DEVELOPMENT OF HEALTH CENTRE CONCEPT WITH SPECIAL REFERENCE TO BASIC HEALTH SERVICES IN INDIA.

By - Dr.J.R.Bhatia

1. Henry-R.Zimmer (1948) and P.Kutumbiah(1958) have put forth evidence to suggest that in Emperor Ashokas' time,2000 year ago, official health services for the people were regionalised and integrated at the point of delivery.

2. Lord Dawson of Penna (1920) set forth regionalised health centre concept which had been experimented with in some of the European and American cities since the beginning of the 20th Century Parry,R.H.(1949) has reviewed these efforts. Following Dawson Report, a special Governmental Commission proposed that comprehensive care units be established in regional patterns around base hospitals in order to obtain maximum utilisation of personnel and resources, without duplication.

3. About the same time and following Russian Revolution in 198, health services in Russia were completely reorganised on regionalised basis,with integration of curative and preventive services at all levels and primary emphais on prevention of diseases, as corner-stones of the services. Details of these services as they have developed to-date are available in WHO,Public Health paper No.35(1960).

4. European Conference on Rural Hygiene(1931) defined health centre as Institution for the promotion of health and welfare of the people in a given area which seeks to achieve its purpose by grouping under one of or coordinating in some other manner under the direction of the health officer, all the health work of that area together with such welfare and relief organisations as may be related to the general public health work". The Conference further recommended that where a modern public health organisation is to be created in a new territory, the health centre, as defined above,is the best method of attaining the desired result".

5. Jacocks(1933) reviewed and elaborated the concept of demonstration health health centres organised by Rockefellor Foundation in Ceylon and later in India. These centres organised only preventive health services(The concept was imported from city Health Centres in U.S.A.)

6. John B.Grant started teaching health Centres in several Asian countries including India(e.g.Singur).Special features of these centres were comprehensive health services,use of these centre for education of physicians and other members of health team and training of village youth to work as voluntary health workers.Details of this concept are available in"Health Care of the Community".

7. The Bhore Committee(1946) recommended a regionalised system of health services in India, providing comprehensive health services based on health centres and sub-centres in rural areas. A special feature of this report is that it recommended that all health services be tax supported and manned by fully salaried personnel. Another important feature of this report is the emphasis on the production of "social physician"- a 'basic doctor'.

8. Health Services in Britain(1968) describes the details of National Health Services in England which started in 1948, organised on the principle of regionalisation, the service is comprehensive,tax supported and almost free. Special feature is choice of physician by the patient and vice verse.It is, however, not as integrated or prevention oriented as USSR services.

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9. Health Services in Europe (1965) describes Yugoslav Health Services organised and developed in the fiftees. The services are comprehensive and integrated and based on the principle of regionalisation. Special feature is compulsory health insurance of the total population. A very interesting aspect is that the services are self-supporting, self-managed and locally financed.

10. Dutt, P.R. (1962) describes development of Primary health centres in India immediately after independence and in the ninteen fiftees as an integral part of community Development programme, echoing and elaborating the idea mentioned in para 4 above. This movement implemented the principle of regionalisation in the field of health for the first time. In contemporary India experience with primary health centres has underlined the need for professional and administrative integration of health activities and functions and for making the services sufficiently comprehensive.

11. Health Survey and Planning Committee (1962) found the quality of services organised by Primary health centre inadequate and advised strengthening of existing PHCs. Before new centres are established. They also emphasized the need for strengthening sub-divisional and district hospital so that they may effectively function as referral centres.

12. Chadha Committee (1963) held the view that maintenance phase of national C.D.C. Programme is the responsibility of the general health services, which should be adequately strengthened particularly in rural areas. They recommended integration of nation C.D.C. programmes with basic health services, including F.P. and suggested one multipurpose workers per 10,000 population, to be increased later to one for 5000 population. This concept and approach has been further developed in "Integration of Mass campaigns against specific diseases into General Health Services".

13. Almost the same time National Family planning programme adopted extension approach and suggested separate additional staff for F.P. work in PHC areas. This staff was later increased. The details are available in F.P. Programme of 1962-63.

14. Mukherjee Committee (1966) reviewed the "1963 scheme" for basic health services as also the new F.P. extension scheme and held that whereas health services should be provided in an integrated manner and the workers should be multipurpose for the basic health field, he can provide only information services in the field of family planning. The Committee suggested a parallel hierarchy so as to ensure promotion of F.P. mass campaign.

15. Master Plan (1970) noted regional and rural urban disparities in particularly in the matter of distribution of doctors and hospital beds. They pointed out that there is close inter-dependence between medical profession, health services and medical education and recommended that all these three be tackled simultaneously. They suggested that "reasonable" medical facilities be provided in rural areas within the remaining period of 4th plan, by taking doctors and beds to within "reasonable approach of the people". By this they hoped that the country may see the beginning of an assurance, if not an insurance, of a family comprehensive health care for millions of families.

16. National strategy on Health (1972) and National Health Scheme for Rural Areas (1972) carried the concept further and gave concrete suggestions for implementation. They suggested 3 fold increase in the number of PHCs, two-fold increase in the number of sub-centres and field staff, increase in no. of beds in rural areas to reach on bed per 1000 population, improved quality of services by ensuring full staffing and provision of more drugs at PHCs. and hospital etc. and utilising the services of practitioners of I.S.M. & Homeopathy, one for 2000 population, for easy accessibility of routine and minor treatment facilities.

medico friend circle bulletin

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EVOLUTION OF THE EXISTING HEALTH SERVICES SYSTEMS OF INDIA

D. BANERJI*

A Profile of the Policy Formulators and Health Administrators : After Independence, the health services system of the country was shaped by the two key political decisions of the new leadership. Following the political commitments made during the struggle for Independence. provision of health services to the vast masses of the people—particularly for those living in rural areas—was made an important plank of the Directive Principles for the State Policy of the Indian Constitution [1] . The other political commitment which turned out to be an even more sacred and of overriding importance was to bring about the desired changes in the health services system without making any basic changes in the then existing machinery of the government.

The personnel of the Indian Medical Service of the British days and the " Brown Englishmen " were called upon by the Indian leadership to provide the initiative in shaping the proposed new health services system for India. These personnel, who like those of the Indian Civil Service, belonged to elite class of administrators. They were former officers of the British India Armed Forces who had opted for civilian work. They were also trained in the traditions of the western countries. Political independence brought to the fore two additional issues which profoundly affect the cadre of the Indian Medical Service. Firstly, the withdrawal by the British officers after Independence caused a sudden vaccum in their ranks. This came as a windfall to a number of not so competent officers, who were catapulated into positions of key importance simply because they happened to become senior in the cader because of the very large number of vacancies caused by the departure of the British. Secondly, by adhering strictly to the seniority rules, when the health services were expanded very rapidly to meet the requirements of the newly formulated health programmes, the administration drew more and more from the relatively small group of people who had entered the services in, say, 1930-35, 1935-40 or 1940-45 to meet the very rapidly increasing manpower needs for key posts. As a result, a large number of the key posts in the health services got filled by persons, who, even from the colonial standards, were not considered to be bright.

Such a massive domination of the organisation by men who were trained in the colonial traditions and whose claim to a number of vital posts in development administration was based merely on their being senior in the cadre, led to a virtual glorification of mediocrity, with all its consequences[2] pp.55-57. What was even worse, such a setting was inimical to the growth and development of the younger generation of workers. Often these young men had to pay heavy penalties if they happened to show, on their own, enterprise, initiative and imagination in their work. Conformism often earned good rewards. This ensured perpetuation of mediocrity within the organisatian.

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Because of their being inadequate for the job, these Brown Englishmen went out of the way to appeal foreign experts for help and the latter have generously responded to such entreaties. A large number of foregin experts were invited to play a dominant role in almost every facet of the health services system of the country[3]

Medical Colleges, Teaching Hospitals and other Medical Care Facilities In Urban Areas

Two divergent forces in the country—availability of relatively very much larger amounts of resources for the health sector and perpetuation by the technocrats, the bureaucrats and the political leadership of the old privileged class, western value system of the colonial days gave shape to a health service which had a strong urban and curative bias and which favoured the rich and the privileged.

It is significant that when the country had only about 18,000 graduate physicians and about 30,000 licenciate physicians [4, p. 35], one of the first major decisions of the popular government of India in the field of health was to abolish the three year post matriculation licenciate course in medicine [5. p. 313]. While recognising "the great lack of doctors", the very large majority of the members of the Health Survey and Development Committee (Bhore Committee), probably "strongly influenced by the recommendations of the Goodenough Committee in the United Kingdom" [6, p. 340] asserted that resources may be concentrated "on the production of only one and that the most highly trained doctor" [6 pp. 339,349]. The Committee had made elaborate recommendations concerning the training of what it termed as the "basic doctor" and stressed that such training should include "as an inseparable component, education in community and preventive aspects of medicine" [6,pp. 355-359].

The Medical Council of India, a direct descendent of the Medical Council of Great Britain, which is the statutory guardian of standards of medical education in India, has issued repeated warnings against reviving the licenciate course. The Health Survey and Planning Committee of 1961 (Mudaliar Committee) [5] has also emphatically rejected the idea of reviving such a short-term course because they were "convinced that the proper development of the country in the field of health must be on the lines of what we consider as the minimum qualification for a basic doctor" (p.349). It went on to state: "India is no longer isolated and is participating in all problems of international health. The WHO has laid down certain minimum standards of qualifications. In view of India being an active member, participating in all public health measures on an international basis, we think it will be unfortunate if at this stage once more the revival of a short term medical course is to be acceptcd" (p.349).

One of the saddest ironies of the medical education system in India is that resources of the community are utilised to train doctors who are not suitable for providing services in rural areas where the vast majority of the people live and where the need is so desparate. By identifying itself with the highly expensive and urban and curative oriented system of medicine of the west, the Indian system actively encourages the doctors to look down on the facilities that are available within the country, particularly in the rural areas, and they look for jobs abroad and thus cause the so-called brain drain. As if that is not enough, till recently these foreign trained doctors have been pressurising the community to spend even much more resources to attract some of these people back to the country by offering them high salaried prestigious positions and making available to them very expensive super sophisticated medical gadgets. These foreign trained Indian specialists, in turn, actively promote the creation of new doctors who also aspire to "go to the States" to earn large sums of money and to specialise. Emphasis on specialisation, incidentally, causes considerable distortion of the country's health priorities thus causing further polarisation between the haves and the havenots.

Those who are unable to go abroad, they try to settle down in private practice in urban areas, often linking their practice with honorary or fullfledged jobs in urban health institutions run by the government. Only some government jobs are non-practicing. As a result of such considerations, a desparately poor country like India finds itself in a paradoxical position in relation to the distribution of the doctors in the country : the urban population, which forms 20 per cent of the total, accounts for 80 per cent of the doctors.

To be sure, pretending to follow the recommendations of the Bhore Committee, soon after Independence upgraded departments of preventive and social medicine were created in medical colleges, at the instance of the government and of the Medical Council of India, to act as spear-heads to bring about social orientation of medical education in India. However, as in the case of so many other ambitious and morally lofty government programmes, concurrently it was also ensured that the very spirit of this programme is stifled, if not totally destroyed, by actively discouraging in various ways its actual implementation. For instance instead of mobilising the finest brains in the profession to bring about social orientation, most of the

positions in the departments of preventive and social midicine were filled by the discards, who were often found intellectually inadequate to get into the highly competetive and prestigious clinical disciplines, or even the paraclinical disciplines. This gave enough opportunities to the threatened foreign trained super specialists to ridicule the entire discipline of preventive and social medicine and bring it down almost to the bottom of the prestige heirarchy of disciplines in a medical college[17]. Significantly, the political leadership —the ministers and legislators, who are beholden to these super specialists for their personel needs of various kinds, winked at this systematic desecration of the philosphy of social orientatien of medical education in the country [18].

Along with the very rapid proliferation of very expensive teaching hospitals for medical colleges, each having a number of specialities and super specialities, a number of general hospitals were established in urban areas. The number of hospital beds shot up from 113,000 in 1946 [15, p. 72]. to the present figure of 330,000 [19, p. 34]. There has also been a rapid increase in the number of dispensaries for providing curtive services to urban populations. There were over 1807 urban dispensaries in 1966 [10, p. 120]. The development of medical colleges, teaching hospitals and other hospitals and medical care facilities has accounted for a large chunk of the investment for health services in the country's Five Year Plans [5, p. 76, 14, p. 18]. The recurring cost for these institutions accounts for over three fourths of the annual health budget of a State [11, p. 5].

Mass Campaigns against some major Health Hazards :

The fact that despite their obvious over-riding importance, preventive services have received a much lower priority in the development of the health service system of India provides an insight into the value system of the colonels of the Indian Medical Service, the British trained bureaucrats of the Indian Civil Service and, above all, the value system of the political leadership of free India. The colonels did not appear to relish the prospects of dirtying their hands—getting involved in problems which required mobilisation of vast masses of people living in rural areas. The rural population raised in the minds of these decision makers the spectre of difficult accessibility. dust and superstitious, ignornt, ill-manered and illiterate people. Therefore, when they were impelled to do some preventive work in rural areas, characteristically, they chose to launch military style campaignr against some specific health problems.

Undoubtedly, because of the enormous devastation caused by malaria till the early fifties. this disease deserved a very high priority. But the programme became a special favourite of the colonels not only because it required relatively much less community mobilisation, but it also provided them with an opportunity to build up an administrative frame work to launch an all out assault on the disease in a military style—in developing preparatory attack, consolidation and maintenance phases, in having " unity of command ", and surprise checks and inspections and in having authority to " hire and fire ". Significantly, some of the followers of the colonels went so far as to compare the malaria campaign with a military campaign [12]. Another enthusiast for military methods has written an entire book [13] with a preface from the late Prime Minister Jawaharlal Nehru describing of the growth of the health services in independent India as if he is describing a military campaign.

Experience of implemenation of India's National Tuberculosis Programme brings sharply into focus the limitations of this military approach to developing a health service system for the people of this country. On the basis of a series of operational research studies [14], it was demonstrated that it is possible to offer facilities for diagnosis and treatment to over a million and a half of sputum positive cases who are known to be actively seeking help for their illness from over 12,000 to 15,000 health institutions in various parts of the country. But because of failure of the programme administrators to develop a sound health delivery system on a permanent basis for the rural populations of the country, more than a decade after the launching of the programme, less than one fifth of these sputum positive cases, who have an active felt need, are being dealt with by thc programme organisation [14]. This provides an example as to how the militaristic urban privileged class value system has come in the way of building a health service system to meet even some of the very urgently felt needs of the people of the country.

After some pilot projects, a National Malaria Control Programme was launched with the help of the United States Technical Co-operation Mission, the World Health Organisation and the United Nations International Children's Emergency Fund (UNICEF) in 1953 to cover all the malarious areas of the country, then involving a population of 165 million [13, p. 111]. It achieved a phenominal success; for instance, the number of malaria cases for every 100 persons visiting hospitals or dispensaries declined from 10.2 percent in 1953–1954 to 4.0 percent in 1958–1959 [13, p. 112]. This success emboldened the administrators to think in terms of totally eradicating the disease from the country, once and for all. The danger of the mosquitos developing resistance to the main weapon for malaira

control, DDT, was given as additional reason for embraking on the eradication programme. Besides, pressure was also put on India by foreign consultants from WHO and elsewhere to embark on the eradication programme as it was to become a part of the global strategy propounded by the WHO [13, p. 1].

It was also stated, to give economic grounds for the decision, that while the control programme was estimated to cost about Rs. 270m in the second Five Year Plan (1956-1957 and 1960-1961) and Rs. 350m during the Third Plan (1961-1962 and 1966-1967) and thereafter continued to remain a heavy item of expenditure, " the cost for the eradication programme was estimated to be Rs. 430m in the last three years of the Second Plan and Rs. 580m for the entire Third Plan with the annual expenditure becoming negligible thereafter " [13, p. 113]. The immediate successes of the National Malaria Eradication programme were even more spectacular, but a disastrous snag developed in implementing the maintenance phase of the programme [15, pp. 4-6]. It turned out that among other factors, because of preoccupation of the administrators with specialised mass campaigns against malaria and other communicable diseases, they had not paid adequate attention to building a permanent health service system— the so-called health infrastructure— strong enough to carry on the malaria surveillanee work effectively at the village level. This has been responsible for a series of setbacks to the National Malaria Eradication Programme, resulting in the reversion, at a very considerable cost, of large segments of the maintenance phase population on to consoldation or attack phases. Instead of getting rid of malaria once and for all by 1966, as it was envisaged in the late fifties, 40 per cent of the population is still to reach the maintenance phase [15, p. 5]. The National Malaria Eradication Programme thus continues to drain huge quantities of scarce resources even today thus making it even more difficult to find resources to develop the health services infrastructure.

During the last four years, for instance, less than 3 percent of the additional population (9.4 units) has entered the maintenance phase [15, p. 5]. Meanwhile the country is forced to set aside huge chunks of its very scarce recources to prevent the programme from sliding still further. As against the envisaged expenditure of Rs. 1,015 m, the National Malaria Eradication Programme has thus far sucked in over Rs. 2,500 m, [16, p. 225 and 20]. In addition, Rs. 967m have been set aside for it for the next five years [15, p. 23-24] and even this allocation might have to be raised still further. In spite of this the chances of eradicating malaria in the foreseable future does not appear to be very bright. So the country will be compelled to keep on pouring in resources on this programme to see that the disease does not come back in an epidemic form as it has happened in some other countries.

Also, following the model of the NMEP, a specialised military style campaign was launched in 1963 to eradicate smalipox within three years [13, p. 130]. Once again the campaign conspicuously failed to achieve the result of eradication. Only recently (1973–74) yet another campaign has been launched to eradicate smallpox " once and for all " [15 pp. 31-38]. A mass campaign to providc BCG vaccination to cover the entire population of the country, and to continue to do so periodically, was the first effort to deal with the problem of tuberculosis in India as a public health problem [15 pp. 120121]. This programme, unfortunately, also failed to yield the desired results [21]. Special compaigns have also been launched against leprosy, filariasis, trachoma and cholera with even morc discouraging results [15 pp. 61106].

The health service system of the country had hardly recovered from the consequences of the very eostly failures of the mass campaigns against malaria, smallpox, leprosy, filaria and trachoma, when a large bulk of investment in health was cornered by another specialised campaign– this time it was against the rapidly rising population of the country. The Fourth Plan investment in family planning was Rs. 3,150m as against Rs. 4,500m for the rest of the health sector of the country [2, p. 11]. This involved deployment of an army of 125,000 persons [2. p. 15]. All of them were specially earmarked for doing family planning work only. Significantly, once again, this programme was also developed by officers belonging to the Indian Medical Service— the colonels, with strong backing from foreign consultants from various agencies. Predictably, once again, this compaign also failed to attain the demographic objectives, with disastrous consequences, both to the programmes for socioeconomic development as well as to the development of a sound infrastructure of health services for the country [2, pp. 222-224, 17].

Recognising, at long last, the weaknesses of this campaign approach, recently the Government of India has veered round the idea of providing an integrated package of health, family planning and nutrition services with particular emphasis on the weaker sections of the community [18, p. 184]. This package in turn, is a part of a bigger package of thc Minimum Needs Programmes of the Fifth Five Year Plan (1974–1979) which is meant to deal with some of the very urgent social and economic needs of the rural populations of the country [29, Pp. 87-91].

Development of a Permanent Integrated Health Service System for Rural Areas :

The Health Survey and Development Committee[16], which was set up by the British Indian Government in 1943 to draw a blueprint of health services for the post-war British India, had shown exceptional vision and courage to make some very bold recommendations. These included development of an elaborate health service system for the country, giving key importance to preventive aspects with the "countryside as the focal point" [6, p. 6]. To forestall any criticism of the recommendations on grounds of practicability, pointing out the achievements in health in the Soviet Union within a span of 28 years (1913-1941), it asserted that its recommendations are quite practical, in fact relatively very modest, provided there was the will to develop the health services of the country [6, p. 10]. Unfortunately, however, the leaders who took over from the British did not show this will. They had quoted, often out of context, the recommendations of the Bhore Committee to justify abolition of the licenciate course and to establish a very large number of medical colleges with sophisticated teaching hospitals in urban areas. They also invoked the Bhore Committee to justify to setting up an even more sophisticated All India Institute of Medical Sciences in New Delhi on the model of the Johns Hopkins Medical Center of the U.S.A. [5, p. 322]. A number of other postgraduate centres for medical education were also set up in due course. It, however, took them over seven years even to start opening primary health centres to provide integrated curative and preventive services to rural populations of the country [21]. These primary health centres were a very far cry from what was suggested by the Bhore Committee; they did not have even a fourth of "the irreducible minimum requirements" of staff recommended by the Bhore Committee for a given population (and that too only as a short term measure) [16, p. 11]. Furthermore, it took more than 10 years to cover the rural populations in the country even with this manifestly rudimentary and grossly inadequate type of primary health centres.

The entry of the National Malaria Eradication Programme into the maintenance phase and concurrent development of an extension approach to family planning provided a transient impetus to providing integrated health and family planning services through multipurpose male and female workers [21]. But the clash of interests of the malaria and the family planning programmes again led to the formation of unipurpose workers for malaria and family planning [22]. What was even worse, application of very intensive pressure on various workers of primary health centres to attain family planning targets led to the neglect of whatever health services which were earlier being provided by the PHCs, thus causing a series of further setbacks to different health programmes [2, p. 40]. Maternal and child health services, malaria and smallpox eradication, environmental sanitation and control of other communicable diseases, such as tuberculosis, leprosy and trachoma, are examples of the services which suffered as a result of preoccupation of health workers with achieving the prescribed family planning targets.

Very recently, following the recognition of the fact that a unipurpose, high pressure military type campaign approach which does not ensure a concurrent growth and development of other segments of health and nutrition services (and, growth and development in other socioeconomic fields) will not be able to yield the desired results, as pointed out above, decisions have already been taken to integrate malaria, family planning, maternal and child health, smallpox and some other programmes and thus provide an entire package of health, family planning and nutrition services to the community through male and female multipurpose health workers [18, 19].

The Indian Systems of Medical Services In India

There are three major indigenous systems of medicine in India : Ayurveda—the Hindu medical system; Unani—the Greek system of medicine which was brought to India from West Asia by the Muslim rulers of India; and the Siddha system, which can be considered to be a specialised branch of Ayurveda. After Independence, these systems were subjected to two contradictory pulls : their being firmly rooted in the culture of the people of the country for centuries and their rich heritage invoked considerable admiration and even certain degree of emotional attachment from a large section of the population of the country. And, at the same time, long neglect of these systems of medicine led to a very sharp deterioration in the body of knowledge. in their institutions for training and research, in their pharmacopia and drug industry and in their corps of practitioners. Therefore, while the leaders of independent India built almost the entire health services on the lines of western system, they have from the very beginning, shown sympathy for the Indian systems of medicine and have made available some grants for conducting research in these systems, for supporting educational institutions and for providing some services to the community [23].

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Dear Friend,

We have received very encouraging responses from the friends to the January – February issue of MFC Bulletin. **Tejpal Jindal** from Sevagram writes, " being the first issue it was beyond expectation. What I liked most was that the articles can be either in English or Hindi. " Appreciating the editorial he perticularly emphasises, " ....Seeing the attitude of young medicos, we are left with no measure but drastic and revolutionary changes. " He also suggests that " there must be compulsory Rural Area Service for three years after internship and then only MBBS degree should be assigned to them. "

The letter from **Shri Bapalal Vaidya,** an eminent authority, in Ayurveda, communicates a sense of agony " the people need to be liberated from the grip of doctors and medicines. But who will do it ? " He appreciates the efforts of MFC in this direction. Refering to the article by D.Banerji, ' History of Health Services in India ' he points out that Charak (First century A. D.) and Susruta (Fourth century A. D.) are revisions of earlier works. Charak Samhita is based on the discources delivered by Punarvasu Atreya to his talented disciple Agnivesh in 6th century B. C. Similarly the Susruta Samhita is also based on an earlier work, the Buddha Susruta Tantra dated 6th century B.C., Nagarjun, a Buddhist scholor, later revised the original work. For further information Gujarati readers may refer to his book *' Charakno Swadhyay '* Part I (Oriental Institute, Vadodara). He adds, " Alopathy with its heavy emphasis on curative medicine almost ignores Preventive Medicine. The students in India should be taught about *Dincharya* and *Rutucharya,* and other preventive aspects of Ayurveda. Ayurvedic education too needs to be changed but unfortunately the vaidyas are helpless as the management is in the hands of Indian Medical Council. "

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Book Review

A Rush for Alternatives

A gradual shift to community oriented health services is quite obvious from the current literature on health and an attempt to evolve an alternative approach is becoming the order of the day. While the trend is welcome, it has to be analysed with caution because at times the cry for comprehension and community either tends to become more of a slogan rather than a well thought of answer to the prevailing problems or is intended to contain an explosive situation as far as possible. Some of the current publications of the WHO and the UN make an interesting study in this context. These are :

1. Alternative approaches to meeting basic health needs of populations in developing countries, WHO
2. Health by the People, WHO
3. What Now (The 1975 Dag Hammarskjold Report)

Of these, the first is a record of the 20th Session of UNICEF–WHO Joint Committee on health policy. The second edited by Newell is a review of certain health plans adopted by different developing countries and the third a document discussing certain broader issues of the contemporary world.

The first document which starts with demands of " revolutionary changes " and " radical reforms " quickly takes shelter under the safety of neutrality and hopes that " inspite of the magnitude and gravity of the problem and the widespread poverty, ignorance and lack of resources, much can be done to improve the health of the people in the developing world. " Newell, however. has taken greater pains to look into the complexity of the problem. He explores the inter-relationships between health and total development of a " comprehensive approach. " It is for this purpose that he receives various experiments in the field of health which were accompanied by a broader developmental process (the degree and extent of which varied in each case). The common feature of these experiments which impressed him most was the wider goal which most of them adopted. " Total development is their objective and in the process of achieving it, communities found means and ways of providing health care to people ". Newell finds this shift from achievement of health as an end in itself, to its being a part of a process of change, very welcome. However, he does not go into the problems relating development in these experiments and prefers to end up by saying, " there are many roads to success. " While both Newell as well as the participants of the 20th session of the WHO join hands in applauding the experiments, Newell's retreat is much sadder.

This is because, the participants of the 20th session do not even make an effort to look into the issues of social and political systems and their relevance to health, while Newell after having recognised the importance of national will and effort (which leads to redistribution of resources) in bringing about large scale overall changes over shorter periods of time, tends to treat all the three categories of experiments with equal enthusiasm and thus obscures the relevance of a variable he himself emphasised. He thereby not only undermines the relative importance of " wider development " essential for better health of the people (which cannot be optimum in a framework where health services alone are made the target for improvement like in Iran) but also ignores the fact that intensive efforts of comprehensive nature conducted by highly dedicated people even if they are consistant with national goals (like India and Indochina), may not necessarily be reproducible at the national level. This is not only because of the highly atypical inputs but also because of the fact that these experiments are conducted within a given socioeconomic system whose premises remain untouched. The moment that becomes a possibility the continuance of the experiment itself would be threatened. He also does not take note of the fact that time is an important factor which varies widely in all the three categories. All this is not to deny the possibility of " many roads to success " but to point out that one has to consider the feasibility as well as the limitations of these various paths.

As far as one agrees in principle with the concept of development which means " satisfaction of needs the poor who constitutes the worlds majority, at the same time, development to ensure the humanisation of man by the satisfaction of his needs for expression, creativity, conviviality and for deciding his own destiny, " there is no reason why health workers may not spell out the kind of societal framework which makes this objective attainable. Once that is done any of the " many roads " may be taken depending upon the reality of the situation and the preferences of the people. By saying therefore, that " the forces that bring about political change are beyond the scope of this discussion ", Newell cannot get away from the responsibility of emphasising the need for such a change. A counter–arguement to this stand is Illich's proposition that it is only through a better understanding of these forces and their influence on health that we can make health services one of the instruments for change.

Another fact that Newell does not realise is, that rejection of political systems of those countries which have succeeded in bringing about major changes in their economic and social base, should not necessarily mean automatic acceptance of the constraints of other political systems. In other words, it is not simply a question of rural development being possible " if one goes about it in an acceptable way ", but of an acceptable political system for rural and overall development. It is because of this contradiction that except China, Cuba and Tanzania (to some extent) none of the other quoted experiments have been able limit either the expenditure on proportionately smaller urban populations or the development of two unequal types of health services within these countries. It is in this respect that the 3rd document (the Dag Hammarskjold report) stands out distinctly both in its lucid analysis as well as its alternative (however, idealistic it might be) to the existing political, social and economic balances.

The attempt of the first two documents to look for alternatives also suffers from certain conceptual, methodological and analytical weaknesses. The basic confusion that creeps into the concept of " primary health care " is due to a lack of distinction between " Basic Health Needs " and " simplified health services. " The result is a premature applause for the later and conclusions like " simple primary health care works ", without actually demonstrating their effectiveness by keeping the non-medical developmental inputs constant (like availability of food, sanitation and increased productivity). This is true for all projects except for Iran where although the project has no inbuilt non health inputs (excluding water and sanitation) but due to the sudden increase in Petrodollars there has been some trickle down effect in the economy resulting in some degree of economic relief in the rural areas. Again, this is not to in any way discredit the efforts to make health services simple and widely available but to point out that their impact is intimately related to the state of availability of other basic facilities to people and that they have to be optimised within the total developmental program . A point which again the Dag Hammarskjold report very clearly makes.

This brings as to the methodological question of what processes these various projects adopted to arrive at the chosen health care delivery system and was the system optimised ? Unfortunately none of the case studies elaborate on this issue. Inspite of impressing the need not to further elaborate on " health services as they are now organised but rather on new ways of identifying basic health needs and of providing simple health measures " both groups of evaluators gloss over this inadequacy of the project reports. In this respect the most that we get is the information that in Cuba and Venezuela good care was taken to make use of epidemiological data while formulating health care programmes and periodic review were made to fix the quality and norms of care but there is no mention of any of the details of these processes. This defeats the purpose for which the whole exercise was meant that is, of evolving an optimum health care delivery system within various kinds of developmental strategies, formulated in different political settings. One, therefore, cannot get away from the responsibility just by saying that " there appears to be no good reason why the world should wait for the answers to be prettily packaged and persecuted ". This may be an impatient optimist's view but is certainly not scientific.

The case studies are further handicapped by the absence of any data pertaining to the indices which might have helped the reader in assessing the impact of these programmes.

Another problem that has not been pointed out by the evaluators is the fact that although most projects have attempted to develop a grass-root worker and some kind of infrastructure to provide curative and preventive services, most of them primarily talk about curative aspects only. While it is true that to begin any kind of total health care programme curative services are essential, it does not exclude the possibility of an interwoven on running programme of public health, Such an approach is not apparent at least in the on going programmes in Niger, Nigeria, Gautemala and even Tanzania. While they all mention communicable disease prevention, immunisation and MCH services, the extent of coverage and continuity of these programmes is not clear.

One, therefore, wonders as to why these projects have been picked up as case studies, as they neither demonstrate optimum resources utilisation nor are they examples of proven effective health care systems. If the idea was to emphasise the importance of total development or variety in health services on hope in the future, then health services of any country could have made the point (even by their failure). However, if the purpose was to develop an optimum alternative, then we have not picked up all the right examples nor gathered relevant information about them.

--IMRANA QADEER (J.N.U. New Delhi)

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COMH 9.3

NEED FOR SETS OF CONCEPTS IN HEALTH SERVICES RESEARCH

A. Health problems and health status

1. What is a case? An episode of illness? A health behaviour event?
2. What is meant by the "general level of health" of individuals and populations?
3. Does "health status" include sets of concepts concerning information and knowledge of health, illness, and of courses of action?
4. Does the "general level of health" include interference with daily activities due to health problems?
5. What are the relationships between the foregoing sets of concepts?
6. Do the above sets of concepts provide an adequate base for concepts to indicate needs for health care and do they contribute to the need for descriptions of lay and professional expectations of care?

Use of medical services

1. The set of concepts concerning the use of health services is multidimensional.
2. Points of entry into the health care system and flow through the system need to be conceptualised.
3. Sets of concepts for describing the content of the transactions between health personnel and lay populations may be aided by distinguishing between health maintaining, illness defining, and sick role behaviour.
4. Both health personnel and the consumers of health care react at cognitive, instrumental, and affective levels.
5. Lay and professional perceptions of some key attributes of health care interactions may be significant for health planning and manpower studies.
6. There is need for concepts which connect the five dimensions to utilization of health services given above.

C. Outcomes of episodes of illness and of health events

1. Particular and current emphases are on concepts of the presence or absence of disease, degree of interference with daily activities and disability, extent of discomfort or distress, and the degree of satisfaction or dissatisfaction with the outcome of illness episodes and health behaviour events.
2. Current emphases need to have sets of concepts which incorporate lay and professional medical assessments, particularly changes in the clinical signs of illness and sickness.
3. Finally, there is need for concepts to denote changes in levels of health knowledge and information.

D. Other personal, family and group attributes

1. Concepts of various components of social structure, both micro- and macro-cosmically considered, are important dimensions to the behaviour of both lay populations and health personnel.
2. All papers stress the need for concepts to describe the components of cultural systems.
3. Concepts for considering socialization processes are discussed by several authors. Past experience with health problems and health maintaining behaviour may be considered socialization processes.
4. The loci of decision-making processes involve responses to symptoms of illness and choices from among alternative sub-systems of health care.
5. The need for concepts to describe communication processes and styles is implicit in all papers.
6. Sets of concepts to denote economic and demographic information apply to both lay populations and the providers of health care.
7. To what extent do the groups of concepts discussed thus far - episodes of illness and other health events, the use of health services, outcome and the preceding attributes - contribute to the development of sets of concepts like vulnerability, susceptibility, predisposisions, and risk factors?

E. Environmental influences

1. Concepts which denote and describe the system of health and medical care.
2. General social characteristics, particularly social and cultural change in the present era.
3. Concepts are needed to describe the demographic structure of populations and of families.
4. Sets of concepts are needed to denote the nature and extent of environmental hazards to health.
5. Attributes of the economy need standardized sets of concepts.
6. Concepts of geographic phenomena are implicit in all of the papers, but the need for such concepts must be made explicit.
7. To what extent may environmental attributes, and the others outlined above, be considered enabling or hindering factors in the achievement of health goals?

PAPER. I.

HEALTH SERVICES IN INDIA: An Introspection

- Abhay Bang

(Working paper presented for the 4th All India Conference of Medico Friend Circle, at Ramanatakara, Kerala on December 29th, 30th and 31st, 1977)

All is not well with the medical profession and health services. Ivan Illich in his book 'Medical Nemesis' questions the contribution of the medical profession and practice to the health of the society.

What stand should we take? Should we continue to be self-hypnotised and fully contented about our profession, harping on its 'Noble' role of service to the humanity?

Or should we do some honest and critical introspection about our real situation and our utility to the society? Such an introspection may endanger our pride and content about our profession. Are we prepared to run that risk?

A. Criteria for Judgement:

What should be the criteria for judging the performance of medical profession?

- Is the art and science of medicine an absolute end in itself?
- Or it should be looked at as an activity delegated to a profession by the society for the service of the society?

This question can probably be better answered if we glance at where from the resources for flourishing of this profession come-

i) Educational privilege we enjoy in becoming a doctor

How many people get education?

- Only 30% are litrate

How many go to University?

- Only 3.2% of the population.

How many get a chance to acquire the most coveted education of today - The Medical Education

Only 0.02% of the population.

ii) Investment by the society in making a doctor:

Estimated to be about 1 lac Rs.

iii) Expenditure by the society for running the medical colleges, hospitals and research centres so as to provide working conditions to the doctors.

iv) Socio-economic status of the doctors in the society and the privileges we enjoy(Ref.No.1).

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It should be obvious that we, by way of our education and profession heavily draw resources from the society. In view of this social obligation, what should be the criteria to judge our performance?

- Utility to the society
- Or utility to further our personal as professional interests?

B. Targets for health Services:

What targets the health services in India should have achieved in the past 30 years of independance?

1) The constitution of India, in its directive principles, says, "The state shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties".

2) The first National Health Conference in China (1950) set an exemplary target in the following words-

" How far can a mother on foot carry her sick child in the heat of summer? That is the greatest distance the nearest health worker should be" .....

3) The Bhore committee in 1946 recommended following guidelines for planning and organising the health services in India-

- Preventive health work should be given more importance
- Rapid extension of health services in rural areas.
- Lack of ability to pay by an individual should not become an obstacle in getting him the required medical care.
- A net work of primary health centres be established.

C. Performance Judged:

Judged against these targets, what is the situation today?

1) Have the standards of Nutrition and Public Health been raised?

- Average Calory intake has gone down. Today it is 2000 calories/day which is far less than required, specially for working class, for whom the calory requirements are 3000 and 3900 for female and male respectively.
- Protein-Calory malnutrition, Vitamin.A. deficiency and Iron deficiency anaemia are still rampent in India.
- Tuberculosis, Leprosy, Filariasis, Malaria are still let loose on the masses.

2) Was preventive work given more importance?

- It is estimated that 60-70% of the health problems in India could be solved if safe water supply and

contd....3/-

system of excreta disposal could be provided to all the people Inspite of this, only 4% of the rural population gets piped water supply; 40% of the urban population and almost zero percent of the rural population is provided with excreta disposal system.

-Expenditure on curative services is 3 times that on the preventive services.

- In health services the preventive work is always neglected as it is dull, difficult and not immediately rewarding.

3. Was rapid extension of health services in rural area done?

- Even after accepting the recommendations of the Bhore Committee, it took 7 years to start the first P.H.C.
- There was no PHC in 38 blocks in Maharashtra till 1974.
- According to WHO Survey(197) rural India where 80% of the population lives and which contributes 75% to the national production receives only 25% share of the health services.
- 90% of the hospital beds are located in the cities and the towns, far from the rural population, which is more exposed to and more vulnerable to the pathogenic agents and hence requires health services more acutely.
- Few years ago the health Minister admitted in the Parliament that there were rural areas where there was no doctor within the distance of 50 miles (what is the distance the Mother on foot with the sick child can walk?) and for more than 1 lac of population, (Mudliar Committee recommended 1 doctor for 3500 population)

4. Was the PHC net work, which was to form the sheet anchor of rural health services, done full justice?

- Bhore committee recommended 1 PHC 10 to 20 thousand population, with each PHC having 3 doctors, 20 nurses 31 other assistants and a 75 bedded hospital.
- At present there is one PHC for 1 lac of population with two doctors, 8 ANM and 8 to 10 ill cared beds at each PHC.
- Very meagre budget for drugs and petrol. (Rs.2500/- and Rs.300/- per year per PHC in UP) with about 100 villages to be served.
- Gross apathy, inefficiency and insincerity in the staff working there.

5. Is money not the most important determinent to decide the standard of medical care a needy person will receive in our country?

a) Govt. health services are very meagre and far away from the needy persons, hence usually inaccessible.

- The budget for drugs for PHC is 2.5 to 10 paise/person/year i.e. grossly inadequate.
- Even out of this quota corruption snatches away a substancial portion.

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Can the poor people in villages get the required medical care from this system?

b) What about private sector? 60% of the total doctors in India work in private sector. But,

- Where do they usually settle, urban on rural area?
- How much malpractice do they do?
- Can the poorest man afford their fees and the cost of the drugs?
- Which class of people can afford to get admitted and treated in the private hospitals?

If this is the state of health services 30 years after the independance, how will you rate this performance against the targets expected to be achieved?

D. Relevance of present system of health services in India

In view of this miserable performance, a critical examination and radical rethinking is needed about our health services system. Are our Medical education, research and health care system relevant economically, socially and culturally to the Indian situation and needs? Or they are blind aping of the medical services in the developed Western countries, suitable only for the requirements of the upper class in India?

I) Medical Education:

i) Aim- What should be the aim of the medical education?

According to the WHO committee for South East Asia", the purpose of the medical education is not to produce Noble Prize winners but to provide doctors for health services who will meet the health needs of the country in which and for which they are trained."

ii) In this light, how much relevant our education is?

a) Conditions we are trained in and trained for
-Conditions we actually have to work in and work for

b) What emphasis is given during our education? More time is spent on cardiology or on diarrhoea & dehydration?

Cardiological diseases are responsible for 2% of deaths in India, while communicable diseases for 55% of the deaths.

Cardio-vascular disorders are predominent in which class? In which countries- developed or undeveloped! Has this something to do with excess of imprtance given to CVS diseases?

c) What type of diagnostic techniques and the methods of management we learn in our textbooks? Are these available and practicable every where in India, more so in the rural area? What adoptations we have made in our medical education to make it suitable for the working conditions and needs of rural India?

d) Which subject is given more importance? Medicine or Preventive and Social Medicine? What is the condition of the PSM departments in our medical colleges?

- The attitude of the students
- The attitude of the clinicians
- The attitude of the staff of the PSM dept. itself.

There was no department of PSM in the Post-graduate Institute, Chandigarh even 15 years after its inception.

Is all this consistant with the realities and the needs of the society?(Ref.No.2).

iii) Have medical institutions been given undue importance in our health planning as compared to our need for the type of health man power?

- After independance the number of medical colleges grew from a handful to 103. There are 13 medical colleges in Maharashtra(3 more than the recommended), Delhi has 4 as against recommended quota of one.

- Number of doctors has incfeased from 17,659 to 137,930
- About 3/4 of the health budget of the states is spent on these white elephants, called medical colleges.
- A big hue and cry was recently raised in Maharashtra for increasing the seats in the Medical Collges. To accommodate these new admissions, the Government has made additional allocation of crores of rupees.

a) What for and whom for these new doctors?

b) Where these doctors are likely to settle after their community-financed(1 lac Rs.each) education is finished?

c) Whether few highly trained doctors at such a colossal cost is the need of the society?

Or we require an army of basic health workers who are trained at low cost, who can be available to that 'Mother on foot', and who can manage routine health problems effectively?

iv) If the choice is between doctor and the auxillary-

a) A doctor:

- Usually comes from which class?
- Psychologically attached to which culture: urban or rural?
- Trained to work in which place: hospital or rural dispensary?

So when such a doctor is given the choice, what does he prefer?

- Migrating to USA or going to rural area?
- Can he identify with -rural culture and people?
- Is he effective in working in a rural dispensary? Are his skills fully utilised?

In summary, is today's doctor fit to work in the rural setting?

b) Auxillary:

1) A villager expects 3 qualities from his doctor: availability; friendliness and skill.

Out of these 3, on how many points auxillary scores over a doctor?

2) Are the skills of an auxillary adequate?

" An Auxillary can treat 90% of children's sicknesses"- Rural health Research Centre, Narangwal

" I am convinced that in any field of health technology, it has been shown that with only 2-3% of conventional medical technology, we could arrive at 90% of necessary quality care".

- Mahler Halfman (Director General, WHO)

3) 31 countries are using auxillaries for providing primary medical care.

Inspite of these facts, the present ratio of doctor to Nurse in India is 10:4 which results in wastage of extrevagant skills of doctor at the cost of paucity of auxil aries. In Sweeden, the ratio is 1:3, which is an ideal one.

v) On this background, what do you think about the Raj Narayan Scheme of training of health workers?

- What are its good points?
- What are its drawbacks?

2) Rdsearch:

- What should be our research priorities?
  - Communicable diseases
  - Nutrition
  - Degenerrative diseases
  - Metabolic disorders
  - Fertility and its control
  - Cardio-vascular diseases

- On which topics usually our academicians (at the expenses of the society) concentrate and publish their research?

- What this disparity?
  - Craving to get personal recognition in Western journals.

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-Cultural slavery of the West (Ref.No.3)

-Unawareness of the needs of India

-Lack of feeling of responsibility and accountability to the society.

Gunnar Myrdal Comments in the challege of world 'Poverty' ....." .. The young intellectuals in India and in most of the non-communist under developed world have been so conditioned by the rigid elite and class structure in which they have been brought up that they do not feel that deep indentification with the poor in their nation.... They do not feel it when in some countries they are radically indoctrinated. This is merely one example of the destructive influence of the fortified class society inherited from the Colonial era."

- In China all University teachers have to spend one year in every three years in the rural area. Can such measure solve the problem of ivory tower research workers?

3) Health Care Service:

The present set up of health care services is based on -Hospitals, PHC and private practitioners.

i) Hospitals: With specialised, well equipped services

- Capital intensive or labour intensive?
- Curative or preventive in nature?
- Where situated?
- How much available and accessible to all people?
- Can we provide this type and standard of medical care for the whole country?
- If not, why this disparity that big hospitals for cities and (with result) no services in the villages?

Is this pattern relevant to our needs?

Jolley and King estimated the cost of treatment per illness at various levels of services as follows:-

Health Centre	...	4 Shillings
Dist. Hospital	....	84 "
Regional Hospital	...	170 "
National Hospital	...	370 "

Due to this raised cost of medical care at hospital, we are able to reach fewer and fewer people and inturn deprive more and more people. This is especially true about socio-economically poor people (60%) of the population). This raises a question- For whom are we responsible? Are we responsible to those who do not reach or can not rea-ch the hospitals? Those who are in grea-test need can not reach the hospitals.

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ii) P.H.C. Its condition we have already examined.

-Does this miserable condition of PHC services(less than 1/4 of the irreducible minmum of Bhore Committee) reflect the level of concern of policy makers and executives for the health of rural poors?

- Can the superstructure of hospitals be effectively and economically utilised without efficient and widespread infrastructure of PHC?

Then where should we first concentrate our limited resources?

iii) General Practitioners:

- Mal distribution: rural- urban
- Cost of treatment
- Attitudes and aims of practice and malpractice.

iv) What approach we need?

a) Aim of the health care should be:

- To make people more and more dependent on medical aid
- To prevent occurrence of the disease and to educate th be self reliant?

b) Then what approach do we need on the following points?

i) Beneficiarics of the care

ii) Priorities of the health programmes

iii) Pattern of health care delivery system and priorities.

iv) Type of manpower

v) Utilisation of non allopathy practitioners? (There are 1,09,504 Homeopathy, 14,000 Siddha, 18,000 Unani, 1,50,000/- trained Ayurvedic and 2,50,000 traditional practitioners in India. On this manpower be utilised after some training?

An effort was done by the Govt. of India to use them(Peasant's doctor) by authorising their practice. What happened to it? What was the reaction of IMA ? Why?

vi) Drug industry.

E) Root causes of irrelevance of present Health Services:

Following incidences should enlighten us:

1) Then Prime Minister Mrs. Indira Gandhi said that India needed such health services which would be cheap and would reach the rural masses. This she said while inaugurating 'Jaslok Hospital in Bombay

Why this disparity between speech and deed?

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Com H 9.5

GENERAL APPROACH TO RURAL COMMUNITY HEALTH SERVICES.

Fundamentally, the health services have to be viewed in the context of overall integrated development of the villages. Health services cannot be fully successful if they are pursued in isolation from the general development activities of the area.

The community health services must be area basedand population based -- providing the total spectrum of health services to the total populace living in a defined geographic area. Primary health care must be available at the doorstep of the receipients.

1. Area Coverage -- Regionalization:

We must accept responsibilities to provide health coverage to the population of a defined area.

Selection criteria of the Area:

A) Need- Poverty and illiteracy
high incidence of diseases
non-availability of health services.

B) Suitability:

- The area should not be too far nor should the area be too near to ~~Patna~~ the city -- then the people will be visiting ~~Patna~~ the city for their health needs.
- Assurance by the community for full cooperation and help.

How ? for example:

i) If there is an already existing useful organisation that can provide us useful assistance.

ii) If the village is well united and there is an effectiv panchayat.

iii) If the village has,or is willing to immediately start, a Village Health Committee, which could help us in several ways, acting as an effective linke between the health workers and the villagers.Such a health committe should preferably be considered a specialized organ of the panchayat unless the panchayat is divided and ineffective. Then the Village Health Committee can be an independent institution.But it must enjoy the confidence of the entire village population.

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iv) If the villagers are willing to contribute their share by:

1. Agreeing to pay a small insurance charge
2. Agreeting to do Shramdan for some health projects
3. Agreeing to contribute volunteers that will help run the health programme.

v) If some data is already available about that area due to previous or on-going survey etc.either in connection with a health programme or as a part of general development activities.

2. Total Population Coverage:

The whole population must be covered.

Priorities: The weak and the vulnerable: children below 6
Expectant mothers
Nursing mothers

Promotion of health and prevention of disease.

Nutrition,Sanitation,Immunisations & Health Education

Adequate simple records.

3. "Health Insurance" Every body pays.

There may be a graded scale,depending upon the economic status.

Advantages: Greater interest taken by the community

Greater community participation

People feel they own the programme--and it is their (as indeed it always should be).

People who pay can also ask for good services, and who can complain if the services are not good.

Keeping accounts develops the idea of accountability

~~Getting things free is a wrong habit~~.

People do not value the treatment that is given free They may even throw away expensive drugs,thinking them worthless.

Getting things free is not a good habit.It should be discouraged.

Some people consider it ethically wrong to give or take things free.

There is no such thing as FREE. ~~medicines~~.If the villagers are not paying for it,somebody else must be paying for it.

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4. The National Context and Constraints:

Ours is a poor country.

Our health services should be affordable on a countrywide basis, perhaps adding upto a few rupees per head per year.

It is no use creating an IDEAL or achieving "excellence", which cannot be copied on a large scale.

We must keep in mind the replicability of our health services. We should be able to demonstrate a pattern of health care which is practicable and effective- not after 50 years, but for the next 5 year plan.

Thus our efforts should have national relevance. We have wasted our opportunity if our health services and experience cannot be multiplied and does not have any relevance for the creation of effective health services on a country-wide basis.

5. Coordination with the State health orgnisation.

Health is a State subject.

We should avoid dual control or parallel and competing health services. We should have a clear understanding with the State health Ministry and the District Chief Medical Officer. We should clearly define our respective roles and establish clear channels of communications and cooperation.

Broadly, our plan for community health services should follow the state pattern. We can fill in the lacunae and strengthen weak links, but we should not drastically after the overall health plan or health strategy. Otherwise we again face the risk of wasting our opportunity and losing all relevance.

6. Utilisation of Existing community Resources:

They include:

Indigenous and homeopathic practitioners
Ordinary simple home remedies
The common lore and grandmas recipes, Yoga.

Health practices of our people, such as personal cleanliness, boiling of milk, breastfeeding of children self reliance etc.

Local educated young men and women, including teachers, post-man etc that can be roped in for various types of "help" that comes to villages.

We must never allow atrophy of local leadership and initiative and fostering an attitude of dependance and passive acceptance. We must guard against the tendancy to pull poeple up by their ears, instea of encouraging them to pull themselves up by their boots-straps. We should resist all well intentioned effort to spoonfeed the people.

Instead, we should encourage local leadership, local initiative and self reliance. At a practical level, we should select suitable educated young men and women from the villages themselves, and train them as health workers. We should also involve the community in all health work, right from the stage of planning onwards.

9. Community Participation:

A community should consider the health services as their own. Community participation is the sine qua non of any successful community programme. This is one reason why the community must pay for its health services partly, if not wholly.

The community must be involved in all stages of the community health programme, including decision making.

Important areas of community participation:

Planning
Financial contributions
Selection of workers from the community
Evaluation of their work.

Village Health Committees can play a very useful role here, as already mentioned.

10. Special Role of Health Education.

Health education is essential in a democratic set-up in order to elicit the willing and enlightened cooperation of the people

It increases peoples competence to look after their own health, thus fostering self-reliance.

It helps people take greater interest in their health services.

It helps people identify incompetent workers or incorrect measures.

Everybody is interested in the working of his/her body, and in health. They will pay attention if health education is imaginatively carried out, using for example puppet shows, one act plays, practical demonstrations, mobile exhibitions, etc.

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The following topics should be covered:

First-aid
Simple nursing
Body knowledge
Yoga
Personal hygiene
Balanced diet.
Some simple preventive measures etc.

11. Phasing and Pilot projects:

We should start with a small area or start with only a few services or both.

We should expand and multiply health ~~servers~~ services as we gain more:

insight
experience
confidence
acceptability
efficiency.

10. Essential Steps:

To Implement the Community Health Programme.

Objective: To create comprehensive integrated community health services for the total population of defined rural areas, with emphasi on vulnerable groups and on prevention.

Such a service should be made available on a regional basis, alongwith effective referral facilities.

Summary of Steps:

1. A managing committee ~~of overall~~ For the Jayaprabha Hospital, ~~Research Centre and~~ Community Health Programme should be established.
2. Constituting a "Planning and Implementation" Committee for the Community Health programme. (if necessary)
3. Selection of suitable area or areas of work. Selection criteria already mentioned in the general approach.

....6/-

4. To study the area(s) to define its problems and assets.

Surveys: This will involve planning and conduction of surveys covering the following variables:

Demographic

Socio-economic

Health - Existing problems
- Existing facilities.

5. Planning:

Preparation of preliminary plan

Discussions

Readjustments

Finalization of the broad plan.

6. Implementation:

Selection and training of workers

Building and furnishing of hospitals, health centres et

Phased beginning of health services.

7. Records-- should receive special attention.

8. Evaluation of Community health services -- both concurrent and terminal. This should help better planning:

Planning

Programming

Administration

Evaluation.

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(Voluntary Health Cell)

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GUIDELINES FOR DEVELOPING ALTERNATIVE MODELS FOR DELIVERY OF HEALTH CARE

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In India, even before the attainment of independence the government was concerned with the problem of providing adequate health services to its population. In order to survey health conditions and health organizations and to make recommendations for future developments of health servi[illegible]e Health Survey and Development Committee (Bhore Committee) was set up in British India in the year 1943. The recommendations of this committee contained in their report of 1946, provided the blueprint for the development and implementation of health services in post-independent India. Of the several aspects of health services organization that this Committee deliberated upon, the more important ones were the following:

1. The need to cut down the preventable morbidity which was estimated by the Committee to be about 50 per cent.
2. The need to correct the imbalances between the rural and urban areas in terms of health facilities and health manpower.
3. The need to provide medical relief and preventive care to the vast rural population of the country.
4. The need to recognise the importance of social, cultural and environmental factors in the preservation of health.
5. The need to develop a philosophy of self-help and cooperative endeavour among people to improve their own health and maintain a healthful environment through widespread health education and increase in general education.
6. The need to shift the emphasis of the health services from a predominantly curative approach to one with sufficient emphasis on prevention and promotion.
7. The need to review the problem of health in the broader perspective of development and its social and economic correlates.
8. The need to provide adequate health protection to all, covering both its curative and preventive aspects irrespective of their ability to pay for it.
9. The importance of social factors such as unemployment, poverty and social customs like purdah and early marriage in ill health.

Considering the fact that it is over 31 years since the Bhore Committee submitted its report and that India attained independence from colonial rule over 20 years ago, the present development of health services obviously is very inadequate and insufficient, both in terms of quality and quantity. A somewhat over-simplistic view of the development of health services tends to look upon it in a fragmented fashion either in terms of increasing the number of doctors and the concomitant increase in the number of medical colleges or in terms of increase in the number of hospitals and dispensaries. The more basic problem and challenge in providing the health services to the growing population of India in relation to the felt need of different populations and sub-cultural groups within the country has not received sufficient attention. Even now, despite sufficient increase in the health budget in the different Five Year plans there are vast areas in the country where even the most rudimentary form of health care is not available. Any plan to provide health care to Indian communities has to reckon with a few basic realities of Indian social life. Prominent among these are the large number of people who are extremely poor and are described as below the poverty line (their numbers are estimated to be 40

per cent of the population), progressively decreasing male female ratio as revealed through the decennial census primarily because of hazards of maternity faced by Indian women (932 women for 1000 men), an exaggeratedly high infant and child mortality; the wide range of preventible sickness to which people succumb; vast illiteracy, especially of females; (even in 1971 census female literacy was only 21 per cent and rural female literacy was only 15 per cent) relative neglect of girls and women The National Committee on status of women has quoted figures to show that women use health services less than men, despite sickness); presence of vulnerable groups who need particular attention in the health organisations -women in child-bearing years and children below five years; the peculiar age-pyramid .h 42 per cent of the population below 14 years; traditional and culturally rooted beliefs on etiology, spread and cure of diseases; existence of and belief in traditional healers, folk medicine and indigenous medical practitioners; nearly 80per cent of Indian population residing in villages often in remote villages with poor or no communications and other modernising forces. A subtle qualitative dimension is the unwillingness of the urban trained doctors to serve in rural areas and the unwillingness of the rural folk to use the existing primary health centres (PHCS) and sub-centres. While some have placed the blame on the attitudes of health personnel, others have placed the blame on the faith of rural folk in traditional indigenous medicines. It is, however, true that the rural folk, the poor and urban slums have relatively little access to health services. Paradoxically enough, these are the very people who are in need of health care.

In the light of these social, cultural, economic and demographic realities, the existing system of health care delivery is not relevant for the country with its vast and varied health problems. The apparent expansion of medical colleges, training institutions for other categories of health personnel and number of hospitals and dispensaries with increasing emphasis on super-specialities limit the use of the health care system to the urban elite only. It is a poor imitation of western models which are not suited to a developing country. The focus on personal health care based on the services of a large number of highly trained physicians and specialists is a capital intensive approach which primarily aims at curative rather than preventive medicine. This model is adequate for western countries where increased standards of living, higher literacy, nutrtion and sanitation have resultedin decreased mortality and morbidity rates and therefore the total thrust of the health care delivery system is on providing specialised services to individuals rather than extending general medical care and comprehensive health care to communities. The Western system, requires an expensive and extensive medical education system sophisticated equipment and literate population with some sophistication about disease and some faith in the medical profession. The only modification that developing countries have done so far while adopting the western models has been the inclusion of Health Assistants with a little training who essentially act as doctor-substitutes while most of the rural people still depend heavily upon indigenous healers. Even the Bhore committee, while outlining the duties of the primary unit staff suggested that Health Assistants should perform both curative and preventive duties of an elementary nature under the directions of a qualified medical officer. The spirit of these recommendations - specifically the role of the women Health Assistants in doing domiciliary visits to perform curative and preventive tasks-has not been reflected in the development of health services in India since the submission of Bhore Committee report. At the time of Bhore Committee report there were 47,500 doctors, while according to recent estimate, there will be 1,66,100 doctors in 1978-79. Ramaiah and Bhandari state that of these 11,000 allopathic doctors will be surplus. It is worth noting that the increase in number of medical colleges, doctors and hospitals and dispensaries during the last 30 years has not resulted insignificant improvements in the health status of the Indian population. Partly, this situation is due to the fact that health facilities are not the only things needed to keep people healthy. Social, economic and developmental factors affect health status. But no efforts have been made so far to make health planning a part of national planning. Consequently no action has been taken to integrate the medical system with the goals of economic development. This has been often referred to as the "technological mis-fit". The inadequacy of this approach is highlighted in a recent WHO paper which states, "There can be no question of simply grafting on to a struggling and largely agricultural economy, a high powered medical

system, with ultra-modern hospitals, specialist surgeries and general practitioners making house calls". What is needed is "adapt or improve upon existing systems but not adopt" as Mahler puts it. There are features about the Chinese development, based on communes and using a large number of simply trained medical auxiliaries or "barefoot doctor" to bring a health message as well as a treatment and prophylactic resource to the rural areas, that may prove suitable for adoption in developing countries. These countries cannot yet achieve a full service in the lines used in the developed countries and well recognize their need to choose priorities. They can easily hinder their own progress by putting too large a part of limited resources into training physicians rather than larger numbers of nurses, technicians, or auxiliaries provide a balanced health team.

Attempts have been made in different projects in India to move away from the traditional model. A common innovation in all these endeavours is t select community workers of low education, train them for a range of simple health care task including health education, nutrition education and environmental sanitation and use them to supplement the available health care personnel. China has developed its own approach to health care delivery and has succeeded in its policy to break down the conventional system of health worker's roles and institutions and tried to develop a new labour intensive model which suits the needs of its predominantly rural population and the overall goals of economic development. Basic to all such efforts has been an explicit recognition of the casal link between health services and increased production. In fact the Chinese view is diameterically opposite to the view of western economists who hold that health is a "Consumption" expenditure rather than a "production" investment. In most experiments with alternative approaches, there is also a recognition of the need to provide basic curative health care and simultaneously improve the environmental health, sanitation and safe water supply. Several health projects round the world, recognizing the need for simultaneous action on both the fronts, have experimented with strategies based on mobilization of community resources for improving environmental sanitation and use of community health workers for delivering primary health care. There is an increasing recognition that more increase in number of trained medical doctors will not automatically result in optimal healthcare to rural populations or improvement in health status of people. Thus the traditional model of the health care pyramid with a heavy top and narrow base, with the major investment of resources in specialists, large urban hospitals and sophisticated equipment and a narrow base of minimal paramedical support is almost obsolete. The newer approaches envisage a model of a health care pyramid with a narrow top with some investment in doctors, hospitals, specialists, equipment, etc, and an enlarging base diverting investment from a few large hospitals to several health centres extending into the periphery with a broad base of primary care workers of various categories and with emphasis on community organisation for health care. In fact, the dictum is "Health by the people" and "health to people". The ruling philosophy in this approach is not "Best for the few" but "good for the many". However, this approach is not to be interpreted as an effort to provide "inferior medicine to the rural poor" or "providing the underprivileged with second class medicine".

In the absence of a universally acceptable alternative model, an attempt is made to list the basic requirements, preconditions and criteria for a suitable model and to suggest some combination or strategies in different approaches to health care delivery.

Some of the important guidelines in designing alternative approaches are listed below :

1. The alternative approach should give primary attention to vulnerable and deprived segments of the population-women in child bearing age, children below five years, the poor and indigent, urban slum dwellers and those who have no access to any form of health care.
2. The alternative must be planned on an appreciation of the multifactorial nature of health. Health is a product of sound, healthful living, adequate nutrition, a proper understanding of one's own body levels of general education, environmental sanitation, hygienic methods of living etc. The inputs in the alternative strategy must be based on this appreciation.
3. The alternative approach should be built upon the principle that health planning is

an integral part of the process of economic development planning. Thus, in the new system primary health care activities should form an integral part of the national health system and community development activities, such as education, adult literacy, agriculture, housing and communication. This needs multi-sectoral planning and an application of the importance of non-health interventions for health system.

4. The overall philosophy of the alternative approach must be to identify and make use of available persons in the community, who are interested, enthusiastic and willing to engage in health-related task. In addition, already existing health worker like the dai, practitioners of indigenous systems of medicine may be suitably trained and utilized. Niger project in Tanzania, and Miraj in India have successfully used the traditional birth attendents and the indigenous medical practitioners.

5. The persons who enjoy the confidence of the community and are considered as sources for health care must be utilized. Categories identified by the Committee on Medical Education and Support Manpower are the village post-masters gram sevikas, school teachers and dais. Alternative approaches should use these functionaries for primary health care tasks.

6. Instead of relying entirely on imported technologies, attempts must be made to combine the wisdom of traditional systems of medicine with the modern. It may be recalled that the success in China's health care delivery is attributable at least in part to this strategy.

7. The experiments on alternative approaches must as far as possible give a trial to the new health policies and strategies initiated by the Ministry of Health and Family Planning, Government of India. The Miraj Project giving a trial to the Multipurpose Workers' scheme, and the Rehbar-i-Sehat at Jammu and Kashmir and the Indian Council of Medical Research (ICMR) funded projects trying out school teachers for delivery of health care are illustrative of this point.

8. Any concern for initiating alternative approaches must consider the problem in the larger perspective of its antecedents and linkages in the training programmes of health personnel. Tanzania and China made simultaneous changes in the medical education curricula and training methodology to give emphasis on rural health and primary health care when the strategy of using community workers and bare foot doctors was launched. In this connection the Shrivastav Committee's recommendation of medical college taking over PHCs to use for student training is a worthwhile step that needs immediate implementation. The possibility of using the sites of alternative experiments for medical student training must be explored. Government Erskine Hospital Project, Mallur and Medicare Plan are already trying this.

9. The alternative approaches to be developed must adopt a service-cum-research approach. This implies the need to develop continuous monitoring, evaluation system and a viable management information system to ensure effective feedback. There is a need to develop other indicators or impact of the new approach than mere service statistics and performance data. To the extent the new approaches need to be carefully evaluated for their replicability, the emphasis should be on the process rather than the product.

10. Most of the Indian experiments seem to owe their success to the devoted, charismatic leadership of the project chiefs. While this is understandable for demonstration purposes, any large scale implementation of tested alternatives must prove their feasibility and success over and above devoted leadership. This will be an important issue in the sustenance of the initial success of the projects and therefore an important criteria for planning alternative strategies.

11. There is a need to rationalise through experimentation and evaluation the number of tiers needed in-between the village level worker and the other health personnel.

12. While it is good to encourage novelty and innovation in alternative health care deliv-

ery strategies, there is also a need to retain certain common parameters in their methodology to ensure comparability. There is a need for baseline measures, concurrent evaluation and contextual studies in order to estimate the usefulness of one particular approach vis-a-vis others.

13. Common to all models or approaches is the need for standardization of basic educational requirement for voluntary community workers, core training content, manuals and instructions, specification of task and roles for each category of worker, drugs and equipment, built-in supervisory mechanism, system of continuing education and referral system.

14. Thus the three basic components in any model are (i) strengthening the infrastructure (ii) integrated development of health services and health manpower through training and (iii) improvement of environmental sanitation.

15. Primary health care in any model or approach should cover minimal treatment of minor injuries, health education, education to pregnant and nursing mothers, immunization for children, nutrition education, family planning and some action for provision of safe water supply, building latrines and waste disposal system. In addition to curative services, the approach must lay emphasis on preventive, promotive and rehabilitative aspects.

16. The approach should be built on continuous, sustained and effective community involvement and should continuously aim at evolving innovative strategies for maximum community involvement. The nature and extent of community involvement must be periodically evaluated.

17. The approach should be effective in terms of cost, technique and organisation.

18. The approach must be based on the local funds rather than relying too much on external funds.

19. It must be broad based and flexible in order to absorb change.

20. The approach must be based on locally available resources and expertise, but must work in close coordination with the existing government infrastructure and voluntary agencies in the area.

21. The overall purpose of the approach should be to increase accessibility to health care, particularly in rural areas, and to vulnerable target population identified earlier.

22. Regardless of the approach an important issue is the career promotion aspect of the community health workers in order to sustain their motivation. In some countries, these workers can gradually reach medical colleges after several years of service. In Nepal, female health aids can become Auxiliary Nurse Midwives (ANMS). □

Why are our rural health services so ineffective?

By JAGADISH C. BHATIA

AFTER our commitment, in terms of the Alma-Ata Declaration, to provide health care to all by the year 2000 AD, the rural health service has become a subject of topical interest in our country.

Several factors contribute this interest. First, 80 per cent of our population live in the countryside; Secondly, more than 70 per cent of our national income comes from the rural sector and it is well known that "health effect" contributes in a major way to the economy.

In spite of the overwhelming importance of the rural sector to our economy, this is the most neglected segment of the population so far as health and medical care facilities are concerned. While 80 per cent of the population live in the countryside, 80 per cent of the doctors have settled down in urban areas.

Further, there are intra-rural imbalance of services as functionally much of the available manpower of either systems is distributed in bigger villages. The smaller and "difficult to reach" villages have no facilities whatsoever. Furthermore, available estimates in India show that by rural-urban break-up of services, the urban population has 8-10 times more institutional facilities and 12 times more hospital beds. Although there has been a considerable improvement in health manpower in India during the last two decades, the rural-urban ratio has remarkably remained unchanged. Therefore, it becomes necessary for our society to be concerned about the health of its rural people. Politically, too, people are demanding higher living standards on some equitable basis and reduction in economic and social inequalities. There are rising expectations for social service, including health services, both in terms of quality and quantity.

Comprehensive

Governmental medical care facilities available in the rural areas thus far are mainly through the Primary Health Centres (PHCs). These PHCs were established as a part of community development programme, way back in 1952, to provide comprehensive health services which, inter-alia, included: medical relief, control of communicable diseases, environmental sanitation, maternity and child health, including family planning, school health, health education and vital statistics. Later, addition in their activities and expansion of many vertical health programmes resulted in a substantial increase in staff numbering from 10-12, when initially started, to 40-50.

What has been the impact of these PHCs on the health status of the people? In the absence of any scientific effort to evaluate the real impact of these institutions, it is difficult to answer this question precisely. However, sporadic evidence does show that our health services have not been very effective in solving the ever-growing health problems of our rural population.

Although the Primary Health Centres have been in existence for the last 30 years, their utilisation by the community has been rather poor. Studies of medical care services in India conducted by the World Health Organisation the Johns Hopkins University Rural Health Research Projects and the National Institute of Health Administration and Education indicate that only 10 to 20 per cent of the villagers utilise Governmental health services.

Awareness

Furthermore, awareness and use of these facilities is limited to villages where these services are located. People living in the peripheral villages either are unaware of these services or find it difficult to reach them because of communication difficulties and distance. The image of PHCs has also been found to be poor. Even among a small proportion of villagers who have used those facilities, the majority have shown dissatisfaction with the services, mainly because of non-availability of medicines and the rude and impersonal behaviour of the doctors. Apart from the doctors, the peripheral health services have a battery of paramedical personnel like basic health workers, vaccinators, auxilliary nurse midwives, family planning workers, etc. These unipurpose workers are now being changed to multipurpose workers, who are supposed to pay domicillary visits regularly in all the villages in their respective areas. A large proportion of people in the rural areas have been found to be unaware of their existence. Thus many villagers continue to be attended by Indigenous Medical Practitioners (IMPs). These IMPs are not, however, those who use traditional herbs, oils and incantatons and have little or nothing to do with modern medicine. On the other hand, they are increasingly using modern medicines. Their number is estimated to be about 400,000 (one for every 1300 population as against one qualified doctor of modern system of medicine for 4700 population), of course with considerable inter-State variations. These IMPs are very popular among rural people and their ranks are being augmented every day. This means that rural people are rapidly becoming aware of the miracles possible through modern medicine and they like modern and allopathic modes of treatment but not the doctors of the allopathic system of medicine available at the Government health facilities.

The Primary Health Centres, as mentioned above, were established on the principle of integration of health services. They are supposed to provide seven types of services which are considered basic by the World Health Organisation (WHO). Studies have, however, shown that doctors hardly spend any time in preventive and promotive care. Maternal and child health services remain neglected. Apart from curative services, the only other activity which receives such attention is family planning work and this too for obvious reasons.

Our internship and other training programmes have also not succeeded in changing the attitudes of young doctors to rural health services. If choice is given to them, they will not be prepared to go to rural areas; even those who, pressed by circumstances, take up jobs with PHCs work half-heartedly and are not able to gain the confidence of the rural people which is so necessary for the success of any community development programme. Rural services are always regarded by them as a stop-gap arrangement and so they always try to get out at the earliest opportunity available. Furthermore, the contents of our training programme are not based on a realistic appraisal of needs of the community and tasks to be performed.

The reasons for the ineffectiveness of rural health services in India are many and not far to seek. Some of these can be summarised as under:

(1) Most of our health services have grown at random based on intuitive judgments and depending upon the urgency of certain problems and availability of resources — physical, financial and manpower. There has rarely been a clear perspective and scientific experimentation with various approaches to the delivery of health care services.

No unanimity

(2) There has been no clear definition of the role and responsibilities of the PHC doctor and other functionaries. Interviews carried out by Johns Hopkins University researchers with the administrators of health and medical services in the State and Central Governments and officials directly involved in the local supervision of Primary Health Centres themselves have revealed that each has a different perspective of a Primary Health Centre and there is no unanimity of opinion on the functions the PHC is supposed to perform and the actual role of the Primary Health Centre doctor. There has thus been a complete role ambiguity and role crisis which has seriously affected the planning and implementation of various rural health programmes and the performance of PHC doctor and other staff members.

(3) Most of our health schemes were sponsored and initiated by the Government and there has been no serious effort to involve the people in decision making process and in the mobilisation of local resources. Our pronouncements and their dissemination through mass media have generated more consciousness among the people about their rights than their duties. This has further dampened their will to participate actively in the various health programmes. This weakening of the capacity of local communities to solve their own health problems and our inability to meet their insatiable demand for health services has resulted in dissatisfaction and frustration with Government health programmes.

No integration

(4) There has been no serious effort to assess the health needs of the people and the effective ways of meeting those needs. The people's acceptance and co-operation would have been much easier to obtain if health programmes were geared to their felt needs. Furthermore, no attempt has been made on a wider scale to investigate community reactions to the programmes. By and large, there is lack of sensitivity and awareness on the part of health workers to social and emotional considerations.

(5) There has been no proper and systematic evaluation of the activities of Primary Health Centres which could have provided guidelines for improving the functioning of these rural health institutions.

(6) Health care cannot be the responsibility of a Health Department alone. The activities of other institutions also contribute to the health status of individuals. There has been no proper integration with other development departments to find a solution to the health problems of the people and bring about an improvement in their health status.

(7) In our Plans the health sector generally gets a low priority, and inadequate resources in terms of staff, equipment and drugs etc. have affected the efficient functioning of our rural health institutions.

(8) Our preoccupation with family planning and target setting in this regard has resulted in the neglect of many more important health activities. This has, to a large extent, alienated our rural population which has been detrimental to the family planning programme itself. The family planning programmes would have been much more effective and sustainable if they had been closely linked with other health promotion activities.

(9) The vertical programmes and multiplicity of workers had resulted only in confusion and resentment among the people.

(10) Our dogmatic adherence to so-called "medical standards" has

(Continued on Page 8)

Rural health service

(Continued from Page 6)

blinded us to the actual health conditions prevalent in the countryside. We have failed to tap the abundant sources of indigenous medical care available in the rural areas and use them for the promotion of various health programmes. Instead of earning the goodwill and enlisting the co-operation of these indigenous medicine practitioners who, by and large, are very influential among the rural people, we have antagonised them with our various pronouncements and activities.

(11) The social science and management component of our training programmes has been minimal and, to say the least, superfluous. The Social and Preventive Departments of medical colleges who are primarily responsible for imparting this training have not received the status and prestige they deserve and the implementation of the training programmes to that extent has left much to be desired. They have not been able to mobilise multidisciplinary teams which are so essential for imparting this type of training. The effort to organise inservice training programmes for different categories of health personnel have been only sporadic and thus ineffective. There has been more emphasis on didactic teaching rather than exposing the trainees to the actual field situations.

The above, by no means, is an exhaustive list of reasons for the tardy development and ineffectiveness of our rural health services. Systematic research would, perhaps, bring out many more factors to help us take necessary remedial measures and reorient our health programmes and activities taking into account the needs of rural communities and our commitments in terms of the Alma-Ata Declaration.

DELIVERY OF PACKAGE OF HEALTH SERVICES THROUGH MULTI-PURPOSE HEALTH WORKERS' SCHEME

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1. More & more advancements in Medical Research might lead us to a complacent thinking that Science has finally won the fight against disease.

2. In a welfare society with a socialistic outlook and approach, all roads shall lead only towards the goal of greatest good of humanity at large.

3. Not only the Educational and Examination Systems of the Training of Medical and Paramedical personnel but also the DELIVERY SYSTEM OF THE HEALTH SERVICES, need complete re-orientation and reorganisation.

4. Epic Victories in the control of communicable Diseases, Exemplary Achievements bringing down Maternal and Infant mortality by TECHNO-MEDICAL REVOLUTION, might disappear if adequate coverage of the entire rural and urban populations is not planned by the Health Services.

5. With all humility we now venture to visualise the future INTER-FACED MEDICAL OFFICERS of the Primary Health Centres of Tamilnadu, who are experts in the MULTI-DISCIPLINARY APPROACH TO DELIVERY OF HEALTH SERVICES, including MEDICARE, MEDICAL EXTENSION, FAMILY PLANNING and APPLIED NUTRITION.

6. Custom decrees, courtesy demands and curriculum compels that the Medical Colleges and Teaching Hospitals turn out only well qualified INTER FACED DOCTORS capable of tackling all medical and health problems subject to availability of auxiliary assistance and other resources.

7. It is of paramount importance and of pathetic urgency that we improve the quality of Undergraduate Medical Education and Pre-Registration Internship Training to Commensurate with the level of expectation of the Community.

8. Not withstanding the existing systems of examination and evaluation at the Internship level complaints are not uncommon that the turnouts are substandard in qualitative training and hence there shall be yet another system of Competence Measurement and Merit Rating, Grading or Assessment at the level of Internship also. However unorthodox the suggestion be, criteria need be codified for Competence Measurement of Government Medical Officers at periodic intervals.

9. Use-effectiveness of METHODS employed in the Delivery of Comprehensive Health Care needs evaluation at every level.

10. Through knowledge in COST BENEFIT ANALYSES coupled with Organisation and Methods Study, Operational Research, Productivity Techniques, Supervision Skills Development, Man Management, Materials Management, Methods Management and Money Management, is a MUST for every Medical Officer of a Primary Health Centre.

11. The medical Officer is the "King Pin" of the P. H. C. He shall equip himself with TECHNO-MANAGERIAL CAPACITIES and then only Productivity, Profitablity and Public Satisfaction would follow.

12. Abundant experience in Curative Medicine alone will not turn out Interfaced Medical Officers. Adequate Exposure to Field Work as the Head of a "HEALTH TEAM" would make him an instant success in the practice of Community Medicine.

13. India now needs no Glamour Medicine nor Spare-part Surgery. Privileged few only are admitted and treated in the most sophisticated Tower Blocks of Teaching Hospitals. Common Man cries not for "Heart Exchanges" but for "Change of Heart" among Medical and Paramedical personnel. Lip service to his 'FELT NEEDS" amounts to a cruel joke on his crippled mind and body.

14. HOSPITAL ATTENDANCE does not reflect MORBIDITY in the COMMUNITY. Every disease exhibits an "ICEBERG PHENOMENON"

15. For Conducting Morbidity Surveys and for giving greater EMPHASIS,

On Preventive Care	than	Curative Care,
On Early Diagnosis	than	Late Diagnosis,
On Home Contact	than	Clinic Contact,
On Continuous Patient care	than	Episodic Patient care

"Health Team Approach" is more suitable than "Hospital Approach"

16. For the Domiciliary Follow up of Environmental Diseases such as

"PULMONARY TUBERCULOSIS."
HYPO - PROTEINAEMIA,
SEPTIC ABORTION ETC.,

and for the follow up of defaulters and terminal cases of Cancer Clinic, as well as for the early discharged post-operative cases and Low-Birth Weight infants etc., Health Team Approach would be welcome.

17. To achieve the objective of taking medical care and diagnosis to the periphery, through the Health Team, it is essential that there shall be a built-in system of supervisory checks between all the members of the Health Team to maintain quality and for effecting maximum delegation of responsibility to those with minimum training, consistent with good care, supported by excellent communications and medical back up from the main Centre.

18. Under the over all supervision of the Medical Officer-in-charge of the main centre and the Public Health Nurse, 80% of subcentre practice can be delegated to paramedical members of the team. "Daily subcentre-clinics" conducted by the A. N. M. are meant for the management of minor clinical ailments, apart from M. C. H. services. "Weekly Referral Clinics" are to be conducted by the Medical Officer in the subcentre itself.

19. For the Assessment of community health levels, Identification of community health needs, Appreciation of community resources–private and official, Coordination of the work of professional health leaders at local level, Supervision of the work of A. N. Ms. Constant training of field workers and for Delivery of services in the improvised set up, the Public Health Nurse has a major role to play.

20. The logistics on which Government Health Services are formulated are totally different from those of the Teaching Institutions. Medical Education is so much dominated by individual specializations that it cannot be photocopied or portrayed in the community within its economic capacity. As the quality of Health Services depends on the efficiency with which their Delivery System functions it is imperative that we develop a Multi-purpose Health Workers' Scheme.

MULTI PURPOSE HEALTH WORKERS' SCHEME

The Steering Committee on "Health, Family Planning, Nutrition" of Planning Commission has stressed on the following :

i) Proper integration of Health and Family Planning and Nutrition Programmes as such integration is more effective and economical.

ii) Entrusting Multi-Purpose Workers to discharge such integrated functions.

iii) Providing 3 categories of such Health Auxiliaries :

a) at lowest level - Basic Health Workers or ANM,

b) at intermediary level-Health Visitor or Health Inspector.

c) at higher level - Health Supervisor.

iv) To arrive at an effective pattern of services from Operational and Training angle.

"The All India Committee on Multi-purpose Workers has given their recommendations, for setting up Multi-purpose Workers in rural areas of the country". Their main recommendations are:

i) Ultimate objective is to have one "sub-centre" for every 3000 to 3500 Population; to group 4 sub-centres into a sector; to have one Health Centre for 4 such sectors.

ii) Multi-purpose Workers at lowest level are to be supervised by multi-purpose Supervisors at various levels up to State level.

iii) Implementation can be phased depending on availability of personnel :

a) First phase can be to introduce the scheme where Malaria Eradication Programme and Smallpox Eradication Programme have entered into "Maintenance Phase".

b) Second Phase can be to extend this to areas which enter into maintenance.

c) Third phase will be to have this scheme throughout the rural areas of the State incorporating all "Health" Programmes.

iv) Job based training is to be given to each of the Workers to equip them technically to discharge their work;

v) The Dispensaries lying within the jurisdiction of a Health Centre, are to be linked with the Health Centre and subcentre staff shall utilise the Dispensaries to refer the cases.

vi) The training given in "Medical Colleges" shall be modified to equip their trainees to deliver such integrated services.

23. Government of Tamilnadu for their part have been making some headway in implementing the Multipurpose Health Workers' Scheme. The erstwhile "Regional Family Planning Training Centres" have been redesignated as "Health and Family Planning Training Centres". They have now been equipped to train Basic Health Personnel in 'First Aid'. 'Laboratories' have also been equipped to train personnel. Altered Staff pattern to include Sanitarians and Laboratory Technicians is under consideration of the Government.

24. Test Courses on Multipurpose Scheme have been conducted in the HFPTCs Salem and Gandhigram. Since the Government have thought fit to implement the scheme as a "Pilot Project" first in Kanyakumari District, Gandhigram Institute of Rural Health had already constructed a Model Curriculum to train the Medical Officers and Block Extension Educators (To be redesignated as Block Health Supervisors) so that they will take up the Role of Trainers for other echelons of staff in their own Primary Health Centres.

25. Bottle necks are seen at every stage of implementing the Programme. Planning for the judicious redistribution of the functioning Unipurpose Workers in the proposed multipurpose set up is upset either due to excess of male workers or due to near total absence of Maternity Staff under the Directorate of Health Services and Family Planning.

26. Anamolous situation in Tamilnadu is that the existing Maternity Staff are mainly working under the Panchayat union's Administrative Control although to a certain extent technical control over them is vested with the staff of the District Health Officer. The District Family Planning and Maternity and Child Health Officer has got the MCH component only in the official designation. Inter departmental conferences between the Directorate of Health Services and the Directorate of Rural Development only can suggest to the Government ways & means for transfering the Maternity Staff to the Health Services.

27. Unipurpose Vertical Programme Directors have to Compromise their Unitarian Authority at the alter of the Multipurpose Horizontal Programme proposed to be implemented. While some of them welcome the new set up, others caution that dire consequences might follow if the supra-structure of Block, Divisional, District and Regional level Supervisory Officers, well trained in the Logistics and Modus Operandi of all the Component Programmes are not posted and optimal standards are not expected out of the Multi Purpose Health Workers. Ill-equipped, Unsuitable and Unwilling Officers, if posted even in a promoted position of importance, might "Punish" the Programme and the Public, by their lack of Motivation to try out this innovative, well meant but hard to implement Programme.

28. Officers, with no local level authority delegations to solve staff and teething' problems might unknowingly sabotage the very Objectives of the programme.

29. Proper Training envisages that

a) Concepts of the Multipurpose Health Workers' Scheme,

b) Principles and Practice of Health Administration,

c) Principles and Practice of Epidemiology,

d) Implementation of National Malaria Eradiction Programme,
„ National Small Pox Eradiction Programme,
„ National Tuberculosis Control Programme,
„ National Leprosy Control Programme,
„ National Family Planning Programme & other National Health Programmes,

e) Modern methodologies of Maternal & Child Health ~~Statistics,~~ Services

f) Problems of Environmental Sanitation,

g) Compilation and Analyses of Vital & Health Statistics,

h) Unitary and Referral Diagnostic Laboratory Services, &

i) Principles and Practice of Communication and Community Health Education, Techniques and aids,

are all to be synthesised and systematically taught to all the erstwhile Unipurpose Workers and their Unipurpose Supervisors.

30. Elimination of Wasteful Practices in the compilation of Base Line Data which is unnecessarily duplicated by every Unipurpose Programme and avoidance of many people visiting a unit area for Supervision of a small facet of Health Work, might permit us to afford a better equipped Supervisory System and eventually prove to be less costly and more remunerative in Health Status returns.

31 Coming to Cross Roads, three Questions may now be posed about the implementation of Multipurpose Health Scheme.

1. Is it easy ?
2. Is it possible?
3. Is it worth while ?

32. How we wish your Answers for the above three Questions would be as per the following order.

1. Not quite easy.
2. Possible if you have the determination.
3. Definitely so.

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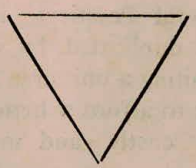

Com H 9.9

GENERAL APPROACH TO RURAL COMMUNITY HEALTH SERVICES

Fundamentally, the health services have to be viewed in the context of overall integrated development of the villages. Health services cannot be fully successful if they are pursued in isolation from the general development activities of the area.

The community health services must be area basedand population based -- providing the total spectrum of health services to the total populace living in a defined geographic area. Primary health care must be available at the doorstep of the receipients.

1. Area Coverage -- Regionalization:

We must accept responsibilities to provide health coverage to the population of a defined area.

Selection criteria of the area:

A) Need - Poverty and illiteracy
high incidence of diseases
non-availability of health services.

B) Suitability:-

The area should not be too far nor should the area be too near to / the city -- then the people will be visiting the city for their health needs.

Assurance by the community for full cooperation and help.

HOW ? for example:

i) If there is an already existing useful organisation that can provide us useful assistance.

ii) If the village is well united and there is an effective panchayat.

iii) If the village has, or is willing to immediately start, a Village Health Committee, which could help us in several ways, acting as an effective link between the health workers and the villagers. Such a health committee should preferably be considered a specialized organ of the panchayat unless the panchayat is divided and ineffective. Then the Village Health Committee can be an independent institution. But it must enjoy the confidence of the entire village population.

..Contd/2-

iv) If the villagers are willing to contribute their share by:

1. Agreeing to pay a small insurance charge
2. Agreeing to do Shramdan for some health projects
3. Agreeing to contribute volunteers that will help run the health programme.

v) If some date is already available about that area due to previous or on-going survey etc., either in connection with a health programme or as a part of general development activities.

2. Total Population Coverage:

The whole population must be covered.

Priorities: The weak and the vulnerable: Children below 6
Expectant mothers
Nursing mothers

Promotion of health and prevention of disease.
Nutrition, Sanitation, Immunisations & Health Education
Adequate simple records.

3. "Health Insurance":

Every body pays.
There may be a graded scale, depending upon the economic status.

Advantages: Greater interest taken by the community.
Greater community participation.
People feel they own the programme-and it is their (as indeed it always should be).
People who pay can also ask for good services, and who can complain if the services are not good.
Keeping accounts develops the idea of accountability.
People do not value the treatment that is given free. They may even throw away expensive drugs, thinking them worthless.
Getting things free is not a good habit. It should be discouraged.
Some people consider it ethically wrong to give or take things free.
There is no such thing as FREE. If the villagers are not paying for it, somebody else must be paying for it.

4. The National Context and Constraints:

Ours is a poor country.
Our health services should be affordable on a countrywide basis, perhaps adding upto a few rupees per head per year.
It is no use creating an IDEAL or achieving "excellence", which cannot be copied on a large scale.

...Contd/3.

We must keep in mind the replicability of our health services. We should be able to demonstrate a pattern of health care which is practicable and effective- not after 50 years, but for the next five year plan.

Thus our efforts should have national relevance. We have wasted our opportunity if our health services and experience cannot be multiplied and does not have any relevance for the creation of effective health services on a country-wide basis.

5. Coordination with the State Health Organisation:

Health is a State subject.

We should avoid dual control or parallel and competing health services. We should have a clear understading with the State health Ministry and the District Chief Medical Officer. We should clearly deine our respective roles and establish clear channels of communications and cooperation.

Broadly, our plan for community health services should follow the state pattern. We can fill in the lacunae and strengthen weak link, but we should not drastically after the overall health plan or health strategy. Otherwise we again face the risk of wasting our opportunity and losing all relevance.

6. Utilisation of Existing community Resources:

They include: Indigenous and homeopathic practitioners Ordinary simple home remedies.
The common lore and grandmas recipes Yoga.

Health practices of our people, such as personal cleanliness, boiling of milk, breast feeding of children self reliance etc.

Local educated young men and women, including teachers, post-man etc., that can be roped in for various types of "help" that comes to villages. ~~is~~ atrophy of local leadership and initiative and fostering an attitude of dependance and passive acceptance. We must guard agains the tendancy to pull people up by their ears, instead of encouraging them to pull themselves up by their boots-traps. We should resist all well intentioned effort to spoonfeed the people.

we must never allow

....Contd/4-

Instead, we should encourage local leadership, local initiative and self reliance. At a practical level, we should select suitable educated young men and women from the vil lages themselves, and train them as health workers. We should also involve the community in all health work, right from the stage of planning onwards.

9. Community Participation:

A community should consider the health services as their own. Community participation is the sine qua non of any successful community programme. This is one reason why the community must pay for its health services partly, if not wholly.

The community must be involved in all stages of the community health programme, including decision making.

Important areas of community participation:

Planning.

Financial contributions.

Selection of workers from the community.

Evaluation of their work.

Village Health Committees can play a very useful role here, as already mentioned.

10. Special Role of Health Education:

Health education is essential in a democratic set-up in order to elicit the willing and enlightened cooperation of the people

It increases peoples competence to look after their own health, thus fostering self-reliance.

It helps people take greater interest in their health services.

It helps people identify incompetent workers or incorrect measures.

Everybody is interested in the working of his/her body, and in health. They will pay attention if health education is imaginatively carried out, using for example puppet shows, one act plays, practical demonstrations, mobile exhibitions, etc.

The following topics should be covered:

First-aid

Simple nursing

Body knowledge

.....Contd/5-

Yoga

Personal hygiene

Balanced diet

Some simple preventive measures etc.

11. Phasing and Pilot projects:

We should start with a small area or start with only a few services or both.

We should expand and multiply health services as we gain more: -

insight
experience
confidence
acceptability
efficiency

12. Essential Steps:

To Implement the Community Health Programme Objectives:

To create comprehensive integrated community health services for the total population of defined rural areas, with emphasised on vulnerable groups and on prevention.

Such a service should be made available on aregional basi alongwith effective referral facilities.

Summary of Steps:

1. A managing committee for the Community Health Programme should be established. (if necessary)

2. Constituting a "Planning and Implementation" Committee for the Community Health Programme.

3. Selection of suitable area or areas of work. Selection criteria already mentioned in the general approach.

4. To study the area(s) to define its problems and assets.

Surveys: This will involve planning and conduction of surveys covering the following variables:

Demographic

Socio-economic

Health - Existing problems

- Existing facilities

.....Contd/6-

THE GANDHIGRAM INSTITUTE OF RURAL HEALTH AND FAMILY PLANNING: GANDHIGRAM.
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ACTION-RESEARCH FOR ORGANIZATIONAL DEVELOPMENT : A RESEARCH PROPOSAL

1. Title of the Study : ACTION RESEARCH IN ORGANIZATIONAL DEVELOPMENT

2. Introduction

During the last few decades research in the field of formal organizations has amply demonstrated that a number of structural and process variables are directly related to organizational productivity and morale. Likert (1961) has delineated some of the crucial variables that discriminate between high and low productive organizations. Though many of these studies are conducted in industrial and business enterprises with a market orientation, the variables themselves seem to be no less important in determining productivity and morale in non-market but service oriented bureaucratic systems.

It is a paradox that while organizational analysis started with the classical work of Max Weber on Bureaucracy, very little has been done in this area by way of intervention or action-research. To be sure, there has been some work done in this area but not in the form of action-research. Most of the studies are either discriptive or classificatory in nature. One recent study by Anthony Downs (1967) seems to go a little further by providing a typology of Bureaucratic systems and by formulating some testable hypotheses about them. Nevertheless, his analysis shows that considerable variation does occur within the so called rigid bureaucratic systems due to variation in styles of leadership and demands of the environment.

Bureaucratic systems are rapidly expanding and are taking into their fold many types of services for the public. The quality and extent of services rendered by these organizations are intimately interwoven with the processor variables which are shown to have direct bearing on productivity in industrial and business organizations. Hence, there appears to be an urgent need to study these variables and explore intervention strategies for influencing these variables in order to promote productivity and morale.

With this background in view it is proposed to design and conduct an action-research within a unit of the Public Health Organization in Tamil Nadu. At the gross root level, it is the Primary Health Center which directly deals with community services and is therefore significant to focus our attention. Intervention at this level seems to have great action potential which could be released by the application of scientific procedures.

3. Objectives and Scope

The study has two objectives :

(a) To study some of the processor variables and examine their relationship if any to productivity of the Primary Health Centers in Tamil Nadu.

(b) To initiate an Action Programme so as to influence some of the relevant processor variables with an overall objective of promoting efficiency and productivity of the Primary Health Centers.

The proposed action-research will have two phases - A study phase and intervention stage. The study phase would last about 12 months and would be devoted to measure some of the significant variables related to organizational performance at this gross root level. The study phase will cover all the 35 P.H.C. units of the Madurai District, Tamil Nadu. The units will be first stratified into low and high on the basis of cumulative record of performance in the family planning programme. The selected organizational variables will be examined for their contribution toward the performance. Variables which explain a significant proportions of variance and could be manipulated will be selected for inclusion in the action programme.

The second phase of the study will be devoted to experimentation and intervention. This phase may include a training component and process consultation as two of the possible strategies to promote organizational development. Other strategies may include team work & participation of the field staff in decision-making and target setting etc. Role definitions, job specifications and training in principles of programme planning could also be considered. Our attempt could be to promote organizational development as an effort to increase organizational effectiveness and health through planned interventions that are based on behavioural science knowledge and skill.

Through a review of literature in this field and by discussion with knowledgeable persons about the nature and working of the Primary Health Centres, certain processor variables are selected for the study. The variables selected for study are the following :

(1) Role Congruence
(2) Leadership style
(3) Communication
(4) Participation in Decision-making
(5) Coordination
(6) Team work
(7) P.H.C. work atmosphere including flexibility or rigidity of rules etc.
(8) Worker attitudes including job satisfaction, morale and Commitment.

In selecting these variables the following criteria were applied :

(a) The variables should have been shown to bear some direct relationship to productivity and morale in organizations.

(b) The variables should be mutable within the constraints imposed on the organization from a higher level in the hierarchy of the Public Health System.

The study phase will be confined to an examination of these eight variables and their relationship to productivity at the Primary Health Center level.

4. Sampling design

It is proposed to collect data on the said variables from all the Primary Health Centers in Madurai District of Tamil Nadu numbering about 35. No attempt will be made to sample the units as there are not many such units. However, the P.H.C. units will be later stratified into high and low performance blocks and the selected processor variables will be examined for their discriminative ability between high and low performance blocks.

5. Independent and Dependent Variables

For the purposes of this study the eight processor variables will be our independent variables. The dependent variable will be the performance of the primary health centers. These variables are operationally defined as under :

A. Independent Variables

(1) Role Congruence

Role congruence refers to the extent of concordance or agreement between three selected dimensions of the role of a public health worker: Role as prescribed by the organization and the role as perceived by the worker himself; the role as prescribed or perceived and the role as actually carried out in the organization. Implicit in this analysis is the assumption that the greater the congruence between the three dimensions, the more effective will be the performance. In-congruence may lead to axiety, guilt and even frustration in that role besides adversely affecting performance. The more diffused the job functions the greater the role ambiguity and the more specific the job functions the greater the congruence among the dimensions.

The extent of role congruence can be measured by using a checklist of job functions or by eliciting job functions as perceived by the incumbant of a position and his superior. For example a completely randomised list of functions relating to Medical Officer, the Block Extension Educator., the Sanitarian or the Health Visitor or the Health

Assistant can be administered to each one of them to check functions which they consider are their role specific. To the extent the functions as perceived by Block Extension Educator and the Medical Officer agrees there is role congruence between prescribed and perceived dimensions. Similarly role or functions actually carried out and functions as perceived can be compared for congruence.

Alternatively, role congruence could be measured through the help of an interview guide. This may be better than using checklist which may be suggestive or at best tap simple yes-no answers at a superficial level. The interview has to be unstructured and therefore very skilled interviewers have to be engaged for this purpose.

(2) Leadership Style

The three dimensions that will be studied under this variable are : (1) Work facilitation efforts; (2) Human Relations skills and (3) Goal emphasis. We may have to use different approaches or instruments to measure each of these dimensions. Whatever the approach or instrument used, it is necessary to study this variable from subordinates point of view or community point of view.

One approach and perhaps the most commonly used approach is to list several items under each of the three dimensions of leadership and obtain a rating on a three or five point scale on each item. Such ratings can be obtained by the immediate subordinates of an officer and if possible by other equals. It is customary to have an odd number of raters (3 or 5) so that the problem of equal number rating one way as in the other way does not create problem. Village leaders or patients who had frequent contacts may also be able to rate the Medical Officer.

Besides rating we can also observe the leadership style of atleast the key figure (M.O.) over a one month period in a sample of situations such as a staff meeting, supervisory conference, field inspection etc. We can use a check-list or guide for such observations and assign marks. This approach will give a measure independent of the bias of his subordinates. Inter-rater agreement is as essential for the first as for the second approach. However, the latter being done by trained raters should give better measure.

Either or both of the above approaches may be used in the area of Human Relations skills. In regard to the dimension of work Facilitation Behaviour we may ask several important questions to selected subordinates the answers to which when taken together indicate roughly work facilitation or blocking behaviour. How genuinely the Supervisor is interested in hearing and understanding the work problems of his subordinates, how

often he helps by taking immediate and necessary follow-up action etc. may give some indication of this behaviour. To be able to make this judgement workers should have a least a minimum of 6 months experience of working under the particular supervisor. The probable respondents could be sanitarian, the Health Visitor and the Block Extension Educator. Goal emphasis may be treated as a part of work facilitation dimension as they should go hand in hand to get productive outcomes. We can have some items on this dimension in the same schedule.

(3) Communication

When we talk of communication we are interested in communication relating to planning and execution of health and family planning services flow of work and efficiency of work and communication that helps in sound decision-making. For this to be achieved communication should be facilitated both upward and downward as well as sideward. With regard to upward communication, the crucial questions can be whether the supervisors encourage and seek programme relevant information and whether they do actually use such information in discussions about problems and decisions to be made. With regard to downward communication the important questions may relate to such issues as to what extent valuable information is speedily communicated downward and to appropriate categories of personnel, to what extent the personnel are well informed of expected changes in programme, strategies or new assignments together with a rational basis for such proposed changes etc. Sideward communication may be useful for team work or coordination of effort. For example the communication between the Block Extension Educator and the Health Visitor or the Sanitarian and the Auxiliary Nurse Midwife could help in programme coordination at the field level. The frequency of this communication may be expected to be less than the frequency of downward or upward communication unless the leader makes special efforts to facilitate this type of communication.

Administration of a schedule or a questionnaire to selected respondent categories could give us some measure of this variable. Bias in reporting about upward communication is more likely to occur in such a procedure. Bias could also occur with regard to reporting on downward communication probably with a lesser frequency. Alternative method to measure communication is to observe the organizational activities over a period of fortnight or a month and record material relating to communication. Such observation can be made by Competent persons and every detail should be recorded in a process form before scording. Scoring of such qualitative data has to be done very carefully. The question is whether we will be able to get all relevant data in a short observation of the organization process in one fortnight or a month. If this method is feasible it could provide a basis for comparing reported data on communication.

(4) Participation in decision-making

While broad policy and administrative decisions are made at the state or district level, the P.H.C. still would have considerable room as to how to carryout the programme or what strategies could be adopted to achieve the targets or goals set for the organization. It is vital that lower level field staff be adequately involved in making these decisions. Their experience and insights could help a lot to making right decisions or adopting appropriate strategies of action in the community.

The extent to which participation is sought or elicited can be measured by the administration of a schedule. It can also be measured through observation of certain processes - staff meetings and group discussions conducted at the P.H.C.

(5 & 6) Coordination and Team Work

We may treat this as a single dimension if not as a single variable. Coordination of work within the organization and coordination of work with other outside organizations or departments are both essential for effective results. Team work implies a little more than coordination as it is based on an understanding of complimentarity of Knowledge and skills of two or more workers. An appreciation for each specialist and a desire to collaborate in solving health problems are basic for successful team work.

Measurement of coordination appears to be simpler than measurement of team work. In measuring coordination we ask such questions as to what extent they work together with other agencies or individuals. Whether the P.H.C. staff work often along with the staff of the Panchayat Union, whether they seek the help of such voluntary organizations as Madar - Sangams, Youth Clubs etc. and whether they utilise the resources of other departments of the government available in an area etc. Team work cannot be measured by such direct questions. Instead, we have to ask a number of indirect questions, the responses to which give some indication of use of team concept in actual work situation. For example we can ask certain questions on the way programmes are actually implemented. How is a D.T.P. Programme organized and executed in a village - who are the professional staff that participate - what does each professional or specialist do - Whether such specialists plan together so that they can share work responsibilities and equip themselves with needed materials etc.

Because of the tendency to give a socially desirable response, it may be much better to use some other method of measurement. Observation of certain field programmes as they are carried out and observation of certain planning sessions or staff meetings when plans are drawn out for implementation of a programme could give us a measure of coordination and

team work. An observation guide could be used so that relevant information is recorded for giving scores later on.

(7) Work atmosphere including morale and commitment

Work atmosphere could be studied from the point of view of the physical setting and also from the point of view of the social and psychological climate within which work is to be carried out. The physical setting could include items like office accommodation, furniture, equipment needed to carry out job responsibilities, air and ventilation, provision of living quarters etc. The social dimension could include quality of social relations that exist among co-workers, the worker and the supervisor, values, norms and attitudes relating to work etc. Worker attitudes, morale and commitment all seem to form a part of this dimension. Only individual level job satisfaction has to be separated.

Physical dimension of the work atmosphere could be measured through observation and rating on a five point scale by the independent competent researchers. The social and psychological dimension, however, has to be measured by depth interviews with selected categories of staff. An interview guide could be worked out for this purpose.

Some workers have tended to view morale as equivalent to individual job satisfaction while others have viewed it as a property of the group. Yoder (1970:543-568) has presented an enlightening discussion on the variables of commitment and morale. Commitment according to him consists of a syndrome of attitudes, understanding and feelings that identify the team-dedicated participant. Morale means "evident commitment" i.e. exhibiting the behavioural symbols and symptoms of personal commitment.

When morale is viewed as a property of the group as distinct from individual job satisfaction, the emphasis is on social reactions and on attitudes toward group values rather than toward individual values. Feelings of cohesiveness, sense of belonging and interest in working toward group task goals are important elements of commitment or morale.

The morale syndrome can be measured through behavioural indicators which are explicit or those which are implicit. The explicit aspect could be noticed through what the individuals speak, write or say in response to a questionnaire. The implicit dimension has to be inferred from such indicators as absentecism, turnover, sluggishmens in work, disciplinary problems, restriction on output etc. It is obvious that we can use an interview schedule as well as rate the level of morale in an organization by independently observing the objective behavioural indicators specified above. The interview schedule may include measures of cohesiveness, sense of belonging and commitment to task (programme) as well as organization. It is not known to what extent commitment to one is independent of commitment to the other.

(8) Flexibility and Rigidity of the system

Independent of the leadership style, the organization may have imposed certain constraints that could affect the efficiency of work. We have to ask ourselves flexibility in what respects or rigidity in what aspects of the structure or process. Rules and regulations regarding recruitment, transfer or promotion of personnel appear to be restrictive on the Medical Officer. So also some procedures to be followed for purchase of equipment, repairs to existing equipments are rather restrictive. The program target set at higher level are restrictive in certain respects. Apart from such restrictions there appears to be considerable freedom to the Medical Officer to organize, direct and conduct the programmes of public health and family planning. However, the rewards or punishments he could offer for doing or not doing good work are very limited. He has to play on the psychological or social needs of workers to motivate them in the absence of powers to administer economic rewards or punishments.

The areas of flexibility and rigidity could be studied through intensive interviewing in selected dimensions of work and administration. Existing rules and procedures for the functioning of the organization and powers of the Medical Officer could also be studied. Area-wise rating on a five point scale with regard to flexibility and rigidity could be attempted. But the basic question we have to answer is whether or not this variable isconstant across P.H.C. units. If it is so, the question to ask is how the flexibility of the system is exploited by the Medical Officer for effective work.

B. The Dependent Variable

For the purpose of this study the dependent variable will be the work turned out by the staff of the primary health centre in the health and family planning programmes. Cumulative performance over a three year period immediately preceding the date of survey will be considered. Both the quality and quantity of work turned out i.e. performance will be considered. Some indices for quality and quantity of work turned out in the following areas will be developed and used :

1. Medical care services
2. Communicable disease control
3. Environmental sanitation
4. M.C.H. services
5. Family Planning services

C. Control Variables

In examining the relationship between processor variables and the performance of a P.H.C. , we have to control for the effect of other variables like input variables and the environmental variables like the levels of socio-economic development. Though we are not directly measuring these variables we have information on these variables from another study which we could use at the time of analysis of data. We have data on input variables like man-months of supervisory and subordinate personnel, vehicle mileage, money spent etc. and on socio-economic variables on the concerned blocks. We can examine how much of variance in performance is explained by socio-economic variables, input variables and processor variables separately and together by all of them.

6. Expected Relationships between Independent and Dependent Variables

(i) Role Congruence and productivity

An individual's performance can be expected to bear some direct relationship with his role specificity. To the extent the role calls for diffused functions and is ambiguous the incumbent may be asked to perform duties which are unrelated to the training and preparation the incumbent had. This may result in poor performance parity because the incumbent does not have necessary preparation and partly because dissatisfaction and frustration experienced by the worker. Such conflicts between perceived functions and those assigned would contribute to poor morale in the organisation besides waste of talent. Therefore we expect the greater the congruence between perceived and assigned functions, the greater the satisfaction and better the performance. Efficient utilisation of human resources calls for assignment of duties and responsibilities in keeping with the talents and skills of individual workers.

(ii) Leadership style and Productivity

The style of leadership including supervisory behaviour will be related to work performance both directly and indirectly via other variables in our study such as communication, participation in decision-making, coordination and team work, work atmosphere, job satisfaction, morale and commitment. The direct relationship is established via dimensions of work facilitation behaviour, goal emphasis and the human relations aspects of the leadership style. In fact it appears that leadership style is a key variable in productivity of the Primary Health Centre. Hence, we expect there will be a direct relationship between three dimensions of leadership as expounded in this study and productivity of the organization. The variable will also be directly related to communication, worker participation in decision-making, team

work, work atmosphere, job satisfaction, morale and commitment. Thus both directly and indirectly this variable seem to influence productivity.

(iii) Communication

Communication on programme - related issues and problems in the field is vital for decision-making and adopting suitable strategies in the field. To the extent there is free and frank communication on such matters the work flow will be facilitated. Lack of adequate information could hamper decision-making. Therefore we expect a direct relationship between communication and productivity.

(iv) Worker participation in decision-making

Worker participation in decision-making specially in the area of programme strategies and solutions to field problems can be expected to bear a direct positive relationship with performance and productivity of the organization. Such participation helps in getting all relevant and useful data from persons who have rich field experience. It provides a sense of recognition and status to the low paid workers who in fact have a direct responsibility to implement the programmes. We therefore, expect the higher the level of involvement of such workers in decision-making, the greater the productivity.

(v) Coordination

Coordination of the activities of the P.H.C. with the activities and involvement of other departmental staff, specially that of the community development and rural welfare should boost the success of the programmes of health and family planning. This helps to reinforce same educational and motivational processes as are used by the staff of the Primary Health Centre and it may also enable the staff of other departments to look at total development of the community rather than confining to their own field of special interest. Coordination with voluntary organizations would give a sense of community participation and thus contribute to the success. Therefore we may expect a direct positive relationship between coordination and productivity.

(vi) Team work

While coordination is from without, team work is from within the organization. It is based on a sense of joint responsibility of all members of the staff to programme success. It generates mutual respect and acceptance of all disciplines as necessary and their joint effort as vital to programme success. Such team work may result in better solutions to the problems than would be the case when each worker

tackles it from his/her individual perspective or speciality. Further such team work would contribute to morale and thus indirectly also help success of programmes. Therefore we expect a positive relationship between team work and productivity.

(vii) Work atmosphere and Commitment

It is obvious that the physical and social circumstances under which work is carried out are important determinants of performance. Likewise commitment and morale are important determinants of performance. Therefore we expect a positive relationship between performance and these two variables.

(viii) Flexibility and Rigidity of the System

As indicated earlier, there appears to be more rigidity in the PHC organization in rules of recruitment, promotion, transfer, administration of economic rewards etc. However, this is a more or less constant factor across PHC units. On the other hand the Medical Officer of the PHC seems to have considerable freedom in programme execution strategies, supervisory style, work facilitation and human relations aspects. He could also encourage innovative approaches to solution of field problems, generate team work and provide psychological rewards for good work. Thus the question is to what extent the flexible areas of the system are exploited by him to increase performance. This behaviour may vary across P.H.C. units and needs to be measured. We do not have any specific hypothesis on rigidity vs flexibility, independent of Diagramatic representation of the relationship among these variables is provided on the last page.

7. Sources of data and methods of data collection

The type of information we require in this study is not likely to be available in a written form. Therefore most of the information has to be collected either by interviewing knowledgeable persons or persons who are affected by the processes we are concerned with. It is assumed that most of the relevant information can be collected by interviewing the Medical Officer, the Sanitary Inspector, the Extension Educator and Lady Health Supervisor. The method of data collection that ismost appropriate for a given variable has to be adopted. In otherwords we have to be more flexible in our data collection procedures specially when we are concerned with processor variables. As far as possible interviews will be supplemented by observation, rating systems and such other procedures. It is proposed to spend between 20 to 30 days in each primary health centre to get as much information as possible and to cross check data obtained though different sources. A team of atleast two investigators will study each primary health center under the supervision of an experienced researcher to assure quality of data collection.

Under the typology of organizations worked out by Blau and Scott (1962: 51-54), the Public Health Organization would be considered as a service type of organization where the primary emphasis is on professional services to the client population. Therefofe, in evaluating the performance of such an organization it may be useful to consider its impact on client population besides evaluating it from the point of view of its members. Underlying assumption in such an evaluation is that an organization which is high on the processor variables would have provided more satisfactory services than the one that is low on these variables. Several categories of client (local community) population can be considered here such as leaders, former patients, current patients etc. A sample of these categories could be interviewed in the respect of Primary Health Centers that are high or low on processor variables.

8. Procedure for data analysis

The primary goal of this study is to measure the eight process variables and examine their relationship to work turned out by the primary health centers over a three year period. Since we are proposing to study only the lower level units in a complex bureaucratic system, the constraints imposed on these units from higher level centers are to be considered in evaluating their performance.

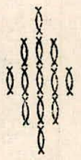
From the point of view of analysis we are interested in examining the strength of relationship of each independent variable to performance. The idea is to select those processor variables that explain a significant proportion of variance in performance of the primary health centers for incarporating into an action programme. The amount of variance in the dependent variable explained by each variable separately and all of them together will be examined by correlation and regression analysis. Since the variables involved are only few and the number of units of observation are about thirty five P.H.C's computor analysis may not be needed. Using electronic desk calculators available in the Institute we can analyse this data. If however, we are going to cover all P.H.C, units in Tamilnadu we have to invest lot more money than is provided in the attached budget. Also analysis will have to be done by computor usage.

9. Time Schedule for the Study

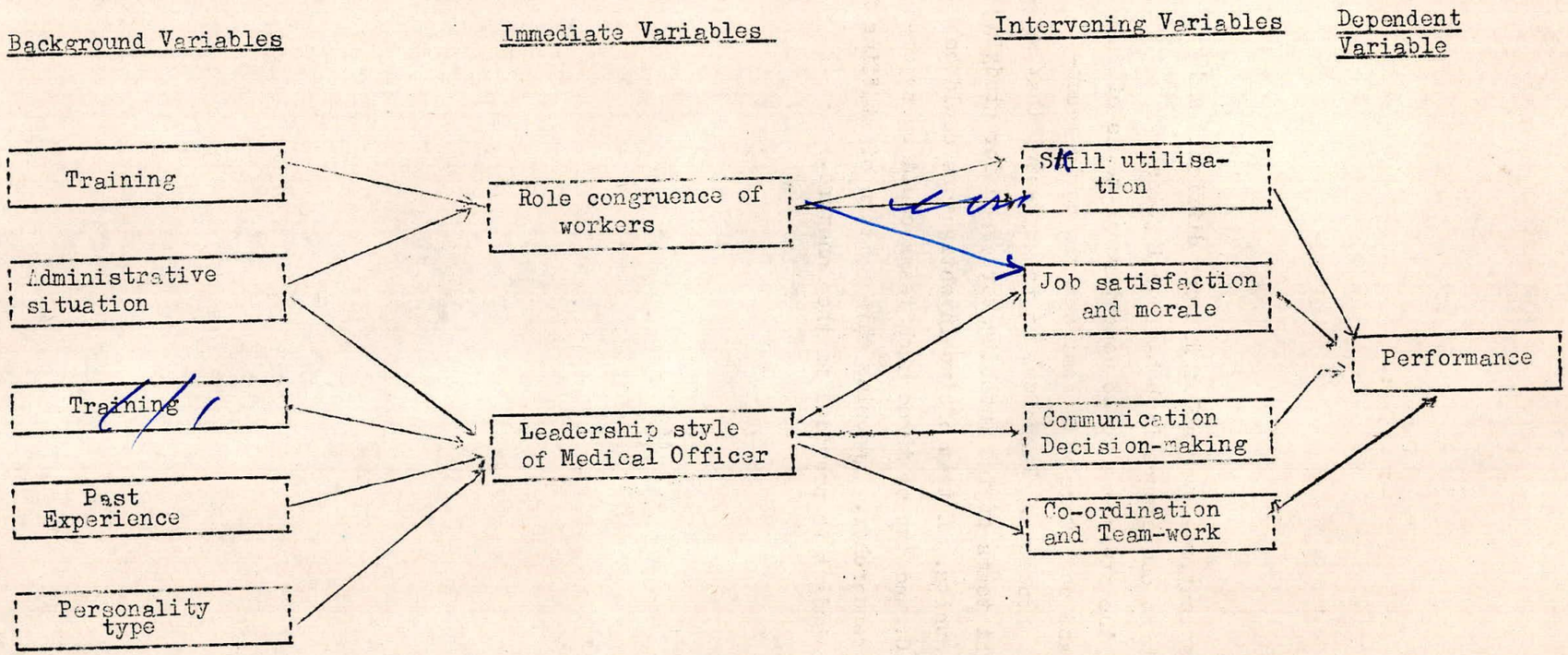
(a) Designing the study and pretesting of instruments, including pilot study	..	4 months
(b) Data collection	..	8 months
(c) Data analysis & report writing	..	4 months
Total time	..	16 months

10. Budget estimate

The study of organizational variables is very difficult and requires people with high competence in behavioural science research. Preferably the study has to be done through teams of skilled interviewers and observers with some experience in measurement of behavioural phenomena. Therefore it is suggested that we constitute six to eight teams of two investigators each for studying intensively in P.H.C. units. A team of two investigators could be assigned to each P.H.C. and two or three such teams could be supervised by a competent researcher. Assuming this pattern of staffing for the study a tentative budget is provided in the Annexure.



DIAGRAMATIC REPRESENTATION OF THE RELATIONSHIP
BETWEEN PROCESS VARIABLE AND PERFORMANCE



P.S. We have to include resource utilization as one of the intervening variables if we think it is different from manpower skill utilization and coordination with other agencies etc.

APPENDIX-A

SOME SUGGESTED ITEMS FOR INCLUSION IN MEASURING INSTRUMENT ROLE CONGRUENCE

Dimensions

1. Role as perceived by the supervisor Vs role as perceived by the incombent.
2. Role as perceived by the incombent Vs role as actually carried out.
3. Role as perceived by the supervisor Vs role as actually carried out.

Better than using a checklist which may tap mechanical responses we could do some depth interviewing with an interview guide - i.e list of areas/items/questions on which we need to get information. Supposing we are interviewing the Extension Educator the following questions may give as relevant information.

(a) A detailed description of activities he generally carried out in the PHC.

(b) His own perception about the expected functions of an Extension Educator.

(c) What he thinks his supervisor's perception of Extension Educator's functions in a PHC

(d) Whether what is assigned and what he perceives as his functions congruent or not.

(e) Were there are some conflicts between his expected functions and functions assigned to him - if so how frequent and pervasive were these conflicts.

(f) Performed functions.

Comparable questions can be asked of the Medical Officer who is the immediate supervisor of the Extension Educator.

Some method of Scoring and obtaining a numerical score for this variable has to be worked out.

Leadership Style

As indicated in the design this variable will be measured from a three dimensional perspectives Work facilitation behaviour, Human relations and Goal emphasis. The following are some of the items or questions that measure each of the three dimensions:

Work facilitation

1. He encourages members to work as a team
2. He makes contact with other departments for the sake of the members.
3. He stresses the need for new practices.

4. He encourages the team members to put forward new ideas.
5. He has members share in making decisions.
6. He convenes periodic and regular staff meetings for planning programme.
7. He encourages members to express ideas and opinions.
8. He sees that members have all materials they want for their work.
9. He lets the team members do their work in the way they think best.
10. He provides means for members to communicate with each other.
11. He gives advance notice of changes.
12. He sees to it that the work of members is coordinated.
13. He provides facilities for interdepartmental coordination.
14. He is willing to make changes when necessary.
15. He uses his influence with outsiders in the interest of his team members.
16. He puts suggestions by the team members into operation.
17. He encourages the use of certain uniform procedures.
18. He gets the approval of his team members on important matters before going ahead.
19. He lets team members set their own goals.
20. He finds time to visit members at their work spot.
21. He sees that members who are in need of technical help are given help.
22. He permits deviation from advance tour program in case members think it necessary.
23. He maintains definite standards for performance.
24. He permits change of approach to meet new situations.
25. He keeps well informed about the progress of his team.
26. He utilises staff meetings in a way to advance knowledge about better ways of doing things.
27. He helps team members constructively to think and solve problems.
28. He assigns members to particular tasks.
29. He insists that everything be done his way.
30. He does not tolerate any member who does not adhere to departmental instructions strictly.
31. He rejects suggestions for change.
32. He changes duties of members without first talking it over with them.
33. He resists changes in routine way of doing things.
34. He decides in detail what shall be done and how it shall be done.

Goal emphasis

1. He sees to it that members are working to their capacity.
2. He emphasizes the quanlity of work.
3. He stresses being ahead of other team members
4. Heencouragesmembers for greater effort.
5. He talks about as to how much should be done.
6. He emphasizes meeting of deadlines.
7. He encourages slow working members to greater efforts.
8. He uses achievement as the main criteria for evaluating all his team members.
9. He mobilizes team efforts to greater achievement when he finds targets are not being reached.
10. He sets examples by working hard himself.
11. He emphasizes the quality of work.
12. He asks for more than what members can do.
13. He encourages them to put extra efforts in national interest.
14. He lets members work at their own speed .
15. He advises members to take it easy.
16. He never cares to review work together.

Human Relations

1. He does personal favours for his team members.
2. He expresses appreciation when members do good work.
3. He defends team members against outside criticism.
4. He invites members to his home.
5. He is easy to understand.
6. He complements a member on his work in presence of others.
7. He helps the members of his team with their personal problems.
8. He stands up for his team members even if that makes him unpopular.
9. He sees that a member is rewarded for a job well done.
10. He speaks in public in the name of the team.
11. He encourages his team to organize social activities.
12. He discusses his personal problems with team members.
13. He reacts favourably to anything members do.
14. He takes the blame when outsiders criticize the work of center.
15. He gives out where credit is due
16. He tries to keep his team in good standing with those in higher authority.
17. He looks out for the personal welfare of individual members.
18. He attends social events of his team members.
19. He associates with members regardless of their positions.

20. He backs up the members on their action.
21. He criticizes a specific act rather than a person.
22. He makes members feel at ease when talking to them.
23. He is friendly and approachable.
24. He publicises outstanding work of his team.
25. He refuses to compromise a point.
26. He rules with an iron hand.
27. He criticizes poor work.
28. He speaks in a manner not to be questioned.
29. He criticizes members in front of others.
30. He critizes members for small mistakes.
31. He treat members like cogs in a mechine.
32. He rides the members who make mistakes.
33. He reverses his stand when he meets outside criticism.
34. He blames members when anything goes wrong.
35. He presents only his own point of view.
36. He draws a definite line between himself and his team members.
37. He acts without consulting his team members.
38. He pits one member against another.

P.S. The questions are not arranged in a random way.

Communication- an inventory of items

1. The extent to which each member feels he has the information he needs to do his job well.
2. The extent to which each superior(your) and each of his subordinates have the same understanding as to responsibilities, roles, goals, and deadlines.
3. The extent to which each superior(your) is correctly informed as to the expectations, reactions, and perceptions of each of his subordinates and conversely.
4. The extent to which each superior(your) is correctly informed of the obstacles, problems and failures of each of his subordinates in encountering in his work, the assistence each subordinate finds helpful or of little value; and the assistance each wishes he could get.
5. The extent to which members of your organization at all hisrarchical levels are motivated to communicate fully and accurately all the important information to all persons for whom the information is relevant and valuable and to omit the irrelevant in order to avoid overloading the communication system.
6. Upward Communication
   a) The extent to which upward communication via line organization is perceived as adequate.
   b) The extent to which upward communication via line organization is perceived as accurate.

c) The extent to which there are forces leading to accurate or distorted information and nature of these forces.

d) The extent to which there is a felt need for supplementary upward communication system(e.g. suggestion systems etc.)

e) How free do you feel to approach your superior and to communicate with him? Is he friendly and easily approached?

f) How well does he listen to you?

g) To what extent are members of your organization interested in listening to you?

i) Are they(and your superior) interested in knowing about your problems?

ii) Do they (and your superior) ask your opinions when a problem comes up which involves your work?

iii) Are they(and your superior) interested in suggestions?

iv) Do they(and your superior) values your ideas, seek them and endeavor to use them?

Worker participation in decision-making

(1) How do members of your organization feel about the decision-making process as related to programme priorities, strategies, and handling of field level problems?

(a) To what extend do they feel that decisions are made at the right level and by the right people? Are persons involved in decisions relating to their work?

(b) To what extent do members feel that their ideas, information, knowledge of processes, and experiences are being used?

(c) To what extent do members feel that important problems are recognized and dealt with promptly and well?

(d) To what extent do they feel that the decision-making process makes full use of all the relevant information available within or to the organization.

(2) To what extent are the decision makers fully and correctly aware of problems, particularly those problems at lower levels of the organization?

Team work and Group work

1. To what extent does your organization(and your superior) holdgroup meetings to make decisions and solve work-related problems? Are such meetings worthwhile?

(a) Does your organization(and your superior) help each team or group, including yours, developing skill in reaching sound solutions?

(b) Does your organization(and your superior) help each teach or group, including yours, develop the skill in effective interaction and in becoming a well-knite team rather than developing hostile subfactions?

(c) Does your organization (and your superior) use the ideas and solutions which emerge, and does it (he) also help each group to apply its solutions?

2. Does your organization (and your superior) encourage working in teams rather than each worker doing his own job?

(a) If you work in teams who are the people who constitute such work teams in your organization?

(b) How well do you think these teams have worked?

(c) What are the advantages you find in such team work?

3. How often do you make joint visits to field?

(a) For what kind of programmes?

(b) For what reasons?

Co-ordination

Definition

For purposes of this study we restrict the work co-ordination to joint or collaborative activities between one organization and another and reserve the concept of team work to coordination of activities of specialists within an organization.

Co-ordination of activities at the P.H.C. level could be studies from the point of view interdepartmental coordination as well as coordination of activities of the Primary Health Center with those of other voluntary organizations working in a given area.

Extent of co-ordinated work can be measured by asking specific questions to selected P.H.C staff and also to selected staff of other organizations or agencies. The extent of concordance in such reporting could be taken as a test of reliability of the answers given in this area. Alternatively we could observe the activities of the P.H.C. over a specified period of time to see the institutionalized mechanisms they have for coordination and how often they do really work hard for obtaining coordination or how successful they are as reported or evaluated independently by an observation team.

Some questionnaire items

Are there other departments/with whom you co-ordinate the work of your organization?

Yes [ ] No [ ]

If 'Yes' which are the departments/organizations with whom you most frequently or often co-ordinate the work in health and family planning?(Specify)

Is such co-ordination desirable from the point of your own work or organization's productivity?

How successful (you think) you have been in obtaining such co-ordinated help from other departmental staff/ organizational staff?

What problems(if any) have you faced in getting such co-ordinated?(Specify)

What is the mechanism you have to obtain such co-ordination?

Work atmosphere

1. The extent to which members of your organization feel that the atmosphere of the organization is supportive and helps each individual achieve and maintain his sense of personal worth and importance.

2. The extent to which cooperative attitudes exist.

   (a) The degree of confidence and trust among peers, among the different hierarchical levels, and among the different organizational units.

   (b) The extent to which attitudes toward superiors, peers, subordinates, and other relevant persons in organization are favourable.

   (c) The level of peer-group loyalty(attitdues of subordinate members of work group toward each other, ie. peer-group loyality, attitude toward superior, and attitude and behaviour of superior toward subordinates)

3. The level of co-operative attitudes within each unit of your organization, among units, and among various parts of the organization, such as, line and staff, divisions, departments, and headquarters.

On the Commitment Variable

If morale is defined not as an individual job satisfaction but as a property of the group signifying essentially a sense of identity with the team and its goals, then it has to be measured in terms of this feeling of belongingness, identify with group goals and zeal to work toward group goals etc. Following Yoder (1970) we may treat morale as evident commitment and therefore need not distinguish the two in terms of operationalization and measurement. We have to pay more attention to operationalistation and measurement of morale and conceptually distinguish it from measurement of job satisfaction at the individual level.

A further important distinction we have to make is between commitment to an organization or commitment to a programme. In terms of success of family planning is there going to be a difference if we concentrate on the one rather than the other dimension? Are they really distinct and separab le dimensions? Can an individual be committed to programmes of an organization but not to the goals, philosophy, methodology etc. of an organization?

'A'	'B'	'C'
Co-operative attitudes Mutual acceptance Identification with work group including M.O. Cohesiveness of group. Optimism about group success. Conviction regarding group goals.	Identification with original goals. Acceptance of original Phil. and methods of work. Preference to stay with the organization when a alternative job is available outside.	Identification with Family Planing Programme. Acceptance of F.P contraceptive methods. Evidence of use in one's own family (if eligible to do so)

Items under A,B,C above refer to commitment to team, organization and programme respectively, we may obtain a total score on commitment by adding up scores on each dimension specified above.

APPENDIX - B

BUDGET ESTIMATE FOR ACTION-RESEARCH UNIT

I. A. For Data Collection

1. Research Officers 12 @ Rs.700/=. /-
per mensem for 8 months Rs.700+100(D.A) =800
Rs.800 x 8 =Rs.76,800

2. Research supervisors 3 @ Rs.800/=
per mensem for 8 months Rs.800+100(D.A)=900
Rs.900 x 3 =2700 x8 =Rs.21,600

B. For data analysis and report writing

1. One Research Supervisor @ Rs.800/=
per mensem for 4 months Rs.800+100(D.A)=900
Rs.900 x 4 = =Rs. 3,600

2. One Statistician @Rs.600/=p.m.for
4 months Rs.600+100(D.A) = 700 x 4 =Rs. 2,800

C. For Action Part of the programme

1. One Research Supervisor @Rs.800/=pm.
for 2 years Rs.800+100(D.A)=900 x 24 =Rs.21,600

2. Two Research Officers @ Rs.700/=p.m.
for 2 years Rs.700+100(D.A)=800 x24 =Rs.19,200

D. One Director of Project for 3 years
@Rs.1050/= in the scale of Rs.1050-50-1200

Pay and D.A. for I year = 13,800
II year = 14,400
III year = 15,000
43,200 =Rs.43,200

II. Travelling Allowance for Research Staff
over a period of 3 years @Rs.10,000 per year =Rs.30,000

III. Office equipment, etc. =Rs.20,000

IV. Stationary and Printing =Rs.10,000

V. Contingencies =Rs.10,00

Total of I to V = Rs.2,58,800

VI. W/S =Rs.10,000

VII. Training =Rs.10,000

Total estimate for Action-Research Unit =Rs.2,78,800

OPERATIONAL RESEARCH IN HEALTH CARE DELIVERY
RURAL HEALTH TRAINING CENTRE, NAJAFGARH

Dr. R.K. SETH, D.P.H., (Calcutta)
D.P.H. (Toronto)
Officer-in-charge, Rural Health Training Centre, Najafgarh (Delhi)

Paper presented at XIIth Annual Conference of All India Association for the Advancement of Medical Education, Ahmedabad, dated the 12-14th January, 1973.

The present complex at Najafgarh came into existence in 1937 as a Rural Health Unit. The aims and objectives were to study and recognise the particular health problems of the area, to chalk out effective methods to solve them and to utilise as a Training Centre for personnel from various other institutions.

As a result of the recommendations of the Health Survey and Development Committee, the Rural Health Unit was converted into a Primary Health Centre in 1953. Incidentally, this was the first Primary Health Centre to be established in the country. Two more primary health centres having 5 sub-centres under them were added from 1955 to 1957. In 1957 this unit was taken over by the Directorate General of Health Services, Government of India and redesignated as Rural Health Training Centre. Since then the Centre has developed as a training-cum-service centre. The various functions of this Centre are:-

1. Research
2. Training
3. Service

Service:

To provide integrated health services to an area which consists of 72 villages with a population of about 135000 scattered over 432 sq. k.m. is one of the important functions of this Centre. The delivery of health care takes place through the three primary health centres which functions under the overall supervision and technical control of the Officer-in-Charge. The staffing pattern of the primary health centre is by no means standard as compared to laid down pattern. The population load per staff member is as below:-

Doctor	-	1	for every	22,000
Dispenser	-	1	" "	45,000
Extension Educator	-	1	" "	45,000
Sanitary Inspector	-	1	" "	27,000
Public Health Nurse	-	1	" "	27,000
Lady Health Visitor	-	1	" "	13,500
Midwife/Trained Dai	-	1	" "	6,500

Medical Relief:

This is designed mainly as an institutional service. The out-patient clinics give diagnostic and therapeutic services for minor and moderate ailments. Facilities are available for referring severely or chronically ill patients as well as those suffering from intractible diseases to the major central hospitals for investigation and admission. In most cases it is possible to arrange for conveyance also.

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The demand for curative services is constantly on the increase as is indicated in table No.1 below:-

Table No. 1

O.P.D. Attendance

Year	Total attendance
1968	154283
1969	171726
1970	175744
1971	185724

The above figures indicate that during the last few years OPD attendance is sharply rising in the primary health centres. Consequent to such a heavy rush in the OPD the primary health centre doctor is mostly confined to the OPD in providing treatment for minor ailments. As such he does not get sufficient time to devote to field duties which is one of the most important components of his responsibilities. Estimated distribution of a doctor's time in a primary health centre is given below: (weekly).

OPD	-	63.3%
Office work	-	20.3"
Field Visits	-	16.4%

Because of the heavy rush in the OPD the doctor is not in a position to do justice to all the patients. According to a study conducted at primary health centre, Najafgarh the time devoted by a doctor in examining and diagnosing the disease of a patient is shown below:-

Table No. II

Time spent by a doctor with a patient

Time spent	% of patients
½ minute	10.4
1 minute	50.0
2 minutes	37.2
3 minutes	0.1
34 minutes	2.3

The patients seeking relief have also to spend a lot of time after having doctor's consultation and getting medicines etc.

Though the throws strain on the limited resources of the Centre, it is encouraging to note that the public is drawn more and more towards the primary health centre for curative facilities which results in providng opportunities of developing contacts and confidence between the staff and the people.

A study conducted on the distance of the villages from the health centre for utilisation of its services showed that the attendance varies inversely with the distance i.e., people living nearer the health centre avail of more facilities that those at the periphery.

Table No. III

O.P.D. Attendance - Distance wise

Distance (in miles)	% of OPD attendance
1 mile	61.8
1-2 miles	18.5
2-3 miles	3.5
3-4 miles	9.7
4-5 miles	1.5
5+ miles	5.0

About 80.00 per cent of the OPD patients in the primary health centres were from the villages situated within a radius of 2 miles. Age-wise distribution of the OPD patients during the last few years is shown below:-

Table No. IV

Age-wise Distribution

Age group (in years)	1969	1971
0 - 1	11.83	16.95
1 - 4	16.64	16.16
5 - 14	23.18	20.11
15 - 34	24.94	23.47
35 - 54	15.20	16.81
54+	8.11	6.60

Maximum number of the patients attending the primary health centres came from the age group of 5-14 years and 15-34 years which was followed by other age groups.

Najafgarh which was once predominantly rural is gradually developing into an urbanised area. But so far appreciable change has been noticed in the general morbidity pattern. Digestive, respiratory and parasitic and skin diseases still occupy first few places in the morbidity table.

Table No. V

Morbidity pattern (OPD Patients)

	1968	1971
1. Infective and parasitic diseases	8.0	4.2
2. Allergic, endocrine system, metabolic and nutritional diseases	9.6	6.17
3. Diseases of blood and blood forming organs	0.1	0.18
4. Diseases of nervous system and sense organs	10.1	7.77
5. Diseases of circulatory system	0.5	0.27
6. Diseases of respiratory system	21.4	18.67
7. Diseases of digestive system	17.0	19.39
8. Diseases of urinary system	1.5	1.04
9. Diseases of reproductive system	0.6	0.96
10. Deliveries and complications of pregnancy child birth and puerperium	0.8	1.44
11. Diseases of bones, joints and muscles	3.4	6.47
12. Diseases of the skin & cellular tissue	16.8	13.75
13. Symptoms of senility and ill defined conditions	0.1	8.21
14. Accidents, poisoning and violence	10.1	11.4

Besides institutionalised medical relief, medical relief at the peripheral level is also provided by the subcentres. The maternity and child health staff while visiting villages on their routine visits are also expected to give symptomatic treatment

to the cases of minor ailments which they come across in the villages. For this purpose they hold clinics after finishing the domiciliary visit. As such it has been made possible to cover the minor ailments and follow up of certain important communicable diseases like tuberculosis etc. This type of domiciliary medical relief service helps not only in making available medical relief at the peripheral level thus reducing work load in OPD of a primary health centre but also in winning the confidence of rural communities for establishing fruitful working relationship with them. It also contributes in softening their resistance and ensures their active participation for new public health programmes which are introduced from time to time.

Prior to 1966 the patients requiring specialist's treatment or investigations were referred to city hospital at a distance of about 17 miles from the primary health centre. It was, however, experienced that because of lack of adequate transport facilities, costly procedure involved in staying in the city hospital coupled with the lack of less confidence of the rural folk in hospital services and the difficulty of having direct contact with different environments, the rural folk had been hesitating to be referred to a city hospital. Keeping this attitude of the villagers in view the system of making available specialised services right at the primary health centre level itself was thought of and the idea ultimately materialised in 1966. Since 1966 specialists from the Safdarjang Hospital have been visiting primary health centre. Najafgarh and Palam twice a week.

Like-wise for reasons enumerated above, it was further observed that patients from the surrounding villages even show reluctance to get admitted as inpatients in the primary health centre of area. They prefer to be treated indigenously rather than take treatment from a primary health centre. To find out the attitude of the villagers towards sickness and treatment, the villagers were interviewed and it was revealed that they give more importance to their work in the field and less to their health.

Table No. VI

Patients attended by Specialists

Year	Medical	Eye	ENT	Paediatrics	Surgical	Total
1969	936	1135	110	236	509	2926
1970	818	1017	976	89	437	3337
1971	898	1311	1183	-	560	3952

Majority of the patients are provided medical relief through the OPD or MCH clinics but some patients who need continuous medical care are admitted in the indoor wing of two primary health centres which have a combined strength of 26 beds. Due to the limited bed strength available with the centres it was found that only 0.9 per cent of those attending the OPD could be admitted in the indoor. Average number of patients per day varied from 9.2 to 10. While the average length of stay per patient was 6 days, bed occupancy ratio is also quite high (89.0%).

It is noted that out of the total indoor admission 56.6% came from villages within a radius of 1 mile whereas 76.1% of the total patients came from villages lying within a radius of 3 miles from the centre. Morbidity pattern of inpatients is shown below:

Table No. VII

Table No. VII

Morbidity pattern of impatients

		%
1.	Infective, parasitic	30.4
2.	Deliveries	21.2
3.	Respiratory	18.0
4.	Digestive	11.7
5.	Others	18.7

In short, medical relief still continues to be a major public health problems, though it is desired very often that it should occupy a less time of a medical officer in a primary health centre in comparison to the preventive and promotive programmes. For minor ailments it has been found from observations and studies that the presence of doctor is not so essential in treating these cases and could very well be looked after by an experienced public health nurse or compounder. This will enable the doctor to devote more time to the field work. Since the existing facilities at the disposal of a primary health centre are not enough to meet the demands of the community the doctor is expected to guide the community in utilising their own resources for health improvement programme. It appears that a satisfactory medical care programme of curative facilities is very much necessary at the present time to make a proper impact on the public whose confidence in public health workers can be built by demonstrating and providing that in need he will be properly looke after.

M.C.H. Services:

The maternal and child health services have necessarily to be institutional and domiciliary. This has been organised in such a way that each normal antenatal case attends at least once in each trimester for check up by the medical officer. The fundamental objective of the MCH services is to provide a total welfare care.

The working objectives of the maternal services as have been envisaged are:-

(1) That every expectant mother is registered as early as possible and not later than 20 weeks. She is given necessary medical attention, health supervision at regular periods which would result in safe delivery and birth of a healthy child.

(2) Reduction of prematurity through proper ante-natal care.

(3) Making domiciliary midwifery safe through training and supervision of indigenous dais.

The Objectives of Child Health Services are:

(1) Complete medical care

(2) Protective immunization

(3) Health Supervision of pre-school children

(4) Prevention of nutritional disorders.

Maternal and child health services operate from three main MCH centres, 5 subcentres and II dai centres. The staff consist of 3 lady doctors, 5 public health nurses, 10 lady health visitors and 21 midwives trained dais who are directly involved in this programme. Family planning programme has been fully integrated with the MCH services. The worker ratio with the population is shown below:

One lady doctor for 45,000 population
One public health nurse for 27,000 population
One lady health visitor for 13,500 population
One midwife/trained dai for 6,500 population.

Ante-natal service:

Aimed at early detection and total care of pregnant women from the time pregnancy is correctly diagnosed till its termination. The following table reveals the analysis of registration.

Table No. VIII

Period of registration (in weeks)

Year	10-20 weeks	21-28 weeks	29-40 weeks	Total
1968	63.0	29.0	8.0	100.0
1969	62.3	22.1	15.6	100.0
1970	55.0	45.0		100.0
1971	60.2	39.8		100.0

It would appear that 58.0% antenatal cases in the area are registered by weeks of pregnancy and approximately 88.0% received care by 28 weeks of pregnancy. Registration is done by midwife/trained dais, 85 indigenous dais (80.00% of whom have received orientation training) have been provided delivery kits and are also conducting cases in collaboration with the field staff. Though majority of the cases are registered in their respective villages, some women residing in the nearby villages report directly in the clinics for registration. As was observed in general OPD, the antenatal mothers too find it difficult to attend the clinics from long distances. In the absence of any complaint, they do not realise the need for a check up by the medical officer. In fact even during the home visiting of lady health visitor or midwife many of the pregnant mothers try to evade the issue and feel shy to get examined. Health education and persuation seems to be necessary to impress on the mothers that the antenatal examination is necessary from the preventive aspect.

Table No. IX

Ante-natal clinic attendance

Distance from centre (in miles)	No. of mothers registered	No. of mothers attending clinics at least once	
		No.	%
Less than 1 mile	378	359	97.9
1 - 2 miles	436	192	44.0
2 - 3 miles	295	34	11.3
3 - 4 miles	205	22	11.0
4 - 5 miles	121	29	24.0
5 +	57	8	14.0

Since mothers find it difficult to walk up to the centres it may be necessary and possible for a mobile team to include examination of pregnant mothers in their homes and spare them the strain of coming to the centre. The lady health visitor herself should be able to screen cases during her domiciliary visits and keep complicated cases for examination by the doctor at the time of her visit to the village.

Summary:

1. The attendance in the out-patients department of the primary health centres is showing an upward trend indicating an increasing demand for curative services.

2. The primary health centre doctors do not get sufficient time to perform field duties as most of his time (63.3%) is spent in the OPD. On the contrary it has always been emphasised that the doctor should devote maximum time in the field to carry out his operational responsibilities for which he needs managerial capabilities relating particularly to efficient use of resources (men, building, equipment, drugs, supplied, transport, indenting - stocking etc.) record keeping communication, planning, coordination and supervisory functions. Due to the heavy rush in the CPD the doctor in 60.4% cases is able to devote only thirty seconds to one minute in examining and diagnosing the diseases of a patient.

3. About 93.5% of the OPD patients in the primary health centres are from the villages situated within a radius of 4 miles. Out of this 61.8% are from within one mile radius. (This finding is similar to Pondichery (Datta and Kale), Andhra (Griffith) and Uttar Pradesh findings where 94.10% and 87.0% per cent cases come down from a radius of 3 miles.

4. Attendance from children upto 14 years was 53.22 of the total attendance. This finding agrees with the observations of Study where attendance of children from the above age groups was round to 55.0 per cent. There appears to be a slight difference when compared with the findings of other studies where the children upto the age of 14 years was found to be 47.4% (Pondicherry), 42.0% in Andhra and 40.0% in Uttar Pradesh.

5. Morbidity pattern of OPD patients at Najafgarh indicates that diseases of digestive system (19.99%) respiratory system (18.67), skin 13.75%) and Cellular system occupy morbidity table. The morbidity pattern shows some similarity with the disease pattern as observed at Singur where also 21.4%, 19.3% and 14.3% OPD patients were found to be suffering from diseases of digestive and respiratory system and of skin and Cellular tissues respectively. Still, dissamilarities are observed with regard to parasitic infections and accidents and violence. The comparitively statement is shown:

		Najafgarh	Singur
(1)	Accidents, poisoning and violence	11.4	4.7
(2)	Parasitic and other infections	4.2	19.0

6. 21.2% of admissions were due to obstetric. Average number of cases per day in a primary health centre varies from 9.2 to 10. The average length of stay per patient was six days. In Pondichery the average duration of stay in the centre was found to be 3 days. Bed occupancy ratio at Najafgarh is 89.0%.

7. 58.0% ante-natal cases in the area are registered by 20 weeks of pregnancy and approximately 88.0% cases receive care by 28 weeks of pregnancy.

8. Visit to ante-natal clinics varies inversely with the distance. 97.9% mothers living within a mile from centre visited the clinic at least once during their antenatal period, whereas only 14.0% cases came to such clinics who were living at a distance of more than 5 miles.

9.

10. 44.9 per cent deliveries are conducted by centre midwives as compared to Pondichery study which disclosed that only 16.8 per cent deliveries were conducted by the centre midwives. The Registrar Central of India (1969) during their

half yearly sample registration of births and deaths during 1966-67 reported that 8.20% of the birth in the rural areas are attended by village midwives or elderly women in the family or neighbourhood and only 11.0 per cent by trained personnel. As such the Najafgarh study shows that staff at Najafgarh is covering large number of deliveries.

11. Of the total village indigenous dais practising midwifery in the villages 80.0% have received orientation training to equip themselves with scientific and asptic skill in midwifery and post-natal care and have been supplied with midwifery kit with the provisions of refill. Deliveries are conducted by these dais with latest knowledge and thus reducing the number of tetanus cases to nil.

12. Due to the improved MCH services health hazards associated with child birth and early infancy have considerably been brought down as shown by the declining trend in birth rate, infant death rate/maternal mortality rate and crude death rate. It is found that on an average the infant received 8-9 visits in home and 2.5 visits at the clinic. The toddler receives on an average 6 visits.

Like all other rural area of the country, bacterial and parastic diseases still flourish in the rural areas of Najafgarh, the reasons being due to low level of sanitation prevailing in the area. Gastro-intestinal diseases like Diarrhoea, dysentery are still prominent to some extent more specially during summer months. Enteric fever is present in endemic form and round the year. Parasitic infestation rate varies from 30-35% among the villages. However, some of the important communicable diseases like small-pox, diptheria have been completely eradicated from the area.

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LIST OF COMMUNITY HEALTH PROJECTS IN INDIA

~~This project list is incomplete~~

Andhra Pradesh

1. CSI Victoria Hospital,Dichpalli,Dist.Nizamabad 503175.- is a few hours bus journey north of Hyderabad airport and railway junction. They emphasise MCH and Leprosy and Care for 21,000 population. Director: Dr.L.M.Hogerzeil.

   This hospital is testing a one shot treatment Rifampicin for leprosy and has a medical insurance scheme for villages.

2. CSI Hospital,Jamalamadugu,Dist.Cuddapah,A.P. does not have a domicilliary programme but they do 2000 tubectomies yearly and run a nutrition rehabilitation unit.(contact person is Dr.G.Arthur Samuel)

3. Anantpur: Rayalaseema Development Trust is directed by Fr.Vincent Ferrer on the edgue of the twon 150 miles north of Bangalore and 300 miles south of Hyderabad on the main highway.

   This project, started 1975 employs doctors in villages.There is also tremendous activity in other community development works especially in water development. Dr.Titmus is contact person for the community health work. 14 clinics were running each with a doctor,ANM and ayah by early 1976, thus serving basic health care to 70,000 population,namely nutrition and immunisation for under fives,safe water supply and care of mothers and illness care.

4. Philadelphia Leprosy Hospital,Salur,Dist.Srikakulam,AP(contact person- Dr.R.H.Thangaraj,Med.Supdt.)

   Also they have started a comprehensive scheme for some 20,000 popele at Pravathipuram some 20 miles from the hospital.

   Salur is several hours by car from the airport at Vishakapatnam.

5. Indo-Dutch Project for child welfare,6-3-885,Somajiguda,Hyderabad.

Bihar

Brothers to All Men International,P.O.Bunladganj,Gaya 823003 has a health programme ~~mx~~ run by Dr.G Pais which by 1974 with resident ANMs serving 20,000 people. There is also literacy and agricultural extension work. This place is some hours south of Patna by bus.

Delhi

Community Health Dept.Holy Family Hospital,Okhla,New Delhi (Contact person-Sr.Anne de Souza)

This programme stresses MCH and Nutrition and has lately tried to reduce costs by using village women as health workers.Population served is about 20,000.

Himachal Pradesh

Willingdon Hospital,Manali,Dist.Kulu,H.P. During 1976 Dr.Surinder Kaul is caring for 900 villages in scattered hamlets in this mountainous area using 5 village health workers.

In October this place is reached by plane to Kulu then an hour by bus.Normally snow ~~mx~~ blocks the valley from Nov.to March and it is in summer an all day bus journey from Chandigarh or the railhead at Kalka or Ropar where a bus can also be obtained are reached by overnight train Kalka mail,or Himachal Express to Ropar.

....2/-

Karnataka

Mallur Health Cooperative,St.Johnes Med.College,Bangalore. Dist.Kolar, Karnataka is 35 miles from Bangalore off the Hyderabad road(If visiting Anantpur in A.P. this is on the way) Contact person is Dr.Ravi Narayan of Prev.Medicine,St.Johns' Med.College,Bangalore.

Mallur rt relies on a cess on milk produced to finance the health scheme.V.Mallur is not poor.Village level workers will be increasingly used in future to reduce costs.

Population served is around 4,000 in 5 villages and services are comprehensive.Bangalore has an airport.

C.S.I.Hospital Bangalore takes care of a slum population at Sherrif Gardens(Supdt.Dr.Benjamin Issac).

Baptist Hospital,Hebbal,Bangalore has a small village health programme on the edge of the city on the road to Hyderabad.

St.Martha's Hospital Bangalore take care of a village on the edge of the city.

Kashmir.

CNI JBM Hospital,Anantnag,Kashmir is an hr.or so by bus from Srinager airport. A village health scheme coverting 5000 people in villages and using 9 village health workers was to start in 1976.Contact person is Dr.M.Xaview,Medical Supdt. or Miss Grace Butt,PHN.

This area is a purdah area being a conservative Muslim area.The hospital trains Kashmir girls as ANMs which was in 1975 the only such school in the State outside the capital.

Madhya Pradesh

Padhar Hospital,village Padhar,Dist.Betul,MP-Supdt.Dr.C.Moss Surgeon Dr.V.Choudhrie,incharge community health,Dr.Veronica Moss. This hospital is Hqrs for the State VHA and its travelling Secretary. The hospital is 120 miles north of Nagpur and airport and is reached from Nagpur by bus

Dr.C.Moss through a Water Development organisation in Betul has sunk 400 wells.Dr.V.Moss plans a village health programme to serve Ghond tribals who have high child mortality. Population served will be 36,000 work to start in 1976.

Christian Hospital,Chattanpur,via Harpalpur,M.P.

Maharashtra

1. Dr.P.M.Shah(Res.10 Suruchi Nariman Point,Bombay 400021) is Prof.of Pediatrices at Grant Med.College Bombay Central. He has 2 projects which he visits each week in Dist.Thana, 90 km.north of Bombay.

   a) Palghar older backed by WHO
   b) Kasa newer backed by CARE

Both these projects stress MCH and nutrition and utilise part-time village women supervised by ANMs of the nearest primary health centre.A full day is needed for one project and visitors without permission will not be entertained.The work is well documented and many papers have been published.

....3/-

Drs.Raj and Mabelle Arole at Comprehensive Rural Health Project, Jamkhed,Dist.Ahmednanagar,Maharashtra. This is reached by overnight train from Bombay-Bombay Howrah Express-getting into Ahmednagar arriving Ahmednagar 8 am. This project cannot be visited without prior approval from Drs.Arole, as they have many visitors and accomdation is limited.

This programme uses village health workers(village women) backed by a mobile team of paramedicals.This project was writtin up in WHO's Health by the People published 1975.

Integrated Health Services project,Miraj Med.Centre,Miraj, Dist.Sangli,Maharashtra is reached by overnight Mahalaxmi Express from Bombay.Director is Dr.Eric Ram. Future of this project beyond '76 is uncertain.Director of the entire centre is Dr.R.Kolhatkar. The project served 216,000 people using AHWs and controlling 2 primary health centres and was well decimented.

Foundation for Research in Community Health at V.Dhokawde, P.O. Awas,Dist.Kolaba,Maharashtra is reached by one and ha half hour lunch from Ferry wharf Bombay to Awas and then a short bus journey to Wandwa.Prior permission to visit is necessary.

This project serves 30,000 population and employs some 30 village health workers,backed by a doctor and social worker. Contact persons are Mr & Mrs.Aloke Mukerjee.They have studied the effectiveness of VHWs for illness.

Chinchipada Chrisitian Hosp.Dhulia,Dist.Maharashtra

Director Comprehensive Health Care & Dev.Project,Mission Hospital,PO Pachod,Dist.Aurangabad,Maharashtra.

Orissa

1. Christian Hospital,V.Diptipur,Dist.Sambalpur,Orissa is reached by Steel Express. Miss Marilyn Mills PHN or the Supit.is the contact person. They care for 8,500 population using illiterate village women. Though remote this is one of the best village programmes in a famine prone area.
2. Christian Hospital.PO Nowranpur,Koraput Dist.(Orissa)

Punjab

1. Dept.of Community Medicine,Christian Med.College & Hospt. Ludhiana-Prof.& Dir.Dr.Mrs.Harbans Dhillon.

   This Dept. serves 50,000 in the slums of the city and 60,000 in the rural areas, staff being entirely provided by CMC using intern doctors and ANMS The home visting skills of the nurses in this programme are very good. Immunisation and family planning are stressed.Documentation is good.

   The Obst.& Gynec(Prof.B.Howie) runs several model under fives clinics and a big postpartum programme. The Postpartumm program The Post partum programme of this Dept.gives MCH care to 50,000 people in the urban area of Gulchaman Gali in Ludhiana city and screens for family planning the outpatients and inpatients of CMC Hospitals a total of nearly 29,000 interviewed yearly. Documentation is good.

2. Director,Community Health,MacRobert Hospital,Dhariwal, Dist.Gurdaspur. Contact person Dr.I.S.Oberoi.This place is reached by full day bus from Ludhiana or by overnight Frontier Mial.The programme has a well documented immunisation programme using staff going out daily from the hospital.Under five clinics are run

TAMIL NADU

1. Nutrition Rehabilitation Centre and village Child Care Centres Dr.A.Venkataswamy, Nutrition Rehabilitation Centre,Govt.Erskine Hosp. Madurai.This is a reference centre for Vit.A deficiency blindness prevention & they have 2000 children with severe malnutrition being fed in village feeding centres, with the help of balasevikas. Dr.K.A. Krishnamurthy,Prof.Of Ped.has a strong community emphasis.

2. Dr.Kottar Social Service Society c/o Bishops House PB No.17 Nagercoil 629001 Kanya Kumari Dist. This project gives some MCH care.There is a huge CRS feeding programme with 30,000 beneficiaries using hundres of village girls.

3. Christian Fellowship Hosp.centre in V.Oddanchatram,Dist.Madurai (Director Dr.Jacob Cherian who is also President of VHAI and Dr. A.K.Tharien who is a past President of CMAI) They train community health guides.

4. Deenbandu Medical Mission,R.K.Pet,631303.Dist.Chingleput,TN reachable by a few Hrs.by bus. This mission has been doing community work for over 20 yrs.Dr.Prem John MPH has recently written 1975 a new project proposal to serve 20,000 with special attention to the poorest 40% of the people using village level volunteers and village midwives.

5. CSI Hospital,Woriur near Tiruchirapalli,Supdt.Dr.Mrs.Stephen supervises ANMs resident in nearby village.A small but good programme.Ktchen gardens are emphasized.

Tiruchirapalli ia an airport.South of Madras,Woriur is only a few miles from the airport.

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ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವು ಅನುಷ್ಠಾನಗೊಳಿಸುವಲ್ಲಿ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳ ಪಾತ್ರ

ಕೈಚುಳಕದ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮದ ಕ್ಷೇತ್ರದಲ್ಲಿ ಕರ್ನಾಟಕ ರಾಜ್ಯ ವಿಶಿಷ್ಟವಾದ ಸ್ಥಾನವನ್ನು ಪಡೆದಿದೆ. ತಂತ್ರ ಮತ್ತು ಮಹಿಳೆ ಆರೋಗ್ಯದ ಮಹತ್ವವನ್ನು ಮನಗಂಡು 1930ರಷ್ಟು ಹಿಂದೆಯೇ ಅಂದಿನ ಮಹಾರಾಜರು ದೂರದೃಷ್ಟಿಯಿಂದ ಬೆಂಗಳೂರು ಮತ್ತು ಮೈಸೂರಿನಲ್ಲಿ ಎರಡು ಜನನ ನಿಯಂತ್ರಣ ಕೇಂದ್ರಗಳನ್ನು ತೆರೆದಿದ್ದರು. ಈ ಕೇಂದ್ರಗಳು ಇಡೀ ವಿಶ್ವದಲ್ಲೇ ಸರ್ಕಾರಿವತಿಯಿಂದ ಪ್ರಾರಂಭಿಸಲಾದ ಪ್ರಥಮ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕೇಂದ್ರಗಳು ಎಂದು ಹೇಳಲಾಗಿದೆ. ಇದು ನಿಜಕೂ ಕರ್ನಾಟಕ ರಾಜ್ಯದ ಹೆಮ್ಮೆಯೆಂದು ಹೇಳಬಹುದು.

ರಾಜ್ಯದ ಎಲ್ಲಾ ಆರೋಗ್ಯ ಮತ್ತು ವೈದ್ಯಕೀಯ ಸಂಸ್ಥೆಗಳಲ್ಲೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮತ್ತು ತಾಯಿ ಮಹಿಳೆ ಆರೋಗ್ಯ ಸೇವೆಗಳ ಸೌಲಭ್ಯವನ್ನು ಕಲ್ಪಿಸಲಾಗಿದೆ. ರಾಜ್ಯದಲ್ಲಿ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವನ್ನು ಮೊದಲಿನಿಂದಲೂ ಸ್ವಯಂ ಇಚ್ಛೆಯಿಂದ ಕಾರ್ಯಕ್ರಮವಾಗಿಯೇ ನಿರ್ವಹಿಸಿಕೊಂಡು ಬರಲಾಗುತ್ತಿದೆ. ಇದರಲ್ಲಿ ಯಾವುದೇ ರೀತಿಯ ಒತ್ತಡ ಅಥವಾ ನಿರ್ಬಂಧಗಳಿಗೆ ಅವಕಾಶವಿಲ್ಲ. ಅರ್ಹ ದಂಪತಿಗಳಿಗೆ ನಾನಾ ಕುಟುಂಬ ಕಲ್ಯಾಣ ವಿಧಾನಗಳನ್ನು ತಿಳಿಸಲಾಗುತ್ತಿದೆ. ತಮಗೆ ಇಷ್ಟವಾದ ವಿಧಾನವನ್ನು ಅನುಸರಿಸುವುದು ಅರ್ಹ ದಂಪತಿಗಳಿಗೆ ಸೇರಿದ್ದು.

ತಾಯಿ ಮಹಿಳೆ ಆರೋಗ್ಯ ಸೇವೆ:

ಕುಟುಂಬ ಕಲ್ಯಾಣದ ಒಂದು ಅವಿಭಾಜ್ಯಅಂಗ ವೆಂದರೆ ತಾಯಿ ಮಹಿಳೆ ಆರೋಗ್ಯ ಸೇವೆ. ಈ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಗರ್ಭಿಣಿಯರು, ಬಾಣಂತಿಯರು ಮತ್ತು ಮಹಿಳೆ ಆರೋಗ್ಯ ರಕ್ಷಣೆಗೆ ವಿಶೇಷ ಗಮನ ನೀಡಲಾಗುತ್ತಿದೆ. ಈ ಕಾರ್ಯಕ್ರಮದ ಮಹತ್ವವೆಂದರೆ ಮಹಿಳೆಗೆ ರೋಗದ ವಿರುದ್ಧ ರಕ್ಷಣ ಚಿಕಿತ್ಸೆ ನೀಡುವುದು. ಮಹಿಳೆಗೆ ಸಾಮಾನ್ಯವಾಗಿ ಬರುವ ಕ್ಷಯ, ಪೋಲಿಯೋ, ಧನುರ್ವಾಯು, ಗಂಟಲು ಬೇನೆ, ನಾಯಿಕೆಮ್ಮು, ದಡಾರ, ವಿಷಮಶೀತಜ್ವರ ಮೊದಲಾದ ಮಾರಕ ರೋಗಗಳ ವಿರುದ್ಧ ರಕ್ಷಣ ಚಿಕಿತ್ಸೆಯನ್ನು ನೀಡಲಾಗುತ್ತಿದೆ. ಹಾಗೆಯೇ ಗರ್ಭಿಣಿಯರಿಗೆ ಧನುರ್ವಾಯುವಿನ ವಿರುದ್ಧ ಹುಚ್ಚುಮದ್ದು ಕೊಡಲಾಗುತ್ತಿದೆ. ರಕ್ತ ಕೊರತೆಯಿಂದ ದುಷ್ಪರಿಣಾಮ ದವಿರುದ್ಧ ಗರ್ಭಿಣಿಯರು, ಬಾಣಂತಿಯರು ಮತ್ತು ಮಹಿಳೆಗೆ ಕಬ್ಬಿಣಾಂಶದ ಮಾತ್ರೆಗಳನ್ನು ಒದಗಿಸಲಾಗುತ್ತಿದೆ. 'ಎ' ಅನ್ನಾಂಗದ ಕೊರತೆಯಿಂದಾಗುವ ಅಂಧತ್ವದ ವಿರುದ್ಧ ರಕ್ಷಣೆಗಾಗಿ ಒಂದು ವರ್ಷದಿಂದ ನಾಲ್ಕು ವರ್ಷದವರೆಗಿನ ಮಹಿಳೆಗೆ ಆರು ತಿಂಗಳಿಗೊಮ್ಮೆ 'ಎ' ಅನ್ನಾಂಗಪಾಕ ಅಥವಾ ಮಾತ್ರೆಗಳನ್ನು ಕೊಡಲಾಗುತ್ತಿದೆ.

ತಾಯಿ ಮಹಿಳೆ ಆರೋಗ್ಯ ರಕ್ಷಣೆ ಸಂಬಂಧಪಟ್ಟ ಎಲ್ಲಾ ಸೇವೆಗಳನ್ನು ಇಲಾಖೆಯ ಕ್ಷೇತ್ರ ಕಾರ್ಯಕರ್ತರು ಮನೆಯ ಬಳಿಗೇ ಹೋಗಿ ನಲ್ಲಿಸುತ್ತಾರೆ. ಹೆಚ್ಚಿನ ತೊಂದರೆಗಳಿದ್ದು ಸಂಬರ್ಭದಲ್ಲಿ ವಿಶೇಷ ಚಿಕಿತ್ಸೆ ಪಡೆಯಲು ನೆರವಾಗುತ್ತಾರೆ.

ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮ ಪ್ರಾರಂಭವಾದಾಗಿನಿಂದ ಇದುವರೆಗೆ ಸುಮಾರು ಶೇಕಡಾ 90ರಷ್ಟು ಜನರಿಗೆ ಕಾರ್ಯಕ್ರಮದ ಬಗ್ಗೆ ಅರಿವು ಮೂಡುವಂತಾಗಿದೆ. ಶೇಕಡಾ 60 ರಷ್ಟು ಅರ್ಹದಂಪತಿಗಳ ಒಲವು ವಕ್ಕಪಡಿಸುವಂತೆ ಮಾಡಿದೆ. ಮತ್ತು ಶೇಕಡಾ 42ರಷ್ಟು ಅರ್ಹ ದಂಪತಿಗಳು ಒಂದಲ್ಲ ಒಂದು ಕುಟುಂಬ ಕಲ್ಯಾಣ ವಿಧಾನಗಳನ್ನು ಅಳವಡಿಸುವಂತೆ ಮಾಡಿದೆ.

ಸಮುದಾಯ ಶಿಕ್ಷಣ ಮತ್ತು ಮಾಧ್ಯಮವು ಜುಮುಳೆಗಳು ಜನರಿಗೆ ಕುಟುಂಬ ಕಲ್ಯಾಣದ ವಿಧಾನ ಗಳನ್ನು ತಿಳಿಸಲು ಬಹು ಪರಿಣಾಮಕಾರಿ ಪಾತ್ರವನ್ನುವಹಿಸುತ್ತದೆ. ಕುಟುಂಬ ಕಲ್ಯಾಣದ ವಿಷಯ ಜನರಿಗೆ ಗೊತ್ತಾಗುವಂತೆ ಮಾಡುವುದು ಅದರ ಪರಸ್ಪರ ಸಂಬಂಧ ಮತ್ತು ಅವರಿಗೆ ನಾನಾ ಕಡೆ ಸಿಗುವ ಸೇವಾ ಸೌಲಭ್ಯ ಮತ್ತು ಪ್ರಯೋಜನವನ್ನು ತಿಳಿಸುವುದು ಈ ಜುಮುಳೆಗಳ ಉದ್ದೇಶ. ಗ್ರಾಮಾಂತರ ಪ್ರದೇಶದ ಜನರು ಸಾಮಾನ್ಯವಾಗಿ ಅನಕ್ಷರಸ್ಥರು ಮತ್ತು ಸಂಪ್ರದಾಯಸ್ಥರು ಇದ್ದುರಿಂದ ಅವರಿಗೆ ಸಣ್ಣ ಕುಟುಂಬದ ಪ್ರಯೋಜನವನ್ನು ಸ್ಪಷ್ಟವಾಗಿ ತಿಳಿಸಿ ಹೇಳಬೇಕಾಗುತ್ತದೆ. 'ಸಣ್ಣ ಗಾತ್ರದ ಕುಟುಂಬ' ದ ಸೂತ್ರವನ್ನು ಜನರು ಒಪ್ಪಿಕೊಂಡು ಇದನ್ನು ತಮ್ಮ ಜೀವನದ ಅವಿಭಾಜ್ಯ ಭಾಗವಾಗಿಸಿಕೊಳ್ಳುವಂತೆ ಪ್ರಚಾರಪಡಿಸಬೇಕಾಗಿದೆ.

ಜಾನಪದ ಚಿತ್ರ ಪ್ರದರ್ಶನ, ವಸ್ತು ಪ್ರದರ್ಶನ, ದೂರದರ್ಶನ, ರೇಡಿಯೋ, ಜನಪದ ಕಾರ್ಯಕ್ರಮ ಗಳು, ಜಾತ್ರೆ ಉತ್ಸವ ಮತ್ತು ಪತ್ರಿಕಾ ಪ್ರಕಟಣೆಗಳು ಜನಾಭಿಪ್ರಾಯ ಮೂಡಿಸುವ ಮಾಧ್ಯಮಗಳ ಮೂಲಕ ಜನಸಾಮಾನ್ಯರಿಗೆ ಜಾಗೃತಿಸ್ಫೂರ್ತಿ ಮತ್ತು ಪ್ರಚಂಡಸ್ಫೂರ್ತಿ ಏರ್ಪಡಿಸಿ ಸಣ್ಣ ಕುಟುಂಬದ ಸೂತ್ರವನ್ನು

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ಒಪ್ಪುವಂತೆ ಮನವೊಲಿಸಲಾಗುತ್ತಿದೆ. ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವು ಮೊದಲೇ ಹೇಳಿರುವಂತೆ ಅರ್ಹ ದಂಪತಿಗಳು ಸ್ವಯಂಪ್ರೇರಿತವಾದ ಕಾರ್ಯಕ್ರಮವಾದ್ದರಿಂದ ಯಾವುದೇ ಒತ್ತಾಯಕ್ಕೂ ಆಸ್ಪದವಿಲ್ಲ. ಆದರೆ ಅರ್ಹ ದಂಪತಿಗಳ ಮನವೊಲಿಸುವಲ್ಲಿ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಹೆಚ್ಚು ಪರಿಣಾಮಕಾರಿಯಾಗಿ ಕಾರ್ಯನಿರ್ವಹಿಸಲು ಸಾಧ್ಯವಿದೆ. ಈ ಅಂಶವನ್ನು ಮನಗಂಡು ರಾಜ್ಯದಲ್ಲಿ ಭಾರತೀಯ ಕುಟುಂಬ ಯೋಜನಾ ಸಂಘ, ಕ್ರಿಶ್ಚಿಯನ್ ಮೆಡಿಕಲ್ ಅಸೋಸಿಯೇಷನ್, ಭಾರತೀಯ ರೆಡ್‌ಕ್ರಾಸ್, ರೋಟರಿ, ಪರಿಣಿತ ಸೇವಾ ಸಮಾಜ, ಎಂಬಿವೆ ಮುಂತಾದ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳೇ ಅಲ್ಲದೆ ಪುರಸಭೆ ಹಾಗೂ ನಗರ ಸಭೆಗಳಂತಹ ಸ್ಥಳೀಯ ಸಂಸ್ಥೆಗಳು ಪಾಲುಗೊಳ್ಳುವಂತೆ ಮಾಡಲಾಗಿದೆ.

ಈ ರಾಷ್ಟ್ರೀಯ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮದನ್ವಯ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕೇಂದ್ರಗಳನ್ನು ನಡೆಸುವ ಸಂಸ್ಥಾನ ನಿಯೋಜಿತ ಶಸ್ತ್ರಚಿಕಿತ್ಸಾ ಮುಖ್ಯತರ ಸೇವಾ ಶಿಬಿರಗಳನ್ನು ನಡೆಸುವ ಸ್ಥಳೀಯ ಹಾಗೂ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳಿಗೆ ನಿಯಮಾನುಸಾರವಾಗಿ ಸಹಾಯಧನ ಹಾಗೂ ತಾಂತ್ರಿಕ ಮಾರ್ಗದರ್ಶನ ಒದಗಿಸಲಾಗುತ್ತಿದೆ.

ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮದನ್ನು ಜನತೆಯ ಆಂದೋಲನವನ್ನಾಗಿ ಪರಿವರ್ತಿಸಲು ಸ್ಥಳೀಯ ಸಮುದಾಯದ ಸಹಕಾರ ತುಂಬಾ ಮುಖ್ಯವಾಗಿದೆ. ಏಕೆಂದರೆ ಅವರು ಸಮಾಜದಲ್ಲಿ ತುಂಬಾ ಪ್ರಭಾವ ಬೀರುವ ಶಕ್ತಿಯುಳ್ಳವರಾಗಿದ್ದು, ಸ್ಥಳೀಯರನ್ನು ಸಂಪರ್ಕಿಸಲು ಪರಿಚಯವಿರುವುದರಿಂದ ಅವರು ಹೊರಗಡೆಯವರಿಗಿಂತ ಯಶಸ್ವಿಯಾಗಿ ಜನರನ್ನು 'ನಮ್ಮ ಕುಟುಂಬದ ಸಮಾಜ' ಕ್ಕೆ ಒಪ್ಪಿಸಲು ಅನುಕೂಲವಾಗುತ್ತದೆ.

ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮದನ್ನು ಇನ್ನೂ ಹೆಚ್ಚಿನ ಪರಿಣಾಮಕಾರಿಯಾಗಿ ಅನುಷ್ಠಾನಗೊಳಿಸಲು ಹಾಗೂ ಅರ್ಹ ದಂಪತಿಗಳಿಗೆ ಹೆಚ್ಚಿನ ಸೇವಾ ಸೌಲಭ್ಯ ಒದಗಿಸಲು ಇಲಾಖೆ ಸಿಬ್ಬಂದಿವರ್ಗದವರ ಜೊತೆ ಸ್ಥಳೀಯ ಜನಾಭಿಪ್ರಾಯ ಮುಖಂಡರು ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಸಹಕರಿಸಬೇಕು ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವು ಅನುಷ್ಠಾನದಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸಬೇಕು.

ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸಿದರೆ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮದ ಗುರಿಯನ್ನು ಸಾಧಿಸಲು ಕಷ್ಟವಾಗಲಾರದು. ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮವನ್ನು ಜನತೆಯ ಕಾರ್ಯಕ್ರಮವನ್ನಾಗಿ ಪರಿವರ್ತಿಸಲು ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಸಕ್ರಿಯವಾಗಿ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಪಾಲ್ಗೊಳ್ಳಬೇಕು. ಎಲ್ಲಾ ಹಂತಗಳಲ್ಲೂ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು ಪಾಲ್ಗೊಳ್ಳುವಂತಾಗಬೇಕು. ಈ ಉದ್ದೇಶವನ್ನು ಮನಗಂಡು ಮುಂದಿನ ವರ್ಷಗಳಲ್ಲಿ ಈ ಕೆಳಕಂಡ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಹಾಕಿಕೊಳ್ಳಲಾಗಿದೆ.

೫೦ ಮತ್ತು ಹೆಚ್ಚು ಹಾಸಿಗೆಯುಳ್ಳದಲ್ಲಿ ಜನಸಂಖ್ಯಾ ಸಮಿತಿಗಳನ್ನು ರಚಿಸಿಕೊಳ್ಳಲು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮತ್ತು ಕಾರ್ಮಿಕ ಮಂತ್ರಿಗಳ ಅಭಿಪ್ರಾಯಕ್ಕೆ ರಚನೆ ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಪ್ರಚಾರ, ಶಿಕ್ಷಣ ಒದಗಿಸಲು ಕಾರ್ಯಕ್ರಮ ಹಾಕಿಕೊಳ್ಳಲಾಗಿದೆ. ಇನ್ನು ಮುಂದೆ ಜನಸಂಖ್ಯಾ ಸಮಿತಿಗಳು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನಕಾರ್ಯದಲ್ಲಿ ಮುಖ್ಯಪಾತ್ರವಹಿಸುವಂತೆ ಮಾಡಲು ಉದ್ದೇಶಿಸಿ ಜನಸಂಖ್ಯಾ ಸಮಿತಿಗಳಲ್ಲಿ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳಿಗೆ ಹೆಚ್ಚು ಪ್ರಾತಿನಿಧ್ಯ ಕೊಡಲಾಗಿದೆ.

೫೦ ಮತ್ತು ಹೆಚ್ಚಿನದಲ್ಲಿ ಮತ್ತು ಹೆಚ್ಚಿನ ಹಾಸಿಗೆಯ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳಿಗೆ ಮಹಿಳಾ ಮಂಡಳಿಗಳಿಗೆ, ಯುವಕ ಮಂಡಲಿಗಳಿಗೆ, ಅಂಗನವಾಡಿ ಕಾರ್ಯಕರ್ತೆಯರಿಗೆ, ಶಾಲಾ ಉಪಾಧ್ಯಾಯರುಗಳಿಗೆ, ಆರೋಗ್ಯ ಇಲಾಖೆಯ ಸಿಬ್ಬಂದಿಗಳಿಗೆ ಹಾಗೂ ಕಾರ್ಮಿಕ ಮಂಡಳಿಯವರಿಗೆ ಮಾಹಿತಿ ನೀಡಿ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನ ಕಾರ್ಯದಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಭಾಗವಹಿಸುವಂತೆ ಮಾಡಲು ಒಂದು ದಿನದ ತರಬೇತಿ ಶಿಬಿರಗಳನ್ನು ಏರ್ಪಡಿಸಲು ಉದ್ದೇಶಿಸಲಾಗಿದೆ.

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Paper distributed at VHAK-FEVORD-K workshop on 17/3/90 by Dept. H+FW, GOK

F.No.73.
Com H 9.14

SCHEME OF 'MINI FAMILY WELFARE CENTRES' AS A MODEL UNDER INNOVATIVE SCHEME OF GRANT IN AID ASSISTANCE TO VOLUNTARY ORGANISATIONS FOR PROMOTION OF MCH, IMMUNISATION & SMALL FAMILY NORM.

OBJECTIVE

The basic approach of the model is to establish Mini Family Welfare Centres to promote MCH, Immunisation of Family Welfare Programme amongst the section of population resistant of family welfare programme and having high birth rates. This will be applicable to town and city upto a population of 1,00,000 and rural areas. Preference under the scheme will be such districts which have been identified as lowCPR and high birth rates (Annexure-I).

2. The objective of the scheme will be entirely motivational to create a link between the infrastructure of Health and Family Welfare facilities and the community to promote responsible and healthy motherhood and small family norm.

3. The salient features of the scheme are:-

3.1 The Scheme of Mini Family Welfare Centre will be operative amongst the population group resistant to Family Welfare programme. For urban areas, it will be limited to slum and unauthorised areas, in towns with population ranging upto one lakh. In the rural areas, the scheme will be restricted to areas having low CPR and high birth rate.

3.2 The objectives of the scheme will be entirely motivational to serve as a link between the infrastructure of Primary Health Centres, Sub-Divisional Hospitals and Family Welfare Centres, Voluntary Organisation Hospitals/Clinics and the community.

3.3 The population to be covered in urban areas will be 25,000 divided into five field units of 5,000 each. In rural areas, the population to be served by each unit be 15,000 consisting of five field units of 3,000 each.

3.4 Structure:- Each project will consist Mini Family Welfare Centre (MFWC) with a unit co-ordinator as Incharge. Each Mini Family Welfare cennre will have five units. In each field unit there will be five Sahelies to be selected from Anganwadi workers, Balwadi teachers or any instructor under other child survival schemes from the operative units under those schemes located in the area of operation of these project. The lady workers from community can also be appointed as Saheli (i) if above named workers are not willing (ii) due to special requirement of the segment of population to be covered. One of the saheli worker will be selected as group leader after ascertaining the leadership quality and watching their work for about three months.

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4. This scheme is both for urban and rural areas. Through this model, attempt is to reach the grass root levels and create awareness in the community served in a phased manner step by step from the very beginning of family formation i.e. marriage. In gradual and step by step method the MCH and family planning is generated as the family do steps keeping a continuous touch with the bride developing into young mother. She is also trained in the art of motherhood by the grass root level. Voluntary worker known as 'Saheli' in this model. This trained mother becomes an agency herself for passing these traits to the new brides in her family and those in close proximity. Thus gradually the MCH & Family Welfare motivation would progress in a chain like manner and in our course the worker will have to concentrate on lesser number of families and contact with trained mother would be of maintenance centre.

5. <u>The Mini Family Welfare Centre</u>

The Mini Family Welfare Centre will have 5 field units and each unit will serve a population of 3,000 in rural areas and a population of 5,000 in urban areas. The following conditions have to be fulfilled:-

(1) The Mini Family Welfare Centre will be situated in the area of population served by it. Its 5 fields units will be disbursed around in the area of operation.

(2) The Mini Family Welfare Centre will be attached for clinical and referral services to the nearest PHC of community Health Centre of Urban Centre in city area or voluntary Organisation Hospital/ Clinic to be specifically earmarked in this project.

(3) The Mini Family Welfare Centre will serve as a depot for supply of contracoptives like condoms and oral pills.

(4) The Mini Family Welfare Centre will serve as a unit for Community uplift by (i) Imparting Health Education (ii) training married young women in the art of motherhood; (iii) Immunisation in children and mothers; (iv) motivating the community specially the target couples to have small family norm and (v) ensuring proper sanitation and hygenic conditions.

(5) The staff should be employed from the community to be served specially the grass root level work the Family Female Voluntary worker 'Saheli'.

(6) The Basic principle involved in the success of mother is to create rapport with the newly wed bride and follow the couple through their reproductive phase including first pregnancy, delivery, post natal caro, spacing of pregnancy, second pregnancy and finally sterilisation. During the follow up she will be educated and helped as the need arises in various phases step by step, ensuring a healthy marital life, healthy healthy pregnancy period, safe delivery, healthy and trained motherhood and Finally ensuring spaced small

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family. This step by step approach will provide complete MCH cover and Family Planning. This approach will produce well trained mother who can help other newly weds in her family and neighbourhood.

(a) Methodology

In average there are three to four marriages performed each marriage session in a village/cover area of an average 800 to 1,000 population.

(b) First Step

To establish rapport with the Newly Weds and their family and this is done by 'Saheli' (Family Female Voluntary Worker) by ensuring her presence in the marriage and creating closeness to the family by presenting a small gift to the newly wed. This gift may be small and consist of some general items of brides use. In this gift pack there should be nothing related to Family Planning, so that no sensitivity is created in the family or with the bride. This primary rapport with family of newly wed and the bride herself will open the path for consequent visits.

(c) Second Step

The worker pays a casual visit to know the Welfare of the newly wed and creating personal friendship with her. This may be done at a convenient and congenial time.

(d) Third Step

During the casual visits 'Saheli' (Family Welfare Female Voluntary worker) may come to know about the conception occuring in the newly wed. From this, the visits of the worker is goal oriented and purposeful. The worker should start educating the mothers regarding the conception, pregnancy, nutrition, for mother and child and few does and doesnot in sanitation. During this visit the worker should congratulate and encourage the would be mother and take her into confidence. This is the best period when the young mother is most receptive and inquisitive to learn about motherhood in confidence through a friend.

(e) Fourth Step

The would-be mother is gradually prepared to come to the Primary Health Centre/Hospital with the help of elder family members specially the mother-in-law. Thus the routine ante-natal help is provided and would-be mother is told about healthy motherhood, protection of self from tetanus, nutriative value of specific foods to be taken and role of sanitation in pregnancy and delivery. She is educated for preparing clothese for delivery and the child to come. Complete checking is done at the nearest centre and if she is a risk case, she should be referred to Community Health Centre. Thus at

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one side the would-be mother is educated for motherhood and at the other side she is given full ante-natal services and care.

(f) Fifth Step

'Saheli' (Female Family Voluntary Worker) thus fully prepares the would-be mother to have safe healthy delivery. Physically and mentally, she should be motivated for delivery at home or Community Health Centre or a Hospital as the case may be. The Voluntary Worker should as far as possible attend the delivery for providing psychological confidence in the mother to be.

(g) Sixth Step

As the delivery takes place the 'Saheli' should present another 'Gift Pack' containing articles like Baby Soap, powder, Clean Napkin etc. With a small booklet of baby care and Birth card. The use of each article is to be fully explained putting emphasis on baby immunisation, nutrition and knowledge about oral rehydration along with method for preparing it. This all should be done in home surroundings in presence of womens' gathering which is a usual way. After delivery, by this step continuation of contact is ensured and knowledge is gained by other mothers, elderly ladies and other would be mothers.

(h) Seventh step

The new mother is now prepared to listen about spacing methods and be made interested in the use of Nirodh, Copper'T' oral pills. The need of spacing be generated through knowledge about the healthy development of baby if spacing is adopted. Also Family planning is talked but casually and if the need is generated services are provided.

(i) Eighth step

If the need for second child is shown in a strong manner the worker should wait and help her through the second pregnancy. But usually for the second pregnancy the mother is fully prepared. Gifts may be repeated for the second delivery to create a final approach to sterilisation after second delivery.

Thus, it is seen thatstep by step the young lady is approached as per need creation and helped and educated gradually when she is fully receptive. A person is not receptive for everything, every time but she becomes very receptive at the time of need and this is the key of success in above methodology.

Secondly, this scheme ensures creation of trained mother who can become a natural trainer in future.

Third advantage is that the image of the 'Saheli' (Family Female Voluntary worker) gradually grows and in this way she is herself sought for reducing her work gradually and also the number of visit in later period.

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Unit coordinator will be a full time employee and primarily Extension Educators and will be required to develop rapport with the Primary Health Centres, Sub-Divisional Hospitals, Family Welfare Centres and voluntaryorganisations, Hospitals/Clinics where he will be required to send the motivated persons. In case of male unit Coordinator he will also try to motivate the men in his areas for adopting a small family norm and terminal and spacing methods of family planning.

Unit Coordinator will have a degree in Science or Social. Science and Biology from the recognised University. Preference will be given to persons having two years experience in health care/ family planning activities.

(b) Group Leader

Group leader will primarily be a Saheli but she would also be given an additional responsibility to assist the Sahelies and act as group leader of the unit. She will establish rapport with the Primary Health Centre, Sub-Divisional Hospital and other Hospitals/ Clinics and main basic records to be passed over to the unit Coordinator. She will help to develop a programme for motivation of women in reproductive age group for a small family norm. She will extend support to Sahelies by visiting family etc.

(c) Saheli

There will be one saheli for a population of urban area and 600 in rural area. The saheli will from the Anganwadi worker/Balwadi workers or instructors or otherChild survival scheme from the units located in the area of operation of the project. The lady workers from community can also be appointed as saheli (i) if above narmer workers are not willing. (ii) due to special required men , if the segment of population to be served. Besides the honorarium of Rs.100/- p.m. motivational and that benefits for sterilisation and IUD cases will be possible to the Saheli in addition in accordance with the prescribed by the respective State Government.

(11) Monitoring and Evaluation

This will be done each month at the level of PHC in rural set-up and at district level in city set-up by M.O., PHC/CMO respectively in their regular meetings. Project Manager will present the report regarding the work of the centre under various heads like:-

1. Referral Cases.
2. MCH Work
3. Motivation.
4. House Visits.
5. Educational programme
6. Training programme
7. Area profile.

12. Release of funds

Release of funds will be under the Central Sector scheme for grant-in-aid to Voluntary organisations. The amount of Rs.66,709/- for meeting the cost of implementation of the scheme during one year period will be paid into two instalments. The first instalment for the six months will consist of full non-recurring expenditure and 50% of recurring expenditure. The second instalment will be given when the project starts operating after completion of three months of the project life on receipt of the progress report and expenditure statement for the first quarter.

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COM H 9.15

UPASI COMPREHENSIVE LABOUR WELFARE SCHEME.

"Glenview" P.B.No.11 Coonoor -1.

Ref.No:CLWS/18/80.

5th December, 1980.

To

ALL MEMBERS - UPASI.

Dear Sir(s):

MEDICAL INFORMATION.

** Herewith I am enclosing an extracts from the "WHO Chronicle" on -

(a) Containing the rising cost of medical care.

(b) Health care means more than doctor.

The two topics extracted would be of great value to managers and medical officers alike.

Yours faithfully,

Dr.(Mrs.)V. Rahamathullah,
Medical Adviser.

Encl:**

Copy to: The President & Members,
Executive Committee.

The Convener & Members,
Rural Development Sub Committee.

Attached

CONTAINING THE RISING COST OF MEDICAL CARE.

(Extract from WHO Chronicle, 31:408-412(1977)

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This is based on a paper prepared by Dr.B.M. Kleczkowski, Dr.E.P. Mach, and Dr.R.G. Thomas, for a meeting of experts on raising medical care costs held in Geneva, in May 1977 under the International Labour Organisation.

To help contain costs, administrators are asked in this article to consider (i) revised structures of benefits that would accord at least equal treatment to outpatient and home care, prepaid group practice, and other less costly types of care; (ii) better cost accounting to permit more accurate measurement of the relative costs of different kinds of care; (iii) measures to increase the cost-consciousness of physicians and the public; (iv) various ways to contain the costs of drugs; and (v) how to promote self-care. For the longer run the article examines the role of preventive medicine in cost containment.

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1. By making care ever more widely available at little or no direct cost to the consumer, it increases demand for services more rapidly than supply.

2. By being too often considered as simply another way of paying for existing kinds of medical care without providing incentives for changing to less expensive, more rational methods, it helps perpetuate the existing bias towards the more costly kinds of treatment and does not strike at the root of increasing costs.

For the relatively wealthy industrialized countries with schemes already in force, the costs are verging on the intolerable. For developing countries

looking to social security as a means of expanding medical care but from a much smaller resource base, these distortions can nullify the potential of social security to provide improved care for wage earners and can broaden the already wide gap between health care for the urban worker and that for his rural counterpart. These are the reasons why cost containment, or at least a process of rationalization, is being subjected to increasingly close study.

The bias towards hospitalization:

Too often, plans provide maximum benefits only for treatment in hospital, thereby inclining patients to opt for (and, equally, physicians to prescribe) this most expensive of all forms of treatment, even when out-patient or home care would be as good or better and less expensive in many cases. This bias is reinforced by the widely held public impression that only the latest technology and newest medicines administered by the most highly skilled specialists - of the sort available only in hospital - can provide effective treatment. What is overlooked is that, once in hospital, the patient is often caught up in a medical care chain without real incentives for reducing costs.

Typically, the patient himself does not care about the cost of treatment because "someone else" is paying for it. The physician who prescribed the treatment has neither the incentive nor often even an awareness of

the need to be cost-conscious because he bears no part of the cost. The hospital, as provider of the prescribed services, is not likely to inquire too closely as to the usefulness of the treatment or its cost, so long as it is assured of receiving payment. Finally, the third party, once he receives the bill that includes all the costs passed along through the chain, is poorly positioned to question charges after the fact.

With hospital costs as the largest and most rapidly growing component of the total cost of medical care, they become an important target for efforts to contain costs. However, because medical care, especially in hospital, is so labour-intensive, staff salaries alone amount to as much as 70% of the operating costs, which cannot be reduced significantly without affecting services adversely; much the same is true of the other major hospital operating costs. It is thus necessary to look for greater operating efficiencies and, more particularly, for better use of the available supply of beds as the primary means of containing costs.

Abuse of advanced technology:

Another important contributor to the explosion in the cost of medical care has been the uncritical acceptance of new technology and the very expensive devices necessary to put this technology into practice. Whether prompted by high public expectations of yet another miracle treatment, a propensity to equate the latest with the best, or a competitive desire for

prestige in a medical version of "keeping up with the Joneses", this attitude leads to investment in costly techniques and facilities, which are needed by only the most seriously ill, who constitute only a small fraction of those needing health care.

What this means in economic terms is that, while health has broadened the base of the medical care cost pyramid by making care much more widely available, advanced technology contributes to raising the height of its peak. Taken together, these two factors result in much higher total cost rather than more equitable distribution of services according to needs. In extreme cases, it means that the technology itself determines who will be treated rather than social need, other more traditional factors.

Medical manpower costs - a vicious circle:

This bias towards hospital treatment and advanced technology bears both directly and indirectly on the cost of medical manpower. By requiring a large staff of specialists to take full advantage of the hospital's facilities, this type of medical care draws upon the most highly trained, and therefore most expensive, members of the medical profession. Also it usually involves more different kinds of care than simple regimes, thereby adding to costs, yet producing few measurable health advantages in terms of either mortality or morbidity.

How to contain medical care costs:-

1. Revised benefit structure: By changing the structure of health benefits so as to accord more equal treatment to health services other than hospital care, e.g., home or outpatient care, administrators could provide a financial incentive for both patient and prescribing physician to consider the full gamut of possibilities for treating a particular ailment, perhaps arriving at a less expensive, but equally effective, alternative to inpatient care. In fact, recent studies have increasingly emphasized that the organization of medical services may be second only to morbidity in determining hospital utilization. In one example of prepaid group practice in the USA, emphasis on outpatient and preventive care reduced hospital use by about 50% within five years; the latest report indicates that the rate of hospital utilization by this group practice even after a number of years was about half that of a similar group in the same city participating in an open fee-for-service plan. Similar experiences in socialist countries, where fully integrated services give equal emphasis to curing, prevention, rehabilitation, and social services, suggest, that this approach provides a useful basis for selecting the care actually required by individuals and most convenient for them. Hospital care thus be comes but one alternative among a number of options.

2. Better cost accounting: Arriving at an accurate estimate of the overall savings that result from this substitution of one kind of health service for another

has proved to be difficult. Most current accounting systems divide costs along administrative lines, i.e., staff, equipment, drugs, etc., or lump them together into simpler units such as cost per inpatient day or per hospital bed. They also tend to ignore such essential variables as the degree of health risk or the gravity of the problem being dealt with. Thus, they do not lend themselves to making meaningful comparisons of the costs and benefits of dealing with a given health problem in different ways.

Recently, however, there has been progress towards developing systems of standardized cost accounting for each medical care programme that pinpoint the relative cost of each and make it possible to evaluate the most costly kinds of treatment against the benefits resulting from them. To know that the same benefit can be obtained at lower cost is clearly to the advantage.

3. Medical cost-consciousness: Since the physician in most cases decides how much and what kind of medical care his patients "demand" and such demand more or less automatically follows supply, he has a potentially vital role to play in cost containment. Yet most physicians are poorly equipped by both training and personal inclination to perform effectively in this role. Few medical schools devote any attention at all to the basic economics of me-dical care; instead, the atmosphere of a lavishly equipped hospital, whether deliberately or not, tends to create a predisposition towards the latest, and often the most expensive, in diagnostic and therapeutic equipment

and techniques. The sense of professional pride inculcated into me-dical students while in training inhibits many practising physicians from considering community nurses, family health workers, and other "physician extenders" as qualified to perform a significant portion of their routine medical duties. While none of these attitudes and viewpoints is likely to be susceptible to rapid change, least of all, there are signs of growing cost-consciousness on the part of physicians; these must be encouraged by every available means.

4. Cost of drugs: Another important factor in the upward pressure on the cost of medical care is the large and increasing consumption of drugs, both by prescription and for self-medication. In France during a recent year, for example, over 18% of all health insurance expenditures went to pay for drugs used by outpatients. For all of Europe, it is estimated that the total bill for drugs amounts to more than 10% of the funds spent on health services. Unlike other components of medical care costs, the pattern of increasing drug consumption appears to be relatively independent of how health services are organized. The USA with its liberal system, the United Kingdom with its National Health Service, and Poland with its centrally planned and run system all have similar patterns of increasing drug use.

In fact, the rate of increase of drug use and the types of drug used appear to depend primarily on the number of preparations available in the market for either

self-medication or prescription use and on prevailing prescription practices. For example, the volume of drugs attributed to self-medication amounts to 35% of total drug consumption in the USA, 22% in Switzerland, and 18% in France. Consumption of acetylsalicylic acid (aspirin), the drug most commonly self-administered, averages over 60 tablets per person annually in Europe and as high as 225 tablets in the USA.

Adding to the volume of self-medication is the market tendency towards inappropriate prescription of drugs. Perhaps prompted by the patient's belief that all medical consultations, to be satisfactory, must result in a prescription or for other reasons, physicians seem all too willing to prescribe drugs, whether or not they are needed. In the USA, it is estimated that the great majority of all physicians engage in this practice; there, 60% of all drugs prescribed against the common cold were antibiotics and sulfonamides, which are both expensive and ineffective in such cases.

With this combination of excessive public reliance on drugs and the tendency of physicians to overprescribe, governments have tried a number of regulatory measures. To help physicians sort out the conflicting advertised claims made for the increasing numbers of drugs being marketed by the pharmaceutical industry, some governments have set up neutral advisers on drug information at the state level and have limited the promotion of new drugs to factual statements only. What is needed, in addition, is broader public awareness and understanding of the proper role of drugs in treating disease.

They can promote the concept of "essential drugs", whereby drug purchases are concentrated on those drugs that are of proven efficacy against defined health problems and are available at a reasonable cost.

5. Self-care: The often overlooked fact that as much as 75% or more of all health care is undertaken without professional help provides another focus for efforts at cost containment. Despite some opposition from the more conservative elements of the health professions, it is estimated that about 25% of all illness episodes seen in general practice could be treated entirely through self-care and another 15% or so would have a better outcome if supplemented by self care, particularly "guided self-care" by which the patient would learn to understand his ailment and what he can do about it.

For example, in a controlled experiment that taught a group of haemophiliacs and their families how to manage their bleeding problems, the rate of hospital usage was reduced by 90% over one year, with equivalent savings in hospital costs. Moreover, absenteeism from work or school was cut by 74%, outpatient visits by 76%, and the total cost of health care by 45%. In another example of guided self-care, a telephone "hot line" installed in a clinic treating diabetics resulted in a two-thirds reduction in the incidence of diabetic coma and a one-half reduction in the number of emergency admissions over a two-year period; this occurred despite an increase in the clinic population from 1000 to 6000.

Guided self-care does not always provide such immediate benefits because of the time and money spent on providing training, but once the training is completed it can provide a low-cost substitute for professional care that is immediately available and can be adopted to the needs of the patient. Self-care by patient can also have an important bearing on reducing costs by making doctors prescribe treatment more responsibly.

6. Prevention: The five containment measures just discussed are all aimed primarily at keeping the cost of the curative component of health care within bounds since this is where the bulk of medical care funds are spent, even though such expenditure have been shown to have little effect on the general health status of the population. One final measure-prevention is likely to command a greater share of future funds as accumulating scientific knowledge buttresses existing evidence dat genetic and environmental factors, plus human behaviour and life style, rather than disease are the major determinants of health. Schemes should thus be prepared to provide support and encouragement to cost effective programmes of preventive medicine.

These programmes include early identification of those at high risk of chronic disease and giving individuals every opportunity and incentive to change their life style.

Another approach to prevention is the early detection of disease. The cost of systematic medical screening of every effectively treated case is often substantial, particularly when applied on a mass scale.

None the less, there is sufficient epidemiological evidence to indicate that the incidence of many chronic conditions can be significantly reduced through preventive care by putting into effect what is already known about them, thus reducing the burden of chronic care which hospitals are so often called upon to finance. What is missing are the economic incentives, necessary motivation of healthcare providers and consumers, and the kind of organizational structure that will make such achievements possible. Although countries have come well past the old and outdated notion of limiting health coverage to confirmed cases of disease, they generally have some way to go in bringing about the conditions that will permit preventive care to make a maximum contribution both to containment of medical care costs and to the improvement of health status. This is the challenge of the future.

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sspd.
5.12.1980.

HEALTH CARE MEANS MORE THAN DOCTORS.

(WHO Chronicle - Vol.31, 1977)

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Health problems cannot be solved by the health sector alone. This was learnt after much money and energy went towards increasing the number of doctors and hospital beds. The idea was to model health services after the examples of the wealthy developed nations. Health is influenced by poor living condition, unsafe water, malnutrition and wrong dietetic and some harmful cultural practices. Hence, today, extension of services to where people live and delivery of health by people in the community have shown much more promise of fulfilling the desire of the century "health for all by 2000 A.D.".

Community health workers, health auxilleries and para-medicals are able to improve the health of the community at a fraction of a cost of highly trained professionals. They are able to pinpoint the underlying causes of disease in the community and they are instrumental in organising their fellow citizen to take action for health.

Today, health care systems are changing their perspective, away from big hospitals to the needs of the community. The emphasis is to link communities to the health centres.

It must be emphasized that prevention and promotion are the most important aspects of health care and needs support from all levels. The problem must be attacked at its origin - the community.

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sspd.
5.12.1980.

Com H 9-16

Role of Voluntary Agencies (India)

Social work based on the spirit of Sympathy, [illegible]

Spiritual urge to help one's fellow beings in distress visited in different societies from the time immemorial.

Bhagwat gita says "charity is valid if it takes into account DESH, Kal, and Patra. (Place, time andrecipient)

Kaulalaya has mentioned in his Arthasastra the responsibility for the care of the poor aged, distribite etc.

In king Ashoka's formi Gopas were like Social workers.

Social work through religion	Voluntary
British Perior and Social reforms	Voluntary
Gandhian Social work	Voluntary
Post independence.	4 crores in 1.5 yr.
Public coporation	Govt. Public _ Voln.

Traditionally, bulk of the Scoial welfare Services in our country was organised by voluntary agencies who with their long have been playing on importent role in providing services for the underprivileged.

Now there are thousands of voluntary agencies with lakhs of workers in it About 6000 of them are an grant in aid rolls in cnetral Social welfare bound and /or with stats Govt. assistence.

A voluntary organisation properly speaking in an organisation which whenther its workers are paid or not is initiated and governed by its own mombers without external control - Voluntary action is by its very nature local.

Non official agencies:-

Voluntary organisations are Sponthneous in their origin.

Non offical agencies may be sponussed by govt.

CHANNELS OF VOLUNTARY EFFORT

CASH
KIND
VOLUNTARY SERVICES

THROUGH

INDIVIDUAL	VOLUNTARY AGENCIES	SEMI GOVT. AGENCIES
1. Voluntary through agency	Voluntary Workers	1. Adho Committes
2. Personel Service at individual	2 paid Workers	2. Permanent committes.

GROWTH OF VOLUNTARY AGENCIES

1901 - 1960

PERIOD	NO. OF AGENCIES	%
Before 1900	107	1.78
1901-10	71	1.18
11-20	138	2.30
21-30	303	5.05
31-40	522	8.70
41-50	1350	22.50
51-60	3263	54.39
No. information	246	4.10
TOTAL	6000	100.00

NUMBER OF INSTITUTIONS ACCORDING TO THE SPONCERING AGENCIES

S = States, R = Religion organisations O = Others T = Total

S	R	O	T	S	R	O	T
A.P.	15	290	305	My.	27	381	408
Ass.	7	337	344	Or.	11	232	243
Bi.	15	213	228	Pun.	8	142	150
Gu.	19	539	558	Raj.	11	268	279
J.K.	2	19	21	U.P.	13	312	325
Ker.	73	520	593	W.B	77	869	946
M.P.	9	241	250	Del.	7	87	94
T&M.	52	359	411	Others	9	65	74
MH.	61	710	771				
			Total		416	5584	6000
					6.9%	93.1%	100%

INSTITUTIONS WORKING FOR THE WELFARE OF HANDICAPPED PERSONS

Categroy of Beneficiaries	Run by Voluntary agencies		Run by Govt.		Total	
	NO.	%	NO.	%	NO.	%
BLIND	115	55.1	16	55.2	131	55.1
DEAF & DUMB	60	28.7	11	37.9	71	29.8
CRIPPLED	22	10.5	2	6.9	24	10.1
MENTALLY	12	5.7	-	-	12	5.0
TOTAL	209	87.8	29	12.2	238	100

ANALYSIS OF GRANTS

Upto 1966

FIELD	NO. OF AGENCIES	%	Amount in crores	%
Child Welfare	2337	39%	2.63	43%
Womens Welfare	2920	49%	2.26	37%
Welfare of the handicapped	243	4%	0.62	10%
general welfare	468	8%	0.65	10%
TOTAL	5960	6.16 100	6.16	100

DISTRIBUTION OF THE AMOUNT SANCTIONED
ACCORDING TO FIELD OF SERVICE

1953-1966.

TOTAL 6.16 CRORES

STATES WHERE 740 LAKHS SANCTIONED.

State	Child welfare	Women welfare	Welfare of the handicapped	General welfare	Total
A.P.	20.10	15.51	3.26	2.75	41.62
Gu.	19.18	20.98	4.03	3.84	48.03
Mad.	29.49	17.38	7.93	3.65	58.45
Maha.	33.66	28.43	18.31	6.24	86.68
Mys.	21.88	15.85	2.69	4.55	44.97
U.P.	13.33	14.61	4.82	11.41	44.17
W.B.	29.91	37.21	4.34	8.76	80.22
TOTAL	263.59	225.66	62.06	64.78	616.09
	40%	35%	12%	13%	100%

ACTIVITIES OF W.H.O.

1. Strengthening of the health Services.
2. Family Health.
3. Health Manpower development
4. Communicable disease control.
5. Non. " " "
6. Immunology.
7. Prophylactic, diagmovtic and Therapntic Substance.
8. Environmental Health.
9. HEalth statistics.
10. Biomedical research.
11. Health literature-information.
12. Cooperation with other organisations.

Family Health.

M.C.H.

NUTRITION

HEALTH EDUCATION

HUMAN REPRODUCTION.

Improved management of preg; childbirth, fixbibity regulation

Promotion of growth of young children.

Prevention of diseases during pregnency and childhood.

Promotion of the health of the family.

F.P. MCH centres in 70 projects in 60 countries.

In India community oriented teaching in Prediatrics

Special fuding for children.

(with UNICEF and other organisations)

At the 26th Session of the regional Committee for S.E.A. the following 4 areas were recommended as diserving high regional priority.

1. Communicable disease control
2. Family health
3. Nutrition
4. Provision and manitanence of water suply and drainage.

High birth and death rates (meternal and infant mortabily) emphasige the importance of~~xxxxxxx~~ necessity of according high proiority to family health in S.E.A. region.

1976to 1977 - MCH and F.P. will be included into general health sercices.

Special health measures againest malnutrition.

Which is the other agencies

Development of Community health Nursing Services (1975)

Strengthening of the depts. of Pac, Obs. and P&S.M. (1958-77)

Applied Nutration programme (1964)

Nutrition traning

Health education in Schools, including family life edu.

Central education

Blindness prevention.

OFFICIAL RECORDS OF WHO. NO. 220

Proposed programme budject for the financial yr.

1976, 1977.

No.	Regular	Other	Total	%	Total
1974	239745	1066872	1305817	7.1	21463109
1975	230850	1654514	1875364	8.1	2016472
1976	221730	1446727	1668457	9.1	17417157
1977	225370	1734380	959750	7.5	15903241

For Meironal and Child health.

Red Cross

Meternity and child welfare as an integral part since 1931 to assit in MCH.

gives Technical and financial assistance

Health education

Kits to midwife

Special welfare programme in U.P.

Family welfare planning.

Ford Foundation

Manity rural health services and F.P.

1. Orientation and training centres.
2. Research cum action projects
3. Pilot project in rural health services (gandtigra)
4. Establishment of NIHAE.
5. Calcutta water suply and drainage scheme.
6. F.p. programmes (follower lips)

Rockefeller foundation

To promote the welI being of mankind.

Begining Public health and Medical education.

India 1920.

Worm control - Madras.

A.I.I. Hygine & Pub. He. Culcutta.

Now for

xkmmar

Improvement of agriculture.

Rural training centres.

Medical education.

F.P.

CCARE (cooperative for American Relief Every where) 1946.

1961 on India.

Mid day meal programme.

USAID (Upisted

USAID (United Sates agency for international development)

Control of Communicable diseases.

Water suply and Sanitation.

Medical, Nursnig and Health education

Nutritions

F.P.

Colomboplan:-

NIIMS - (Newguland)

UNICEF- Education

Health
Nutrition Applied Nutrintion programme.

Water suply 986 Blocks.

Social Welfare 347 Training Institutions.

UNDP Agriculture

Industry 267 Production centres

Education

Health and Social Welfare

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GOVERNMENT OF KARNATAKA

DIRECTORATE OF HEALTH AND FAMILY WELFARE SERVICES, BANGALORE

HEALTH AND FAMILY WELFARE COMPONENTS AVAILABLE FREE FOR HEALTH CARE DELIVERY THROUGH VOLUNTARY ORANISATIONS

Sl. No.	Programmes	Beneficiaries	Methodology	Objective	Role of the voluntary organisations	Remarks
1	2	3	4	5	6	7
	NUTRITION PROPHYLAXIS PROGRAMMES					
1.	Iron and Folic acid tablets for mothers (Iron-60mg; Folic acid 0.5 mg.)	Expectant and Nursing mothers, women Family Welfare acceptors.	1 tablet to each of these women daily for 100 days.	Prophylaxis against Nutritional Anaemia	Voluntary organisations can distribute these drugs to the beneficiaries.	1. Monthly quota to be distributed once in a month. List of beneficiaries to be maintained in prescribed, form. 2. To be obtained from D.H. & F.W.O./ P.H.C./Sub-centre.
2.	Iron and Folic acid tablets for children (Iron-20 mg Folic acid 0.1 mg)	Children below 12 years of age School going and pe-school.	1 tablet daily for 100 days	do	do	do
3.	Vitamin 'A' concentrated Sol.2 lakhs units strenght.	All children from 1 to 4 years.	Once in 6 months in the form of capsule or liquid.	For preventions of night blindness, Keratomalacia and other complications due to Vitamin 'A' deficiency.	do	1. This programme is taken up in the rural area at present. 2. To be obtained from P.H.C. or sub-centre.

..Contd/2-

1	2	3	4	5	6	7
IMMUNISATION PROGRAMMES						
1.	D.P.T.	All children from 3 months to 3 years.	Start at 3rd month and 3 doses at an interval of 4 to 8 weeks with a booster dose 18 to 24 months later.	Prevention of Diphtheria, Tetanus, pertussis (whooping cough)	Completion of 3 doses. Voluntary organisations can organise immunisation campaign in the rural area and slums in the urban areas and carry out the immunisations.	1. Vaccine to be stored in refrigerator at t of 4°c to 10°c. 2. To be obtained f D.H.& F.W.O./P.
2.	D & T	All children between 3-8 years.	Two doses at an interval of 4 to 8 weeks (Primary Vaccination i.e. no DPT previously given) Booster dose in case of previous DPT after an interval of one year.	Prevention of Diphtheria and Tetanus.	Completion of 2 doses or one booster dose Voluntary Oranisations can organise immunisation canpaigns in the rural areas and slums in urban areas and carry out the immunisations.	do
3.	T.T.	Antenatal cases	In case of antenatals 3 doses-starting 1st dose at 16-20 weeks, 2nd dose at 20-24 weeks & 3rd dose at 36-38 weeks.	Prevention of Tetanus	Voluntary organisations can take up as a part of MCH Service and immunise anatenatals.	do
4.	B.C.G. Vaccination	3 months to 19 years	Earliest at the age of 3 months	Prevention of Tuberculosis	Voluntary organisations can arrange mass immunisation programmes with the assistance of Dist. T.B. Centres.	1. Vaccine to be s in regrigerator. 2. Vaccine availabl Dist. T.B. Cent

...Contd/3-

1	2	3	4	5	6	7
5.	Smallpox Vaccine	Primary only	At the age of 3-9 months	To prevent smallpox	Voluntary oranisations can take up as part of MCH services and conduct Primary Vaccinations.	1. Vaccine to be stored in refrigeration. 2. Vaccine available at the PHC
6.	Polio Oral Vaccine	All children 3 to 9 months	Start at 3rd month and 3 doses at an interval of 4 to 8 weeks with a booster dose at 18 to 24 months.	To prevent Polio myelitis	do	1. Vaccine to be stored at - 20°c. Likely to be available during next financial year.
FAMILY WELFARE PROGRAMMES						
1.	Sterilisation	Couples with two children and above	Vasectomy, Tubectomy	Permanent method for limiting the family.	1. Voluntary Organisations can organise sterilisation camps with the assistance of local Primary Health Centre/Urban Family Welfare Centre. 2. Motivate eligible couples for undergoing sterilisation, IUD insertion at the nearest Primary Health Centre or hospital. They can act as depot holderns for distribution of contraceptives. They can ensure follow up services by the staff by closely associating with Primary Health Centre/ Urban Centres and the Community. 3. They can establish Urban Family Welfare Centres in areas left uncovered by Government institutions after approval by Government. 100% assistance will be provided by Govt.	
2.	Loop	Couples with one or two children.	Loop insertion	For spacing the children Temporary method of Family Planning.		
3.	Nirodh	Newly married couples, and couples with one child.	6pieces or more at a time depending on usage. Distribution once a month.	For spacing the children Temporary method of Family planning.		

....Contd/4-

2	3	4	5	6	7
Oral Pills	Couples with one or two children.	Oral pills-first 3 cycles to be distributed directly under the supervision of doctor and when there is no untoward effect, pills may be distributed by non-medical personelle. Beneficiaries to be examined by a doctor once in 6 months or earlier whenever indicated.	For spacing the children-Temporary method of Family Planning.	4. Volutary organisations having their own hospital, approved by Government for conducting tubectomy operation can maintain sterilisation beds for which bed maintainence charges will be paid by Government as per rules. 5. Private Practitioners recommended by Local Indian Medical Association and approved by Government can take up vasectomy operations and IUD insertions The beneficiaries eligible for compensation amount. The Private Practitioners are eligible for service charges at the prescribed rate fixed by Government provided the services are rendered free to the community. They can also take up distribution of contraceptives including oral pills. 6. Nursing homes run by private practitioners and voluntary organisations, satisfying all the conditions as per M.T.P. Act and recognised by Government can take up M.T.P. Services.
Medical Termination of Pregnancy.	Pregnant woman upto 20 weeks where pregnancy is unwanted.	Medical institutions (Private or Government) recognised under M.T.P. Act can taken up this programme.	To safeguard the health of the beneficiaries as a welfare measure.		

NOTE: (1) Iron Folic acid tablets, D.P.T. Vaccine, Diptheria and Tetanus, Vaccine, Tetanus-Toxoid, B.C.G. Vaccine, Small-pox Vaccine, B.C.G. Vaccine Contraceptives are available free:

(i) depending on the availability of stock with Government.
(ii) depending on refrigerator facilities available with the organisation.
and (iii) provided the services are rendered free to community.

.....Contd/5-

INTERNATIONAL CLASSIFICATION OF DISEASE

Modified LIST 'C' to be used for monthly statistical report from MALLUR HEALTH CO-OPERATIVE CENTRE.

1. Typhoid, Paratyphoid & Salmonellosis
2. Bacillary Dysentery & Amoebiasis

3a. Cholera

3b. Gastroenteritis and other diarrhoeal diseases

4. Tuberculosis (Respiratory)
5. Tuberculosis (All other)
6. Brucellosis
7. Diphtheria
8. Whooping cough
9. Sore throat and scarlet fever

10a. Small pox

10b. Chickenpox

11a. Measles

11b. Mumps

11c. Poliomyelitis

12. Viral Encephalitis

13a. Infective hepatites

13b. Jaundice due to other causes

14. Typhus and other Rickettsioses
15. Malaria
16. Syphilis and sequelae

17a. Gonococcal infection

17b. Other veneral diseases

18a. Ascariasis (Roundworm)

18b. Oxyuriasis (Threadworm, pinworm)

18c. Other Helminthiasis

19. All other infective and parasitic infections excluding 1-18c
20. Malignancies
21. Benign neoplasms
22. Thyroid diseases
23. Diabetes mellitus

24a. Malnutrition

24b. Vitamin defficiencies

....2

25. Other endocrinal and metabolic disorders

26a. Hookworm Anaemia

26b. Anemia due to other causes

27. Mental diseases

28. Diseases of the eye

28a. Inflammatory

28b. Foreign body

28c. Other diseases of eye excluding 28a, b and cataract

29. Cataract

30. Diseases of the ear

a. Furunculosis

30b. Otitis media

30c. Mastoiditis

30d. Foreign body

30e. Any others

31. Diseases of the nervous system and sense organs excluding eye and ear

32. Active Rheumatic fever

33. Chronic Rheumatic heart disease

34. Hypertensive heart disease

35. Ischaemic heart disease

36. Cerebrovascular heart disease

37. Venous thrombosis and embolism

38. Other diseases of circulatory system

39. Acute resp infections

40. Influenza

41. Pneumonia

42.a. Bronchitis with or without emphysema

42b. Asthma

43. Diseases of Tonsils and Adenoids

44. Pnamoconiosis and related diseases

45. Other diseases of the respiratory system

a. Coryza, Rhinitis and sisusitis
b. Pharyngitis and Laryngitis

46. Diseases of teeth and supporting structures

a. Dental cares

....3

46b. Dental abcess

46c. Any other infection or ulcers

47. Peptic ulcer

48. Appendicitis

49. Intestinal obstruction and Hernia

50. Gall bladder disease

51.a. Other diseases of digestive system - indigestion

51b. Any other

52-55. Diseases of the kidney and genito-urinary systems

56. Abortion

57. Other complications of pregnancy, childbirth and puerperum

58. Delivery without mention of complication

59. Infection of skin and subcutaneous tissue

a. Scabies

59b. Ringworm

59c. Boils

59d. Paronychia

59c. Other infections

60. Other diseases of skin and subcutaneous tissues

61. Arthritis and spondylitis

62. Other diseases of musculosteletal system and connective tissue

63. Congenital anomalies

64. Certain causes of perinatal mortality

65, Other specified and ill-defined diseases

66. Road transport accidents

67. All other accidents

68. Attempted suicide and self inflicted injury

69. Attempted homicide and injury purposely inflicted by other persons, legal intervention.

70. All other external causes

66N Fractures

67N Intracronial and internal injuries

69N Adverse effect of chemical substances

70N All other injuries.
