, knowledge and attitude that will enable them to implement programs that will benefit the health of the Province.**

Lessons learnt:

Access to better services can be improved by :

- Training and supporting the TBAs and field staff
- Increasing female para-medical staff
- Creating linkages with community health workers
- Strengthening referral system, improving drug supplies and diagnostic facilities
- Utilization is being improved by encouraging community participation and health education

School Nutrition Program:

Started in 1991 with the collaboration of Sindh Education Dept.

Aim is to explore alternative strategies to develop an effective School Nutrition Program in rural Sindh and increase parental and community awareness of the importance of child nutrition and education.

Initiatives:

- **Explore possibilities of community involvement at school–village level in improving education and nutrition.**
- **Improve the nutrition status of primary school children.**
- **Explore the possibilities of implementing school nutrition program through NGOs.**

The initial study by AKU showed prevalence of malnutrition to be high in rural children and parents are aware of the need for better health and education for children. They are ready to collaborate for the welfare of their children.

The Urban Health Project (UHP):

An integrated model of health and development initiatives in poor urban squatter settlements of Karachi.

Phase 1 (1985-94)

Primary Health Care (PHC) centers in five squatter settlements of Karachi

Each PHC module served a pop. of 10,000, and the Program covered approximately 50,000 people.

The PHC Program concentrated on improving the health status of mothers and children under 5, and was later extended to families.

Lesson Learnt in Phase 1

IMR fell from 126 to 64; the under five mortality rate from 177 to 83.

Supervision and training need to be strengthened

No comparison or control population.

Interventions of a more global and developmental nature like safe water supply, sanitation and income generation were also considered in order to have continuous improvement in health.

Moreover the sustainability of these interventions without adequate community involvement was also found to be questionable.

Phase II (1994-1999)

Based on Pre-defined criteria, six intervention field sites were selected amongst the 500 squatter settlements of Karachi.

Steps wise Evolution of the Project

- **Formation of community groups and prioritization of health issues**
- **Capacity building of CMTs and communities**
- **Provision of basic health and development services**
- **Improvement in the quality of existing health services**
- **Networking with government institutions and NGOs**
- **Training for medical/ paramedical personnel**
- **The annual cost per person thus figures out to be Rs 49 (less than I U.S $)**

Achievements:

- **An excellent, continuing learning experience for faculty, CBOs, NGOs and community**
- **Empowering poor squatter communities in mobilizing resources**
- **Catalyst for disadvantaged communities to organize and seek partnerships with government and non-government agencies**
- **A PHC system focusing on prioritized aspects of maternal and child health**
- **Capacity building activities have helped volunteers, health providers and CHMTs to assume increasing responsibilities**

Conclusion:

- Like all universities with a social commitment, through these activities AKU is responding to the critical health and social development need of Pakistan and other developing countries

- These activities demonstrate the value of community participation in improving the health of vulnerable groups

- The process of empowerment in communities (with the university serving as a catalyst, technical resource and an intermediary between communities, government, and NGOs) is a stepping stone towards sustainable primary health care and social development.

COMH

INDIAN EXPRESS - 12-4-97.

Bangalore Hospice Trust

These tender hands rock you to sleep

Suma Ramachandran

DEATH is the ultimate reality of life but very few are prepared to meet it. It's worse when it is untimely and caused by a terminal disease that relentlessly corrodes your being and is not satisfied until it takes away your life, and nearly the lives of those left behind.

What do you do when a loved one is going to die? When the doctors can do no more? When he/she is discharged from the hospital to make way for someone else whose life *can* be saved? When you know practically nothing about how to take care of the patient at home? When you can't think of things like wills and last rites?

It was the realisation of problems like this which convinced Kishore S Rao, founding member of the Bangalore chapter of the Indian Cancer Society, to start the Bangalore Hospice Trust.

The main aim of the trust is to provide palliative care and support to people so that they can die in peace, with dignity and free from pain. This is the sixth hospice in the country but the first and only one which provides a home care service.

"I believe that the time when the patient is discharged from the hospital is the most crucial," says Rao. "The psychological trauma alone is often unbearable: thoughts of your end being near is when you need counselling the most."

The trust has two teams of two members each: a trained nurse and a family counsellor, on call round the clock. It works in co-ordination with oncologists all over the city who inform them of the terminal patients who have been discharged from hospitals. Alternately, they are also contacted by the families of patients themselves.

Once they reach the family, the first thing they do is give the patient relief from pain if possible. The nurse then trains family members on how to take care of the patient's physical needs. "There are little things like how to lift the patient without causing him/her pain, how to change sheets when the patient is lying on the bed, which the layman knows nothing about," explains Rao.

He recounts some cases which stand out as instances where the home care system helped families cope with the loss of a dear one.

Caring at the most crucial time

A five-year-old girl had been discharged from the hospital. The father had spent all his money and even sold his tiny meatshop, which was their only means of income, on the girl's treatment. The mother would not move from her bedside, neglecting the needs of the rest of the family. In such a case, there wasn't much for the nurse to do. But the situation called for a counsellor to help the family come to terms with the fact that their little girl was going to go away forever.

Another little girl was found by the team in a slum in Frazer Town, sitting in her little hutment with the tumour on her knee swollen and causing a lot of pain. For the first few days, the girl said absolutely nothing while the nurse administered painkillers. When she did speak, she said, "I think I've caused my family enough trouble. It's time I died."

"When someone so young says something like that, you know how important it is to provide help and counselling to the terminally ill," remarks Rao.

The idea of starting a hospice came to Rao when he was invited by the State Government to be on the governing council of the Kidwai Memorial Institute of Oncology and saw the insecurity that dying patients went through when they had to be discharged from the hospital.

Starting a trust was not too difficult. The Rotary Club of Bangalore, Indiranagar, came forward to help since they wanted to be involved in a continuing project, and so did the Indian Cancer Society.

BHT is setting up a 50-bed hospice for terminally ill patients in Whitefield where they have got five acres of land from the Government on a long lease. *Karunashraya*, as the centre will be known, will provide free care for all patients, irrespective of caste, sex or economic conditions.

"In the past also, more than half our patients have been from the lower-middle class and poorer sections of society," reveals Rao. To date, BHT has taken care of over 200 patients. The home care system will continue even after *Karunashraya* starts functioning in a year's time.

In fact it started because Rao did not want the trust to keep asking for funds for *Karunashraya* without having anything concrete to show their would-be helpers. "I knew it was going to take time to collect the kind of money we would need to build the centre and in the meantime, we could lose credibility. So we started the home-care system."

BHT's teams work with certain guidelines. The treating doctor's advice and instructions alone are taken. There is no interference in the type of treatment the patient wishes. (Many want to try last-ditch efforts with other medical systems.) And BHT's teams never take sides in terms of religion. They help the family with information, if it is asked for, in terms of lawyers to make wills, where to get medical equipment for the patient and what the costs might be.

The going has not been easy. Death is after all a depressing situation and according to Rao, the strain has begun to tell on the counsellors. BHT is on the lookout for interested, strong-hearted persons who would be willing to spend time with their patients. ■

Contributions to BHT, a public charitable trust, are exempt from income tax under Section 80G (50 per cent deduction) and Section 35AC (100 per cent deduction) of the Income Tax Act.

For further information, contact Bangalore Hospice Trust, c/o The Indian Cancer Society, New Thippasandra Main Road, HAL 3rd Stage, Bangalore 560 075. Phone: 5254127. Internet - http:/www.pcweb.com/karuna

Dr. Narayanan,

Some information on our plans and existing Home care Service. Trust your man is in touch with our staff.

KSHOO
(KISHORE RAO)

VNR/AC

Please start a file if we don't already have one on Bangalore based organisations and put in all these letters from organisation for which we do not have a seperate file

RN
3/6/97

To CMF/VB/SPT/ARS 27/5

For information

Recently James father had been referred to this group as well

RN
20/5/97

received
19/5/97 (139)