Subject: Project "Enhancing preparedness for management of Epidemics in Bangalore" from Dr. Girish
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Dear All,

Attached is the first draft of the continuation document (Call for action, Forward March, Be prepared) for your critical inputs.

Thanks and with regards,

Dr. Girish

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To RRP for perusal and discussion
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Enhancing preparedness for management of Epidemics in Bangalore

a public health advocacy endeavour

be prepared

The city of Bangalore witnessed outbreak of Gastroenteritis during the months of February and March 2001. During the consultation held by Office of the Chief Health Officer, BMP it was decided to focus on not just the immediate and short term but plan for medium term as well as long term to combat future outbreaks. It was recognised that there was a need to initiate a systematic and co-ordinated effort at the city level to monitor and forecast epidemics. Sanitary vending of food and aspects of food hygiene was another key issue.

Adopting the "call for action" and "marching forward" to document the micro-epidemics and enhance the preparedness of the health staff and health care facilities, the Core team has facilitated the following endeavours:

a) Formation of the Epidemic Combat Task Force, ECTF and the Joint Monitoring teams, JMT. The perceived responsibilities and activities of the team as agreed upon by the members have been formulated.

b) Drafting the Epidemic Manual for the city of Bangalore.

Efforts are currently on to delineate the most appropriate system for flow of information from the different health care institutions (The Sentinel Reporting Centres). This is necessary because the city should be prepared to adequately respond to outbreaks and ensure for its citizens a desirable health status.

A preliminary planning interaction is scheduled on the Tuesday, the 8th January 2002 at Jnana Jyothi, ???Training Centre for Urban Affairs, adjacent Chowdiah Memorial hall, opposite Vaidika Sabha, Kodandaramapuram, Bangalore. The agenda for group discussion is finalising the Reporting formats, Flow of information, Case management strategies, and Responsibilities of individual stakeholder.

The major outcome of the deliberations would be to arrive at the Calendar of events for the different stakeholders. This would enable the city to anticipate an outbreak and appropriately respond to it.

Concurrent efforts are on towards ensuring the Safe vending of foods. Banning the vending is difficult; confiscating and seizing the food articles is labourious. The lessons learnt from the ongoing model WHO-GOI project in Bangalore are given alongwith.

More details of all the endeavour is available on request.

Do not be part of the rumour.

Call for Action

Background:

In the wake of the outbreak of Gastroenteritis in the city during the months of February and March 2001 the Office of the Chief Health Officer and other concerned officials had scheduled an interaction with the faculty from the departments of Community Medicine and Paediatrics from the Medical Colleges of Bangalore City, BWSSB officials, Superintendent of ED Hospital and select NGOs. The consultative group met on the 19th of March 2001 and 7th of April 2001.The interaction focussed on the immediate, short term, medium term as well as long term plans to combat this and future outbreaks.

The meeting analysed the existing situation as:

1. ***Reports in the media are usually the source of information of the outbreaks.***
2. ***The exact cause of the early outbreak in February 2001 could not be ascertained.***
3. ***Immediate measures undertaken included super-chlorination (apart from establishment of Help desks). This saw a fall in number cases being reported.***
4. ***Enforcement of Sanitary vending of food needs to be publicised.***
5. ***A systematic and co-ordinated city level effort needs to be initiated.***

The following is the **CALL FOR ACTION:**

a) **Document the micro-epidemics, which precede the larger ones.**

- Set up a vigilant health information gathering system utilising the sanitary health inspectors, health workers and Link workers with inputs from the local general practicitoners, nursing homes and hospitals. Lay reporting systems to be initiated. The mass media to be made a partner in the endeavour. An uniform, common, simple and comprehensible reporting format to be utilised.
- An intersectoral emergency response team to assess the day to day situation and take necessary intervention.

b) **Enhance the preparedness of the health staff and health care facilities with proactive support from the City Medical Colleges.**

- Orient and sensitise the faculty at Isolation hospital regarding principles of epidemiological investigation. Strengthen the available facilities including staff to combat the epidemic.
- Make available module / protocol for standard case management and investigation at all Offices of the MOH.

c) **Immediately address the Hygiene and Sanitation of the street food vendors.**

- Make available potable water and appropriate sanitary facilities at common street food vending locations (FOOD COURTS).
- Orient and sensitise (Food Handlers; Food Inspectors) regarding hygienic food handling and vending methods.

d) **Undertake regular and frequent intersectoral meetings.**

e) **Delineate long term solutions for water and sanitation problems.**

Enhancing preparedness for management of Epidemics in Bangalore

a public health advocacy endeavour

FORWARD MARCH

Background:

In the wake of the outbreak of Gastroenteritis in the city during the months of February and March 2001 a consultation was held by Office of the Chief Health Officer, BMP with the faculty of Medical Colleges in Bangalore City, BWSSB officials, Superintendent of ED Hospital and select NGOs. The consultative group had interactions and decided to focus on not just the immediate and short term but also plan for medium term as well as long term plans to combat future outbreaks.

The major lacunae in the existing reporting system was that it was not uniform or complete. If not all the health care settings, it did not cover even the major health care establishments in the city. There was a need to initiate a systematic and co-ordinated effort at the city level to monitor and forecast epidemics apart from publicising the enforcement of sanitary vending of food and aspects of food hygiene.

Adopting the call for action to document the micro-epidemics and enhance the preparedness of the health staff and health care facilities with proactive support from the City Medical Colleges and concerned NGOs a host of activities have been initiated.

1. The proposal to establish an Epidemic Management Cell for the city which has the objective of not just to respond and function as the Information Cell but also become a barometer for the health status of the City.

   The members drawn from multiple and broad based background constitute the health intelligence input requirements in the City. When called for, due to an epidemic or out break, they have overriding powers, enabling them to co-ordinate and execute the necessary action for epidemic control. The major health care institutions in the city to become Sentinel Surveillance Units and the system of information flow to be continuously monitored according to a calendar of events.

2. The formation of the Joint Inspection Team, JIT and the Epidemic Combat Task Force, ECTF

   The 5 JITs each comprising of a Deputy Health Officer of BMP and an Executive Engineer each from the Engineering departments of BMP and BWSSB would draw out a protocol for inspection and monitoring.

   The ECTF comprising of the Zonal Health Officers of BMP, Additional Chief Engineers of BWSSB and Zonal Chief Engineers of BMP would review the emerging situation and take necessary action with technical support from the Medical Colleges, State and National Institutions of Health, Professional Bodies and NGOs.

3. A One-day workshop is to be scheduled on Friday, 21st December 2001 to arrive at the consensus system that will be in place for the City with effect from 1st January 2002. The convenors for the subgroups are as follows: Case Definition and Management Protocols – Dr. Sujay, SJMC; Case Investigation Protocols – Dr. Girish, MSRMC; Information Dissemination – Dr. Mahendra, KIMS.

Enclosed alongwith is the name, address and contact for communication. The endeavour is part of the Citizen - Government initiative to take Bangalore Forward. Please do indicate your willingness to be a partner in the endeavour.

POLICY BRIEF

Com II-71.

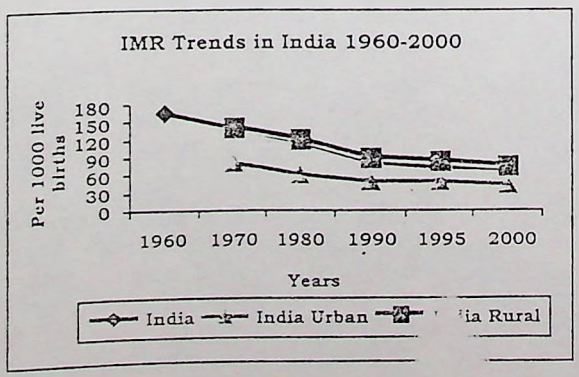
Save Public Health - Ensure Health for All NOW!
Make Health Care a Fundamental Right!

One of the best ways to judge the well being of the people of any nation is by examining the standards of health that ordinary people have attained. Healthy living conditions and access to good quality health care for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Hence it is high time that **people's health is given priority as a national political issue.** The current health policies need to be seriously examined so that new policies can be implemented in the framework of quality health care for all as a basic right. The following sections first take a look at the hard realities of people's health in India today, and examine some of the maladies of recent health policies. Next the availability of various resources, which could be utilised for an improved health care system is discussed, finally followed by certain recommendations to strengthen and reorient the health system to ensure quality health care for all. We hope these **recommendations will be incorporated by political parties in their election manifestos** for the upcoming general election as a demonstration of their commitment to public health. Jan Swasthya Abhiyan, a national platform working for people's health, looks forward to such a commitment from all political forces in the country.

How can India's Health be shining when ...

- **Infant and Child mortality snuffs out the life of 22 lakh children every year,** and there has been very little improvement in this situation in recent years.[1] We are yet to achieve the National Health Policy 1983 target to reduce Infant Mortality Rate to less than 60 per 1000 live births.[2] More serious is the fact that the rate of decline in Infant Mortality, which was significant in the 1970s and 80s, has slowed down in the 1990s, (See graph below)

- **130,000 mothers die during childbirth every year.** The NHP 1983 target for 2000 was to reduce Maternal Mortality Rate to less than 200 per 100,000 live births. However, 407 mothers die due to pregnancy related causes, for every 100,000 live births even today.[1] In fact, as per the NFHS surveys in the last decade Maternal Mortality Rate has increased from 424 maternal deaths per 100,000 live births to 540 maternal deaths per 100,000 live births.[3]



- **Three completely avoidable child deaths occur every minute.** If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala,[1] then **18 lakh deaths of under-five children could be avoided every year.** The four major killers (lower respiratory tract infection, diarrheal diseases, perinatal causes and vaccine preventable diseases) accounting for over 60% of deaths under five years of age are entirely preventable through better child health care and supplemental feeding programs.[3] The most recent estimate of complete immunization coverage indicates that only 54% of all children under age three were fully protected.[4]

- **About 5 lakh people die from tuberculosis every year**[18], and this number is almost unchanged since Independence![19] 20 lakh new cases are added each year, to the burgeoning number of TB patients presently estimated at around 1.40 crore[2] Indians !

- India is experiencing a **resurgence of various communicable diseases** including Malaria, Encephalitis, Kala azar, Dengue and Leptospirosis. The number of cases of **Malaria has remained at a high level of around 2 million cases annually** since the mid eighties. By the year 2001, the worrying fact has emerged that **nearly half of the cases are of Falciparum malaria,** which can cause the deadly cerebral malaria. The outbreak of **Dengue** in India in 1996-97, saw 16,517 cases

and claimed 545 lives[3]. Environmental and social dislocations combined with weakening public health systems have contributed to this resurgence.

- Diarrhea, dysentery, acute respiratory infections and asthma continue to take their toll because we are unable to improve environmental health conditions. **Around 6 lakh children die each year from an ordinary illness like diarrhoea.** While diarrhea itself could be largely prevented by universal provision of safe drinking water and sanitary conditions, these deaths can be prevented by timely administration of oral rehydration solution, which is presently administered in only 27% of cases[3].
- Cancer claims over 3 lakh lives per year and **tobacco related cancers** contribute to 50% of the overall cancer burden, which means that such deaths might be prevented by tobacco control measures[2].
- Estimates of mental health show about 10 million people suffering from serious mental illness, 20-30 million having neuroses and 0.5 to 1 percent of all children having mental retardation[2]. **One Indian commits suicide every 5 minutes[5]!**

As a nation, today there is a need to look closely at the deep problems in the health system, rather than making exaggerated claims. There is a need to recognize the growing health inequities, and urgently implement basic changes in the health system.

With political will and people's involvement, ensuring good quality health care for every Indian is possible!

The growing inequities in health and health care are unjust !

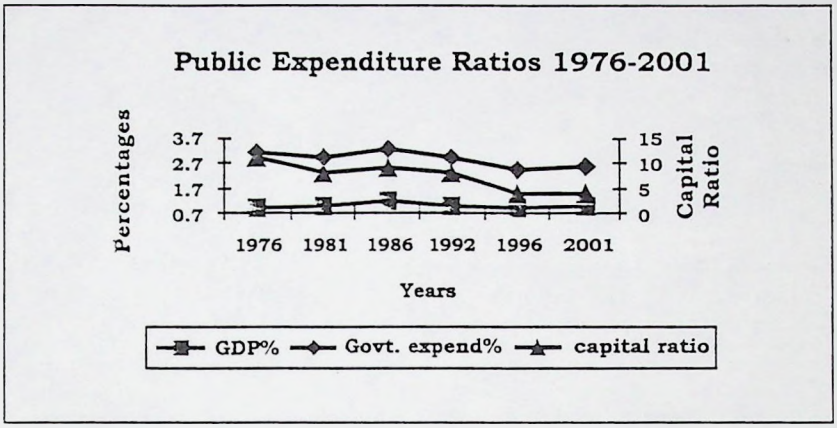
The Constitution of India guarantees the 'Right to Life' to **all** citizens. However, the disparities relating to survival and health, between the well off and the poor, the urban residents and rural people, the adivasis and dalits and others, and between men and women are extremely glaring.

- The Infant Mortality Rate in the poorest 20% of the population is **2.5 times higher** than that in the richest 20% of the population. In other words, an infant born in a poor family is two and half times more likely to die in infancy, than an infant in a better off family[3].
- A child in the 'Low standard of living' economic group is **almost four times** more likely to die in childhood than a child in the better off 'High standard of living' group. An Adivasi child is one and half times more likely to die before the fifth birthday than children of other groups[3].
- A girl is 1.5 times more likely to die before reaching her fifth birthday, compared to a boy! The **female to male ratios** for children are rapidly declining, from 945 girls per 1000 boys in 1991, to just 927 girls per 1000 boys in 2001[16]. This decline highlights an alarming trend of discrimination against girl children, which starts well before birth (in the form of sex selective abortions), and continues into childhood and adolescence (in the form of worse treatment to girls)[3,15].
- Dalit Women are one and a half times more likely to suffer the consequences of chronic malnutrition (stunted height) as compared to women from other castes. Children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.
- A person from the poorest quintile of the population, despite more health problems, is **six times less** likely to access hospitalization than a person from the richest quintile. This means that the poor are unable to afford and access hospitalization in a very large proportion of illness episodes, even when it is required.
- The delivery of a mother, from the poorest quintile of the population is **over six times** less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. An adivasi mother is half as likely to be delivered by a medically trained person[3].
- The ratio of hospital beds to population in rural areas is **fifteen times** lower than that for urban areas[14].
- The ratio of doctors to population in rural areas is **almost six times lower** than the availability of doctors for the urban population[14].
- Per person, Government spending on public health is **seven times lower in rural areas**, compared to Government health spending for urban areas.

These **health and health care inequities are increasing**, and are deeply unjust -- a just health system would ensure that all citizens, irrespective of social background or gender, would get basic quality health care in times of need.

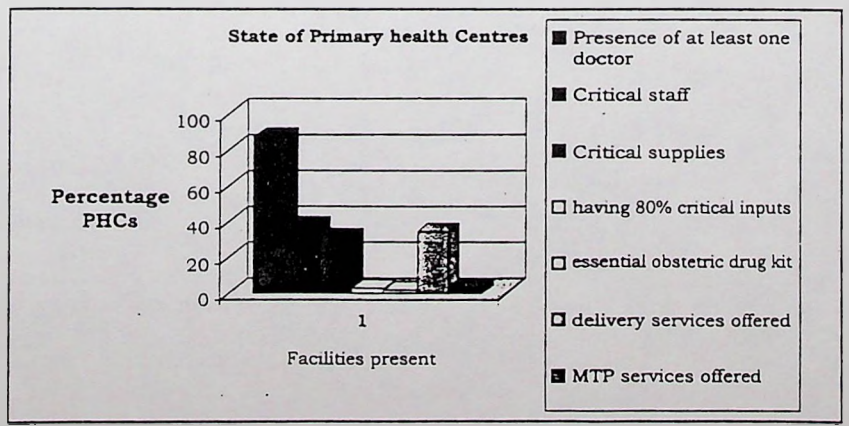
Public health being weakened, people's health being undermined

The NDA Government has recently claimed that one of its signal achievements has been the allocation of 6% of GDP to Health care. In reality, the government spends just 0.9 % of the GDP on Health care and the rest is spent by people from their own resources. Thus only 17% of all health expenditure in this country is borne by the government — this makes the Indian public health system grossly inadequate to meet healthcare demands of its people, and makes the health sector the **most privatised in the world.** Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia[6]). The W.H.O. standard for expenditure on public health is 5% of the GDP. The average spending today by Less Developed Countries is 2.8 % of GDP, but India presently spends only 0.9% of its GDP on public health, which is merely one-third of the less developed countries' average[6] !



The consequence of this dismally low allocation, which stands at the lowest levels in the last two decades, (in contrast to 1.3% of GDP achieved in 1985), is deteriorating quality of public health services. For example, Primary health centers (PHCs), meant to serve the needs of the poorest and most marginalized people have the following shocking statistics:

- Only 38% of all PHCs have all the critical staff
- Only 31% have all the critical supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs.
- In spite of the high maternal mortality ratio, 8 out of every 10 PHCs have no Essential Obstetric Care drug kit!
- Only 34% PHCs offer delivery services, while only 3% offer Medical Termination of Pregnancy!
- A person accessing a community health center would find no obstetrician in 7 out of 10 centers, and no pediatrician in 8 out of 10!



Source: 7

Private health care and essential drugs are increasingly unaffordable !

The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban biased, tertiary level health services with profitability overriding equity, and rationality of care often taking a back seat.

- A growing proportion of Indians cannot afford health care when they fall ill. National surveys show that the number of people who could not seek medical care because of lack of money increased significantly between 1986 and 1995[5]. The proportion of such persons **unable to afford health care almost doubled**, increasing from 10 to 21 % in urban areas, and growing from 15 to 24% in rural areas in this decade[5].
- **Forty percent** of hospitalised people are forced to borrow money or sell assets to cover expenses[5].
- **Over 2 crores of Indians are pushed below the poverty line** every year because of the catastrophic effect of out of pocket spending on health care[10].
- Irrational medical procedures are on the rise. According to just one study in a community in Chennai, **45% of all deliveries were performed by Cesarean operations,** whereas the WHO has recommended that not more than 10-15% of deliveries would require Cesarean operations[17].
- Due to **irrational prescribing**, an average of 63 per cent of the money spent on prescriptions is a waste. This means that nearly two-thirds of the money that we spend on drugs may be for unnecessary or irrational drugs[11].
- The pharmaceutical industry is rapidly growing...yet only 20% of the population can access all essential drugs that they require. There is a proliferation of brand names with over 70,000 brands marketed in India, but the 2002 Drug policy recommends that only 25 drugs be kept under price control[13]. As a result, many drugs are being sold at 200 to 500 p[illegible]cent profit margin, and essential drugs have become unaffordable for the majority of the Indian population.

Health policy developments since the 1990s have critically weakened the health system

The effectiveness of the public health system and access to quality health care, especially for the poor has worsened since the decade of the 1990s, due to a variety of policy developments, at both national and state levels:

- Stagnant public health budgets and decreasing Government expenditure on capital investment for public health facilities.
- Introduction of user fees at various levels of public health facilities.
- Freezing of new recruitments and inadequate budgets for supplies and maintenance in the public health system.
- Contracting out health services or privatisation of health facilities.
- Encouragement of growth of private secondary and tertiary hospitals through tax waivers, reduced import duties, subsidized land etc. which have led to a further expansion of the unregulated private medical sector.
- Promotion of 'Health tourism' for foreign visitors, while basic health services remain inaccessible for a large proportion of the Indian population.
- Conducting occasional, expensive and largely ineffective 'Health melas' instead of upgrading the public health system as a sustainable solution.
- Deregulation of the pharmaceutical industry, lax price controls on drugs — the list of drugs under price control being proposed to be reduced to 25 drugs (compared to 343 drugs under price control in 1979.)
- Many bulk drug manufacturing units have closed down due to liberalized import and dumping as a result of the implementation of the WTO agreement and autonomous economic liberalization policies. Due to reduction of customs duty and increase of excise duty, imported drugs will become cheaper while local drugs will become more expensive.

Is this inevitable ? Can only developed countries manage good health care for their people ?

Indians need not accept poor health as their inevitable fate! Many other developing countries, which have given a high priority to people's health, have achieved much better health outcomes compared to India. As a country, we spend a higher proportion of the GDP on health care compared to these countries – but an overwhelming percentage of this (83%) is private expenditure. As a result we have a weak public health system with poor health outcomes forcing families to spend a lot on private medical care, which is expensive, and not always appropriate, leaving us with **'poor health at high cost'!** Here is how some other Asian countries are doing in comparison with India...

Health Outcomes in Relation to Health Expenditures in some Asian countries[10]

	Total Health Expenditure as % of GDP	Public Health Expenditure as % of total	Under 5 Mortality	Life Expectancy	
				Male	Female
India	5.2	17	95	59.6	61.2
Sri Lanka	3.0	45.4	19	65.8	73.4
Malaysia	2.4	57.6	14	67.6	69.9

Does India have the resources to provide health care for all ?

As a country, Indians spend more on health care than most other developing countries, but this is mostly out-of-pocket spending. Health care facilities have grown substantially, but these are mostly in the private sector. The system is producing more and more healthcare professionals, but we lose them to the private sector, or to western countries. To give some idea of the available health care resources in India –

- Compared to 11,174 hospitals in 1991 (57% private), the number grew to 18,218 (75% private) in 2000[11]. In 2000, the country had 12.5 lakh doctors and 8 lakh nurses! At the national level, there is one allopathic doctor for every 1800 people, or one doctor from systems including ISM and homeopathy for 800 people. This means there are more doctors than the required estimate of one doctor for 1500 population[12].
- Approximately 15,000 new graduate doctors and 5,000 postgraduate doctors are produced every year and one-fifth of them leave the country for greener pastures[13].
- We have an annual pharmaceutical production of about 260 billion rupees[14], and we export a large proportion of these drugs - Sadly, while our exports grow, 30% of our people do not have access to all the drugs they require.

In short, we have substantial health care resources, but because of the privatised, unregulated and inequitable nature of the health care system, it is unable to ensure good quality health care for a majority of citizens. Rather than producing more doctors or setting up more private hospitals, what we need is a reorganisation of the health system, with substantial strengthening of public health, greatly enhanced public expenditure, regulation of the private medical sector and an overall planned approach to make health care resources available to all.

What can be done as immediate steps ?

The objective should be to **make Health care a Fundamental right and an operational entitlement**. This would require a National Public Health Act, which mandates right to basic healthcare services to all citizens through a system of universal access to healthcare. The Indian Constitution through its directive principles provides the basis for the Right to health care, and the Indian state has ratified the International Covenant of Economic, Social and Cultural Rights which makes it obligatory on its part to comply with Article 12 that mandates right to healthcare. Universal access to healthcare is well established in a number of countries including not only developed countries like Canada and United Kingdom, but also developing countries such as Cuba, Brazil, Costa Rica and Thailand. There is no reason why this cannot be made a reality in India. Hence we need to set in motion processes, which will take us towards the goal of universal access to health care, in a Rights-based framework and with equity.

Some immediate steps related to the health care system that need to be taken include:

- Making healthcare a fundamental right by suitable constitutional amendment. The formulation of a National legislation mandating the Right to Health care, with a clearly defined comprehensive package of health care, along with authorization of the requisite budget, being made available universally within one year.
- Significant strengthening of the existing public health system, especially in rural areas, by assuring that all the required infrastructure, staff, equipment, medicines and other critical inputs are available, and result in delivery of all required services. These would be ensured based on clearly defined, publicly displayed and monitored norms.
- The declining trend of budgetary allocations for public health needs to be reversed, and budgets appropriately up-scaled to make optimal provision of health care in the public domain possible. At one level adopting a fiscal policy of block funding or a system of per capita allocation of resources to different levels of health care, with an emphasis on Primary Health Care will have an immediate impact in reducing rural-urban inequities by making larger resources available to rural health facilities like Primary health centers and Rural hospitals. Simultaneously, the budgetary allocation to the health sector must be increased substantially, targeting the 5% of GDP as public expenditure on health care as recommended by the WHO.
- If the public health system fails to deliver it should be treated as a legal offence, remedy for which can be sought in the courts of law. The public system must ensure all elements of care like drug prescriptions, diagnostic tests, child birth services, hospitalization care etc. One way to ensure this could be that in exceptional situations, where patients who do not receive these services from the public facility they may be referred to seek them from alternate facilities, which are registered with the state agency. Such registered and regulated facilities would honour such referrals, for which the state would reimburse them at a mutually agreed rate. This would maintain pressure on the public health system to provide all elements of care, and would ensure that the patient is not deprived of essential care at time of need.
- Various vulnerable and marginalised sections of the population have special health needs. There is a need for a range of policy measures to eliminate discrimination, and to provide special quality and sensitive services for women, children, elderly persons, unorganised sector workers, HIV-AIDS affected persons, disabled persons, persons with mental health problems and other vulnerable groups. Similarly, situations of conflict, displacement and migration need to be addressed with a comprehensive approach to ensure that the health rights of affected people are protected. The **People's Health Charter** deals with issues related to such special sections of the population, and can provide a basis for formulation of appropriate policy initiatives, in consultation with organisations representing these social segments.
- Putting in place a National legislation to regulate the private health sector, to adopt minimum standards, accreditation, standard treatment protocols, standardised pricing of services etc.
- Adopting a rational and essential medications-based drug policy. All States must have an essential drugs and consumables list and all the drugs and consumables on this list must be under price control. Further all state governments must adopt procurement and distribution

policies similar to what has been done by the Tamilnadu State Medical Services Corporation and hence ensure that essential drugs in the list are actually available in every facility.

- The state should introduce a new community-anchored health worker scheme, and implement it in a phased manner with involvement of people's organizations and panchayati raj institutions, in both rural and urban areas, through which first contact primary care and health education can be ensured.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas.
- All state level coercive population control policies, disincentives and orders should be revoked. Disproportionate financial allocation for population control activity should not be allowed to skew funding from other important public health priorities.
- Integration of medical education of all systems to create a basic doctor ensuring a wider outreach and improvement of access to health care services in all areas. Effective regulation of the growth of capitation based medical colleges.

Conclusion

The persistence of unacceptably large numbers of avoidable deaths, resurgence of communicable diseases, declining quality of public health services and unaffordable, often inappropriate private medical care need not remain the lot of over a billion ordinary Indians. Recent policy changes of privatisation, declining public health budgets and pro-drug industry measures need to be replaced by strong public health initiatives, with the active involvement of communities and civil society organisations.

By and large, India today possesses the humanpower, infrastructure, national financial resources and appropriate health care know-how to ensure quality health care for all its citizens. What is needed is a major restructuring and strengthening of the health system. This involves two major ingredients: popular mobilisation for operationalising the Right to Health Care, and the political will to implement policy changes necessary to transform the health system. Jan Swasthya Abhiyan is today involved in the former task, by reaching out to people across the country, enabling them to mobilise for their just health rights. It calls upon political parties, which recognise people's right to healthy lives, to address the latter task, and to perform their historic duty by establishing and operationalising the Right to Health care as a Fundamental right.

This document focuses on the need for strengthening of the health care system, and certain immediate steps required for this. However, improvement of people's health requires equally importantly, provision of other necessary **facilities and conditions required for a healthy life**, such as safe drinking water, sanitation, food security, healthy housing, basic education and a safe environment. The **People's Health Charter** has dealt with these issues, and may be taken as a guideline to develop effective policies and improve people's living standard in order to achieve better health.

Published by CEHAT for JAN SWASTHYA ABHIYAN

Indian People's Health Charter

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of 'Globalisation' seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economies of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, as well as the sections of poor in the rich nations, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum - the right to **Health For All, Now!**

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of International Finance Capital. The forces 'Globalisation' through measures such as the structural adjustment programme are targeting our resources - built up with our labour, sweat and lives over the last fifty years - and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure - such as they were - have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation. We declare health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning.
- A sustainable system of agriculture based on the principle of land to the tiller – both men and women – equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment
- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concept of health care.

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the 'market' that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases and appropriation of bio-diversity
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor
- The corporatization and commercialization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptive technology which are directed primarily at the poor and women
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach
- Institutionalization of divisive and oppressive forces in society, such as communalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation with the active participation of the community. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.

2. The primary health care institutions including trained village health workers, sub-centers, and the PHCs staffed by doctors and the entire range of community health functionaries including the ICDS workers, be placed under the direct administrative and financial control of the relevant level Panchayati Raj institutions. The overall infrastructure of the primary health care institutions be under the control of Panchayats and Gram Sabhas and provision of free and accessible secondary and tertiary level care be under the control of Zilla Parishads, to be accessed primarily through referrals from PHCs.

   The essential components of primary care should be:
   - Village level health care based on Village Health Workers selected by the community and supported by the Gram Sabha / Panchayat and the Government health services which are given regulatory powers and adequate resource support

- Primary Health Centers and sub-centers with adequate staff and supplies which provides quality curative services at the primary health center level itself with good support from referral linkages
- A comprehensive structure for Primary Health Care in urban areas based on urban PHCs, health posts and Community Health Workers under the control of local self government such as ward committees and municipalities.
- Enhanced content of Primary Health Care to include all measures which can be provided at the PHC level even for less common or non-communicable diseases (e.g. epilepsy, hypertension, arthritis, pre-eclampsia, skin diseases) and integrated relevant epidemiological and preventive measures
- Surveillance centers at block level to monitor the local epidemiological situation and tertiary care with all speciality services, available in every district.

3. A comprehensive medical care programme financed by the government to the extent of at least 5% of our GNP, of which at least half be disbursed to panchayati raj institutions to finance primary level care. This be accompanied by transfer of responsibilities to PRIs to run major parts of such a programme, along with measures to enhance capacities of PRIs to undertake the tasks involved.

4. The policy of gradual privatisation of government medical institutions, through mechanisms such as introduction of user fees even for the poor, allowing private practice by Government Doctors, giving out PHCs on contract, etc. be abandoned forthwith. Failure to provide appropriate medical care to a citizen by public health care institutions be made punishable by law.

5. A comprehensive need-based human-power plan for the health sector be formulated that addresses the requirement for creation of a much larger pool of paramedical functionaries and basic doctors, in place of the present trend towards over-production of personnel trained in super-specialities. Major portions of undergraduate medical education, nursing as well as other paramedical training be imparted in district level medical care institutions, as a necessary complement to training provided in medical/nursing colleges and other training institutions. No more new medical colleges to be opened in the private sector. No commodification of medical education. Steps to eliminate illegal private tuition by teachers in medical colleges. At least a year of compulsory rural posting for undergraduate (medical, nursing and paramedical) education be made mandatory, without which license to practice not be issued. Similarly, three years of rural posting after post graduation be made compulsory.

6. The unbridled and unchecked growth of the commercial private sector be brought to a halt. Strict observance of standard guidelines for medical and surgical intervention and use of diagnostics, standard fee structure, and periodic prescription audit to be made obligatory. Legal and social mechanisms be set up to ensure observance of minimum standards by all private hospitals, nursing/maternity homes and medical laboratories. Prevalent practice of offering commissions for referral to be made punishable by law. For this purpose a body with statutory powers be constituted, which has due representation from peoples organisations and professional organisations.

7. A rational drug policy be formulated that ensures development and growth of a self-reliant industry for production of all essential drugs at affordable prices and of proper quality. The policy should, on a priority basis:

   - Ban all irrational and hazardous drugs. Set up effective mechanisms to control the introduction of new drugs and formulations as well as periodic review of currently approved drugs.
   - Introduce production quotas & price ceiling for essential drugs
   - Promote compulsory use of generic names
   - Regulate advertisements, promotion and marketing of all medications based on ethical criteria
   - Formulate guidelines for use of old and new vaccines
   - Control the activities of the multinational sector and restrict their presence only to areas where they are willing to bring in new technology
   - Recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices
   - Promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unethical research, especially in the area of contraceptive research, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognized. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift the onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception. Facilities for safe abortions be provided right from the primary health center level.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralization in the decision making process, related to health care, at all levels as well as adherence to the principle of right to information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

- Integration of health impact assessment into all development projects
- Decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners
- Reorientation of measures to check STDs/AIDS through universal sex education, promoting responsible safe sex practices, questioning forced disruption and displacement and the culture of commodification of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.

14. Women-centered health initiatives that include:

- Awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in upbringing and life conditions within and outside the family; preventive and curative measures to deal with health consequences of women's work and violence against women
- Complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector
- Special support structures that focus on single, deserted, widowed women and minority women which will include religious, ethnic and women with a different sexual orientation and commercial sex workers; gender sensitive services to deal with all the health problems of women including reproductive health, maternal health, abortion, and infertility
- Vigorous public campaign accompanied by legal and administrative action against sex selective abortions including female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives that include:

- A comprehensive child rights code, adequate budgetary allocation for universalisation of child care services
- An expanded & revitalized ICDS programme. Ensuring adequate support to working women to facilitate child care, especially breast feeding
- Comprehensive measures to prevent child abuse, sexual abuse and child prostitution
- Educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory quality elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

- Banning of hazardous technologies in industry and agriculture
- Worker centered monitoring of working conditions with the onus of ensuring a safe and secure workplace on the management
- Reorienting medical services for early detection of occupational disease
- Special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. The approach to mental health problems should take into account the social structure in India which makes certain sections like women more vulnerable to mental health problems. Mental Health Measures that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support & community based management of mental health problems be promoted. Services for early detection & integrated management of mental health problems be integrated with Primary Health Care and the rights of the mentally ill and the mentally challenged persons to be safe guarded.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly. Services that cater to the special needs of people in transit, the homeless, migratory workers and temporary settlement dwellers.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising, sponsorship and sale of their products to the young, and provision of services for de-addiction

Constituents of the JAN SWASTHYA ABHIYAN

The Jan Swasthya Abhiyan at the national level is the coalition of the networks of voluntary organizations and peoples movements involved in healthcare delivery and health policy, who made themselves a part of the Peoples Health Assembly campaign in India in the year 2000, and have continued to participate in this process. These national networks have numerous constituent organisations, which implies that a few hundred organizations are involved directly in the national process. Beyond these networks, several hundred other organizations have been involved at state, district and block level activities across the country. The networks that constitute the National Coordination Committee of Jan Swasthya Abhiyan are:

1. All India Peoples Science Network
2. All India Democratic Women's Association
3. All India Drug Action Network
4. Asian Community Health Action Network
5. Bharat Gyan Vigyan Samiti
6. Catholic Health Association of India (CHAI)
7. Christian Medical Association of India (CMAI)
8. Federation of Medical Representatives and Sales Associations of India (FMRAI)
9. Forum for Creche and Child Care Services (FORCES)
10. Joint Women's Programme
11. Medico Friends Circle (MFC)
12. National Alliance of People's Movements (NAPM)
13. National Alliance of Women's Organisations (NAWO)
14. National Federation of Indian Women (NFIW)
15. Ramakrishna Mission
16. Voluntary Health Association of India (VHAI)
17. Association for Indian Development, India (AID-India)
18. Breastfeeding Promotion Network of India (BFPNI) National Resource Groups:
19. Centre for Enquiry into Health and Allied Themes (CEHAT)
20. Centre for Social Medicine and Community Health, Jawaharlal Nehru University
21. Community Health Cell (CHC)

The representatives of all the above organisations constitute the National Coordination Committee of JSA, which is the national decision making body of the coalition. N.H. Antia is the Chairperson and D. Banerjee is the Vice-Chairperson of JSA. National organisers of JSA include B. Ekbal as Convenor, Abhay Shukla, Amit Sengupta, Amitava Guha, Thelma Narayan and T. Sundararaman as Joint convenors, with Vandana Prasad and N.B.Sarojini as National secretariat members.

Jan Swasthya Abhiyan presently has state units or contacts in the following states:
Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal.

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PROPOSAL FOR HEALTH CENTRES & MATERNITY HOSPITALS UNDER I.P.P.-VIII BANGALORE EXTENDING THE PROJECT TO 11 CITIES OF KARNATAKA STATE.

A. INTRODUCTION

The proposed Project is an extension of India Population Project-VIII, Bangalore, to other Cities of Karnataka State. IPP-VIII is an IDA assisted Project. It provides IDA with the opportunity to extend rapid but targeted assistance to the most vulnerable groups through an agency which is already implementing the Project satisfactorily.

The special features of the Project are that:

a) To assist the Govt. of India (GOI) in expanding the coverage of Family Welfare (FW) and Reproductive and Child Health (RCH) services to previously unserved urban slums.

b) To act as a vehicle to improve the quality of services to be delivered to the urban poor.

c) Increase the demand for family welfare services by substantially improving the participation of Private Voluntary Organisations and Communities in the design, delivery and supervision of family welfare services to be delivered to the slum communities by IEC activities.

d) Institute Innovative Scheme, under which investments in Female Education and Vocation training, nutrition, awareness, environmental sanitation through community participation, would be supported.

e) In all 11 Cities, Health Centres are proposed on the basis of one Health Centre for 50,000 population. Out of the 50,000 population around 20-30 thousand are expected to utilise the Health Centres facilities. In the case of Hubli-Dharwad and Bhadravathi, the number of Health Centres proposed is on the basis of one Health Centre for 40 thousand populations. This is because the population is scattered and will not avail the health facility if the distance is more than 3-5 K.M. from their residence.

B. GOALS AND OBJECTIVES

The goals set for various indicators under the National Health & Family Welfare Programmes for the year 2000 to be attained in the Project Area are follows:

1.	Infant Mortality Rate	< 60
2.	Perinatal Mortality Rate	< 30 - 35
3.	Pre-school child mortality (1-5 years)	< 10
4.	Maternal Mortality Rate	< 2
5.	Crude Birth Rate	< 21
6.	Crude Death Rate	< 9
7.	Effective Couple Protection Rate-(%)	>60
8.	Pregnant Mothers receiving Antenatal Care	100%
9.	Immunisation Status (%)	
	a) TT for pregnant women	100
	b) TT for school children	100
	c) DPT (children 3 years)	85
	d) Polio (infants)	85
	e) BCG (infants)	85
10.	Institutional deliveries (%)	95

As per the National Health Policy, the services would be taken nearer to the door steps of the people ensuring full participation of the community in the process of Health Development.

The specific objectives of the project are to:

a) Improve maternal and child health, and

b) Reduce the fertility among the urban poor.

These objectives would be achieved by undertaking activities in five broad areas:

a) Expanding service delivery to slum populations through improvements in outreach services using volunteer female health workers selected from slum communities, and upgrading of existing and construction of new health facilities.

b) Improving the quality of family welfare services provided to slum populations, by upgrading the supervisory, managerial, technical and inter-personal skills at all levels of new and existing medical and para-medical workers through pre-service, institutional in-service and on-the-job-recurrent training; and increasing the availability of drugs, medicines and other appropriate health supplies.

c) Increasing the demand for family welfare services through an expanded programme of information, education and communication (IEC); increased participation of the slum community through their representatives and groups in the preparation and implementation of various project.

activities and the increased participation of Private Voluntary Organisations and Private Medical Practitioners in the delivery of family welfare services to slum communities.

d) Strengthening the management and administration of municipal Health Departments through appropriate upgrading of Management Information Systems (MIS), IEC, training, civil works, and audit and accounting functions, as well as integrating and/or strengthening co-ordination of health services with the provision of environmental sanitation and water supply services.

e) Supporting Innovative Schemes which cover a range of additional services including supplementary nutrition, creche programs, environmental sanitation drives, education and skill training programme for females, especially adolescent girls, Non - Formal School and RCH interventions.

C. Services to be delivered

Promotive and preventive health services specifically family welfare and maternal and child care services would be delivered to the urban poor through a network of Health Centres / Referral Health Centres of the Municipal Corporation.

The services planned to be provided by the Maternity Hospitals and Health Centres are listed below:

Service	Health Centre	Maternity Hospital
Promotive		
Health & Nutrition Education	Yes	No
Knowledge of vaccine preventable diseases & diarrhoea	Yes	No
Family Planning	Yes	Yes
Health Care		
Antenatal Care	Yes	Yes
Normal Deliveries	No	Yes
High Risk Deliveries	No	refered to major hospitals
Post Natal Care	Yes	Yes
Immunisation of Mother & Child	Yes	Yes
Nutritional Care of children upto the age of five	Yes	No
Medical check-up and follow-Up of school-going children	Yes	No
Treatment for minor ailments	Yes	Yes
Nor surgical care for children needing specialist attention	No	Yes
Minor gynaecological procedures	No	Yes
Laboratory Tests: Basic	No	Yes

Family Planning

Counselling and advice on appropriate method	Yes	Yes
Supply of Condom/Oral Pill		
Initial	Yes	Yes
Subsequent	Yes	Yes
Check up & insertion of IUD	Yes	Yes
Sterilization	No	Yes
M.T.P	Yes	Yes
Domicilliary follow-up of Acceptors	Yes	No

The Health Centre will refer to the Maternity Homes pregnancies and cases requiring gynaecological procedures, sterilization and M.T.P and attention by Paediatrician.

The Maternity Hospital, in turn, will direct cases with major complications requiring surgical intervention such as Caesarean Section, children with congenital abnormalities to appropriate hospitals.

New Health Centres and renovation of existing centres is also part of the proposed project. Actions will be initiated after rapid low cost base line survey by consultants.

D. **The Outreach Programme.**

The Outreach Programme will be operated by each Health Centre with three ANMs and ten Link Workers. The Link Workers will be selected from the slum dwellers and will report to ANMs. They will be given requisite training by the specifically trained Officer under I.P.P. – VIII. They will be paid a monthly honorarium of Rs.500/-.

The job responsibilities of the outreach workers are:

		LHV	ANMS	Link Workers
1.	Detection of Antenatal cases	Yes	Yes	Yes
2.	Regn. of Antenatal cases	Yes	Yes	No
3.	Antenatal Care & Post Natal Care	Yes	Yes	Yes
4.	Immunization	Yes	Yes	No
5.	First aid services for mothers and children	Yes	Yes	No
6.	Health Education	Yes	Yes	Yes
7.	Nutrition Education	Yes	Yes	Yes
8.	Motivation of cases for FP	Yes	Yes	Yes
9.	Depot Holders for Condoms, Oral Pills and ORS Packets	Yes	Yes	Yes
10.	Supervision & Training of Link Workers	Yes	Yes	
11.	Referral to next level	H.C.	H.C.	ANM
12.	I.E.C. activity	Yes	Yes	Yes

The outreach programme will provide different MCH & FW services according to predetermined schedule at places in/or close to slums such as anganwadis, community halls or other places owned by the Corporation/CMC.

The additional recurrent cost of the outreach programme is to be estimated.

E. STAFF PROPOSED FOR A HEALTH CENTRE

1)	Lady Medical Officer	-	1
2)	Lady Health Visitor	-	1
3)	Auxillary Nurse Midwife	-	3
4)	Link Workers	-	10

F. JOB FUNCTIONS OF FIELD STAFF

The field staff will conduct Eligible Couple Survey in their allotted population. The L.H.V. will have a population of 5000 in addition to supervision of the work of A.N.M.s and Link Workers. Each A.N.M. will have a populatioon of 15,000. Each Link worker will cater to a population of 5000.

They will prioritize the Eligible Couples according to the parity and age for F.W Coverage.

They will register 100% Ante natal cases preferably in the first trimester.

They will ensure 100% immunisation of all pregnant. mothers and infants in their juridiction

They will assist the Anemia Control Programme through distribution of FS Adult and Children tablets.

They will ensure small and healthy family by acceptance of O.P,CC, IUD and sterlization in their area.

They will conduct outreach programmes such as Antenatal immunization clinics, awarness programmes, well baby show, clean hut competition, Health Check up Camps in the slums.

They will identify innovative schemes(to be conducted through NGOs), like Creches Non Formal School, Vocational Training, Male Participation in H & FW Programme.

The Health Centre Staff will identify and select Link workers(Selection Criteria enclosed Annexure) They will conduct the relevant I.E.C. activities to create demand for the FW & MCH programmes.

G. JOB FUNCTIONS OF THE LMO

She will be the overall responsible for effective implementation of FW & MCH, RCH activities etc in the jurisdiction of the Health Centre to achieve the goals and objectives. She will submit the periodical reports as per the norms.

H. EQUIPMENT /FURNITURE /DRUGS/ CONSUMABLES

Procurement of necessary modern equipments and replacement of unserviceable equipments is proposed for all New Health Centres and existing U.F.W.C.s. Similarly furniture will also be provided for New Health Centre and existing U.F.W.Cs. Drugs and consumables is also to be provided for all New Health Centres. Partial support of drugs will be provided for the existing U.F.W.Cs. (Details are given in Annexure)

H. CIVIL WORKS

New Health Centre construction is proposed in all the 11 cities. The centres will be located as close as possible to the slums . Building Plans approved for IPP-VIII Bangalore will be utilised for the cities where Maternity Homes / Health Centres is proposed. The tenders for all works will be advertised in National newspapers (NCB) by IPP-VIII Office Bangalore. Thereafter evaluation will be done at the project office in Bangalore, by for technical and financial bids.

One representative from each City will be a member of the evaluation committee, where the lowest evaluated responsive bidder will be awarded the work order from the Central Project Office IPP-VIII Bangalore. Supervision of work will be done by the Engineering Department of the beneficiary City. Payment of bills will be made by Project Co-ordinator IPP-VIII Bangalore after receipt of bills duly certified by concerned CMCs & Corporation Commissioner. M/s. TOR Steel Research Foundation India who are already appointed for quality control will be authorised to function as consultant for quality control at five stages of civil construction for the beneficiary cities. Health Centre Type design A,B & C, and type design for 12 bed maternity home is shown in annexure will be utilised based on the availability of sites/area.

J. TRAINING

All Medical, Paramedical Staff of Maternity Homes/ U.F.W.C.s/Health Centre., are to be trained in the aims and objectives of I.P.P. – VIII also the implementation of programme. The training will be taken up by the IPP-VIII Training Centre at Kodandaramapura, Bangalore. For training Link Workers, each city will identity three persons (trainers) who will be trained at Bangalore. Thereafter for Link Workers, training will be done at the city level by these trained trainers.

The areas in which training is to be provided are:

1. Management Development, Planning, Programming.

2. NGO participation strategies.

3. Monitoring & Supervision

4. Communication, Motivation, and providing quality care.

5. Clinical Update

6. Health Care & FW Update

7. Promotive and preventive Health Care & Family Welfare.

8. Re-orientation practical training for Laboratory Technicians

9. Maintenance of Stock Records & Collection & submission of periodical reports.

10. Orientation on Extension Approach, field training.

11. Male Participation.

12. Training Methodology

The training centre will be utilised for the training programmes. The cost of training will be met out of the budget allocated to individual cities.

K. <u>I.E.C.</u>

One community development officer is proposed for each city to co-ordinate, I.E.C. and Women Development activities. Materials already produced by the IPP-VIII Bangalore will be made available to all the cities. Budgetary provision is made to prepare IEC materials according to local needs if necessary.

Materials already produced by the IPP-VIII, Bangalore will be made available to all the cities as per budget provision made in proposal.

L. Innovative Schemes

The beneficary cities will identify the programmes to be taken up like Creches, NFS, Vocational Training, Male Participation in F.W. programmes etc. The collabration will various NGO's will be worked by the individual cities. The budget any allocation for NGO's will be made based on the approval of the Project Implementation Committee to the beneficiary cities. Selection Criteria for NGOs is given in the Annexure.

M. MIES

Monthly Reporting Formats designed for IPP-VIII, Bangalore will be followed by the beneficary cities. The compiled reports have to be sent to the IPP-VIII, Bangalore for onward submission to GOK, GOI and World Bank authorities. Rapid low cost base line surveys will be taken up for each city to enable planning, monitoring & evaluation of the Project.End line survey will be conducted at the end of the project period.

N. Community Participation:

The health personnel of the respective Corporation, Private Voluntary Organisations and representatives from the slums would be involved in the decision making process planning and co-ordination of programmes, and effective implementation through a series of work shops.

"Social, Health & Environmental" Clubs "SHE" Clubs at the individual slum level will be formed. These SHE Clubs at the gross root level form the nucleus for effective community participation and are critical for the success of the Project. Annexure .... Guide lines.

The LMO will promote the formation of SHE Club in each of the slums under the jurisdiction of the health Centre. The families residing in the slums will be enrolled as member of the SHE Club by collecting a monthly subscription of Rs. 5/- per family. (optional)

It shall be registered and the Management Committee will have atleast three women members out of 5.

The members of the Committee will elect a Chairman from one among them.

The Functions of SHE Club may be as follows:

a) Create awareness of environmental hygiene.
b) Chalk out hygiene and sanitation programme for the slum.
c) Create awareness of MCH and FW programmes.
d) Prepare a plan of activites for the health centre based on priority of the inhabitants.
e) Co-ordinate with health centre to ensure availability of services.
f) Discourage child marriages and early motherhood.
g) Organise non-formal education for girls not in school.
h) Ensure availability of free medical aid to the needy, and
i) Manage the funds of the Club for the benefit of the Community for any of the activites mentioned above.

The subscriptions and grants received will be banked in the name of the Club and jointly operated by the Chairperson and LMO.

O. **Involvement of Private Medical Practitioners who are practising in and around slum.**

The Private Medical Practitioners would be involved in:

a) Motivating for Family Planning, MCH activity also male participation.

b) Immunising children and pregnant women.

c) Providing patient care and emergency services on payment basis.

d) Referring to hospital for specialized care.

e) Helping in effective service utilisation.

The list of PMPs volunteering to participate in the programme will be made for each Health Centre. The Health Centre will involve the PMPs attached to it by supplying the following items free of cost:

a) Vaccines and cold chain equipment for immunization.
b) IUD, Oral Pills and Condoms for insertion/distribution to acceptor.
c) Tetanus toxiod, Iron and Folic acid tablet for ANC & PNC.
d) ORS packets for treatment of dehydration and
e) Promotion literature for display and distribution.

MATERNITY HOSPITALS:

In Mysore, Gulbarga, Davangere, Bellary, Raichur & Shimoga, 12 bed maternity Homes are planned. The type design approved by World Bank for IPP-VIII Bangalore will be utilised. The procedure adopted for awarding contract will be similar to that adopted for health centres.

The following staff are proposed for each maternity home.

1)	Lady Medical Officer	-	1
2)	Staff nurses	-	3
3)	Peons	-	3
4)	Ayahs cum Sweeper	-	3
5)	Lab Technician	-	1
6)	Driver	-	1

One ambulance is proposed for each maternity home. To provide essential obstetric care round the clock staff quarters for LMO proposed.

REFERRAL:

The referral facilities have been built into the health care delivery system that is planned for all the cities. The link worker will refer cases to the ANM who in turn refers to the health centres. The health centres will refer antenatal for investigations, deliveries, sterlisations etc., to the maternity homes or district hospital as the case may be. The maternity home will refer cases to government major institution for any obstetric emergency or specialised obstetric care. Each maternity home is provided with an ambulance for referral purpose and drivers quarters is proposed for each maternity hospital.

MANAGEMENT:

The Project Office IPP-VIII Bangalore will be the nodal office for implementation of Extended IPP-VIII Project for 11 Cities of Karnataka.

The Project Co-ordinator IPP-VIII will be the ex-officio Nodal Officer will be the member secretary for Project Implementation Committee for Extended IPP-VIII Cities of Karnataka.

IPP-VIII Project Office level one Executive Engineer, one Assistant Executive Engineer, one clerical staff, one Accounts Superintendent and one clerk for Accounts Department will be appointed exclusively for Extended Cities Project. Each city will be engaging one Accounts Superintendent and one clerk. One Community Development Officer with MSW qualification will be appointed on contract basis till the end of Project period. For each city the Municipal Commissioner/ Health Officer will be designated as the Project Officer. He will be overall responsible for civil works & service delivery.

Committees to be constituted under the IPP-VIII , Extended Project.

I. **State Level Project Advisory and co-ordination committee.**

The existing SLPA & CC will continue in the extended Project of IPP-VIII with the addition of the commissioners of the beneficiary cities as members. Secretary to Govt. Health & FW will be the member secretary of the committee.

II. Extended **Project Implementation Committee** headed by the Health Secretary-I, with the Project Co-ordinator, IPP-VIII as member secretary and the Commissioners, Chief Engineers and Health Officers of the beneficiary cities as members will be constituted.

Please see the page 15/16 for details.

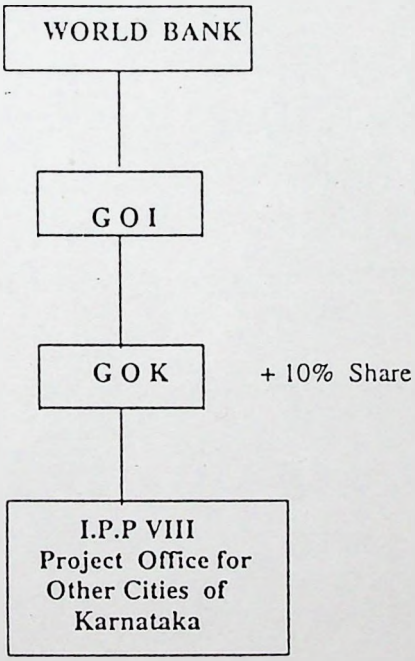
COMMITTEES CONSTITUTED FOR MONITORING IPP-VIII PROJECT ACTIVITIES

	Existing Committees			Proposed Inclusions
I. -	STATE LEVEL PROJECT ADVISORY & CO ORDINATION COMMITTEE. (EMPOWERED COMMITTEE)			
	1) Chief Secretary to GOK	..	Chairman	
	2) Secretary to Govt. Finance Dept.	..	Member	1) Commissioner of Corporations, CMC of Beneficiary Cities.
	3) Secretary to Govt. Health & FW Dept.	..	Member - Secretary	
	4) Secretary to Govt. Urban Devpt. Dept.	..	Member	
	5) Secretary to Govt. Planning Dept.	..	Member	
	6) Jt. Secretary to GOI Ministry of Health & FW	..	Member	
	7) Project Administrator & Addl. Secy to Govt. Karnataka health Systems Devpt. Project.	..	Member	
	8) Project Co-ordinator IPP-VIII. Bangalore	..	Member	

	Existing Committees			Proposed Inclusions
II.	**Project Implementation Committee (P.I.C.)**			1) Commissioners of Corporations of Beneficiary Cities.
	1) Health Secretary, Government of Karnataka.	..	Chairman	2) Health Officers of Municipal Corpns. of the Beneficiary Cities.
	2) Dy. Secretary to Govt. Urban Devpt. Dept.	..		Urban Devpt. Dept.
	3) Health Officer, Benefeciary Cities	..	Member	
	4) Chief Engineer, Beneficary Cities	..	Member	
	6) Secretary, Karnataka Slum Clearance Board,	..	Invitee member	
	7) Jt. Director, Women & Child Devpt. Dept.	..	Invitee Member	
	8) Project Co-ordinator IPP - VIII. B.M.P.	..	Ex - Officio- Member - Secretary	

R. FUND FLOW

Funds would be released by the Govt. of India to the State Government and thereafter to the IPP-VIII Bangalore. The proposal for sanction of expenditure under various heads will have to be placed before the Project Implementation Committee for necessary approval. Bills for having incurred expenditure will be paid by the IPP-VIII Project Office Bangalore. Permanent advance will be placed at disposal of the Project Officer designated for each city. This can be utilised for salaries and other contingencies. Separate account will have to be maintained for the funds released in each city and the funds shall not be diverted.



Statement Showing the Slum population and General Population in the 11 selected cities with MCH & FW facilities.

Sl.No.	Name of Cities	Population as on 1991 census	Project 2001	Slum Population (Notified Slum)	Existing UFWC	PPC
1	Mysore	6,53,345	8,95,067	23,872	7	2
1	Hubli / Dharwad	6,48,298	7,71,391	30,780	7	2
2	Belgaum	3,26,399	5,16,278	19,301	2	1
3	Gulbarga	3,04,099	3,97,167	10,367	2	1
5	Tumkur	1,38,903	2,06,046	61,814	1	1
6	Davangere	2,66,082	4,36,592	1,30,978	1	1
7	Bijapur	1,86,939	2,25,565	67,670	-	2
8	Bellary	2,45,931	2,84,114	85,234	1	1
9	Raichur	1,83,138	2,70,178	81,053	-	1
10	Bhadravathi	55,475	66,747	20,398	-	-
11	Shimoga	1,75,258	2,15,682	64,705	-	-

Com H-71.
Sen

Review of Implementation of

Community Needs Assessment

approach for Family Welfare in India

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No: HRN-C-00-00006-00, beginning July 7, 2000. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

April 2001

Policy Project II
The Futures Group International

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Contents

Foreword

The nearly five years since India abolished its target system have been filled with both confusion and innovation. Confusion, because of the uncertain trumpet that prevailed at every level, and innovation, because states and districts have made sincere efforts to find new ways to deliver services under a broadened set of objectives. This volume traces the experiences of nine states in their overall programs and in their special trials. An excellent synthesis chapter comes first that details the tribulations since 1996 and reviews the nine state experiences.

This book is the successor to *Targets for Family Planning in India: An Analysis of Policy Change, Consequences, and Alternative Choices*, which appeared in 1998. Its first chapter traces the history of target setting and the consequences for the program, as well as the factors that led to the 1996 policy reversal. Other chapters present the experience of certain states in the first year or so of the transition.

The transition continues; it is by no means complete. The puzzles of how to blend enlarged objectives with softened work rules, during a flow of top down directives that often conflict with each other, have yet to be entirely resolved. In one sense the ambiguities will never be resolved in such a complex and far flung set of programs, but the major adaptations are likely to settle down after a few more years. A mosaic of program variations now exists, each one in flux and moving toward something new. This evolution must continue, not to a perfect end point but toward a system whose principle features lack the old rigid targets and one that has widened its aims.

While some sympathy with the old system persists and the targets in some form have not died easily, a few profound changes have occurred that seem irreversible:

- The old worker-specific, method-specific, and month-specific quotas are largely out of favour and gone.
- The rhetoric of the field-the vocabulary of discourse-has been largely transformed, to speak of the felt needs of the people, community interests, and multiple services.
- Truly major changes have been made to move toward new work rules, toward other methods to accompany sterilization, and toward other services than just contraception.

These changes are necessarily embraced within an administrative structure that continues much as before. The line from Delhi, with its large share of total funding and its central directives, down through the state managers and the districts, will not go away.

Moreover workers cannot simply be sent out to do good by their own lights and their own motivations. The context now is an admixture of the new ideology with the inevitability of top down budgets, staff allocations, and overall goals. Much of the enduring confusion in these five years arises from that tension-how to forge a field program that allows for worker judgment, community power, and local options, while simultaneously showing real achievements for urgent national goals.

The nine state reviews in this volume show what is needed from the research side: a ceaseless examination of experience from the general program and from trails of program variations. Each review broadly examines the reproductive health program in the whole state, describes creative projects there, and traces the transition toward a target-free approach that is adapted to local conditions, while still setting achievement expectations at the grassroots level. If reviews like those in this volume had not been done they would have been most urgently needed, and it is vital that they be continued on a regular basis.

The present review is offered with appreciation to Victor Barbiero, Director of the Population, Health, and Nutrition Office, and to Sheena Chhabra, Team Leader of the PREM Division, both of USAID in India, for their encouragement and support. Partial financial support was provided by the Rockefeller Foundation, which is gratefully acknowledged.

Reproductive behaviour has changed over most of India since the national program began 50 years ago, and the program, with all of its problems, deserves a generous share of credit. By 1992 fertility had fallen much below its traditional level: nine of the 15 largest states had crude birth rates in the 20s and had total fertility rates below three. The national averages were 29 and 3.4, and by the 1998-99 survey 48% of couples were using contraception. Yet replacement fertility is a good way off, and state programs will emerge only gradually that strike the right balance between operational effectiveness and sensitivity to the persons they serve. That process will be informed and advanced by studies like the ones provided in this volume.

John A. Ross
Senior Fellow
The Futures Group International

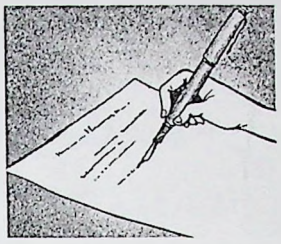
Abbreviations

AD	Additional Director
AGTP	Awareness-Generation Training Programme
AIDS	Acquired Immuno Deficiency Syndrome
AN	Antenatal
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ANMTC	ANM training centre
AVSC	Association for Voluntary Surgical Contraception
ARI	Acute respiratory infection
AWW	Anganwadi Worker
CBD	Community-based distribution
CBR	Crude Birth Rate
CC	Condom
CDMO	Chief district medical officer
CDR	Crude Death Rate
CEO	Chief executive officer
CHC	Community health centre
CMIE	Centre for Monitoring Indian Economy
CMHO	Chief medical and Health Officer
CMO	Chief Medical Officer
CMS	Chief Medical Superintendent
CNA	Community needs assessment
CPR	Couple Protection Rate
CSSM	Child survival and safe motherhood
Cu-T	Copper-T
DAP	District action plan
DDMHO	Deputy District Medical and Health Officer
DHFWO	District Health and Family Welfare Officer
DMHO	District Medical and Health Officer
DIFPSA	District Innovations in Family Planning Services Agency
DIO	District Immunization Officer
DPC	District Planning Committee
DPT	Diptheria Pertussis Tetanus
DUDA	District Urban Development Agency

EC	Eligible Couple
ECR	Eligible Couple Register
ELA	Expected Level of Achievement
FRU	First Referral Unit
FW	Family Welfare
FWHC	Family Welfare Health Centre
GOO	Government of Orissa
GOI	Government of India
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit ...
HDI	Human Development Index
HMIS	Health Management Information Systems
ICDS	Integrated Child Development Services
IEC	Information, education, and communication
IFA	Iron and folic acid
IFPS	Innovations in Family Planning Services
IMA	Indian Medical Association
IMR	Infant mortality rate
IPD	Integrated Population and Development
IPP	Indian Population Project
ISM	Indigenous Indian System of Medicine
ITPD	Integrated Tribal Development Programme
IUCD/IUD	Intrauterine Contraceptive Device/ Intrauterine Device
KFW	Kreditanstalt für Wiederaufbau (KFW)
LHV	Lady Health Visitor
MCH	Maternal and child health
MIM	Maternal and Infant Mortality
MMR	Maternal Mortality Rate
MIS	Management Information Systems
MO	Medical Officer
MHFW	Ministry of Health and Family Welfare
MPHA	Male-public Health Assistant
MPW	Multi-purpose Worker
MSS	Mahila Swasthya Sangh
MTP	Medical termination of pregnancy
NACO	National AIDS Control Organization
NFHS	National Family Health Survey
NGO	Non-governmental organization
NIC	National Informatics Centre
NID	National Immunization Days
NIHFW	National Institute of Health and Family Welfare
NSS	National Swayam Sevika
OR	Operations research
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PBA	Pregnancy-based approach
PHC	Primary health centre
PLA	Participatory Learning for Action
POL	Petrol, oil, and lubricants
PRC	Population Resource Centre
PRI	Panchayati raj institution
PSM	Preventive & Social Medicine
PVO	Private voluntary organization
RCH	Reproductive and child health
RH	Reproductive Health
RMP	Rural Medical Practitioner
Rs.	Rupees
RTI	Reproductive tract infection
SC	Scheduled Caste
ST	Scheduled Tribe
STD	Sexually transmitted diseases
SIFPSA	State Innovations for Family Planning Services Project Agency
SIHFW	State Institute of Health and Family Welfare
STI	Sexually transmitted infection
TBA	Traditional Birth Attendant
TFA	Target-free approach
TFR	Total fertility rate
TT	Tetanus toxoid
UIP	Universal Immunization Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary of Indian Terms

Anganwadi	A village-level centre under the ICDS Programme
Bal Kalyan Samitis	Children Welfare Committees
Crore	1 crore = 1,00,00,000
Dai	Traditional midwife
Dudugi	Local announcement
Gram Pradhan	Village headman
Gram Sabhas	Village Committees
Jowar	Millet
Lakh	1 lakh = 1,00,000
Mahila Sammelan	Women's conference
Mahila Swasthya Sangh	Women's Health Group/Organization
Ma Raksha Mahotsara	Safe Motherhood Festival
Panchayati Raj	Body of local government at village level
Vanaspati ghee	Vegetable Oil
Tur	A type of pulse
Taluka	Territorial division below district
Pradhan/Gram Pradhan	Headman/Village Headman
Pucca	all-weather
Zilla Sarkar	District Planning Committee
Zilla Swasthya Samiti	District Health Committee



Implementation of the Community Needs Assessment Approach in India

Gadde Narayana
Naveen Sangwan

Background

Since its inception in 1951, the Indian Family Planning Programme has undergone many changes to meet the varied challenges over the years. At different times, the programme has been expanded either to integrate services, as was done in the 1970s with the multi-purpose workers scheme. In recent years, in order to focus on the range of services critical for the health of women and children, the programme has been expanded to include elements of new schemes such as Child Survival and Safe Motherhood (CSSM), Universal Immunization, and Reproductive and Child Health (RCH). [1]

Prior to 1996, the programme used a target approach as the means to stabilize population growth. All services, planning, and financing were geared to achieving the demographic goals of reducing the birth rate and the rate of population growth. To achieve the long- and short-term demographic goals, this approach set targets in terms of a couple protection rate (CPR), which was further broken down into method-specific targets, with special focus on sterilization. The central government prescribed these targets annually for each state, which in turn passed the annual targets through the system down to the facility level.[2] Thus, achievement

[1] Leela Visaria, Shireen Jejeebhoy and Tom Merrick, "From Family Planning to Reproductive Health: Challenges Facing India" in International Family Planning Perspectives, January 25, 1999, p 844-49

[2] Gadde Narayana, Shalini Kakkar and Venkatesh Srinivasan, Target Free Approach for Family Planning In India in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices; The Futures Group International, New Delhi, 1998

of contraceptive targets became the principal indicator of success for India's population stabilization effort. The target system placed little importance on clients' personal choices and did not encourage the use of a wider range of family planning methods. As the target system increasingly took its toll on services and quality, criticism grew as well. By the end of the 1980s, population experts, researchers, academicians, donors, and non-governmental women's groups in India had all registered strong objections to India's family planning programme. These factors, along with international developments during the 1994 International Conference on Population and Development and the 1996 International Women's Conference in Beijing, created a need for a change in approach.

In April 1996, the GOI introduced a major revision of its approach to family planning and primary health care. The MOHFW abolished method-specific family planning targets, and replaced it with what was initially called the TFA.

In April 1996, the Government of India (GOI) introduced a major revision of its approach to family planning and primary health care. The Ministry of Health and Family Welfare (MOHFW) abolished method-specific family planning targets, and replaced it with what was initially called the Target-Free Approach (TFA).[3] The main aim of the TFA was to shift the focus to clients' needs and to improve the quality of services. This paradigm shift called for planning to start at the basic facility level and to be based solely on identified client needs and intentions. Health workers would conduct surveys to ascertain these needs. In other words, the former "top-down" approach was to be replaced by a genuine "bottom-up" approach in which health workers' case loads would be determined by identified local needs. At the same time that targets were abolished, however, MOHFW provided minimal guidance to the states on how to implement the new policy. As a result, in 1996 and 1997, most states lacked operational methodologies to assess community needs, develop realistic performance goals and plans, and institutionalize quality in service provision, especially at the district level and below. TFA at the operational level was even misinterpreted in some states as "no targets means no work." To avoid these unfortunate misconceptions and direct the programme more towards clients' needs, the new programme was recast into the "Community Needs Assessment" (CNA) approach in September 1997.[4] The underlying philosophy of the new approach, however, remained the same as the TFA.

Objectives of the Paper

This paper synthesizes the results of nine case studies carried out by the POLICY Project in the states of Andhra Pradesh, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, and Uttar Pradesh. The objectives of the case studies were to:

- examine the transition from the original target system to the TFA and subsequently to CNA approach
- Analyze the countrywide implementation of CNA and the impact of the new system on programme performance
- Identify programmatic shortcomings that affected the transition, draw lessons from the experiences of implementation, and identify steps that could be taken to improve the management and performance of the new client-oriented system.

[3] Ministry of Health and Family Welfare, Manual on Community Needs Assessment Approach, Government of India, 1998

[4] Ministry of Health and Family Welfare, Manual on Community Needs Assessment Approach, Government of India, 1998

The case studies for nine states follow this synthesis chapter.

Introduction of the Target-Free Approach

Starting in the 1960s, the Ministry of Health and Family Welfare annually fixed method-specific targets, which largely determined the character of programme implementation, monitoring, and evaluation at all levels. Over the years, this led to a situation where the achievement of contraceptive targets rather than client services became the major objective of public providers.[5] The obsession with targets and emphasis on sterilization resulted in poor coverage of younger and low-parity couples, virtual neglect of modern spacing methods, and inflated performance reports particularly for spacing methods. These conditions combined to severely limit the demographic impact of the programme. Not surprisingly, informed contraceptive choice, clients needs, and quality of services were inadequately addressed. The centralized planning and top-down target setting hindered management innovation and flexibility.[6] As a result, the overall reproductive health situation in India remained poor, and GOI found itself responding to performance shortfalls by periodically adjusting the timeframes for achieving programme objectives.

Population experts argued that focus on numerical targets thwarted attainment of the desired demographic impact and that excessive pressure to achieve targets resulted in over-reporting and mismanagement. Non-governmental Organizations (NGOs) and women's groups argued that the central government's notion that India's birth rate must be reduced by vigorous promotion of contraception was a violation of human rights. The poor quality of care provided to women by service-providers was taken as a sign of how little regard those providers had for women's health. In the 1980s and early 1990s, several key stakeholders, including donor agencies, stimulated discussion of varied viewpoints and advocated for a shift from the target-oriented approach to innovative ways of meeting reproductive health needs using an integrated approach.

There was a growing interest in replacing the target system with an entirely different approach—one that would shift programme emphasis from providers to clients. In September 1995, GOI abolished targets in the states of Tamil Nadu and Kerala and requested every state to select one or two districts to test the TFA. The new approach envisaged decentralized planning at the sub-centre level, in consultation with the community, to determine annual workloads based on local needs. By shifting more explicitly to identified client needs and involving the community, the GOI also hoped to stimulate better quality services. Expected levels of achievement (ELA), instead of targets, were now to be set by workers at the grassroot level—female auxiliary nurse midwives (ANMs) and male multi-purpose workers (MPWs)—in response to community needs.

In the 1980s and early 1990s, several key stakeholders, including donor agencies, stimulated discussion of varied viewpoints and advocated for a shift from the TFA to innovative ways of meeting reproductive health needs using an integrated approach.

Basic Characteristics of TFA

- Provide services according to client needs and eliminate centrally determined targets

[5] Gadde Narayana, Shalini Kakkar and Venkatesh Srinivasan, Ibid, TFGI, New Delhi, 1998

[6] Naveen Sangwan and Rishikesh M. Maru, "Target-Free Approach: An Overview" in Journal of Health Management, 1.1, 1999, p 71-96.

- Provide a wider choice of safe contraceptive methods and greatly strengthen and expand reproductive health services

- Emphasize the quality of services and decentralize programme planning and management to the district level and below

- Build partnerships with the community and make the programme a "people's programme."

Change from TFA to CNA

In April 1996, without rigorously addressing the experiences gained by all the states in implementing the TFA, the central government decided to abolish targets throughout India, making the entire nation target free. Targets were removed without adequate preparation and without discussion of what would replace the old system. No new monitoring system was proposed to replace the target system. At the policy level, the shift to the TFA was recognized as a necessary step for enhancement of the quality of services. At the implementation level (state and district), however, the only guidance programme implementers received was in the form of a manual (written in English) to orient them on decentralized planning, starting at the sub-centre level.

To convey clearer guidelines to health workers and to simplify the implementation of the TFA concept and philosophy, the government renamed the TFA as the Community Need Assessment (CNA) approach.

In September 1997, the government realized that the TFA manual was not proving to be useful in implementing the new approach and that the term TFA was a misnomer. Many health workers equated TFA with "no work" or "no more monitoring based on targets" and became complacent. The formats introduced to estimate community needs and expected levels of achievement were too complex to be followed by the workers. The training provided to health workers in the use of these formats was inadequate and lacked uniformity. To convey clearer guidelines to health workers and to simplify the implementation of the TFA concept and philosophy, the government renamed the TFA as the Community Need Assessment (CNA) approach. In 1998, they developed and distributed a CNA manual to replace the TFA manual. Currently, the programme follows the CNA approach.

Analysis of the Transition from Targets to CNA

Moving away from targets to the TFA is a major organizational change. Implementation of an organizational change of this kind in a vast bureaucratic system is a daunting task. The change process involves three stages: planning, implementation and stabilization. The main purpose of planning is to develop a strategy for implementation. It involves identifying critical implementation issues and designing operational strategies to implement the change.

Figure 1
The Shift from Targets to CNA

	Target Approach		Community Needs Assessment Approach
Driving Force	Targets	→	Community needs
Orientation	Provider	→	Client
Concern	Target Achievement	→	Quality of care
Goal	Demographic impact	→	Reproductive health status
Approach	Top-down	→	Bottom-up

Experiences of Implementing TFA/CNA

On a pilot basis in 1995–96, GOI designated a single district in 18 different states and two entire states as "target free." The objective was to learn from experience and determine the feasibility of adopting the TFA nationwide. In the absence of guidelines, each state responded according to their level of comprehension of the new policy. For instance, Andhra Pradesh designed a very comprehensive information and monitoring system and was ready to test run the system in the target-free districts of East Godavari and Medak. The government of Rajasthan introduced a new innovative information and service delivery system in Dausa and Tonk districts. Uttar Pradesh carried out operations research in Agra and Sitapur districts. Tamil Nadu designed and introduced a new information system at all levels. Other states largely waited for further instructions from the central government.

The initiatives taken by the states are an indication of the recognition of the need to change or revamp the information and monitoring systems of the family welfare programme. GOI, without taking into account the changes contemplated or implemented and without a comprehensive review of experiences gained in the first phase of implementation of the TFA, imposed the TFA in all states in February 1996. Several states initially resisted the change and wanted the old target system to continue with some cosmetic changes. GOI responded to the situation by directly instructing District Collectors or District Magistrates to abolish targets and to introduce the target-free system with the help of centrally designed new formats. Guidelines and a budget to train workers and medical officers were given directly to district authorities. State-level Directorates of Health and Family Welfare were mere spectators to this process. The training was conducted without supervision, it was not of uniform quality, and many did not understand the philosophy behind the new approach. The formats provided were complex and many workers could not understand how to calculate the ELAs based on sample surveys. Training programmes involving several hundred thousand workers throughout the country could not be completed until the end of 1997.

Family planning performance in most states declined from 1996 to 1997, creating a negative reaction, particularly among top-level managers who answer directly to their immediate political bosses. The decline in performance in traditionally high performance states was marginal, but in states like Uttar Pradesh and Bihar, it was sharp and perceptible. After several consultation meetings and workshops, GOI realized the limitations of the TFA formats and manual and the negative effect of the term "target free." The manual was subsequently revised, and in a meeting held for representatives of state governments in September 1997, in New Delhi, the revised manual was approved at the same time as the name of the approach changed. In many states with weak monitoring systems, the workers stopped visiting villages to provide services and expected villagers to visit clinics that were located far away with no transport facility. The term CNA was chosen to convey the message that the workers' responsibility is to assess the needs of the community and provide services as per the community needs. A senior GOI officer, reflecting on the prevailing situation, stipulated, "We may have adopted a target-free approach, but this is with reference to numerical method-specific targets. We are not in a goal-free situation. We still

In many states with weak monitoring systems, the workers stopped visiting villages to provide services and expected villagers to visit clinics that were located far away with no transport facility.

have our goals and objectives intact, and this needs to be emphasized." [7]

The CNA approach has modified formats for data collection. The number of formats was reduced from 14 planning and reporting formats for the TFA to nine formats for the CNA approach. GOI dispatched the English version of the CNA manual and formats to state governments in 1998, necessitating reorientation of workers. In addition, GOI instructions were not clear on whether the new formats should replace the old ones or continue as a parallel activity. Training of workers remained a major issue. A uniform training programme was designed to cover all workers in the country without taking into account differences in capabilities and skills, which turned out to be a major obstacle to institutionalizing the new system. In many states, the printed formats for CNA were not made available. Implementation of the CNA approach was not uniform, varying from district to district within a state as well as from state to state. Given this scenario, states responded to the new system in different ways. Some states have blended the old approach with the new approach and designed new monitoring systems. Some have tried to implement the new system, completely replacing the old system. A few others have neither the old nor the new system in place. The TFA, however, succeeded in making the lexicon, and the use of such terms as 'quality of services', 'community or client needs', 'integrated approaches', and 'expected levels of performance' are used to reflect the new philosophy of service delivery. The following sections of this paper summarize the experience of nine states in adopting the new system.

In Andhra Pradesh, with strong political backing available to the state's programme, the Department of Health and Family Welfare initiated the formulation of a comprehensive state population policy that included both demographic and RH goals.

Andhra Pradesh

In the first phase of the TFA, Andhra Pradesh abolished targets in East Godavari and Medak districts. Even before selecting these districts for the TFA, the Directorate of Family Welfare designed a new information and monitoring system to completely replace the old system. TFA districts were selected to pretest the new system. This process was discontinued, however, after an enthusiastic beginning due to lack of support from the central government.[8] The performance in both TFA districts declined considerably. Many at the state level thought that the new approach would present a major hurdle to achieving the state's demographic objectives. With strong political backing available to the state's programme, the Department of Health and Family Welfare initiated the formulation of a comprehensive state population policy that included both demographic and RH goals.[9] The legislature approved the state population policy, the first of its kind in the country, in 1997. In the mean-time, the state completed CNA training at all levels. The workers generate expected levels of performance after conducting surveys, and these numbers are compiled at various levels to arrive at expected levels of performance

[7] Department of Health and Family Welfare, Government of Madhya Pradesh and IIHMR, Proceedings of the Workshop on Population Policy for Madhya Pradesh: Identification of Issues and Challenges, The POLICY Project, The Futures Group International, 1999

[8] C.B.S. Venkata Ramana, "Target-Free Approach for Family Welfare: A Review of Experiences in Andhra Pradesh", in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices, The Futures Group International, New Delhi, 1998, p 26-47.

[9] Government of Andhra Pradesh, Andhra Pradesh State Population Policy: A Statement and A Strategy, 1997

at the district and state levels. At the end of this exercise, in their meetings with district officers, state officers compare the policy objectives and the ELAs arrived at based on data collected from below.[10] After considerable discussion and negotiation, the district and state officers reach a consensus on the ELA for the year. The districts, in turn, distribute these numbers to all health institutions in the district. Performance monitoring systems at both the political and administrative levels in the state were strengthened, and additional resources were provided to districts to achieve results. Consequently, performance, particularly sterilization performance, has significantly improved while spacing method use has remained more or less the same over the same period of time. Senior administrators of Andhra Pradesh strongly believe that the state government, given its structures and systems, has no capacity to serve spacing method users. So the programme strategy places major emphasis on the public sector for sterilization services and on the private sector for marketing of spacing methods. Recently, the state government has promoted male sterilization. An experimental project conducted to promote male sterilization in two districts was a major success, with the number of male sterilizations conducted in a year exceeding that of female sterilizations. According to the results of National Family Health Survey II (NFHS II), Andhra Pradesh's achievements are especially significant in family planning acceptance, immunization coverage, and maternal health care services—particularly antenatal care (ANC) and institutional deliveries.[11] Having achieved replacement level fertility, Andhra Pradesh now intends to concentrate its efforts on reducing infant mortality and increasing age at marriage. Many state administrators feel that they have a successful model for others to follow.

Bihar

Bihar is one of India's large states with low contraceptive prevalence and high fertility. Its performance in regard to deliveries assisted by trained providers and immunization coverage of children is also a cause for concern. The Department of Family Welfare introduced the TFA in one of the relatively better performing districts in 1995–96. The department reviewed the experiences in implementing TFA in this district with the help of an external agency. Even before discussing the issues involved, GOI mandated introduction of the TFA in the entire state. The state government stopped providing targets and discontinued monthly performance review meetings at all levels. The department could not train workers in the use of the new formats, since many in the department did not comprehend the content of the manuals themselves. In 1998, two years after introduction of the TFA, a donor agency helped the state initiate the training of workers. Even after training, few workers are in a position to use the new formats. No annual surveys are conducted to determine the ELA based on community needs assessment. ELA are generated in the beginning of each year based on the past year's performance or based on workers' perceptions. Many of the medical officers in the state considered the TFA as the "tension-free approach" because there was no need for accountability after the introduction

Many of the medical officers in the state considered the TFA as the "tension-free approach" because there was no need for accountability after the introduction of the new system.

[10] Gadde Narayana and A. Kameshwara Rao, Community Needs Assessment Approach in Andhra Pradesh, The POLICY Project, The Futures Group International, New Delhi, 1999 (Mimeo)

[11] International Institute for Population Sciences, Andhra Pradesh: National Family Health Survey-India, 1998-99, Bombay, 2000.

of the new system.[12] Performance of all methods, particularly sterilization, sharply declined in 1996–97 and remained low after that. Many in the department felt that there was a perceptible improvement in the quality of services offered after introduction of the TFA, in terms of method acceptance among low-parity and young couples. However, there is no evidence to support this assertion, and, therefore, it looks more like a justification for poor performance. More intensive efforts are required to build capacity and to improve programme management to make the CNA approach a success in the state.

Gujarat

The government of Gujarat introduced the TFA in Valsad district in 1995–96. The workers were briefed about the TFA and asked to improve the quality of services. In the initial months, due to lack of any guidelines about the new approach, the performance of the district declined drastically, sending panic signals to the administration. Several review meetings with Primary Health Centre (PHC) medical officers and workers occurred that emphasized the need for regularly updating registers of workers to serve the community. Due to these intensive efforts, method-specific performance at the end of the year was only 17-20 per cent less than what it was in the previous year. The TFA was introduced in all districts in April 1996 but only in November 1997 did the state receive clear guidelines from the central government on how to implement the new approach. The Health and Family Welfare Department trained 2,422 medical officers and 16,890 workers by March 1998. Workers then carried out a community-level survey with the help of formats given to them and estimated the expected levels of performance. Following this process, the estimated workloads were unrealistically high in a large number of districts and low in others. The Directorate advised the districts to take past performance as a benchmark and compare past performance with the estimated expected levels of performance. In Gujarat, workers prepare sub-centre plans based on surveys but these numbers are scaled down or up based on past performance.[13] In general, reported performance declined slightly in 1996–97 for all family planning methods and subsequently remained stagnant at that level. Monitoring of family planning performance is now based on ELA. In addition, the state has indicators to monitor quality of services. State officials were not perturbed by the marginal decline in performance and were confident that the new system would be fully institutionalized within a couple of years and start yielding results.

The TFA was introduced in all districts in April 1996 but only in November 1997 did the state receive clear guidelines from the central government on how to implement the new approach.

Karnataka

Based on instructions received from GOI in 1995, the government of Karnataka selected Mandya district to experiment with TFA. Mandya district officers passed on the information to the PHCs and workers. There was no decline in year-end performance. One of the medical officers of Mandya observed, "Performance in the district remained more or less the same even without targets because workers in this district do not have to make much effort. People accept family planning on their own. In such a situation, targets or lack of

[12] D. K. Mangal and Gadde Narayana, The Target-Free Approach in Bihar: A Review of Experiences, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

[13] C.V.S. Prasad and D. K. Mangal, The Community Needs Assessment Approach in Gujarat, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

them make no difference".[14] With the introduction of TFA in 1996, the state made substantial changes to the government-prescribed formats. Workers conducted annual surveys with the help of the eligible couple registers (ECRs), but this data remained unutilized because the targets were prescribed from the top. After the TFA was mandated, the state realized the need to use these data and the centrally prescribed coverage norms to arrive at ELA at all levels. However, the centrally prescribed formats were not useful for calculating the expected levels of achievement for family planning methods. The state directorate, therefore, instructed districts to take past performance into account to arrive at ELA for family planning methods. Some districts considered the past year's performance and others took a three-year average of past performance levels to arrive at the expected level of achievement for family planning. Karnataka also conducted training programmes to reorient health workers as well as members of Panchayati Raj Institutions (PRIs) and anganwadi workers (AWWs). In fact, implementation of the new system preceded the training programmes. In general, workers, supervisors, and medical officers welcomed the new approach and adhered to all instructions provided in terms of training programmes, use of survey formats, and preparation of sub-centre-level workplans. However, many felt that the new approach has not addressed and is not helpful for addressing the tremendous variations within the state. Absence of such differentiated approaches makes micro-level planning a theoretical rather than a practical exercise. The state needs to develop different formulae for different regions or districts to estimate expected levels of performance. Sterilization performance in the state improved slightly after introduction of TFA. Reported performance on all spacing methods showed a decline of 5-10 per cent after 1996–97.

Madhya Pradesh

Madhya Pradesh was one of the first states to conduct elections to local bodies after the 73rd and 74th amendment to the Constitution of India and devolved significant authority and responsibility to the elected bodies. The elected bodies became responsible for implementation of PHC and family welfare programmes, and all health workers were transferred to PRIs. As a result of structural changes in programme implementation, the previously major role of Department of Health and Family Welfare became marginal. At the same time, elected representatives of PRIs had little knowledge of programmes and lacked the skills and experience to govern. It is in this milieu that the TFA was first introduced in Narsinghpur district. Workers were asked to conduct an eligible couple (EC) survey and set their own targets in order to improve performance. The family planning performance of the district dropped substantially in 1995–96. After introduction of TFA in the entire state, workers were instructed to follow the GOI guidelines, conduct eligible couple (EC) surveys, and set their own ELA based on past performance. The state completed the training of district officers in 1997–98. Since workers did not receive any training during the two-year period in which TFA was implemented, the methodology followed to calculate expected levels of achievement varied

Madhya Pradesh was one of the first states to conduct elections to local bodies after the 73rd and 74th amendment to the Constitution of India and devolved significant authority and responsibility to the elected bodies.

14. P. Ramakrishna Reddy, P. Hanumantharayappa and K. M. Sathyanarayana, The Community Needs Assessment Approach in Karnataka, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

from one institution to another.[15] Information collected with the help of ECRs designed a few years prior to the introduction of the TFA was not sufficient to prepare micro-plans. Realizing this and to be in tune with the requirements of the TFA formats, the Madhya Pradesh government completely modified the ECRs and made newly printed registers available to all sub-centres. ANMs collected the information but were not in a position to process the information to identify unmet need for family planning and RH services. Instead of training ANMs, this responsibility was entrusted to statistical officers at the PHC level. There was no involvement of PRIs in the assessment of community needs. The state government has, however, prepared a blueprint for training elected representatives about their roles and responsibilities. The Madhya Pradesh government formulated a state population policy in January 2000, that clearly spells out its family planning and RH objectives for the next decade.[16] Integrated approaches involving elected representatives of local bodies are essential for achieving these objectives. Family planning performance in the state declined considerably for all methods except for oral contraceptives. Political commitment to the family welfare programme in Madhya Pradesh is very high, and the department is trying to implement mechanisms to continuously evaluate performance and review strategies for achieving policy objectives.

Political commitment to the family welfare programme in Madhya Pradesh is very high, and the department is trying to implement mechanisms to continuously evaluate performance and review strategies for achieving policy objectives.

Maharashtra

Maharashtra selected Satara and Wardha districts in 1995–96 to abolish targets. Satara district officials prepared a district action plan that emphasized the need for a maternal child health (MCH) approach for family planning. Satara district implemented its plan after conducting a baseline survey in the district with the help of health workers. Wardha has not made any attempt to prepare a plan. In 1996–97, TFA was extended to all districts. After review of the TFA manual provided by GOI, the Directorate of Family Welfare modified the formats to suit local conditions and termed the new approach "self-determination of targets."[17] The quality of training varied by district, and community involvement was negligible. More systematic efforts were made to train workers on the CNA approach in 1997–98. In addition to the material provided by the central government, the Directorate introduced four data collection formats to be used by sub-centre functionaries to assess community knowledge and to estimate ELA for Family Planning/RH services. By March 1998, all health functionaries in the state were trained in the CNA approach. Training programmes were evaluated and strengths and weaknesses identified. However, the implementation of the CNA approach was beset with several problems. The formats designed required several modifications to capture the relevant information. While the need to modify the formats was recognized, additional resources necessary to make the modifications were not available. Since the attempts to prepare micro-plans were not successful, the government of Maharashtra decided to use the findings of each district's RCH survey to prepare district-level plans.

[15] Ashok Das and K. M. Sathyanarayana, The Community Needs Assessment Approach for Family Welfare in Madhya Pradesh, The POLICY Project, The Futures Group International, New Delhi, 2000 (Mimeo)

[16] Government of Madhya Pradesh, Madhya Pradesh Population Policy, January 2000

[17] Subhash Salunke and Sharad Narvekar, Target Free Approach for Family Welfare: A Review of Experiences in Maharashtra, in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices, The Futures Group International, New Delhi, 1998, p 49-78

The draft plans prepared by the district officers required several modifications and refinements, which were never made. During this period, family planning performance declined considerably, but MCH services improved to a large extent. Maharashtra has long been considered as a state with clear vision for implementing innovative strategies to achieve results. Several other states, particularly in the south, have recently shown better performance than Maharashtra, however. One of the main reasons for this discrepancy is that half of Maharashtra's population lives in urban areas, and there is no PHC and family planning service delivery system to cover urban populations, particularly those living in slums.[18] Senior officers of the Directorate also believe that the department's complacency as a result of past performance has led to stagnation. Several attempts made to revamp service delivery systems have not yet yielded results either due to lack of systematic effort or resources. Maharashtra recently introduced a series of disincentives that are both harsh and unrealistic to improve performance in order to reach replacement level fertility within a short span of time.

Orissa

Orissa selected the newly formed Kurda district to implement the TFA in 1995–96. The government of Orissa introduced a new ECR in 1993–94 and made printed registers available to all sub-centres. Sub-centre workers conducted surveys in all villages in 1994–95 and updated data in 1995–96 to identify ECs. Method-specific targets given to the workers were withdrawn after introduction of the TFA in the district. The directorate toyed with the idea of introducing a birth-based approach to improve maternal and child health services, but these ideas never took concrete shape. After the introducing TFA in all districts, the Directorate issued instructions to prepare district plans based on norms set by the state.[19] These norms stipulated that the ELA for each sub-centre should not be less than 30 sterilizations, and 30 IUDs, 15 oral pill, and 65 condom acceptors. Districts generally followed these norms in preparing the plans they submitted to the Directorate. Performance was monitored weekly at the sector level. Training of health functionaries in the TFA was completed in all districts by the end of 1997. After introduction of the CNA approach, no further training was conducted. The CNA formats provided by the central government were sent to all districts with instructions that the new formats should replace the old TFA formats. The Directorate planned to conduct CNA training in 1999. Sterilization and condom performance in the state declined sharply after introduction of the CNA approach while users of oral contraceptives and IUDs increased considerably during the same period. Orissa faces several unique problems that are major obstacles for effective programme management. In the 1990s, Orissa divided its 13 districts into 30 districts. The infrastructure available in 27 of the new districts is grossly inadequate, and resources are not available to improve the situation. Orissa also experiences severe cyclonic storms almost every year, disrupting the normal functions of all departments. The health department spends most of its energy and resources

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[18] Tara Kanitkar (ed) Proceedings of the Workshop on Population Policy for Maharashtra: Issues and Challenges, Centre for Health Policy and Research, Pune, 1999 (Mimeo)

[19] K. M. Sathyanarayana and Ranjana Kar, The Target-Free Approach for Family Welfare in Orissa: A Review of Experiences, The POLICY Project, The Futures Group International, New Delhi, 1999

to contain epidemics that follow natural calamities. Still, the state has a relatively good database at the sub-centre level, which could be used to provide services based on client needs. This will only be possible, however, when the state identifies and formulates new strategies to provide quality RH services.

Rajasthan

Even before introduction of the TFA in 1994–95, the government of Rajasthan decided that the unmet need for family planning services should be the focal point for all programme implementation efforts. To introduce the unmet need concept at the village level, sub-centre registers and report formats were completely redesigned and workers trained in their use. Workers were instructed to conduct surveys to identify unmet need for both limiting and spacing methods in the month of May, and districts were to consolidate all information and prepare district plans in the month of June. The extent to which the workers satisfy unmet need has become the basis for performance monitoring and evaluation.[20] In addition, the Department of Family Welfare introduced concurrent evaluation by external survey research agencies to check for inflated performance reporting at all levels. The new system was introduced in two districts to begin with and rapidly expanded to all districts. By the time the central government decided to implement the TFA, Rajasthan had its new system in operation in the entire state. There was considerable reluctance on Rajasthan's part to replace its system with the one suggested by GOI. Rajasthan's system, which identifies needs every year in each household, was considered far better than the approach suggested by the central government, which involved a series of calculations to arrive at estimates of client needs. In 1997, the department further expanded its system to identify unmet need for RH services. A monthly feedback system based on reviews of reported performance was established in 1998–99. To review Family planning and RH performance, senior directorate officers visit each district once every two months. Identification of unmet need with the help of household surveys and a revamped monitoring system has helped Rajasthan to improve its family planning performance considerably. It is the only state that has not experienced a decline in family planning performance after introduction of the TFA. The Rajasthan government also formulated a state population policy in 1999 that clearly articulates the goals and strategies for the family welfare programme.[21] Rajasthan, for understandable reasons, has not paid much attention to the CNA approach and the new formats proposed by GOI.

Even before introduction of the TFA in 1994–95, the government of Rajasthan decided that the unmet need for family planning services should be the focal point for all programme implementation efforts.

Uttar Pradesh

Uttar Pradesh selected two districts—Agra, a high-performance district and Sitapur, a low-performance district—to experiment with the TFA. With the help of resources from the USAID-funded Innovations in Family Planning Services (IFPS) Project, the pregnancy-based approach and the unmet need for family planning services approach were introduced in both districts. Registers were designed and workers trained in the use of the new registers. Though family planning performance in both districts

[20] Ram Lubhaya, Target-Free Approach for Family Welfare: A Review of Experiences in Rajasthan, in The POLICY Project (ed) Targets for Family Planning in India: An Analysis of Policy Change, Consequences and Alternative Choices, The Futures Group International, New Delhi, 1998, p 70-101

[21] Department of Family Welfare, Population Policy of Rajasthan, Government of Rajasthan, 1999

declined drastically after introduction of the TFA, a slight improvement in MCH services was observed. In 1996–97, Uttar Pradesh extended the TFA to the entire state, but the training given to workers to implement the new approach was ineffective. Moreover, the state government had deleted the family planning programme from the 20-point programme, and district magistrates were instructed not to monitor family planning programme performance.[22] Overall programme performance drastically declined. After this, the Department of Family Welfare started systematic preparatory work to strengthen the target-free system from 1997–98 onwards. Training was conducted in all PHCs in the state with the help of facilitators and a guide developed specially for that purpose. All workers were trained by November 1997. Uttar Pradesh received the CNA manual to replace the old TFA manual from the central government in March 1998. The Directorate of Family Welfare decided to continue with the TFA formats rather than introduce the CNA formats and retrain all workers. During this period, the department took several decisive steps to improve access to and the quality of a wide range of RH services rather than solely concentrating on family planning. These steps included provision of quality reproductive and child health services through RCH camps, tetanus toxoid (TT) campaigns covering all pregnant women, dai training to increase the proportion of deliveries conducted by trained personnel, and decentralized planning at the district level using a participatory approach. In addition, contraceptive marketing of condoms and oral contraceptives in rural areas is expected to increase spacing method use. The Government of Uttar Pradesh has recently formulated a population policy with clear strategies to integrate services, decentralize delivery systems, and improve service quality.[23] To realize the policy objectives, the CNA approach has to be further strengthened in the state by conducting annual household surveys to identify unmet need for family planning and RH services. Uttar Pradesh discontinued this practice in the mid-1970s. A common feature in other states, the Department of Family Welfare has decided to reintroduce annual household surveys with the help of simple formats to identify unmet need for RH and family planning services in four districts on a pilot basis. At the same time, the department will develop a more comprehensive management information system (MIS) to cover the entire state in a phased manner.

The Government of Uttar Pradesh has recently formulated a population policy with clear strategies to integrate services, decentralize delivery systems, and improve service quality.

Conclusions

Moving from targets to the target-free approach represented a major organizational change, and an enormous challenge to India's public health system. Planning for change involves consensus and clear understanding among stakeholders on the reasons for change, the direction of change, and processes to be followed in introducing change. Due to poor experience with targets, the reasons for the national-level change were clear and in tune with the thinking of the international community on the subject. The groundwork done by GOI to educate and build consensus among stakeholders in support of the TFA, however, was grossly inadequate. Resistance to a change of this magnitude was inevitable and, therefore, strategies to overcome resistance should have been planned well in advance.

[22] J. S. Deepak, The Community Needs Assessment Approach for Family Welfare: A Review of Experiences in Uttar Pradesh, The POLICY Project, The Futures Group International, New Delhi, 2000

[23] Government of Uttar Pradesh, Population Policy of Uttar Pradesh, 2000.

The GOI, instead, chose a shorter route by announcing the decision and dealing directly with districts without involving state directorates. The delivery of critical instructions, manuals, and formats to districts to reorient workers occurred several months after the introduction of the TFA. Formats prepared to estimate and plan workloads were very complex and involved several calculations based on many assumptions. Those who designed the formats never thought about the capabilities of the primary users of these formats (i.e., health workers at the sub-centre level). Workers in all states found it uniformly difficult to use the new formats. In addition, the training programmes conducted to familiarize workers with the new procedures did not convey the philosophy behind the new system. Workers and supervisors had their own interpretation of the new approach that was different from the original intent of the programme. Not surprisingly, performance dropped substantially in many states. Interestingly, the high-performance states with strong monitoring systems experienced only a marginal decline in performance while the low-performance states with weak monitoring systems could not avert significant declines in performance. TFA, in effect, widened the gap between high- and low-performance states.

One of the basic problems with the new approach is that it was designed by the central government for use at the sub-centre level. This centrally imposed, decentralized system goes against the core tenet of a decentralized approach for assessing community needs.

One of the basic problems with the new approach is that it was designed by the central government for use at the sub-centre level. This centrally imposed, decentralized system goes against the core tenet of a decentralized approach for assessing community needs. The formats introduced under the new system again rely heavily on a series of quantitative measures for the sake of quality improvement. The way in which the CNA approach has been implemented undercuts the philosophy behind the new approach.

The CNA approach has achieved some notable positive results, however. Resistance to the change has declined. Those working for the family welfare programme at various levels are now largely convinced about the futility of the numbers game as practiced earlier. There is growing recognition of the need for a thorough review of the programme and for introduction of integrated and decentralized service delivery systems with more emphasis on RH services. The recent formulation of integrated population policies by some state governments is, in a sense, an expression of this need. Several states have also realized that community needs should take precedence over programme needs. Change of this magnitude cannot be accomplished in a short timeframe. Realizing this, many state governments have initiated steps to introduce the change in a systematic and phased manner. The process of change has just begun and will probably take a few more years to achieve the desired results. Instead of believing that the TFA or CNA approach is already in place in the country, GOI should encourage state governments to develop their own approaches for assessing community needs and help them to do this by providing resources and technical assistance until the new systems are fully institutionalized.

Table 1
Sterilization Performance Based on Service Statistics
Before and After Introduction of the Target-Free Approach

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	575,728	520,552	513,127	630,043	730,976
Bihar	206,188	264,927	82,421	196,000	125,000
Gujarat	301,928	289,054	241,945	241,364	250,379
Karnataka	371,535	381,571	384,056	395,624	371,275
Madhya Pradesh	401,855	384,342	371,731	367,092	357,243
Maharashtra	582,454	566,168	518,897	571,476	532,714
Orissa	162,085	148,659	134,825	127.046	NA
Rajasthan	203,118	168,245	200,711	224,140	229,295
Uttar Pradesh	516,970	519,399	266,350	307,799	347,401

Table 2
IUD Performance Based on Service Statistics
Before and After Introduction of the Target-Free Approach

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	338,289	282,933	298,127	293,872	287,190
Bihar	206,551	269,889	156,186	222,744	175,609
Gujarat	473,800	452,180	409,139	401,436	413,189
Karnataka	299,504	345,937	376,247	372,341	337,854
Madhya Pradesh	857,822	797,548	598,012	617,928	576,188
Maharashtra	476,283	470,630	453,321	418,711	402,450
Orissa	193,582	209,074	193,167	245,693	NA
Rajasthan	156,060	168,239	204,765	224,100	232,685
Uttar Pradesh	2,194,522	2,193,488	1,664,021	2,029,847	2,084,468

Table 3
Oral Pills Performance Based on Service Statistics
Before and After Introduction of the Target-Free Approach

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	261,864	242,262	242,987	254,499	224,705
Bihar	65,430	67,214	43,582	56,377	44,940
Gujarat	179,025	172,920	160,123	161,914	172,980
Karnataka	138,232	151,145	157,545	156,494	148,931
Madhya Pradesh	476,277	511,288	494,196	560,167	577,126
Maharashtra	418,194	483,269	375,537	375,187	358,821
Orissa	93,904	99,731	106,472	107,722	NA
Rajasthan	92,268	125,230	484,067	402,489	325,465
Uttar Pradesh	487,250	558,509	514,525	764,044	722,290

Table 4
Condom Performance Based on Service Statistics
Before and After Introduction of the Target-Free Approach

State	Before TFA			After TFA	
	1994–95	1995–96	1996–97	1997–98	1998–99
Andhra Pradesh	1,252,752	820,163	613,013	605,137	539,620
Bihar	194,497	191,305	99,945	78,578	98,875
Gujarat	1,292,225	1,105,558	1,105,687	824,116	889,990
Karnataka	395,108	374,687	358,627	323,021	278,626
Madhya Pradesh	1,987,146	2,004,814	1,761,754	1,650,486	1,545,022
Maharashtra	1,168,747	1,163,775	685,855	594,164	586,489
Orissa	467,838	443,483	369,528	255,967	NA
Rajasthan	475,272	519,048	720,414	470,874	374,345
Uttar Pradesh	2,897,773	2,434,224	1,769,096	2,045,682	1,923,835

Table 5
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
TFA in 1995–96	Selected two districts, designed a comprehensive MIS but did not implement the MIS due to lack of positive response from GOI	Selected one district but no instructions were given to the district officers by the Directorate	Selected one district and series of performance review meetings were conducted to arrest possible decline in performance	Selected on high-performing district but no guidance provided on what needs to be done	Selected one district and conducted EC survey	Selected two districts and prepared micro-plans in one district and no plans in the other	Selected one new district with weak infrastructure and conducted EC survey	Selected two districts even before TFA to provide services based on identified unmet need	Pregnancy-based approach and unmet need approach was introduced in two districts in which targets were abolished
Performance in selected districts in 1995–96	Performance declined considerably in both districts	Performance declined considerably	Performance declined only by 17 per cent	Performance of the district more or less remained the same	Performance of the district dropped substantially	Performance in the selected districts declined marginally	Performance declined significantly	Performance improved marginally in both districts	Performance declined considerably in both districts
TFA in 1996–97 Approach Current Situation	Introduced TFA in all districts and also continued with the old system	Introduced target-free training in all districts and the department stopped targets at all levels	Introduced TFA in all districts and conducted household surveys with the help of health workers	Abolished targets but districts took into consideration past performance to arrive at ELAs	Abolished targets and shifted programme implementation to elected bodies of panchayats	TFA was introduced in all districts and GOI formats were modified considerably	Targets were abolished in all districts but state circulated performance norms per sub-centre	State pursued its own system of household surveys to identify unmet need. Serving couples with unmet need was the objective	Abolished targets in all districts and family planning programme was delinked from 20-point programme

Table 5
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
Training for TFA system	Training programmes lacked quality and uniform understanding of manuals. Supervision of training nearly absent	Training was done two years after introduction of the new approach	Training for TFA system was not effective and done without systematic planning	Training was conducted after introduction of new system	No training In the first two years	Training was imparted and TFA was renamed as "self - determination of targets approach"	Training was conducted in all districts and manuals and formats were distributed	Training was conducted but more to satisfy GOI than to introduce the new approach	Training was given for TFA system systematically with facilitators and guidelines in place
CNA Approach	Introduced in 1998–99 and workers were given training. manuals and formats	CNA training was not imparted	Completed training all Medical Officers and workers by March 1998	Training conducted and formats distributed	Training conducted and formats distributed and at the same time completely modified ECRs supplied	Four new formats were introduced in addition to GOI formats and training conducted more systematically	No training was given on CNA approach	No training was given and the department followed its own approach and expanded unmet need concept to RH services	No training was imparted on CNA approach
Current Situation	Objectives set in Andhra Pradesh Population Policy are given more importance than numbers generated from below. ELA is based on negotiations with district officers	Neither is the old target system nor new CNA approach based on client needs	Workload identified with CNA formats was much higher than average annual performance of districts. Districts compare past performance and expected workload and arrive at realistic ELAs	Average performance for the past three years and estimates based on GOI norms are compared and ELA is arrive at by each district.	Health workers collect information with the help of ECRs but do not know how to utilize the information. The collected data remains unutilized. Process followed to arrive at ELAs varied from one institution to the other	New formats introduced were not useful to calculate ELA. District tried to use survey data to prepare district plans but could not succeed. Largely follows a combination of old and new approaches	Most of the districts follow the method-specific norms given by the state government. EC surveys are conducted on annual basis to identify eligible couples that need services	Workers conduct annual survey in May to identify unmet need for Family Planning and RH services. Workers are asked to contact couples with unmet need and provide services based on method choice of client	Workers estimate the ELA and consolidated numbers are submitted to Directorate. Then Directorate negotiates with districts to arrive at a number that is realistic and achievable

Table 5
Summary of Experience in Implementing the TFA/CNA Approach in India

	Andhra Pradesh	Bihar	Gujarat	Karnataka	Madhya Pradesh	Maharashtra	Orissa	Rajasthan	Uttar Pradesh
Monitoring Systems	Performance monitoring systems are strong with high level of political commitment	Monitoring systems were weak before TFA and further deteriorated after TFA	Performance monitoring systems are in place but need to be strengthened	Monitoring systems are in place and no changes introduced after TFA	Monitoring systems are generally weak due to lack of awareness among elected representatives about health systems	Monitoring systems are strong for rural health institutions but urban service delivery systems are weak	Monitoring systems are weak mainly due to formation a large number of new districts. The newly formed districts do not have necessary infrastructure	Monitoring systems were strengthened further at all levels	Monitoring of performance is weak largely due to political interference
Family Planning Performance	Sterilization performance improved considerably while performance of spacing methods fluctuated.	Family planning performance of all methods declined significantly.	Family planning performance declined by 5- 10 per cent for different methods over a period of three years.	Sterilization and IUCD performance marginally increased, oral pill users remained same and condoms users declined.	Sterilization, IUCD and condom performance declined considerably and oral pill performance improved significantly.	Sterilization and IUCD performance marginally declined and oral pill and condom performance declined significantly.	Sterilization and condom performance declined but oral pill and IUCD performance improved significantly.	Sterilization and IUCD performance consistently improved but the oral pill and condom performance fluctuated.	Sterilization performance declined by 40 per cent in 1996–97 and marginally improved after that. IUCD performance remained the same and oral pill performance improved considerably. Condom performance declined.

Main Identity

From: Amarjeet Sinha <A-Sinha@DFID.GOV.UK>
To: <sochara@vsnl.com>
Sent: Monday, March 17, 2003 CHC11 AM
Attach: health report proposal.doc
Subject: Re: (no subject)

Dear Dr. Thelma Narayan,

We have had some more deliberations around the proposed Public Report on Health over the last few months. There is perhaps greater clarity on how we want to take it forward. I am attaching a revised version of the draft proposal for your suggestions. We look forward to your working as part of this group.

Amarjeet

>>> Community Health Cell <sochara@vsnl.com> 01/01/03 01:46pm >>>
Dear Mr. Amarjeet Sinha,

Greetings from Community Health Cell!

My apologies for not replying to your mail of 12th November – travel, ill-health and various commitments were some of the reasons. If it is not already too late I would be happy to join the group. However our team is busy with the Asia Social Forum from 2nd to 7th January in Hyderabad where CHC is organizing 4 workshops. After that I attend a workshop developing a curriculum for gender issues in medical education and then a workshop on health in Hyderabad with Shivakumar and others. Perhaps you may be at one of these?

Best wishes for the New Year.

Dr. Thelma Narayan
Coordinator

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PUBLIC REPORT ON HEALTH – A DRAFT PROPOSAL

STATEMENT OF PURPOSE

Most health indicators for women and children in the more backward States of India, where a considerable population of the country resides, are extremely unsatisfactory, but the political system and the media does not appear to be doing enough to highlight the growing dangers to the well – being of future generations on account of continued neglect. Unlike basic education and literacy, critical indicators of health like Infant Mortality, have almost stagnated in the 1990s.

Health service planning being dominated by the technology centred biomedical perspective, rather than a rational holistic one and with a lack of understanding and appreciation of layperson's perspective on health as a means to well – being, often limits the range and focus of service delivery. It also leads to trivialization of a right to health by equating it merely with delivery of a few services. Neglect of public and preventive health care increases the burden of disease and the cost of meeting it. Destitution on account of illnesses is a frequent occurrence and the growing evidence of economic inequality in the 1990s is likely to compromise further poor people's ability to access quality health care in the absence of effective public funding. Low and inefficient public funding of primary, secondary and tertiary care forces households to seek private health care with very high out of pocket expenditure.

The proposed Public Report on Health would like to focus the attention of the nation on people's right to quality health care. It will do so by looking at people's perceptions of health as a means of over all well – being. This would mean understanding lay perceptions not only about provider – patient relationships or for delivery of services and implementation of programmes, but more so for conceptual frameworks in policy formulation.

While a large number of national health programmes for disease control have their vertical empires with separate sources of national and international funding and priorities, the absence of horizontal integration of such efforts through the Primary Health system compromises their ability to meet felt needs of the people. Local specificities and traditional wisdom are very weak in our approach to health care even though promotion of Indian Systems of Medicine has been tried out on a small scale in many states. The Primary Health System does not seem to address the diversity of health needs of poor people. Extraordinary zeal for family planning and pulse polio like campaigns, while registering limited success, jeopardise the sustainable delivery from the larger health system. Persistence of high incidence of Tuberculosis and Malaria is symptomatic of the health system's inability to deliver health care of satisfactory quality in a sustainable way. The

unsatisfactory indicators of women's well – being are a severe indictment of the health delivery system and its outreach, exceptions like Kerala and Tamil Nadu notwithstanding.

The proposed Public Report on Health would like to focus the nation's attention towards the neglect of people's needs in most regions, in this vital area. It would like to do so by looking at household profiles in sampled villages across a few States (both well performing and not so well performing States – Tamil Nadu, Maharashtra, Himachal Pradesh, Utttar Pradesh, Madhya Pradesh, Orissa and Assam) in a comparable way, to ascertain the diversity of health needs of the people and to see whether or not the health system is geared to meet the community demand. *While the household survey will look comprehensively at all elements that contribute to good health and well – being, the survey of health care facilities will focus on the delivery of such services.* In doing so, it would also look at the range of public – private providers of health care and the extent to which they deviate from ethical practice to exploit people's needs.

Based on an understanding of the community demand and the response of the public health system, it would attempt to develop a critique of the current priorities and the distortions therein and the reasons thereof. The primary household and service delivery survey will inform the inferences that the report would like to draw for further action. In doing so, it will critically look at the legal framework for people's right to livelihood, the extent of community ownership, systems of regulation for quality health care, professional ethics, arrangements for training health personnel, etc.

The proposed Public Report on Health, would like to present an alternative perspective based on people's right to health. The Right to Health is seen as a holistic right that focuses on good health as a means to well- being. While dealing with health in its holistic dimension as a multi-sectoral issue, this Report will specially focus on understanding poor people's perceptions of well – being and health as also the delivery of health and medical services to the marginalized and most disadvantaged sections of the society. This has been the most neglected area so far in the design of health policies and programmes.

THE TEAM

A few preliminary meetings have been held to develop a team to undertake this study. Jean Dreze (Development Economist); K.B. Saxena (retired civil servant with interest in social sector issues); Dr. C. Sathyamala (with considerable field experience in Public Health issues in backward regions/ urban slums); Ravi Srivastava (Economist); Rama V. Baru and Ritu Priya (from the Centre for Social Medicine and Community Health, JNU);

Onkar Mittal (independent worker with experience in the NGO and development agency experience in the health sector); Arti Ahuja (from LBSNAA Mussoorie with an interest in health issues); Thelma Narayan (from the Community Health Cell, Bangalore),

Vimala Ramachadran (development researcher), Anuradha De, Claire Noronha and Meera Samson (from CORD and with experience of working on the Public Report on Basic Education and Health), A.K. Shiva Kumar (works on human development issues), Alakh Sharma (from the Institute of Human Development), and Amarjeet Sinha (civil servant with interest in social sector issues) have so far attended / shown interest in working on this report. Interest has also been evinced in working together by Health Watch, CEHAT, and the JSA. Pushpendra, Dr. Manju Rani and Dr. B. Sekhar have also evinced interest in working with the Group. Efforts to develop partnerships without compromising the basic agenda would be consistently made by the group. The Team will continue to interact with more and more people in various states to identify persons who would like to associate with this work in any manner. As in the case of the Public Report on Basic Education (PROBE), the Group would seek the support of a large number of activists, organizations, academies and institutions in the course of doing the Report. Special efforts will be made to draw upon the support of field investigators with experiences in process intensive programmes like Mahila Samakhya or with other field based activism n the health sector.

INSTITUTIONAL SUPPORT FOR THE STUDY

In the course of preliminary discussions, Dr. H. Ramachadran, Director, Institute of Applied Manpower Research has in principle agreed to provide institutional support for this Study. The detailed modalities will be worked out in the course of the next few weeks. K.B. Saxena, a Member of the Group, is presently working at IAMR and the institutional support from IAMR could be developed under his leadership. Besides providing logistic support, interaction with identified Faculty at IAMR will enrich the perspective of this Group.

THE METHODOLOGY

The overall objective of the Public Report on Health is to present an alternative perspective *to the overly-biomedical, commodified and productivity-oriented(?) approach* on the Peoples' Right to Health within a holistic framework. The report will identify 'how' health, thus defined *(through community perceptions, health service provider perceptions, and epidemiological rationality)*, can be achieved and 'what' needs to be done to move towards it in the present context at a macro level through public policy. The second issue is of access to quality care across a combination of systems viz.–home remedies, various folk, indigenous and allopathic systems–based on a continuum from the home, to community, to primary, secondary and tertiary levels of care. This would include ensuring availability of accessible medical services, promoting rational medical management practices, promoting their rational utilization, and an epidemiologically rational health service sector policy approach with the holistic framework providing the philosophical moorings.

Concrete outcomes could include suggesting:-

(i) A minimum package

- of services
- of structures and facilities

(ii) Regulatory mechanisms involving

- civil society
- local communities
- administrative structures
- professional bodies

(iii) Rules of thumb for assessing policy options

The specific objectives of the field study will include:

(a) Exploring people's perceptions of health and wellbeing and their determinants

- Stratified by SES and gender (and inter-generational)

(b) Documenting illness related information

- Morbidity patterns
- Illness management – No action/home remedies/self-treatment/folk practitioners/ indigenous and allopathic systems
  - Source of treatment- Private/public, their profiles. Primary/secondary/tertiary
- Expenditure on treatment – how much and how the expenses were met
- Perceptions about illness/treatment/public and private health service providers/prevention

(c) Studying the Health Services

- Listing of health services and service providers, public and private
- Management practices of service providers
- Perceptions of service providers of various types at various levels

(d) Analysing Policy Approaches

- Health policy in light of the above
- Specific programme formulation as case studies– to study the determinants and process of decision making.
- Perceptions of policy makers planners administrators
- Exploring options for civil society/professional body led regulation of private providers (for ethical practice)

Methodology

I. The field study conceptualises the peoples' perception of health and well-being, morbidity patterns, perception of illness, their treatment seeking behaviour and the health service providers as interactive and integrated phenomena. The perception of well being and what constitutes quality health services of the community, is to be viewed in relation *to their life context as well as* the perceptions of well being and quality health care by the

different providers of health care. The field study would therefore collect data for objectives a, b & c, taking districts within selected states as the units of study within each state.

Selection of States, Districts, Villages

The Group would like to look at a representative sample of States, both geographically and in terms of the performance in the health sector. The effort is to cover better performing States as also States where the indicators of health and well –being are unsatisfactory. Based on these considerations, the Group decided to carry out the field studies in Tamil Nadu, Maharashtra, Himachal Pradesh, Uttar Pradesh, Madhya Pradesh, Orissa, and Assam. Two districts within each of the selected states would be selected, representing the extremes of development. Within each district 5 villages will be selected purposively. In one of these villages in each of the districts, morbidity patterns will be studied with a longer association. In order to retain the ethical focus in the study, efforts will be made to redress health needs of people identified in the course of the survey by effective local level partnerships with governmental, non governmental and other civil society organizations.

Literature Survey

The Group is aware that a large number of studies on some of the themes being explored in this Study are already available. Literature Survey will therefore be a very important initial activity. The Project will set up a four Member full time team of Research Scholars for extensive literature survey.

Micro studies as initial activity

Altogether, 70 villages in 14 districts will be taken up for detailed study. The starting activity would be to carry out a detailed micro study in each of the 14 districts over 2-4 months, to understand the issues better and to pilot some of the proposed survey schedules to be used in the study.

Collecting data on perceptions of wellbeing and health, morbidity and treatment seeking in each of the villages and colonies of the urban poor would be accompanied by listing of health service providers resorted to, formal and informal. At district level, a

listing of providers and institutions, both public and private, can be undertaken. Through indepth case studies, provider perceptions regarding health, well being and quality services can be elicited as well as prescribing practices documented.

II. Policy analysis could include:

(i) Reconstructing the process of specific programme formulation–eg of Pulse Polio, Hepatitis-B, AIDS control–through study of documents and interviews with persons involved.

(ii) Reconstructing the process of adoption of Health Sector Reform policies at center and state level.

(iii) Analyzing the current policy and programme approaches against the perceptions of the laypeople and the service providers.

TIME FRAME FOR THE STUDY

It is expected that the Study will take between 12-18 months.

BUDGET

The Budget is very tentative and based on the assumption that the institutional partnership with IAMR will work out. The Project office could then be located in the IAMR premises and some of the administrative costs for the study will be lower as existing staff in IAMR could provide support for the Study. The Budget could be divided

Office Space (To be provided by IAMR)

Four rooms - one for the Administrative staff, one for the Research Scholars, one for data entry and for meetings/ Group members, etc.

Telephone/ Photocopier/ Fax/ Computers/ e-mail facility(to be provided by IAMR)

For the entire Project period.

Incidental expenses

Stationary, library books, POL, Travel reimbursements, etc. As far as possible, train travel (II Class) will be provided for. Total Rs. 5 Lakhs .

Literature Survey, Designing Survey Instruments, Data Analysis and Report writing

4 Research Scholars, 2 for 18 months and the other two for 12 months. Two of them will be Senior Research Scholars with emoluments of Rs. 20000 - 25000 per month and two will be Junior Research Fellows with emoluments of Rs. 12000 - 15000 per month. The Members of the Group would take up specific themes for literature Survey. Members of the group will only be paid travel costs, unless they decide to join on a full time basis.

Total requirement – Rs. 11 lakhs.

Microstudies

14 Microstudies by 14 field persons over 1-2 months. The four full time members, other members of the core group, other group members will also undertake the micro studies. Resource persons doing micro studies to be paid Rs.12,000 per month plus TA/DA (not required for core group members who have other source of income/ full time Project Team members. 7 Micro studies to be done by team members and 7 by other professional researchers. Requirement – Rs. 2.40 lakhs.

National/ Regional Workshops to present findings of the micro study and to design survey instruments

5 workshops @ Rs. 1 lakh per workshop. Requirement - Rs. 5 lakhs

Selection and training of Investigators

10 day training programme for 70 investigators - @ Rs. 200 per day (including travel costs). Requirment Rs. 1.40 lakhs.

Survey in 70 villages of 14 districts in 7 States

2 investigators in each of the villages. Each Member of the Group would also carry out the survey in at least one village. The Survey is likely to take about 60 days in 2-4 spells. Each Investigator to be paid Rs. 8,000 per month plus TA/DA. Survey work in about 15-20 villages will be done by members of the Core Group/ Project Team Members.

Total Requirement Rs. 10 lakhs.

Workshops and sharing sessions with Field Investigators

Provision of four such workshops (once every six months) and sharing sessions with Investigators. Requirement – Rs. 2 lakhs.

Morbidity study over 12 months in 14 villages of 7 States

A team of 1 investigator plus a Medical doctor and a para medical support staff (as per need) in the 14 villages selected for morbidity studies. The team will need to spend 6-12 months in the villages studied. Medical Doctor and para medic staff to be paid honorarium, as required. Total Requirement – Rs. 14 lakhs.

Project Staff (To be provided by IAMR)

To maintain accounts, facilitate travel and general coordination work. One Administrative Officer, One Accountant and Two Assistants will suffice (To be provided by the IAMR).

Data Entry support (To be provided by IAMR)

Report writing, Advocacy, Regional Workshops
Rs. 5 lakhs.

TOTAL COST OF STUDY RS. 55.80 LAKHS
Management Cost to IAMR (10 % of total cost) Rs. 5.60 lakhs.
TOTAL COST (INCLUDING IAMR'S MANAGEMENT COST – Rs. 61.40 LAKHS.

Comm-71.

Community Health Cell

From: UNNIKRISHNAN P.V. (Dr) <unnikru@yahoo.com>
To: <PHA-Europe@yahoogroups.com>; "Health NOW!" <info@health-now.org>; "IPHCWORLDWIDEY" <IPHCWORLDWIDE@yahoogroups.com>; <pha-exchange@kabissa.org>; <PHM_Steering_Group_02-03@yahoogroups.com>; <pha-ncc@yahoogroups.com>
Sent: Saturday, June 19, 2004 10:00 PM
Subject: [pha-ncc] People's Health Movement media coverage: THE LANCET- Volume 363, Number 9426 19 June 2004

People's Health Movement media coverage: THE LANCET- Volume 363, Number 9426 19 June 2004
http://www.thelancet.com/journal/vol363/iss9426/full/llan.363.9426.editorial_and_review.29970.1

Viewpoint : *Robert Beaglehole, Ruth Bonita, Richard Horton, Orvill Adams, Martin McKee*

".....This partnership has long been neglected, although it did flourish briefly--at least rhetorically--under the Health For All banner; it might again make an impression under the influence of the **People's Health Movement**.[30] ....."

Read the full article.....

The world is entering a new era in which, paradoxically, improvements in some health indicators and major reversals in other indicators are occurring simultaneously. Rapid changes in an already complex global health situation[1,2] are taking place in a context in which the global public-health workforce is unprepared to confront these challenges. This lack of preparation is partly because the challenges are large and complex,[3] the public health workforce and infrastructure have been neglected, and training programmes are inadequate. These problems are exacerbated by the concentration of funding on biomedical research and the failure to confront and work with vested interests, which promote and sustain unhealthy behaviour patterns.

If public-health practitioners are to address national and global health challenges effectively, the way they work and make their work relevant to these challenges[4] will require a major reorientation. A clear vision of what public health is, and what it can offer, is required. To be achievable, the vision must then be communicated not only to its practitioners, but also to the wider policy community, whose actions are necessary to improve the health of the public. Here, we propose a reformulation of public health appropriate for the global and national health challenges in this new era.

The practice of public health

Approaches to the practice of public health are contingent on time and place. They are distinguished mainly by the amount of authority vested in the state and their main disciplinary base. In terms of state involvement and responsibility, there are two extreme approaches: the state medicine model and the market model. The practice of public health in the USA is an example of the market approach. The aim of this model is to limit government responsibility for public health and to encourage individual responsibility for health improvement, on the assumption that the market will respond to individuals' demands for goods that promote health.[5] The state medicine model, by contrast, envisages a strong role for the state, encroaching in many areas that some might consider private life. A particular version was transposed to the Soviet Union, where public health became a central part of state policy, summarised by Lenin's comment that "if communism does not destroy the louse, the louse will destroy communism".[6] Another version was seen in China for several decades after the revolution of 1949.[7]

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The disciplinary base of public health can be narrow--mainly the medical sciences--or broad and inclusive, bringing together a wide range of disciplines including the political sciences. The medical model has traditionally been identified with the UK, where public health was, until recently, regarded as a specialist branch of clinical medicine.[8] The broad multidisciplinary approach to public health, sometimes referred to as the social justice model, has a long tradition in several European countries, beginning with Virchow in Prussia at the end of the 19th century, with a brief reappearance in some universities in England in the middle of the last century.[9] This approach to public health has been especially strong in Latin America since the middle of the last century,[10] and has echoes in both the Alma-Ata model of primary health care and the new public health of the 1980s. The practice of social medicine has focused on the social and environmental determinants of health and disease and the effects of social and economic policies on health status; this approach has rarely been able to bridge the divide between rhetoric and policy.

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Defining public health

The definition of public health has changed as public health has evolved.[11] Common to most definitions is a sense of the general public interest, a focus on the broader determinants of health, and a desire to improve the health of the entire population. Earlier definitions also made explicit reference to the administration of health care services. The plethora of definitions suggests that a short and succinct definition of public health is needed that is both broad in scope and of wide appeal.

We suggest that a suitable definition of public health is:

"Collective action for sustained population-wide health improvement"

This definition emphasises the hallmarks of public-health practice: the focus on actions and interventions that need collective (or collaborative or organised) actions; sustainability (ie, the need to embed policies within supportive systems); and the goals of public health (population wide health improvement and the reduction of health inequalities).

The ethical underpinning of public health is of equal importance to its definition,[12] but ethical frameworks for public health are new.[13,14] Our view of the ethical basis for public health stems from knowledge of the pervasive effect of the environmental and socioeconomic circumstances that constrain the decisions individuals make about health. This position affirms the positive obligations by governments and communities to protect and improve the health of all their citizens and is based on the assumption that all lives are of equal worth.

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The public-health response to the global health challenges

To tackle the major global health challenges effectively, the practice of public health will need to change. It is not sufficient to focus only on urgent health priorities, for example, HIV/AIDS, tuberculosis, and malaria in subSaharan Africa, or the narrowly focused Millennium Development Goals.[15] Programmes and policies are required that respond to poverty--the basic cause of much of the global burden of disease--prevent the emerging epidemics of non-communicable disease, and address global environmental change, natural, and man-made disasters, and the need for sustainable health development. The justification for action is that health is both an end in itself--a human right--as well as a prerequisite for human development.[16]

Public health as practised now is not in a position to respond effectively to these challenges, mostly because the capacity of the public-health workforce has not kept pace with changing needs. The neglect of the public-health infrastructure and the weakness of many health systems have compounded this problem. In most developed countries, public health has narrowed in focus and, to a large extent, is driven by the research agenda of academic epidemiologists and biomedical scientists.[17] Its focus has often been on what can be measured easily, such as cholesterol or blood pressure, rather than on the immensely more complex issues of the broader social forces that also affect health, directly or indirectly, such as economic transitions. The schism between research and health policy has widened and the focus of health reforms on clinical services has further marginalised public health.[18] The combination of increased attention to bioterrorism and slowing economic growth, with their inevitable squeeze on public-health research in favour

of biomedical research,[19] has further reduced public health capacity.

The global health challenges require a workforce with a broad view of public health, an ability to work collaboratively across disciplines and sectors, and with skills to influence policy-making at the local, national, and global levels. In view of the importance of politics to the development of public-health policy, public-health practitioners should be closely connected with the communities they serve to build the long-term support necessary to respond to global challenges. The enormity of these challenges means that it will be necessary for all members of the health workforce to adopt a public health perspective in their daily activities.

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Key themes of modern public-health theory and practice

Modern public health has five key themes (panel), each of which is an essential feature of modern public-health practice. Regrettably themes are rarely reflected in the reality of public-health practice or in public-health educational activities.

Health systems leadership

This oversight function is a central feature of efforts to improve the performance of health systems.[20] It requires a long-term perspective and involves several specific activities, the most important of which is defining strategic directions for health systems. Defining these directions is a central public-health responsibility, as is the monitoring of progress towards the designated goals and targets of the system. This function requires strong determination from the government to act. Although many other sectors play a part, responsibility for the legislative and regulatory framework for public health rests with governments. Neglected aspects of health system leadership include failures of advocacy or accountability for improving the health of entire populations, with most ministries of health continuing to focus on immediate issues pertaining to health care.[21]

Collaborative actions

Collaboration in partnership with a wide range of groups from many sectors has been the central feature of public-health practice since the mid 19th century. At first, collaborative action was justified as a way of keeping to a minimum the effect of poverty and its associated ill health on early welfare systems. Collaboration across sectors is even more crucial now. In the absence of strong and effective collaborative actions, the benefits of public health science will continue to be more fully taken up by the already advantaged sections of society, as has happened with tobacco control.[22]

Governments are key to ensuring collaborative actions to promote population-wide health improvement because they are ultimately responsible for the health of their populations. When the state downplays this part in favour of individualism and market forces, the practice of public health is inevitably weakened, slowing progress towards health goals. The public-health workforce, because of its broad mandate and skills base, is uniquely placed to improve health through formation of policy-led strategies and delivery of interventions that embrace collective actions.[23]

Multidisciplinary approach

On the basis of the technical developments in epidemiology from the middle of the last century, public health has been dominated by the quantitative sciences at the expense of other public health sciences.[17] It is now recognised that many disciplines are needed to understand the links between the underlying and proximal determinants of health, as well as to provide the evidence base for health policy making by use of appropriate methods to answer appropriate questions to inform policy.[24] Public-health training programmes should include opportunities to study the full range of quantitative and qualitative sciences as well as related sciences such as public-health law,[25] demography, anthropology, and ethnography. Regrettably, only a few institutions, mostly in developed countries, can offer the relevant courses.

A major neglected area of research has been the translation of evidence into effective policies and programmes. This neglect is exemplified by the failure to capitalise on the compelling evidence that the epidemics of cardiovascular disease are mostly preventable.[26] It is rarely appreciated that every year an

estimated 6·3 million adults younger than 70 years die prematurely from cardiovascular disease compared with 5·6 million deaths from AIDS, malaria, and tuberculosis combined (all age-groups).[3] Scientific knowledge is clearly only one of the essential ingredients of effective public-health practice; knowledge must be combined with engagement with civil society and social movements to compel effective action by all those who can make a difference if we are to achieve sustained improvements in population health.[27]

Political engagement in public-health policy

Public-health practitioners need to understand the political nature of the process of developing health policy and act accordingly. Despite the exhortation by Virchow in 1848 for medicine to become political, public-health practitioners have long neglected, or even rejected, this crucial connection. The reasons for such exclusion include the medical dominance of public health practice, the prevailing conservative neoliberal ideology and its effect on health reforms, insufficient attention to the politics of public health in training programmes, insufficient research into the determinants of effective policies and programmes, the power of commercial interests, and above all, the lack of confidence of many public-health practitioners. Of course, what is politically feasible is often constrained, but strong public-health science and leadership together with close civil engagement--including working with the media--can shift the boundaries of what is feasible.[28]

Community partnerships

Working with and in close association to the many communities being served is the most important of all partnerships for public-health practitioners.[29] This partnership is essential for building the long-term community and political support for effective health policies. At the same time it provides an opportunity for population groups to negotiate their inclusion in health systems and to demand the full range of public-health and health services. This partnership has long been neglected, although it did flourish briefly--at least rhetorically--under the Health For All banner; it might again make an impression under the influence of the People's Health Movement.[30]

Public health for the new era

Strengthening public health practice requires that the main themes be acknowledged and acted on, and that they be taught both to new students and to the existing workforce. A supportive framework for public health requires strong and responsive government leadership and adequate resources for personnel and infrastructure, complemented by public-health research, teaching, and services that use the full range of public-health sciences.

The reinvigoration of the public-health workforce will require commitment to its fundamental philosophical underpinning and clearly defined competencies for each of the main themes. It will then be in a better position to advocate for new resources for public-health practice, including attracting a share of the extra resources for promoting health security and from the new global health funds. Some of these extra resources should be directed into building the necessary public-health infrastructure. Assessing public-health training programmes and ensuring that new graduates are equipped in the necessary competencies for all thematic areas are the responsibility of public-health academics. Only a strong public-health workforce will be able to respond to the global and national health challenges. Finally, strengthening public health on an explicit ethical basis and a sound evidence base will promote the role of the state and contribute to building democracy worldwide. Health protection of the workers of the Soviet Union. Moscow, Medgiz, 1947).

Conflict of interest statement

None declared.

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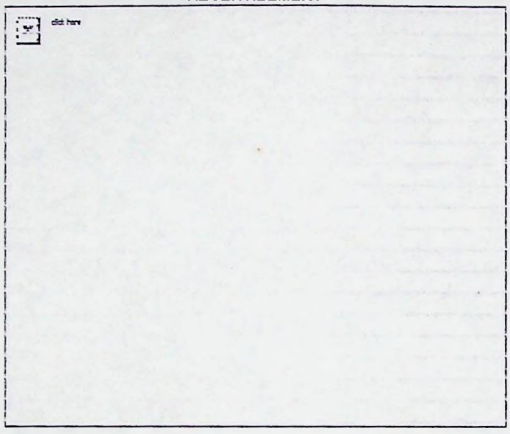

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PUBLIC HEALTH

A life-saving order

While pharmaceutical companies try to persuade the government to reduce the number of drugs under price control, a Supreme Court order directs the government to ensure that the prices of life-saving drugs are kept under strict control.

SIDDARTH NARRAIN

EVEN as pressure from pharmaceutical companies to reduce the number of drugs that are under price control in India increased, the Supreme Court, in an order issued during the proceedings of a petition, said clearly that the government should ensure that the prices of essential life-saving drugs were kept under control. The petition was filed by the All India Drug Action Network (AIDAN), the Medico Friends Circle (MFC), the Low Cost Standard Therapeutics (LOCOST) and the Jan Swasthya Sahyog. Says Colin Gonsalves, the advocate representing these organisations in the Supreme Court: "Any move to reduce the number of drugs in the DPCO [Drug Price Control Order] will be in contravention of the Supreme Court order in the K.S. Gopinath case where the court made an order on March 10, 2003, directing the government to ensure that essential and life-saving drugs do not fall out of price control."

According to the World Health Organisation (WHO), essential medicines are those that satisfy the priority health care needs of the population. The medicines are selected keeping in mind their public health relevance, evidence of safety and efficacy, and cost-effectiveness. Essential medicines are intended to be available in the context of a functioning health system at all times in adequate quantities, in appropriate dosage forms with assured quality and reliable information, and at a cost that the community and individual can afford.

The history of price control in India dates back to the Essential Commodities Act of 1955, which kept a check on prices of essential commodities including drugs. In 1979, there was a list of 347 drugs in the DPCO that were under price control. Over a period of time, as a result of sustained lobbying by the Indian pharmaceutical industry, the number of drugs listed in the DPCO fell to 142 in 1987 and to 76 in 1995. The problem is the absence of a regulatory agency that is empowered to keep a check on the prices pharmaceutical companies decide on and the profit margins they think are acceptable. The National Pharmaceutical Pricing Authority (NPPA), set up in 1997, is supposed to monitor the prices of drugs to ensure that

G.R.N. SOMASHEKAR

A drug store in Bangalore. The criteria for price control in India do not seem to be working. While drugs such as quinine and primaquinine used to combat malaria do not come under price control, analgin, which is banned in many countries because it can cause serious blood disorders, is listed as essential.

they do not flout the maximum price allowed if they are under price control.

In the European Union (E.U.) and Australia, governments have tried complementing pharmaceutical licensing procedures with the ability of a company to demonstrate the cost effectiveness of the drug. For example, the Pharmacy Benefits Scheme (PBS) in Australia and the National Institute of Clinical Excellence (NICE) in England require companies to submit evidence of the costs and effects of new products. In the United Kingdom, the U.K. Pharmaceutical Price Regulation Scheme (PPRS) regulates profits to a band of 17 to 21 per cent on historical capital or the initial capital used to begin the venture with a 25 per cent variation on either side. Companies are free to set prices, provided the rate of return is within the band. If the profits are higher, the companies have to reduce profits the next year and if the profits are lower, they can raise the prices. In France, Italy and Belgium, prices are set in relation to relative cost, prices elsewhere in the E.U., and the contribution made to the national economy.

Reducing the number of essential drugs under price control will be in contravention of the Supreme Court's orders and contrary to the UPA government's CMP.

In India, the authority in charge of drug pricing is not the Ministry of Health and Family Welfare but the Ministry of Chemicals and Fertilizers. The Government of India appointed the Committee on Drug Pricing in 1999; its members included representatives from the pharmaceutical industry, the Secretary of the NPPA, the Drug Controller of India and the Secretary to the Ministry of Chemicals and Fertilizers. In its summary recommendations, the Committee said: "...In most other countries the regulation of drug prices is considered necessary to contain public expenditure due to the government's role in funding social health and insurance schemes that cover hospital and out-patient drugs.... In these countries, a substantial portion of the population is covered through health insurance and public health schemes. As a result, consumers are not affected directly by the high prices of drugs or the high costs of medical services but are made to pay for the increased costs through a high insurance premium. As opposed to this, a substantial portion of the population in India is market-dependent and have to meet all their expenses on this account out of their own pocket, making price regulation of pharmaceutical products unavoidable."

According to Pharmaceutical Policy 2002, which is formulated by the Ministry of Chemicals and Fertilizers, the criteria for price control of bulk drugs are based on the sales figures of drugs, that is, the Moving Annual Total value or MAT value of the drugs concerned. These are calculated by adding up the MAT values of single ingredient formulations of bulk drugs from the retail store audit data published by the market research company ORG-MARG. The idea is to identify bulk drugs of mass consumption, which do not have enough competition for the market to bring down the prices. Bulk drugs are kept under price regulation if the total MAT value in respect of any particular bulk drug is more than Rs.25 crores and the percentage share of any of the formulators is 50 per cent or more or the total MAT value arrived at in respect of any particular bulk drug is less than Rs.25 crores but more than Rs.10 crores and the percentage share of any of the formulators is 90 or more. Since MAT figures decide which drugs will go out of price control, there are many instances of life-saving drugs that are not controlled by drug pricing. According to ORG-MARG, in March 2001, the life-saving diuretic and anti-hypertensive, frusemide, had a total MAT value of Rs.9.48 crores and though the leading brand Lasix manufactured by Avantis had a market share of over 97 per cent, it escaped price control.

A cursory look at the drugs that are on the DPCO shows that the criteria for price control are not working. While drugs such as quinine and primaquinine used to combat malaria do not come under price control, analgin, which is banned in many countries because it can cause serious blood disorders, is listed as essential. Says Amit Sen Gupta, co-convener of Jan Swasthya Abhiyan, a network of organisations that works in the area of health: "The criteria for drug pricing have little to do with the country's health policy, the availability of health care or the diseases that are prevalent. For example, tuberculosis often leads to complications when patients do not comply with the prescribed regimes for treatment because drugs are not available to the patient. When this happens, second and third line drugs are used, but none of these are under price control."

Says S. Srinivasan, from LOCOST, a Vadodara-based trust that manufactures low-cost drugs on a no-profit basis, "If one looks at drug prices in terms of wages, that is, if you look at the costs of drugs for a person earning a minimum wage of Rs.60 in a State like Chhattisgarh, she/he has to spend one month's salary to afford immunisation for hepatitis A and nearly one and a half month's salary to afford treatment for tuberculosis. The difference between the prices of the Tamil Nadu Medical Services Corporation (TNMSC), set up to ensure the availability of essential drugs to government medical institutions in the State, and those charged in the market is glaring. For instance, the daily cost of treatment of tuberculosis using the least expensive brands available in the market is Rs.7.70 while the TNMSC rate is Rs.2.49."

Pharmaceutical companies have been arguing that the number of drugs on the DPCO should be reduced as adequate competition will ensure reasonable prices. But a close look at the prices of drugs shows that this is not true. Often, the top-selling brand of a particular category is also the higher priced one; in other words, the brand leader is often the price leader too. Says Anurag Bhargav, a founding member of the Jan Swasthya Abhiyan and a physician: "If true competition and free market characteristics were present, the brand leaders that would sell the most would be the lowest priced. In reality, the brand leader is often the highest priced. For example, cefuroxime, a broad-spectrum antibiotic, produced under the brand name ceftum, is priced the highest although the brand has a share of 38 per cent, the highest in the market."

Although Finance Minister P. Chidambaram has indicated that the government will reduce the rigours of price control where it has become counter-effective, reducing the number of essential drugs on the DPCO will not only be in contravention of the Supreme Court's orders but also be contrary to the United Progressive Alliance government's Common Minimum Programme, which has promised to "take all steps to ensure the availability of life-saving drugs at reasonable prices". The government also has to worry about the coming into force of trade-related aspects of intellectual property rights or TRIPS in January 2005, which will mean that the generic equivalents of all drugs patented from that date onwards can no longer be produced in the country. ■

Com H-71.

An unhealthy trend

The quality of public health care delivery in India remains woeful while the private health care sector attains impressive heights thanks to the government's privatisation drive.

ASHA KRISHNAKUMAR

A RECENT story in *The Washington Post* narrated how 53-year-old Howard Staab travelled all the way from the United States to New Delhi's Escort Heart Institute and Research Centre for a surgical operation that saved him from a life-threatening heart problem. The procedure cost him $10,000, a mere 5 per cent of the fee he would have had to pay back in the U.S. Staab is but one of the 150,000 foreigners who visited India last year seeking comparatively cheap medical solutions. "If we do this, we can heal the world," Apollo Hospitals' founder-chairman Dr. C. Prathap Reddy said. But who will heal the people of India, while the country waits for the crumbs from medical tourism, which is projected to grow into a $2.2 billion industry by 2012?

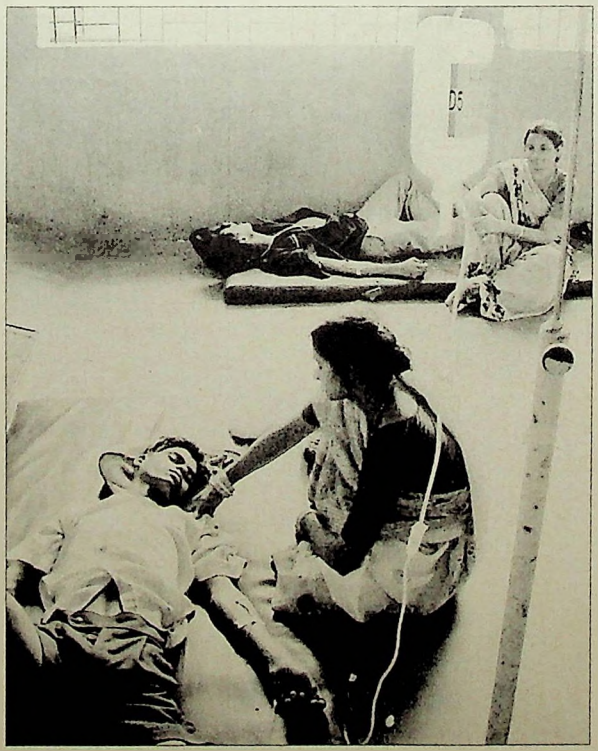
The United Nations Development Programme's (UNDP) latest Human Development Report (HDR) puts India's public spending on health among the lowest in the world – $4 a person a year or 0.9 per cent of its gross domestic product (GDP). Of the 175 countries documented by the HDR, only four have a lower public spending on health than India.

In sharp contrast, India ranks an impressive 18th in private health care spending (4.2 per cent of GDP). The contrast is so stark for very few countries.

India's health care system, comprising government and private sectors, barely covers half its population. The public sector health infrastructure has about five lakh doctors, 7.4 lakh nurses, 3.5 lakh chemists, 15,000 hospitals and 8,70,000 beds. It is a three-tier structure comprising some 23,000 primary health centres (PHCs), 1,37,000 sub-centres and 3,000 community health centres, serving the semi-urban and rural areas. But, according to Ravi Duggal of the Centre for Enquiry into Health and Allied Themes (CEHAT), private health care accounts for 70 per cent of primary medical care and 40 per cent of all hospital care in India. It employs 80 per cent of the country's medical personnel. In 2002, the outlay of the Ministry of Health and Family Welfare was Rs.[illegible]50 crores (US$ 7.5 billion), while the private sector spent Rs.69,000 crores.

China, with which India is often compared, spends 2 per cent of its GDP on health; even Nepal (1.5 per cent), Bangladesh (1.6 per cent) and Pakistan (1 per cent) spend more on public health than India in percentage point terms. In the matter of basic health care infrastructure and facilities, the country is far behind international standards. It has 94 beds per 100,000 people, compared to the World Health Organisation norm of 333. According to some estimates, there are only 43 doctors for 10,000 people in India; exclude the private sector and it becomes an abysmal 1:30.000. Government hospitals need at least 40,000 more doctors and a large number of paramedics.

The demand-supply gap for public health care delivery is large and on the rise, and this gap is increasingly being filled by private health care institutions. The urban health care industry is booming, with a host of private hospitals offering state-of-the-art services for the rich and the middle class. A 2002 study, "Health care in India: The Road Ahead" by the Confederation of Indian Industry and McKinsey & Company, put the total value of the health sector in India at over Rs.1,500 billion or 6 per cent of GDP. Of this, 15 per cent is publicly financed, 4 per cent is financed through social insurance, 1 per cent through private insurance and the remaining 80 per cent is out-of-pocket user-fees. Two-thirds of all users fall into the last category, and 90 per cent of them are from the poorest sections. National data reveal that 50 per cent of the bottom quintile sold assets or took loans to access private hospital care. An annual interest rate of 1,200 per cent on loans is not uncommon; hence many poor people end up in the vicious cycle of bondedness, from which they do not dream to escape during their lifetime – or even



A.M. FARUQUI

At a government hospital in Bhopal.

over generations.

Says Union Health Secretary J.V.R. Prasad Rao: "With health funding being so low, the government can either fund doctors or get medicines or provide support services. Not all of these." In its Common Minimum Programme, the United Progressive Alliance (UPA) government has promised to spend 2 per cent of GDP on health. So far, it has not indicated from where the funds would come nor how they would be spent. But a Health Ministry spokesperson has said that the emphasis would be on enhancing public-private partnership to improve health care delivery. Says Dr. Rama Vaidyanathan Baru of the Jawaharlal National University's Centre for Social Medicine and Community Health: "In its 1947 resolution, the government proposed to spend 12 per cent of GDP on health every year. Even in the best of days, it has never been anywhere close to this figure."

The quality of public health care delivery is woeful. The health care system is not only cash-strapped but also fraught with inefficiency; it is prone to misuse, even abuse. According to Dr. K. Nagaraj, Senior Professor, Madras Institute of Development Studies, Chennai, comprehensive public health care system is to be provided with PHCs at the base and referrals to provide secondary and tertiary care. But the system is hardly effective, making comprehensive health care delivery impossible. First, the system of primary health care is only an infrastructural intervention that does not take into consideration the local needs. Second, the referral system almost never works owing to infrastructural problems such as lack of medical professionals, medicines, transport and so on. According to him, the situation is only worsening with the government's privatisation drive.

In a survey of 100 Rajasthan villages, researchers from the Massachusetts Institute of Technology and Princeton University found an absenteeism rate of 44 per cent among medical professionals in public clinics. The absenteeism was cited to be because of meetings and other work-related problems. Apart from that, the PHCs remained closed half the time. Most rural PHCs did not have running water, electricity or emergency medicines, leave alone phones or vehicles. Some did not even have routine medicines to treat children for fever, cough and the common cold. The survey showed that 65 per cent of households in India go to private hospitals for treatment while only 29 per cent use the public medical sector. Even among poor households, only 34 per cent used PHCs. They are increasingly turning to amateur private "doctors" and faith healers, even to treat such infectious diseases as tuberculosis (TB) and malaria.

According to Nirupam Bajjpai, Senior Development Adviser and Director, South Asia Programme Centre on Globalisation and Sustainable Development, Columbia University, the resurgence of communicable diseases such as malaria and TB in India is partly because of the low levels of public expenditure on health care and the commercialisation of medical care. The country accounts for a third of the TB incidence globally and has the largest number of active TB patients. An estimated 20-30 million episodes of malaria occur in India each year; mortality on account of malaria is the highest in India. Profit-oriented curative care is therefore on the rise, 80 per cent of which is in the private sphere. This has resulted in spiralling medical care costs and rural indebtedness.

Tuberculosis is the big killer, claiming nearly 500,000 lives in India every year. This costs the country $300 million (about Rs.1,350 crores) a year of which more than $100 million (about Rs.450 crores) is direct cost incurred by patients and their families. Says Mira Shiva of the Voluntary Health Association of India: "Medical care has emerged as the second major cause of indebtedness in the country next to dowry."

Public health care spending has been systematically shot down since the early 1990s with health care reforms following the policy of structural adjustment. Even if not explicit, the 2002 National Health Policy's support and encouragement to the private health sector further accentuated the gradual withdrawal of the state from the responsibility of public health care. The state offers subsidies, loans, tax waivers and other benefits for the setting up of private practice, hospitals and diagnostic centres. While about Rs.10 lakhs (at current prices) of public money is spent on the education and training of each doctor, over 80 per cent of those who pass out of public medical schools either joins the private sector or migrate abroad. The country loses Rs.4,000-5,000 million every year as a result of such migration. The private health sector has grown into a giant – in fact the largest in the world – thanks to the support of the state. Its mammoth size notwithstanding, this sector has remained completely unregulated.

Says Ravi Duggal of CEHAT: "All over the world there is a tendency to move towards more organised national health systems and an increased share of public finance in health care. Several countries have universal health care systems where the public sector's share of the fiscal burden is 60-100 per cent. This trend is inevitable in the pursuit of equity and universal coverage."

But what of health care coverage for workers in the organised sector in India? Of the 400 million employed people in the country, hardly 28 million are in the organised sector and covered by comprehensive social security legislation, including social health insurance. The largest of this is the Employees State Insurance Scheme (ESIS), which covers eight million employees; including their family members, it provides health security to 33 million people. In 2002-03, the ESI Corporation spent Rs.12 billion (Rs.1,200 crores) on health care for its member-beneficiaries, averaging Rs.365 per capita. This effectively covers a mere 3.2 per cent of the population. About 0.5 per cent of the population is covered through the Central Government Health Scheme (CGHS), which spends Rs.2 billion (Rs.200 crores) averaging at Rs.450 per beneficiary.

According to Ravi Duggal, while these social insurance plans have been around for a long time, their credibility is now at stake owing to the large-scale outsourcing to the private sector. For instance, in large cities, the ESIS has panels of private doctors, who provide ambulatory care to those covered under the scheme. Similarly, under the CGHS, the beneficiaries have the 'choice' of accessing private health care, with the cost reimbursed. A senior bureaucrat can get reimbursement for a bypass surgery up to a maximum amount of Rs.150,000. Totally, less than 5 per cent of the population has some form of social insurance cover for health through employment.

Says Ravi Duggal: "The limited social insurance coverage is also declining and getting privatised. There is a systematic decline in the role of the state in public health finance. This is contrary to the experience elsewhere, which shows that universal access to health care can only be achieved with financing mechanisms that are largely of a public nature such as social insurance, tax revenues or a combination of these." Experts argue that even from the point of view of economics – labour hours lost and productivity decline resulting from sickness and disease – there is a strong case for providing public health care.

Clearly, seen from the social, economic or political perspective, there is an urgent need to universalise access to basic health care and social insurance. This needs appropriate legislation and a constitutional mandate. By generating the political will to achieve this end and activating civil society to demand health care as a right, the country can take positive steps to strengthen public health care services. ■

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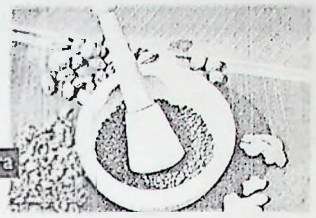
Com H - 31

Traditional Systems of Medicine and Public Health



Shailaja Chandra

Status of Acceptance of Traditional Systems

Although, the use of indigenous (traditional) systems of medicine is widespread and growing, there has been little faith expressed by medical practitioners or the public health community in the efficacy of the systems or the drugs. Coordination between Alternative and Complementary Systems, as they are called in different parts of the world, and the conventional medical care (Allopathy) has not been organized so far except for a few minor examples. Most of the people who avail of alternative medical care, whether in India or abroad, are not referred by allopathic physicians but are mostly self-referred. According to a paper on Medical Malpractice Implications of Alternative Medicine, published in the Journal of the American Medical Association in November 1998, the improvement in the quality of care has been frustrated by long-standing professional rivalry between organized medicine and non-allopathic health practitioners. In the above journal, it was also reported that financial analysts have suggested that consumer spending on alternative medicine may have surged to 69 per cent since 1989, and the market may be growing as fast as 30 per cent annually. Employers and insurers, including several major managed care organisations such as Oxford Health Plans and Health Net, have recently begun to respond to this demand by adding alternative therapies to their insurance products. Some State legislatures in the US have enacted laws that require health insurers to include alternative treatments in the benefits they cover.

In India, the Central Government Health Scheme already extends reimbursement to government servants who prefer to avail of treatment under the indigenous systems. The increasing popularity worldwide of complementary, alternative, indigenous or traditional medicine reflects the changing attitudes and needs of the population. While in the US, 60% of Medical Schools have begun to teach about alternative medical practices, in India, the Medical Council of India, shuns the idea of even introducing an introductory course. Again, in many hospitals abroad, while conventional and integrated medicine programmes are offered side by side, in India, this is limited to a few clinics, which have been opened in Central Government Hospitals in Delhi.

Increasing use of herbal medicine and food supplements

WHO, Geneva have reported that in 1998, 60 per cent of the Australian population used alternative medicine and 17000 herbal products, accounting for one billion Australian Dollars, have been registered. In Belgium, according to a 1998 poll survey, almost 40 per cent of the population have used complementary medicine and 59 per cent of doctors are also using this, and in particular homeopathy medicines. In France 49 per cent of the people have used complementary medicine and homeopathy. Herbal medicines are particularly popular. According to the WHO the global market for medicinal herbs and herbal products is estimated to touch US$ 5 trillion by 2050.

In Germany, there are 10,000-13,000 alternative medicine practitioners and 75 per cent of the physicians use complementary medicine. In the United Kingdom, 90 per cent of the population use complementary medicine and there are 8000 non-allopathic practitioners. In the United States, a National Follow-up Survey has shown that, use of alternative therapies have increased from 40 per cent to 42 per cent and the growth is expected to increase to 60 per cent.

Indian Systems of Medicine

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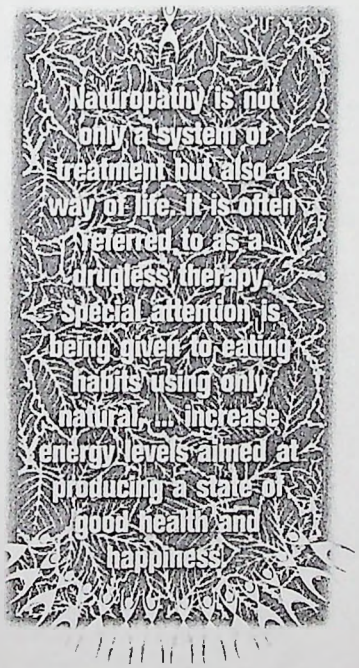

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Traditional Systems of Medicine and Public Health

Shailaja Chandra

Status of Acceptance of Traditional Systems

Although, the use of indigenous (traditional) systems of medicine is widespread and growing, there has been little faith expressed by medical practitioners or the public health community in the efficacy of the systems or the drugs. Coordination between Alternative and Complementary Systems, as they are called in different parts of the world, and the conventional medical care (Allopathy) has not been organized so far except for a few minor examples. Most of the people who avail of alternative medical care, whether in India or abroad, are not referred by allopathic physicians but are mostly self-referred. According to a paper on Medical Malpractice Implications of Alternative Medicine, published in the Journal of the American Medical Association in November 1998, the improvement in the quality of care has been frustrated by long-standing professional rivalry between organized medicine and non-allopathic health practitioners. In the above journal, it was also reported that financial analysts have suggested that consumer spending on alternative medicine may have surged to 69 per cent since 1989, and the market may be growing as fast as 30 per cent annually. Employers and insurers, including several major managed care organisations such as Oxford Health Plans and Health Net, have recently begun to respond to this demand by adding alternative therapies to their insurance products. Some State legislatures in the US have enacted laws that require health insurers to include alternative treatments in the benefits they cover.

In India, the Central Government Health Scheme already extends reimbursement to government servants who prefer to avail of treatment under the indigenous systems. The increasing popularity worldwide of complementary, alternative, indigenous or traditional medicine reflects the changing attitudes and needs of the population. While in the US, 60% of Medical Schools have begun to teach about alternative medical practices, in India, the Medical Council of India, shuns the idea of even introducing an introductory course. Again, in many hospitals abroad, while conventional and integrated medicine programmes are offered side by side, in India, this is limited to a few clinics, which have been opened in Central Government Hospitals in Delhi.

Increasing use of herbal medicine and food supplements

WHO, Geneva have reported that in 1998, 60 per cent of the Australian population used alternative medicine and 17000 herbal products, accounting for one billion Australian Dollars, have been registered. In Belgium, according to a 1998 poll survey, almost 40 per cent of the population have used complementary medicine and 59 per cent of doctors are also using this, and in particular homeopathy medicines. In France 49 per cent of the people have used complementary medicine and homeopathy. Herbal medicines are particularly popular. According to the WHO the global market for medicinal herbs and herbal products is estimated to touch US$ 5 trillion by 2050.

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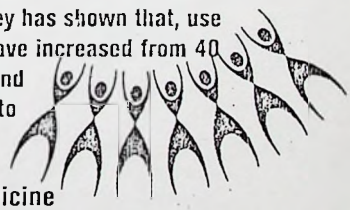

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EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 Background

Government of India with the aid of World Bank have targeted to provide basic health and family welfare services to the urban poor especially the slum dwellers by the turn of the century. Consequently India Population Project-VIII (IPP-VIII) was formulated and implemented in the slums of *Bangalore Metropolitan Area*. With the ultimate goal of providing Family welfare (FW), Maternal & Child Health (MCH) care services, the project is to focus on reduction of fertility levels in the area.

M/S General Automata Pvt. Ltd., Bangalore have been developing an efficient Management Information System (MIS) for the present Project. As an initial task of this assignment, indicators are being developed which not only felicitate the development of Management Information System (MIS) but also help in monitoring the programmes undertaken by the project. THE CENTRE FOR RESEARCH IN HEALTH AND SOCIAL WELFARE MANAGEMENT, BANGALORE has been entrusted with the task of collection of necessary data and assess the present level of the indicators which would help in monitoring of the programme.

1.2. Methodology of the present study

The methodology adopted for data collection in the present study consisted of interview of currently married women in the reproductive age group 15 to 44 years from the households in thirty clusters randomly selected using the methodology of *Probability Proportional to Sample Size* out of all the slums of *Bangalore Metropolitan Area*. From each of the selected clusters, fifty currently married women in the age group 15 to 44 were covered for the survey.

The survey was undertaken during the period 15 to 30, November 1997.

1.3. Sample for the study

A total of 1487 households were surveyed, from the thirty clusters to cover a sample of 1500 married women in the age group 15-44 years. The households had a population of 7796 consisting of 3995 males (51.2%) and 3801 females (48.8%). These households

provided a sample of 262 women who had delivered during the previous year, 1180 children in the age group upto 5 years besides 141 children aged between 12-23 months. In addition 30,400 population was enumerated for information on births in the previous year. .

2. RESULTS OF THE STUDY

2.1. Socio-demographic indicators

2.1.1. Religion and caste

Of the total 1487 households surveyed, 76.1% were Hindus, 17.6% were Muslims and 6.3% were Christians. Majority of the population in the slums were predominantly of under developed castes of the society.

2.1.2. Educational Status

The literacy rate of the population was 75.0%, with a male literacy rate of 79% and female literacy rate of 69.1%. However in majority of them the educational status was restricted only upto higher secondary level.

The dropout rate from schools amongst children in the school going age group is around 14.0% . The dropout rate amongst female children (16.0%) was higher than that of male children (12.1%)

2.1.3. Economic condition

Only 34.9% of the population were gainfully employed, giving a dependency rate of 65.1%. Most of the women respondents were housewives (81.6%).

2.1.4. Mother tongue

Most of the population in the area were of mother tongue other than Kannada (78.1%), indicating that they were from the neighbouring States migrated to the City in search of employment.

2.1.5. Age and sex distribution

The households had a total population of 7796, consisting of 3995 males and 3801 females . The sex ratio in the population was 951.

The percentage of population aged between 0-14 years comprised of 39.8%, which is higher than that of the state average of 36.7% observed by NFHS (1992-93). However this percentage is much higher than the figure of 33.9% for urban areas of the state. Further the proportion of female population in the age group 20-29, prime child bearing age group, is very high (25.5%).

2.2. Nuptiality Indicators

2.2.1. Marital Status of women

Overall, only 13.3% of the women aged between 15-44 were not married., while 75.9% are currently married, 10.4% widowed and only 0.4% were either separated or divorced. The proportion of currently married females in the age group 15-19 years is 41.1% which is very high as compared to only 26.7% in other urban areas of the state (NFHS).

2.2.2. Age at menarche

More than half of women had attained their menarche between the age 13 to 14 years of age (51.7%)., while another 30.1% by 11 to 12 years. Only 18.3% had attained their menarche beyond the age of 14 years. The mean age at attainment of menarche was 13.3 years.

2.2.3. Age at marriage

About 77% of the women had been married by the age of 18 years. The mean age at marriage in the sample was. 16.9 years, with 16.8 years for Hindus, 16.7 years for Muslims and 18.0 years for Christians. The age at marriage which had slightly increased in the previous decade seems to have drifted down in the recent years, as can be observed from comparisons between respondents in different age cohorts.

2.2.4. Age at consummation of marriage

The mean age at consummation of marriage is 17.3 years and more than three fourths (76.5%) of women had their consummation of marriage by 18 years of age. The trend similar to the age at marriage is seen with the age at consummation of marriage also.

2.3. Fertility Indicators

2.3.1. Fertility levels

a. Crude Birth Rate

The crude birth rate in the population is 22.9 which is almost similar to the urban rates of Karnataka (NFHS).

b. Fertility Rates

The General Fertility Rate in the sample was 87.0, while the TFR experienced by the women in the sample is 2.53 . The Age Specific Fertility Rates indicate that the fertility is highest in the age period 20-24 years with an ASFR of 0.2727 followed by 25-29 years with an ASFR of 0.0975 and 15-19 years with ASFR of 0.0829. This indicates that the prime child bearing in the community is amongst women aged 15-29 years, who contribute for 89.5% of the total births in the community.

2.3.2. Fertility trends

a. Age at first pregnancy

As a consequence of early age at marriage and consummation of marriage, the age at first pregnancy was also low in the community. Majority of women had their first pregnancy before completing the age of 18 years (58.4%). The mean age at first pregnancy in the sample was 18.3 years.

b. Number of children ever born and Birth order of last pregnancy

On an average a women had conceived for three times. The proportion of women with upto second parity was only 42.6% in the community.

c. Open birth intervals

The average open birth interval in the community is about 30 months. The mean birth interval was lower with younger mothers.

d. Age and parity of women delivered during previous one year

Nearly two thirds of the women in the community who had pregnancies in the previous one year were young and in the age group 19 to 24 years. (66.0%). Further 9% of these mothers were below the marriageable age of 18 years.

Paritywise, 41.3% of the births were of more than second para while 18.8% of over third para.

2.4. Family planning indicators

2.4.1. Knowledge on family planning sources

The knowledge of women in the sample on family planning is almost universal with 96.3% of women being aware of different methods to prevent births. 47% of women knew about three or more number of methods of family planning, while another 49% were aware of one to two methods. The methods known in the order of percentages were sterilisation of women (92.5%), oral pills (62.4%), IUD (49.8%) and Nirodh (27.7%). Vasectomy was known only to a negligible proportion of women (1.6%). However the communication between the couples on limiting the family size or on family planning methods was restricted to only 34.6% of couples.

2.4.2. Exposure to family planning messages through media

News paper reading was not very common with women and only 22% had access to news papers.

Only 21 to 26% of women had accessed messages on family planning or health through radio broadcast, while the proportion of women who had watched some programme related to family planning on television was around 56 to 58%.

2.4.3. Current Contraceptive Use

a. Couple protection rates

The couple protection rate through modern methods of contraception was 57.0% in the community. Out them majority had adopted female sterilisation (48.9%) and the proportion using spacing methods were very only 8.1%. Amongst the spacing methods Oral pills were practised by 5.1% while IUD by 2.6%. Use of condoms was negligible (1.5%).

b. Religion wise contraceptive use

Practice of contraceptive methods was slightly higher with Christian couples (59.6%) as compared to Muslims (58.3%) or Hindus (56.5%). Practice of permanent methods were more common with Christians (53.2%) as compared to Hindus (49.3%) and Muslims (45.8%).

c. Age wise contraceptive use

The proportion of couples using contraceptives ranged from 9.8% amongst women aged 15-19 years to 77.6% in the age group 35-39 years. However, only 49.1% of women in the prime child bearing age of 15-29 years were using some method of contraception as compared to 72.8% in higher age groups (30+ years). A significant number of couples in the prime child bearing age had undergone sterilisations (39.3%).

d. Paritywise contraceptive use

The contraceptive use rate with mothers upto first para was only 14.3%. The rates gradually increased to 79.5% with mothers of fourth para, beyond which there was declin in the rates. Further, 75% of women of over second parity were practising family planning while this percentage was only 35% with women upto second parity. However, only a small proportion (9.5% of couples) of mothers upto second parity were using spacing methods. This clearly suggests that the programme has to propagate more on spacing methods with younger couples with whom there is greater need for such methods.

2.5. Maternal and child health indicators

2.5.1. Ante-natal care during pregnancy

Only about 5% of mothers did not have ante-natal check up. About 61% of the mothers had initiated the check up in the first trimester while another 30.9% had initiated during the second trimester. Significantly only a small proportion of the ante-natal check up (7.2%) was carried out by the peripheral workers while the remaining were from doctors (90.3%). A third of the mothers had utilised the services of private practitioners for the purpose.

Only 7.6% of the mothers did not have tetanus toxoid immunisation during pregnancy while only 17.6% had consumed a course of 60-90 IFA tablets.

Even though majority of the deliveries were institutional, there were still 14.5% home deliveries which were conducted mostly by unqualified personnel.

Availing of post-natal check up facilities was not very common as only 30.5% of the mothers had such a care.

2.5.2. Child care during infancy and early childhood

a. Breast feeding and weaning

Even though almost all the children (98.7%) were breast fed during their infancy only 53.2% of them were initiated on breast milk within one to two hours after birth. Only half of the mothers had continued breast feeding their babies beyond one year. Large proportion of mothers had started supplementary feeding for infants within six months (73.6%) of age.

b. Management of diarrhoea

About 9% of the children with diarrhoeal episodes did not avail of any medical advice. Private practitioners were the common source of treatment facilities for the episodes (75.4%), while Government or Corporation health facilities were used for only a quarter of episodes (24.7%). Food intake during the diarrhoeal episode was reduced in 45% of the cases while the rest had maintained the quantum of intake as usual.

Only 18.8% children were offered more fluids during the episode and in 30.0% of the children the intake of fluids had reduced, which is not conducive in the management of the episode. Further ORS was administered in only 51.2% of the episodes.

c. Malnourishment in children

In the community only 41.1% of the children aged 7 to 59 months were nutritionally normal as per WHO standards of MAC (MAC >14.0 cms.). 35.6% of the children were moderately malnourished (MAC between 12.6 to 14.0 cms.) while 24.0% were severely malnourished (MAC< 12.5 cms). Although the prevalence of malnutrition decreased with the age of the child, the proportion of severely malnourished children were as high as 30.2% with children aged above 4 years.

d. Immunisation status

Of the children aged 12-23 months, only 79.4% had completed the full schedule of immunisations. The immunisation coverage for BCG was highest with 98.6% followed by Measles (85.1%), DPT (82.3%) and Polio (79.4%).

3.0. CONCLUSIONS

The indicators as observed in the present study leads to the following conclusions.

The population in the slums consisted mostly of the underdeveloped castes, a substantial proportion migrated from the neighbouring States and with low educational attainments. The population has a high proportion of females in the prime child bearing ages. Most of the women were married at early ages resulting in to early and repeated pregnancies.

Even though family planning acceptance rate is not low, the acceptance of F.P. methods by young couples is very low. Use of spacing methods for contraception is significantly low. There was a substantial proportion of unmet need for family planning which can be met by sustained IEC programmes.

Ante-natal care is mostly provided by Private practitioners and is not complete in many of the mothers and post natal care is not very common. There are still a considerable proportion of home deliveries conducted mostly by untrained personnel.

Infant care lacks especially in the components of early initiation to breast milk and provision of more fluids or ORS supplementation during diarrhoea. Immunisation coverage is also not high. Prevalence of malnutrition amongst children aged below five years is also high.

1. INTRODUCTION

1.1. Topography of Bangalore and the Slums

Bangalore City, the capital of Karnataka state is situated at 12^0 50' latitude in the North and 77^0 30' longitude in the East at an altitude of 931 meters above the sea level. The Urban agglomeration of the City is spread over 451 sq. kms. and has a population of 41.7 lakhs according to 1991 census. Population wise the City is the fifth biggest in the Country (1991). The slums of Bangalore City are spread over entire length and breadth and composed of all religions and castes. The slum population of the City is growing in an unplanned and uncontained manner.

1.2. Back ground to the present study

The family welfare programmes in India have been in operation for well over 40 years and despite additional inputs, the progress has been well below the targeted goals, more so in the urban slums of the State. Various developmental programmes initiated by the Government in the slums of the State have not been catching up due to accelerated growth of the slums. Even in the family welfare programmes, the slums have been lagging far below the levels of the state.

Government of India with the aid of World Bank have initiated programmes to provide basic health and family welfare services to the urban poor especially the slum dwellers by the turn of the century. With this in view, India Population Project-VIII (IPP-VIII) was formulated and implemented in the slums of *Bangalore Metropolitan Area*. With the ultimate goal of providing Family welfare (FW), Maternal & Child Health (MCH) care services, the project is to focus at the reduction of fertility levels in the area.

The objectives of India Population Project VIII are:

- Reduction of crude birth rate to 21
- Reduction of infant mortality rate to levels below 60
- Reduction of maternal mortality rate to less than 2
- Increasing couple protection rate to 60%

Management Information System (MIS) is the backbone of any Project to effectively monitor and aid in the implementation of the activities. M/S General Automata Pvt. Ltd., Bangalore, have been developing an efficient MIS for the present Project. As an initial task of this assignment, indicators are being developed which not only facilitate the development of MIS but also help in monitoring of the programmes undertaken by the project. THE CENTRE FOR RESEARCH IN HEALTH AND SOCIAL WELFARE MANAGEMENT, BANGALORE has been entrusted with the task of collection of necessary data and assessment of the present level of the indicators which would help in developing a Management Information System as well as in monitoring of the programmes of the Project.

1.3 Methodology of the present study

The methodology adopted for data collection in the present study consisted of interview of currently married women in the reproductive age group 15 to 44 years from the households in randomly selected thirty clusters amongst the slums of *Bangalore Metropolitan Area.* The *Universe* for the selection of the slums consisted of a list of all the slums with their population obtained from the Slum Clearance Board at Bangalore and updated with the IPP-VIII Project office. The sample of thirty clusters were drawn from this list adopting the methodology of *Probability Proportional to Sample Size.* The list of selected slums and their location are in Appendix 1 and 2.

From each of the selected clusters, fifty currently married women in the age group 15 to 44. Thus a total of 1500 women currently married in the age group 15-44 were included in the study sample. In order to provide representation of all segments of population in the sample, the selected cluster was divided into five equal segments and ten women were interviewed from each segment making up to fifty women in total for each cluster. This method of selection of respondents was adopted from the methodology of Pulse Polio Immunization Coverage Survey conducted by UNICEF (CRHSM,1996).

To have an adequate sample size for data on births, 200 households in each of the selected clusters were covered. Thus 6000 households were enumerated for the purpose.

This was expected to cover a population of about 30,000 which is an adequate sample size to estimate a birth rate of about 25 with an error limit of 10%.

From each of such segments a household was randomly selected and interview conducted and continued in the subsequent household in a sequential manner till fifty women were covered.

The set of variables included for the study are:

- Socio-demographic variables pertaining to family members
- Nuptiality and fertility history of women
- Child rearing practices for the live births in the previous five years
- Exposure of women to health education on family planning through media
- Knowledge, attitude and practices of women on Family planning
- Incidence of diarrhoea amongst under fives in the last one month and its management
- Utilisation of health facilities
- Births in the household in the last one year and related particulars of the mother.

The above information was collected through interview technique on a pre-designed and pre-tested proforma (Appendix 3). Currently married woman in the reproductive age group 15-44 years was the respondent for all information pertaining to women and her child. Some of the data were retrieved from the survey conducted in the slums by the Centre in June 1997 (CRSHM,1977).

The age of an individual and dates pertaining to relevant variables were confirmed by matching them with local events, fairs or festivals.

The survey was undertaken during the period 15 to 30, November 1997.

1.4. Organisation of field work in the study

The interviews were canvassed by trained investigators with good knowledge on the subject matter of study and experience in similar capacity. They were further trained for a period of one week including practical work in the field for the current survey. The

data collection was supervised by a Supervisor as well as Consultants of the study. The filled in questionnaires were thoroughly field edited before data processing.

1.5. Sample for the study

A total of 1487 households were surveyed, in the thirty clusters to cover a sample of 1500 eligible couples in the age group 15-44 years. These households provided a sample of 262 women who had delivered during the previous year, 1180 children in the age group below 5 years besides 141 children aged between 12-23 months. In addition 30,400 population was enumerated for information on births in the previous year.

1.6. Analysis of data

The data from the questionnaires were transferred on to the computer, edited and analysed on SPSS package.

2. RESULTS OF THE STUDY

The results of the study are outlined in the subsequent sections under the following headings.

- Socio-demographic indicators
- Nuptiality indicators
- Fertility indicators
- Family planning Indicators
- Maternal and child health indicators
- Indicators on health facilities

2.1. Socio-demographic indicators

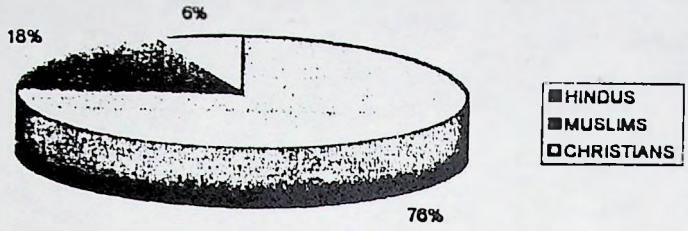
2.1.1. Religion and caste

Of the total 1487 households surveyed, 76.1% were Hindus, 17.6% were Muslims and 6.3% were Christians. There were only 1.4% from Forward castes,. 25.8% from Backward castes while Scheduled Castes and Tribes comprised of 48.9%. Thus it is seen that the slums were predominantly inhabited by under developed castes of the society (Table 1).

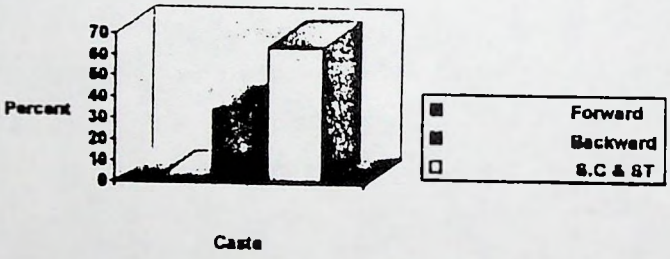
2.1.2. Educational Status

The literacy rate of the population wise 75.0%, with a male literacy rate of 79% and female literacy rate of 69.1%. However the educational status was restricted only to higher secondary level, as only 1.4% of the population had school education beyond this level. Further 39.8% of the males and another 37.6% of the females had education only between primary and middle standards (Table 1).

Religion of households



Caste of Hindus



The school dropout rate amongst children in the age group 6-14 years is around 14.0% . The dropout rate amongst female children (16.0%) is higher than that of male children (12.1%).

2.1.3. Economic condition

Out of the 7796 population in the sample, only 34.9% (2723) were gainfully employed, giving a dependency rate of 65.1%. Amongst males 6.0% were engaged in some type of professional jobs (Table 1).

Even though most of the women respondents were housewives (81.6%), 14.5%, were engaged as coolie workers.

About a third of the households (34.6%) were of the of the opinion that their economic condition over the last three years had improved, while 39.2% expressed that their condition was same and the rest 26.2% thought the condition had worsened.

2.1.4. Mother tongue

Most of the population in the households had their mother tongue other than Kannada (78.1%). Majority had Tamil (37.7%) as their mother tongue followed by Urdu (24.6%) and Telugu (14.2%). This indicates that the population in the slums were mostly from the neighbouring States migrated to the City in search of employment (Table 1) .

2.1.5. Age and sex distribution

The households had a total population of 7796, consisting of 3995 males and 3801 females . The sex ratio which is an indicator of overall health status of a women was 951 which is higher than the sex ratio of 930 for urban areas of the state (Census 1991).

The age and sex distribution of the population is shown in five year groups in Table 2. The population aged between 0-14 years comprised of 39.8% higher than the state average of 36.7% observed by NFHS (1992-93). However this percentage is much higher than the corresponding proportion in the urban areas of the state (33.9%). This may be probably due to a higher birth rate in these slums as compared to other urban

areas. Further the proportion of female population in the age group 20-29, prime child bearing age group, is very high (25.5%) in contrast to males (19.2%).

2.2. Nuptiality Indicators

2.2.1. Marital Status of women

Overall, only 13.3% of the women aged between 15-44 were not married., while 75.9% are currently married, 10.4% were widowed and only 0.4% were either separated or divorced. The proportion of widows is on the higher side as compared to only 3.2% of women aged 15-49 in NFHS survey(1992-93) for urban areas. The proportion of currently married females in the age group 15-19 years is 41.1% which is very high as compared to only 26.7% in other urban areas of the state (NFHS), but similar to those of rural areas. This high proportion of married women in the teen age group is a reflection of prevalence of early marriages which has repercussions on resulting into early motherhood (Table 3).

2.2.2. Age at menarche

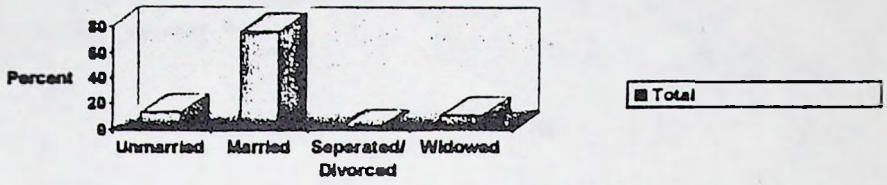
Majority of women had attained their menarche between the age of 13 to 14 years (51.7%), while another 30.1% by the age 11 to 12 years. Only 18.3% had attained their menarche beyond the age of 14 years. The mean age at attainment of menarche was 13.3 years in the sample. The proportion of Muslim women with early onset of menarche was more than those of Hindu or Christian women. In fact this proportion was least amongst Christian women. Early age at attainment of menarche has a bearing on the age at marriage also, as the parents would be eager to get a girl married when once she attains her menarche (Table 4).

2.2.3. Age at marriage

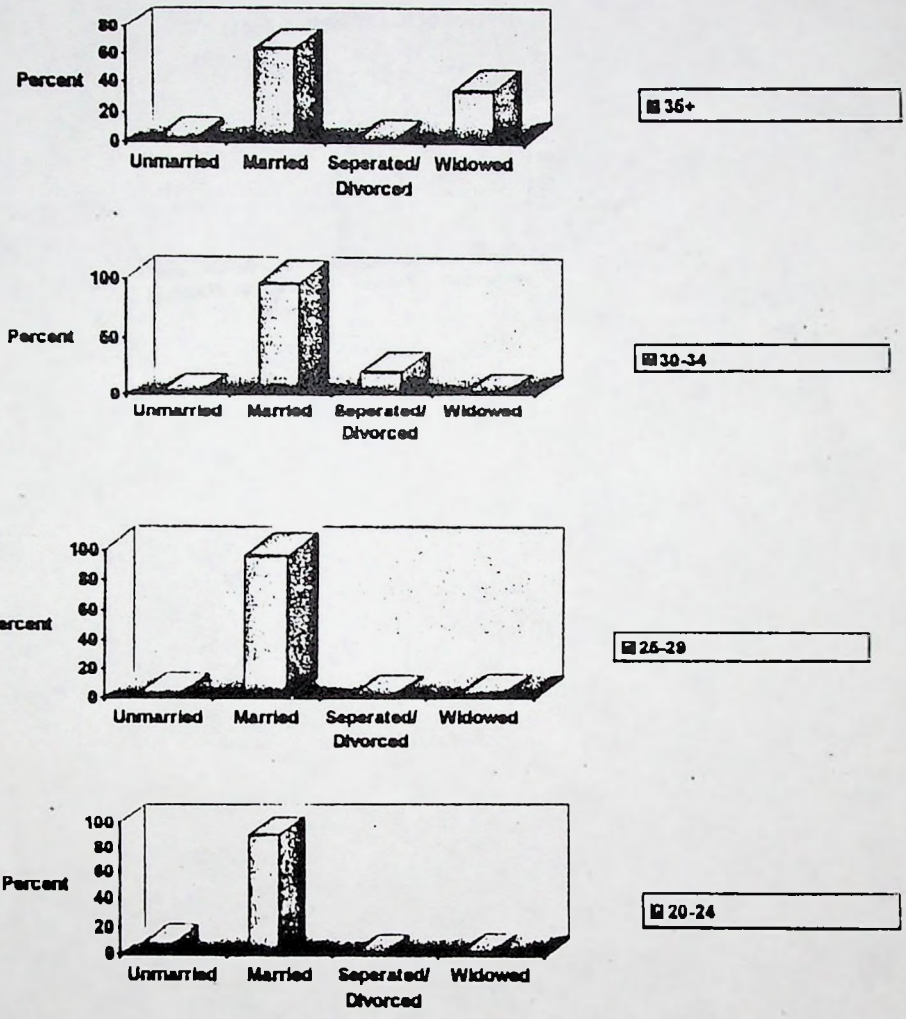
About 77% of the women had been married by the age of 18 years. The mean age at marriage in the sample was 16.9 years, with 16.8 years for Hindus, 16.7 years for Muslims and 18.0 years for Christians (Table 5).

Comparison of age at marriage between the respondents in different age cohorts would provide some information on the trends. As can be observed, the mean age at marriage is lower amongst respondents aged over 30 years as compared to the respondents aged below 30 years, except for the age group 15-19 years, with whom the mean is lowest.

Marital Status of Respondents



Marital Status of Respondents according to their age



A similar trend is observed even in the proportion of respondents married before the age of 18 years. This suggests that the mean age at marriage which had increased in the previous decade might have drifted down wards amongst the slum dwellers, in the recent years.

2.2.4. Age at consummation of marriage

The age at consummation of marriage i.e., the age at which the couple starts cohabiting together has a significant bearing on the number of children they give birth to which in turn affects the health of the mother. More than three fourths (76.5%) of women had their consummation of marriage by the age of 18 years (Table 6).

The mean age at consummation of marriage is 17.3 years, indicating that there is a gap of about 4-6 months on an average between the age at marriage and age at consummation of marriage.

Age cohorts depict similar trends with the age at consummation of marriage as was observed with the age at marriage.

2.3. Fertility Indicators

2.3.1. Fertility levels

The indicators of assessment of fertility in a community are crude birth rate, general fertility rate, age specific fertility rate and total fertility rate. In the present study, these rates are estimated from a sample of 30,400 population covering a period of one year previous to the date of survey.

a. Crude Birth Rate

There were in all 696 births in the sample during the period of an year before the date of survey while the population of the sample covered for the births is 30,400. Thus the crude birth rate in the population is 22.9 which is almost similar to the urban rates of Karnataka (NFHS). Even though no data is available for Bangalore City it may be presumed that CBR of slums would be higher than that of the CITY.

b. General Fertility Rate

With the number of births of 696 for a women population of 8004 in the age group 15-44 in the sample, the General Fertility Rate is 87.0. This rate is similar to 89

observed for urban areas of the State (NFHS) during 1992-93, but much lower than the rural rate of 119.

c. Age Specific and Total Fertility rates

Age Specific Fertility Rate (ASFR) and Total Fertility Rate (TFR) are refined indicators of fertility as they take into account the differential age fertility patterns as well as the age structure of the population. TFR is calculated as five times the sum of all the age specific fertility rates, since in the present study ASFRs are calculated for five year age intervals. This rate would provide an estimate of the number of children that would be born to a women during her reproductive span if she passes through the present fertility level in the community (Table 7).

TFR experienced by the women in the sample is 2.53 . The Age Specific Fertility Rates indicate that the fertility is highest in the age period 20-24 years with an ASFR of 0.2727 followed by 25-29 years with an ASFR of 0.0975 and 15-19 years with an ASFR of 0.0829. This reflects that the prime child bearing in the community is in the age period 15-29 years, contributing for 89.5% of the total births in the community.

2.3.2. Fertility trends

The indicators which are used for understanding the fertility trends are the total number of children ever born, birth order of last pregnancy for mothers in different age cohorts, age at first pregnancy and open birth interval of the last pregnancy. These rates are discussed in the following paragraphs. Further the age and parity of women who had delivered in the last on year is also analysed.

a. Age at first pregnancy

As a consequence of early age at marriage and consummation of marriage, the age at first pregnancy was also low in the community. Majority of women had their first pregnancy before the completion of 18 years of age (58.4%). These trends were similar for different religions in the community. The mean age at first pregnancy in the sample was 18.3 years i.e. almost with in an year of consummation of marriage (Table 8).

b. Birth order of last pregnancy

The mean parity of women of the last birth was about 3.0. The proportion of mothers with one or two parities was only 42.6% while those with over third parity was 32.3%. Even amongst younger mothers aged between 20-24 years, there were about 33%

with over third parity, while this proportion was as high as 63% with mothers over 25-29 years. This suggests that the community has a large proportion of young mothers who have conceived for over three times. (Table 9).

c. Open birth intervals

The mean birth interval from the last pregnancy in the community was 30 months. The means vary considerably between the mothers in the age groups below and above 30 years. The corresponding means in these two age groups were 25.7 and 37.2 months respectively (Table 10).

d. Age and parity of women delivered during previous one year

Majority of the women who had delivered during the previous one year were young and were in the age group 19 to 24 years. (66.0%). 9% of these mothers were below the marriageable age of 18 years, which is a matter of concern.

Paritywise, 41.3% of the births were of over second para and 18.8% were of over third para. Mothers with higher order parity were more amongst Muslims and Christians (27%) as compared to Hindus (15.9%).

2.4. Family planning indicators

The main thrust of the process in the present project is on improving family planning acceptance in the community. As such indicators on the knowledge, attitude and practices of the slum dwellers pertaining to family planning, provides a clear idea to monitor the over all impact of the programmes. The results obtained from the survey data on these indicators along with indicators on unmet demand for family planning are presented below.

2.4.1. Knowledge on family planning sources

The knowledge of women in the sample on family planning is almost universal with 96.3% of women being aware of methods to prevent the births. About 47% of the women knew three or more methods of family planning, while another 49% were aware of one or two methods. The methods known in the order of percentages were sterilisation of women (92.5%), oral pills (62.4%), IUD (49.8%) and Nirodh (27.7%). Vasectomy was known only to a negligible proportion of women (1.6%). However the communication

between the couples on limiting the family size or on family planning methods was very much restricted as only 34.6% of couples communicated on the these topics (Table 11).

2.4.2. Exposure to family planning messages through media

News paper reading was not very common with the women as only 22% had access to news papers.

Only a little more than a third of the women had access to radio either regularly or occasionally (35.2%). Christians are slightly better with the exposure to radio viewing (39.4%). However, only around 21 to 26% of women had accessed some messages on family planning or on health through radio broadcast (Table 12).

Television seems to be better accessible media than any of the other ones as nearly three fourths (74.1%) of the women had an access to it either regularly or occasionally. Christian women are better off in the access to this media followed by Muslims and Hindus. The percentage of women who had watched some programme related to family planning on television was 56 to 58%.

2.4.3. Current Contraceptive Use

a. Couple protection rates

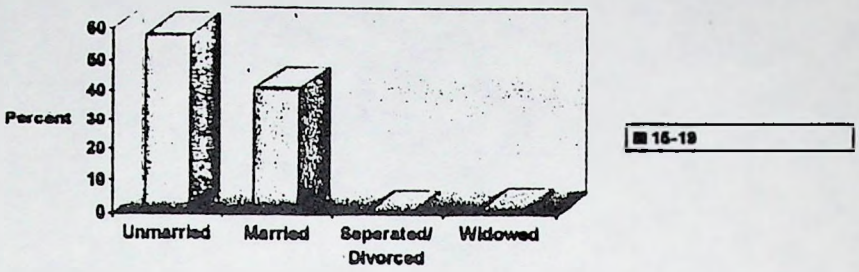
The couple protection rate through modern methods of contraception was 57.0% in the community. Majority of couples had adopted female sterilisation (48.9%) as method of contraception while the proportion of couples using spacing methods was very small (8.1%). Amongst the spacing methods, Oral pills were practised by 5.1% while IUD by 2.6%. Use of condoms was negligible (1.5%) (Table 13).

b. Religion wise contraceptive use

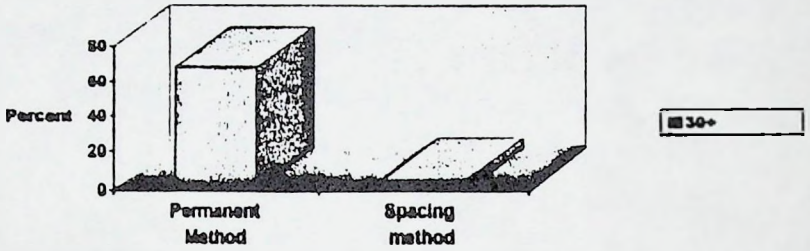
Practice of contraceptive methods was slightly higher with Christian couples (59.6%) as compared to Hindus (56.5%)or Muslims (58.3%). Permanent methods were more common with Christians (53.2%) followed by Hindus (49.3%) and Muslims (45.8%) (Table 13).

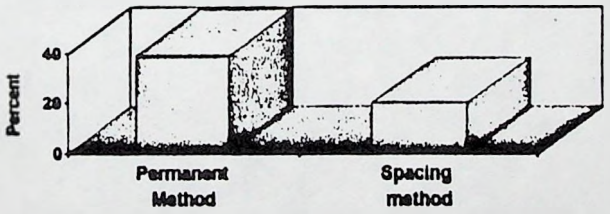
c. Age wise contraceptive use

The proportion of couples using contraceptives ranged from 9.8% amongst women aged 15-19 years to 77.6% with the women in the age group 35-39 years. Only 49.1% of women in the prime child bearing age of 15-29 years were using some method of

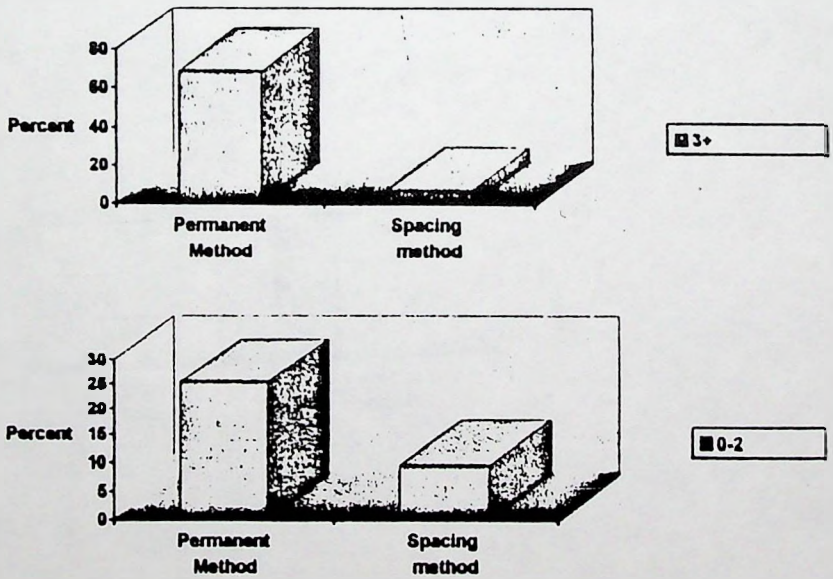


Type of F.P. Methods used by age of Respondents





Type of F.P. Methods used by Parity of last pregnancy of Respondents



contraception as compared to 72.8% in higher age groups (30+ years). Only 39.3% of couples in the prime child bearing age had undergone sterilisations besides the percentage adopting spacing methods being meager (Table 14).

d. Paritywise contraceptive use

Only 14.3% of the women upto first parity were using some method of contraception. Even though this percentage gradually increased to 79.5% with women in fourth para, the percentage decreased later. 75% of women of over second para were using family planning methods while this percentage was only 35% with women upto second parity. Of this 35%, the proportion adopting spacing methods was not much (9.5% couples). This clearly suggests that the programme has to propagate more on spacing methods with younger couples (Table 15).

e. Unmet demand for family planning

Out of 1500 couples 855 were practising one or the method of family planning. Of the remaining 645 couples, 219 (34%) expressed a desire to plan their families by adopting family planning methods in the near future. Of them 198 (30.2% of the total non users) wanted to adopt a method with in a year. As such it is evident that there is about 34% unmet need of family planning in the community. It is further implied that the couple protection rate can be stepped up by about 13% if concerted efforts are made to motivate and provide services to these 198 couples who are willing to adopt family planning in a year's period. Out of the 219 couples, 136 (62.1%) were desiring to go in for permanent methods while the remaining were for adopting a spacing method.

Misconceptions or objections by family members or religion were the prominent reasons for the non adoption of family planning methods. This indicates that IEC programmes have to be stepped up to motivate such couples.

2.5. Maternal and child health indicators

Two of the objectives of the Project relate to reducing infant mortality and maternal mortality in the area. Infant and maternal mortality can be reduced through provision of effective maternal and child health care services, mainly ante-natal and natal care for

pregnant mothers and immunisation services for infants along with appropriate treatment of diarrhoeal diseases of underfive children. Information was collected to arrive at the present levels of the indicators relevant to these activities and the results of the analysis are presented below.

2.5.1. Ante-natal care during pregnancy

As already stated, 262 women had delivered during the previous one year. Of them except for about 5% of mothers all had ante-natal check up (ANC). However, only 61.5% of the ANCs were initiated in the first trimester while another 30.9% were initiated during the second trimester. However those who did not have any checkup were those without proper knowledge about the need for the same Table 16).

Significantly only a small proportion of the ANCs (7.2%) was carried out by the peripheral workers while the remaining were from doctors (90.3%). A third of the mothers utilise private practitioners.

Only 7.6% of the mothers did not have tetanus toxoid immunisation during pregnancy. About 84% of the mothers had iron and folic acid supplementation during pregnancy. But only 17.6% had consumed a course of 60-90 of these tablets.

Even though majority of the deliveries were institutional, there were still 14.5% home deliveries which were mostly conducted by unqualified personnel.

Availing of post-natal check up facilities was not very common as only 30.5% of the mothers had availed of such a care.

2.5.2. Child care during infancy and early childhood

a. Breast feeding and weaning

Even though almost all the children (98.7%) were breast fed during their infancy only 53.2% of them were initiated on breast milk within one to two hours after birth. As many as 27.7% were initiated only after 12 hours. Only half of the mothers had continued breast feeding their babies for over one year. Prolonged breast feeding increases the amenorrhoea period which may reduce the chance of onset of next pregnancy (Table 17).

Large proportion of mothers had started supplementary feeding for infants within six months (73.6%) of age.

b. Malnourishment in children

In the present survey malnutrition was assessed by the mid arm circumference (MAC) of children. In the community only 41.1% of the children aged 7 to 59 months were nutritionally normal as per WHO standards (MAC >14.0 cms.). There were 35.6% of children moderately malnourished (MAC between 12.6 to 14.0 cms.) and 24.0% severely malnourished (MAC< 12.5 cms). Even though the proportion of nutritionally deficient children decreased with the age, the proportion severely malnourished was as high as 30.2% with children over four years of age.

c. Management of diarrhoea

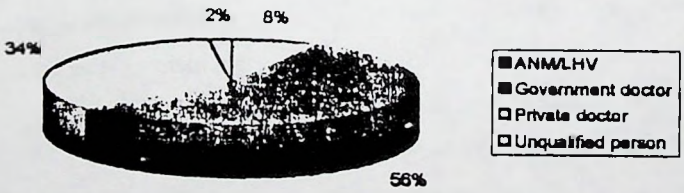
The prevalence of diarrhoea amongst children aged below five years was 14.4 %. About 9% of these episodes did not avail of any medical advice. Most of the mothers availed treatment facilities for the sickness from private health facilities (75.4%). Government or Corporation health facilities were used only by about a quarter of mothers (24.7%). As such it is desirable that these private practitioners are provided with necessary background to initiate educational activities to mothers on various aspects of health including family planning (Table 19 &20).

Nearly 45% of the mothers had reduced the food intake for the child during the episode while the rest had the same quantum as usual. Only 18.8% children were offered more fluids during the episode while in 30.0% of the children the quantum of fluid intake had reduced, which is not conducive in the management of the episode. Further ORS supplimentation was administered in only 51.2% of the episodes.

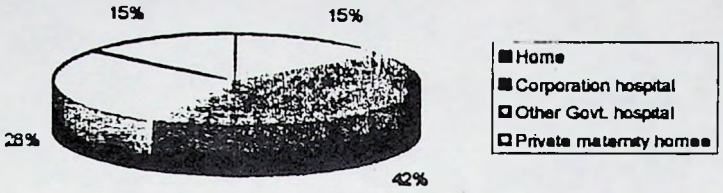
d. Immunisation status

There were 141 children aged 12 to 23 months in the sample. Out of them only 79.4% had completed the full schedule of immunisations. The immunisation coverage for BCG was highest with 98.6% followed by Measles (85.1%), DPT (82.3%) and Polio (79.4%). The drop out rate for DPT is 1.4% from first to second dose while it is 12.8% from second to third dose. For Polio the drop out rate was 2.8% from first to second dose and 13.5% for second to third dose (Table 21).

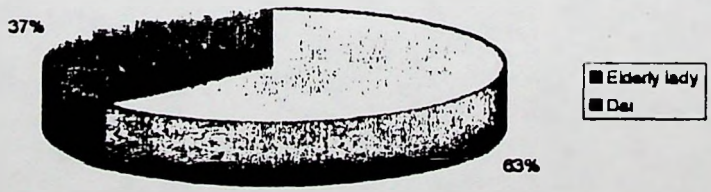
Personnel conducting antenatal checkup



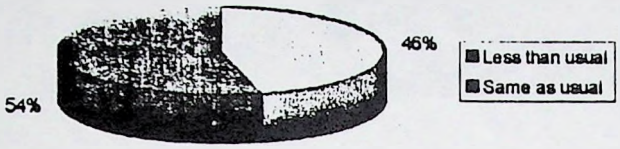
Place of delivery



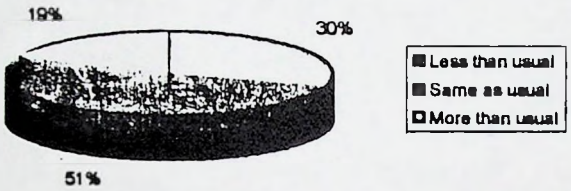
Person conducting home deliveries



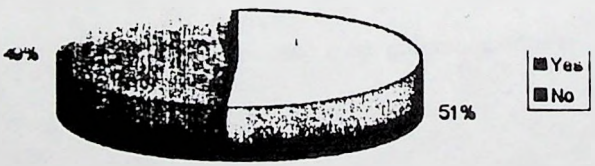
Food intake during diarrohea



Fluid intake during diarrhoea



ORS administered during diarrhoea



3. CONCLUSIONS

The indicators as observed in the present study leads to the following conclusions.

The population in the slums consisted mostly of the underdeveloped castes, a substantial proportion migrated from the neighbouring States and with low educational attainments. The population has a high proportion of females in the prime child bearing ages. Most of the women were married at early ages resulting in to early and repeated pregnancies.

Even though family planning acceptance rate is not low, the acceptance of F.P. methods by young couples is very low. Use of spacing methods for contraception is significantly low. There was a substantial proportion of unmet need for family planning which can be met by sustained IEC programmes.

Ante-natal care is mostly provided by Private practitioners and is not complete in many of the mothers and post natal care is not very common. There are still a considerable proportion of home deliveries conducted mostly by untrained personnel.

Infant care lacks especially in the components of early initiation to breast milk and provision of more fluids or ORS supplimentation during diarrhoea. Immunisation coverage is also not high. Prevalence of malnutrition amongst children aged below five years is also high.

4. REFERENCES

1. Centre for Research in Health and Social Welfare Management:
   Coverage Evaluation Study, Pulse Polio Immunisation Programme, Karnataka State, 1996
2. Centre for Research in Health and Social Welfare Management:
   Baseline Study for IEC component, IPP-VIII, Bangalore Mahanagar Palike, 1977
3. Institute for Socio-Economic Change and IIPS: National Family Health Survey, Karnataka, 1995
4. Registrar General. Govt. of India: Census of India, 1991, Quoted in Sl. No. 3

Table 1. Socio-demographic characteristics of the respondents

Socio-demographic characteristics	No.	%
Religion		
Hindu	1132	76.1
Muslim	261	17.6
Christian	94	6.3
Caste of Hindus		
Brahmins	5	0.3
Lingayat	17	1.1
Vokkaliga	180	12.1
S.C	606	40.8
S.T	120	8.1
Others	204	13.7
Occupation of respondent		
Housewife	1224	81.6
Coolie	218	14.5
Skilled worker	24	1.6
Unskilled worker	6	0.4
Professional	13	0.9
Service	15	1.0
Mother tongue		
Tamil	566	37.7
Urdu	369	24.6
Kannada	328	21.9
Telugu	213	14.2
Others	24	1.6
Economic condition in last three years		
Better off	515	34.6
Same	583	39.2
Worse	389	26.2

Table 2. Age and sex structure of the surveyed population

Age in years	Males		Females		Both	
	No.	%	No.	%	No.	%
0-4	587	14.68	573	15.08	1160	14.8
5-9	546	13.66	522	13.73	1068	13.7
10-14	445	11.13	435	11.44	880	11.3
15-19	352	8.81	404	10.63	756	9.6
20-24	324	8.11	530	13.94	854	11.0
25-29	445	11.14	438	11.52	883	11.3
30-34	365	9.14	256	6.74	621	8.0
35-39	333	8.34	213	5.60	546	7.0
40-44	212	5.31	107	2.82	319	4.1
45-49	154	3.85	88	2.32	242	3.1
50-54	95	2.38	87	2.29	182	2.3
55-59	42	1.05	36	0.95	78	1.0
60-64	40	1.00	56	1.47	96	1.2
65+	55	1.40	56	1.50	111	1.5
Total	3995	100.0	3801	100.0	7796	100.0

Table 3. Distribution of respondents according to age and marital status

		Marital Status				
Age in years		Unmarried	Married	Separated/ Divorced	Widowed	Total
15-19	No.	235	166	-	3	404
	%	58.2	41.1		0.7	100.0
20-24	No.	44	476	2	8	530
	%	8.3	89.8	0.4	1.5	100.0
25-29	No.	9	423	2	4	438
	%	2.1	96.6	0.5	0.9	100.0
30-34	No.	4	249	2	1	256
	%	1.6	97.3	0.8	0.4	100.0
35+	No.	9	410	4	220	643
	%	1.4	63.8	0.6	34.2	100.0
Total	No.	301	1724	10	236	2271
	%	13.3	75.9	0.4	10.4	100.0

Table 4. Distribution of respondents according to religion and age at menarche

	HINDU		MUSLIM		CHRISTIAN		All	
Age in years	No.	%	No.	%	No.	%	No.	%
11-12	322	28.2	109	41.3	21	22.3	452	30.1
13-14	589	51.6	129	48.9	58	61.7	776	51.7
15-16	208	18.2	23	8.7	14	14.8	245	16.5
More than 16	23	2.0	3	1.1	1	1.1	27	1.8
Total	1142	100.0	264	100.0	94	100.0	1500	100.0

$\chi^2 = 52.58$ $P < 0.001$

Table 5. Distribution of women aged 15-44 years according to the age at marriage

		Age at Marriage							
Age of the respondent		Upto 15	16-18	19-21	22-24	25+	Total	Mean	S.D.
15-19	No.	41	8	7	-	1	132	16.39	1.810
	%	31.0	62.9	5.3		0.8	100.0		
20-24	No.	115	225	102	9	-	451	17.06	2.258
	%	25.5	49.9	22.6	2.0		100.0		
25-29	No.	130	173	85	22	7	417	17.18	2.909
	%	31.2	41.5	20.4	5.3	1.7	100.0		
30-34	No.	94	90	32	10	6	232	16.63	2.932
	%	40.5	38.8	13.8	4.3	2.6	100.0		
35-39	No.	83	67	22	11	5	188	16.56	3.300
	%	44.1	35.6	11.7	5.9	2.7	100.0		
40+	No.	40	21	14	4	1	80	16.19	3.139
	%	50.0	26.3	17.5	5.0	1.3	100.0		
Total	No.	503	659	262	56	20	1500	16.86	2.734
	%	33.5	43.9	17.5	3.7	1.3	100.0		

Table 6. Distribution of respondents according to present age and age at consummation of marriage

	Age at consummation of marriage					
Age of the respondent	Upto 15	16-18	19-21	22-24	25+	Total
15-19 No.	39	84	8	-	1	132
%	29.5	63.6	6.1		0.8	100.0
20-24 No.	110	224	107	10	-	451
%	24.4	49.7	23.7	2.2		100.0
25-29 No.	124	173	91	23	6	417
%	29.7	41.5	21.8	5.5	1.4	100.0
30-34 No.	89	93	34	10	6	232
%	38.4	40.1	14.7	4.3	2.6	100.0
35-39 No.	79	71	22	11	5	188
%	42.0	37.8	11.7	5.9	2.7	100.0
40+ No.	36	25	13	4	2	80
%	45.0	31.3	16.3	5.0	2.5	100.0
Total No.	477	670	275	58	20	1500
%	31.8	44.7	18.3	3.9	1.3	100.0

Table 7. Age specific fertility rates of women in the community

Age of mothers in years	No. of mothers	No. of births in the year	Age specific fertility rates
15-19	1387	115	0.0829
20-24	1276	348	0.2727
25-29	1753	171	0.0975
30-34	1439	36	0.0250
35-39	1313	8	0.0060
40-44	836	18	0.0215

TFR=2.53 CBR= 22.9

Table 8. Distribution of respondents according to present age and age at first pregnancy

	Age at first preg.						
Age of the respondent	Upto 15	16-18	19-21	22-24	25-27	Total	Mean
15-19 No.	48	65	18	-	1	132	16.7
%	36.4	49.2	13.6		0.8	100.0	
20-24 No.	84	162	186	19	-	451	18.2
%	18.6	35.9	41.2	4.2		100.0	
25-29 No.	70	146	138	46	17	417	18.7
%	16.7	35.0	33.1	11.0	4.1	100.0	
30-34 No.	44	90	61	22	15	232	18.6
%	19.0	38.8	26.3	9.5	6.5	100.0	
35-39 No.	38	82	43	13	12	188	18.3
%	20.2	43.6	22.9	6.9	6.4	100.0	
40+ No.	17	30	20	7	6	80	18.5
%	21.3	37.5	25.0	8.7	7.5	100.0	
Total No.	301	575	466	107	51	1500	18.3
%	20.1	38.3	31.1	7.1	3.4	100.0	

Table 9. Distribution of respondents according to present age and order of last pregnancy

		Order of last preg.						
Age in years		1	2	3	4	5	6+	Total
15-19	No.	71	20	4	1	-	-	96
	%	74.0	20.8	4.2	1.0			100.0
20-24	No.	105	175	94	37	5	3	419
	%	25.1	41.8	22.4	8.8	1.2	0.7	100.0
25-29	No.	33	115	148	60	35	11	402
	%	8.2	28.6	36.8	14.9	8.7	2.7	100.0
30-34	No.	12	39	59	59	33	27	229
	%	5.2	17.0	25.8	25.8	14.4	11.8	100.0
35-39	No.	3	21	37	55	37	32	185
	%	1.6	11.4	20.0	29.7	20.0	17.3	100.0
40-44	No.	4	6	10	18	11	31	80
	%	5.0	7.5	12.5	22.5	13.8	38.8	100.0
Total	No.	228	376	352	230	121	104	1411
	%	16.0	26.6	24.9	16.3	8.6	7.4	100.0

Table 10 Distribution of respondents according to present age and length of open intervals from last pregnancy

		Open birth inter. in months					
Age of the respondent	-12	13-18	19-24	25-30	31-36	37+	Total
15-19 No.	78	19	15	4	11	5	132
%	59.1	14.3	11.4	3.0	8.3	3.8	100.0
20-24 No.	128	74	73	47	42	87	451
%	28.8	16.4	16.2	10.4	9.3	19.3	100.0
25-29 No.	57	24	37	25	53	221	417
%	13.7	5.8	8.9	6.0	12.7	53.0	100.0
30-34 No.	12	12	7	3	12	186	232
%	5.2	5.2	3.0	1.3	5.2	80.2	100.0
35-39 No.	7	2	1	-	5	173	188
%	3.7	1.1	0.5		2.7	92.0	100.0
40+ No.	-	-	-	-	-	80	80
%						100.0	100.0
Total No.	282	131	133	79	123	752	1500
%	18.8	8.7	8.9	5.3	8.2	50.1	100.0

Table11. Distribution of respondents according to knowledge of any FP method

Particulars	No.	%
Knowledge on FP methods to limit births		
Yes	1445	96.3
No	55	3.7
Number of F.P. Methods known		
Nil	55	3.7
1	313	20.9
2	425	28.3
3	522	34.8
4	175	11.7
5	10	0.7
No.of Couples Communicating between themselves on Spacing of children	519	34.6

Table 12 Distribution of respondents according to media exposure to family planning messages

Type of media	No.	%
News paper		
Yes	331	22.1
No	1169	77.9
Radio	973	64.9
Never		
Occasional	373	24.9
Regular	154	10.3
Television	389	25.9
Never		
Occasional	366	24.4
Regular	745	49.7

Table 13. Distribution of respondents according to religion and F.P. methods currently practised

Methods practised	HINDU		MUSLIM		CHRISTIAN		ALL	
	No.	%	No.	%	No.	%	No.	%
Nil	497	43.5	110	41.7	38	40.4	645	42.9
Female sterilisation	563	49.3	121	45.8	50	53.2	734	48.9
Oral pills	30	2.6	7	2.7	2	2.1	39	2.6
IUD	47	4.1	25	9.5	4	4.2	76	5.1
Nirodh	5	0.4	1	0.4	-	-	6	0.4
Total	1142	100	264	100	94	100	1500	100

Table 14. Distribution of respondents according to present age and F.P. methods currently practised

		F.P. method pract.				
Age of the respondent	Total Women	Female Ster.	IUD	Oral Pills	Condoms	Total practising
15-19 No.	132	4	4	4	1	13
%		3.0	3.0	3.0	0.8	9.8
20-24 No.	451	144	32	15	2	193
%		31.9	7.1	3.3	0.4	42.8
25-29 No.	417	245	28	10	2	285
%		58.8	6.7	2.4	0.5	68.3
30-34 No.	232	152	8	5	1	166
%		65.5	3.4	2.2	0.4	71.6
35-39 No.	188	138	4	4	-	146
%		73.4	2.1	2.1		77.6
40+ No.	80	51	-	1	-	52
%		63.8		1.2		65.0
Total No.	1500	734	76	39	6	855
%		48.9	5.1	2.6	0.4	57.0

Age of the respondent	Total Women	Permanent Method	Spacing method	Total Practising
15-29 No.	1000	393	98	491
%		39.3	20.0	49.1
30+ No.	500	341	23	364
%		68.2	4.6	72.8

Table 15. Distribution of respondents according to order of last pregnancy and F.P. methods currently practised

		F.P. method pract.				
Order of last pregnancy	Total Women	Female Ster.	IUD	Oral Pills	Condoms	Total practising
0-1 No.	314	12	22	9	2	45
%		3.8	7.0	2.9	0.6	14.3
2 No.	371	163	22	10	-	195
%		43.9	5.9	2.7		52.6
3 No.	358	240	13	10	4	267
%		67.0	3.6	2.8	1.1	74.6
4 No.	224	162	11	5	-	178
%		72.3	4.9	2.2		79.5
5 No.	123	91	4	-	-	95
%		74.0	3.3			77.2
6+ No.	110	66	4	5	-	75
%		60.0	3.6	4.5		68.2
Total No.	1500	734	76	39	6	855
%		48.9	5.1	2.6	0.4	57.0

Order of last pregnancy	Total Women	Permanent Method	Spacing method	Total Practising
0-2 No.	685	175	65	240
%		25.5	9.5	35.0
3+ No.	815	559	56	615
%		68.6	6.9	75.0

Table 16. Deliveries in the previous year according to ante-natal care received

Particulars of ante-natal care	No.	%
Had ante-natal checkup	249	95.0
Time of starting ANC		
1st trimester	161	61.5
2nd trimester	81	30.9
3rd trimester	7	2.7
Person providing care		
ANM/LHV	19	7.2
Government doctor	141	53.8
Private doctor	84	32.1
Unqualified person	5	1.9
Doses of Tetanus toxoid		
Nil	20	7.6
1	11	4.2
2	105	40.0
3	126	48.1
IFA tablets consumed		
Nil	43	16.4
Upto 30	102	38.9
31-60	71	27.1
61-90	46	17.6
Place of delivery		
Home	38	14.5
Corporation hospital	186	71.0
Private maternity homes	38	14.5
Person conducting home deliveries		
Elderly lady	24	63.2
Dai	14	36.8
Post natal checkup		
Yes	80	30.5
No	182	69.5

Table 17 . Distribution of children below five years according to the status of breast feeding

Breast feeding pattern	No.	%
Breast feeding after birth in hours		
Never	11	1.3
1-2	440	53.2
3-6	112	13.5
7-12	35	4.2
13-24	88	10.6
24+	141	17.1
Breast feeding duration in months		
1-6	182	22.3
7-9	70	8.6
10-12	157	19.2
13-18	190	23.3
18+	217	26.6
Age at supplementary feed in months		
1-3	142	19.3
4-6	400	54.3
7-9	99	13.5
10-12	76	10.3
13-18	19	2.6
Not started	91	

Table 18. Distribution of underfive children according to mid arm circumference of children

	Age in months							
Mid arm circumference in cms	7-12	13-18	19-24	25-30	31-36	37-48	49+	Total
Less than. 12.5 cms	No. 37 % 24.1	25 17.5	34 23.4	16 19.0	36 23.5	57 25.4	48 30.2	254 24.0
12.6 to 14 cms	No. 77 % 50.3	73 51.0	67 46.2	32 38.1	44 28.8	57 25.5	20 12.6	370 35.6
More than 14 cms	No. 39 % 25.5	45 31.5	44 30.3	36 42.9	73 47.7	110 49.1	90 56.6	437 41.1
Total	No. 153 % 100.0	143 100.0	145 100.0	84 100.0	153 100.0	224 100.0	159 100.0	1061 100.0

Table 19. Distribution of children below five years according to management of diarrohea during previous one month

Diarrhoea management	No.	%
Prevalence of diarrohea		
Yes	170	14.4
No	1010	85.5
Management of episode		
History of seeking medical advice	No.	%
Yes	155	91.2
No	15	8.8
Quantum of food offered		
Less than usual	76	44.7
Same as usual	90	55.3
Quantum of fluids offered		
Less than usual	51	30.0
Same as usual	87	51.2
More than usual	32	18.8
ORS offered		
Yes	87	51.2
No	83	48.8
Total	170	100.0

Table 20. Distribution of women according to place of treatment for sickness

Place of treatment	No.	%
Corporation health facility	25	1.7
Govt. health facility	345	23.0
Private health facility	1130	75.4
Total	1500	100.0

Table 21. Distribution of children aged 12-23 months according to immunisation status

Immunisation schedule	No.	%
B.C.G.	139	98.6
DPT - 3 Doses	116	82.3
- 2 Doses	134	95.1
- 1 Dose	136	96.5
Nil Dose	5	3.5
POLIO- 3 Doses	112	79.4
-2 Doses	131	92.9
-1 Dose	135	95.7
Nil Dose	6	4.3
Measles	120	85.1
No. of children aged 12-23 months	141	

APPENDIX 3

QUESTIONNAIRES USED FOR THE SURVEY

BANGALORE MAHANAGAR PALIKE

INDIA POPULATION PROJECT - VIII

CENTRE FOR RESEARCH IN HEALTH AND SOCIAL WELFARE MANAGEMENT

SURVEY OF SLUMS OF BANGALORE

GENERAL PARTICULARS

1. Name ofthe Ward ..... 2. HH No.....
3. Name of the Area.....
4. Name of the head of household.....
5. Name of the respondent-mother.....
6. Name of the interviewer.....
7. Date of interview.....
8. Identifioation No.....

PROCESSING INFORMATION

Field Edited By :----------

Date :----------

Office Edited By :----------

Date :----------

Entered in Computer By :----------

Date :----------

A. HOUSEHOLD PARTICULARS

Please give the following particulars for all the members of your family who normally stay in the household.

Sl. No.	Name	Relation-ship to HOF	Age in Completed years	Sex Male 1 Female 2	Marital status 1 Married 2 Widowed 3 Separated 4 Divorced 5 Unmarried	Educational Status Illeterate 1 Primary 2 Middle 3 Higher Sec 4 Graduate 5 Technical 6 Post Grad. 7 Child <5 Yrs 8	Occupation	If child > 5 Years going to to School Yes 1 No 2	If child not going to School Reasons School far away Busy in house worl Child unwell Wage earning No school for girl Others (Specify)
1	2	3	4	5	6	7	8	9	10

B. SOCIO-ECONOMIC INFORMATION OF THE HOUSEHOLD

1. What is the religion of the household?

Hindu	1	( )	Jain	4	( )
Muslim	2	( )	Sikh	5	( )
Christian	3	( )	Others (specify)	6	( )

2. If Hindu, what is the caste of the household?

Brahmin	1 ( )
Lingayath	2 ( )
Vokkaliga/Reddy	3 ( )
Scheduled Caste	4 ( )
Scheduled Tribe	5 ( )
Other Hindus	6 ( )

3. Do you think that your family's condition during the last five years is

Better off ( )
Same ( )
Worse ( )

C. EXPOSURE TO HEALTH EDUCATION

1. Have you ever attended any orientation training course on health in the last 3 years? Yes 1 ( ) No 2 ( )

2. If yes, were any of these topics discussed there?

Nutrition	Yes 1 ( )	No 2 ( )
Family planning	Yes 1 ( )	No 2 ( )
Child care	Yes 1 ( )	No 2 ( )
Immunization	Yes 1 ( )	No 2 ( )
Disease prevention	Yes 1 ( )	No 2 ( )

3. Do you read news papers or magazines? Yes 1 ( ) No 2 ( )

4. How often do you listen to radio?

Never 1 ( )
Occasionally 2 ( )
Regularly 3 ( )

5. If you listen to the radio, can you tell us whether you have heard any messages on:

Nutrition	Yes 1 ( )	No 2 ( )
Family planning	Yes 1 ( )	No 2 ( )
Child care	Yes 1 ( )	No 2 ( )
Immunization	Yes 1 ( )	No 2 ( )
Disease prevention	Yes 1 ( )	No 2 ( )

6. How often do you watch TV?

Never 1 ( )
Occasionally 2 ( )
Regularly 3 ( )

7. If you watch TV, can you tell us whether you have watched any programmes relating to:

Nutrition	Yes 1 ( ) No 2 ( )
Family Planning	Yes 1 ( ) No 2 ( )
Child care	Yes 1 ( ) No 2 ( )
Immunization	Yes 1 ( ) No 2 ( )
Disease prevention	Yes 1 ( ) No 2 ( )

D. MATERNITY HISTORY OF THE MOTHER

1. What was your age at puberty?.....

2. What was your age at marriage?.....

3. What was your age at consummation of marriage? .....

4. What was your age at first pregnancy?.....

5. How many times you have conceived till now?.....

6. Out of your conception how many were
   Live births.....
   Still births.....
   Abortions.....

7. Out of the live births how many were
   Males.....females.....

8. When did you have your last pregnancy? .... months back

9. What was the pregnancy order of this?.....

10. Was the pregnancy Wanted 1 ( ) Unwanted 2 ( )

E.OBSTERTICAL INFORMATION FOR THOSE WHO HAVE DELIVERED DURING JUNE 1996 TO MAY 1997 (Even if the child is not alive)

1. Name of the mother .....

2. Age of the mother at pregnancy .....

3. Order of pregnancy .....

4. Date of delivery .....

5. Sex of the child .....

6. Is the child alive now ? Yes 1 ( ) No 2 ( )

7. Did you have any checkup during pregnancy from a person from PHC/Subcentre or Hospital or Doctor or any other person — Yes 1 ( ) No 2 ( )

8. If did not have any checkup. Why?
   - Did not feel its necessity 1 ( )
   - Did not know of its necessity 2 ( )
   - Place of availability not known 3 ( )
   - Place of availability too far away 4 ( )
   - Workers not available 5 ( )

9. If you had checkup at what period of pregnancy you had the first checkup? .... months

10. Who provided you the checkup?
   - Dai 1 ( )
   - ANM 2 ( )
   - LHV 3 ( )
   - Govt.Doctor 4 ( )
   - Pvt. Doctor 5 ( )
   - Others(specify) 6 ( )

11. How many times did you have the checkup?
   a) Home . . . . .
   b) Clinic . . . . .

12. Did you take tetanus toxoid during pregnancy? Yes 1 ( ) No 2 ( )

   If yes, how many doses? .....

13. Were you given folic acid(iron) tablets during pregnancy? Yes 1 ( ) No 2 ( )

   If yes, how many pills did you cosume ? -------

14. Where was the place of delivery?
   - Home/House 1 ( )
   - Corporation Maternity Hospital 2 ( )
   - Major Hospital 3 ( )
   - Pvt.Maternity Homes 4 ( )

15. Who assisted the delivery?
   - Elderly lady 1 ( )
   - Dai 2 ( )
   - ANM 3 ( )
   - LHV 4 ( )
   - Doctors 5 ( )
   - Others (specify) 6 ( )

16. Did you have any checkup after delivery within 40 days from a health personnel? Yes 1 ( ) No 2 ( )

F. CHILD REARING PRACTICES FOR THE LAST LIVE BIRTH

(Collect this information for deliveries in the last five years irrespective of the fact, the child is alive or dead now).

1. Name of the child .....

1a. Age of the child(in months).....

2. Did you breast feed this child? Yes 1 ( ) No 2 ( )

3. If no, why did you not breast feed the baby?

4. If yes, how many hours after delivery you started breast feeding? ... hours

5. How long did you breast feed the child? ... months

6. At what age of the child you started giving supplementary feeding apart from breast milk? ... months

7. Whether your child was given the following immunisation? (Collect information only for children aged 12 to 23 months)

a.	BCG	Yes 1 ( )	No 2 ( )	
b.	DPT	Yes 1 ( )	No 2 ( )	If yes no. of doses.....
c.	Polio	Yes 1 ( )	No 2 ( )	If yes no. of doses.....
h.	Measles	Yes 1 ( )	No 2 ( )	
i.	Vit. A.	Yes 1 ( )	No 2 ( )	

G. KNOWLEDGE,ATTITUDE AND PRACTICES OF WIFE ON POPULATION DYNAMICS AND FAMILY PLANNING

1. Name of the respondent .....

2. Age of the respondent .....

3. What is your opinion regarding the age at which your children should be married? Sons .... Daughters ....

4. What is the legal at which children should be married? Sons .... Daughters ....

8. According to you, how many years after marriage a girl should have her first baby? .... Years

7. After how many years should she have her second baby? .... Years

8. How many children she should give birth to? .....

   a. Of them how many sons and daughters?

   Sons .... Daughters .... No sex preference .....

9. Do you know that there are methods by which one can avoid pregnancies? Yes 1 ( ) No 2 ( )

10. If yes, can you list those methods? .....
.....
.....
.....

11. Have you used any of these methods till now? Yes 1 ( ) No 2 ( )

12. If yes, what are they? .....
.....
.....

13. Are you still using any method now? Yes 1 ( ) No 2 ( )

14. If yes, what method is it? .....

15. Are you satisfied with this method? Yes 1 ( ) No 2 ( )

16. If no, why? .....
.....
.....

17. Who motivated you to adopt this method?

18. Apart from children you already have do you want to have more children ? Yes 1

No	....	2
Undecided/upto God	....	3
DK	....	8

19. When would you like to have your (next) child ?

Within one year/soon	.....	1
1-2 years	.....	2
2+ years	.....	3
DK	.....	8

20. Reasons for not having any (more) child(ren) ?

No more/None	 1
Currently Pregnant	 2
Menopause	 3
Sterile	 4
Others	 7

(Specify)

21. Why are you not using a FP method to avoid pregnancy when you are not interested ?

Going to use soon	 01
Natural Sterility	 02
Currently Pregnant	 03
Lack of Knowledge	 04
Afraid of sterilisation	 05
Cost too much	 06
Can't work after sterilisation	 07
Worry about side effects	 08
Hard to get methods	 09
Against religion	 10
Opposed to FP	 11
Husband opposed	 12
Other people opposed	 13
Difficult to get Pregnant	 14
Menopausal	 15
Inconvenient	 16
Don't like existing methods	 17
Others	 77

(Specify)

22. When are you planning to adopt a FP method ?

Within a year/soon	 1
1-2 years	 2
2+ years	 3
DK	 8

23. Which method are you planning to adopt ?

Male Sterilisation	 1
Female Sterilisation	 2
Copper-T or IUD	 3
Pill	 4
Condom or Nirodh	 5
Safe period for periodic abstinence	 6
Withdrawal	 8
Others	 7

(Specify)

24. Do you and your husband ever talk about the spacing of children?

Often	1
Some times	2
Rarely	3
Never	4

H.DIARROHEAL HISTORY OF CHILDREN BELOW FIVE YEARS DURING THE LAST ONE MONTH AND PLACE OF TREATMENT FOR SICKNESS

	Sl. No. of the child				
	1	2	3	4	5
1. Name of the child					
2. Age of the child in months					
3. Sex of the child Male 1 / Female 2					
4. Did the child suffer from diarrohea in the last one month? Yes 1 / No 2					
5. During the episode did you seek any medical consultation ? Yes 1 / No 2					
6. During the episode how much of usual food was offered? Less than usual 1 / Same as usual 2 / More than usual 3					
7. During the episode how much of fluids wer offered? Less than usual 1 / Same as usual 2 / More than usual 3					
8. During the episode was the child given Oral Rehydration solution? Yes 1 / No 2					
9. Record the MUAC of the child in mms.					

10. If someone is sick in the family where do you go for treatment ?

Corporation health centre	1 ( )
Government Hospital	2 ( )
Private practioner	3 ( )
Home remedies	4 ( )
None	5 ( )

11. What is the reason for seeking this particular facility?

N. DETAILS OF BIRTHS IN THE FAMILY

Sl. No.	
Family Size	
Was there a birth in the Family during June96-May 97	Yes 1 No 2
If Yes, Sex of the Child	Male 1 Female 2
Age of the Mother at delivery	
Order of birth	

Com H-71.

Main Identity

From: "rajan patil" <rajanpatil@yahoo.com>
To: "devika" <devika@xxxeb.com>; "Centre for Resource Education" <hyd2_creind@sancharnet.in>; "Toxics Link Chennai" <tlchennai@vsnl.net>; "Madhumita Dutta" <mdutta@vsnl.net>; "Community Health Cell" <chc@sochara.org>; "ravi" <ravig1@vsnl.com>; "Nitya" <nity68@vsnl.com>; "ananth padmanabhan" <ananth@dialb.greenpeace.org>; <sambavna@sancharnet.in>; "Toxic Link delhi" <tldelhi@vsnl.com>; "PHM" <secretariat@phmovement.org>; <thanal@vsnl.com>; "Manu Gopalan" <mangofor@vsnl.net>; "Nimmi" <nirmala.karunan@dialb.greenpeace.org>
Cc: "disease surveillance" <diseasesurveillance@yahoogroups.com>
Sent: Thursday, June 02, 2005 4:48 PM
Subject: Doctor who spoke out on public health issue is sued

Friends,

deja` vu` isn't it?
history keeps repeating itself.....again n again..
regards,
rajan

BMJ 2005;330:439 (26 February), doi:10.1136/bmj.330.7489.439-a

Doctor who spoke out on public health issue is sued

Sydney Christopher Zinn

A doctor who claims he was doing his job according to the tenets of the Hippocratic oath when he spoke out about risks to health from the operations of a major logging company in Tasmania is being sued for causing alleged damage to the company's business activities.

Dr Frank Nicklason, a staff specialist physician at the Royal Hobart Hospital, is one of 20 defendants, including prominent environmentalists and another doctor, named in the writ by Gunns Ltd, which is seeking almost $A6.3m (£2.6m; $5m; €3.8m) in damages.

Dr Nicklason said the case may stop doctors raising legitimate health concerns because of fear of being involved in prolonged and expensive legal action. He said that although the case would not silence him it had already affected the forestry debate, which is dividing Tasmania.

"It has succeeded in shutting other people up in Tasmania, mainly small local environmental and community groups," he said of the writ, which was served in December.

Dr Nicklason faces years of legal action and a damages claim of $A250 000 for calling for an independent risk assessment of large piles of woodchips in the port of Burnie. He made the call in 2002, as a spokesman for the non-aligned lobby group Doctors for Forests.

He said the Hippocratic oath required him to prevent illness not just in patients but in society as well, and he believed, after talking with experts, that the stockpiles of shredded wood on the wharf posed potential health risks to Burnie's citizens.

H6 - Environmental Health file

6/3/2005

Jan 31/6

His research showed that legionella bacteria, fungal organisms, and wood dust, all of which posed health risks, could have been in the stockpiles, some of which had been undisturbed for years. The local medical community, however, had said nothing.

The management at Gunns is refusing to comment on the case, but its own inquiries found that the stockpiles posed no danger to public health.

The state chairman of the Tasmanian Australian Medical Association Dr Michael Aizen said Dr Nicklason had been caught up in Gunns "shotgun" approach, which was to sue a wide range of its critics.

"In principle I feel that using the law to control the expression of concern about public health is wrong. If Gunns had any concerns they should have replied to Dr Nicklason with scientific arguments," he said.

Rapid Responses:

Read all Rapid Responses

Healthworkers are speaking out in Wales too
susanne mccabe
bmj.com, 25 Feb 2005 [Full text]

Opposes corporate hegemony
Richard Fielding
bmj.com, 25 Feb 2005 [Full text]

Peaceful Public Action Needed to Prevent Gagging Public Health
Anthony Lwegaba

Healthworkers are speaking out in Wales too

26 February 2005

susanne mccabe, retired
cf24 3

Send response to journal
Re: Healthworkers are speaking out in Wales too

In Wales they get suspended. A surgeon from Withy Bush Hospital in West Wales actually dished out leaflets on the streets of Haverford West to highlight concerns about lack of beds in the gynaecological ward. (This was Widely reported on TV last month) The Chair of the Community Health Council publicly supported what the surgeon was claiming as the CHC had been expressing the same concerns. Two weeks later (a litle late in the day maybe) a group of his colleagues wrote a collective letter of support. theeir action was also made public).

People know all too well that the services are failing in Wales. A week after he made his stand two senior nurses from University College Hospital of Wales also spoke out on BBC Wales about the

state of the emergency services there..they claimed they were unable to provide a safe service and that people were 'being treated like animals'.Ambulance drivers seem to feel more intimidated because they tend to speak out anonymously about ambulances lined up outside the hospital for lack of beds to admit people. ~(Again publicised on BBC TV) A month ago the spokesperson from BMA Wales stated that 'doctors are weeping in despair' over the state of the services here.

It takes a lot for this sort of action to be taken by healthworkers but there is a limit to how much stress anybody much less those responsible for the well being of ill people, should be expected to deal with on a daily basis.

Competing interests: None declared

Oppose corporate hegemony

26 February 2005

Richard [illegible]ding,
Senior [illegible]rer,
Univers[illegible] Hong Kong

Send res[illegible]se to journal:
Re: Opp[illegible] corporate hegemon[illegible]

Sir, Your report on Dr. Nicklason who is being sued by a corporation for raising health concerns (Doctor who spoke out on health concerns is being sued, BMJ 2005, 330, 439) is yet another example of a very worrying trend of corporate control over freedom of expression. One section, 121, in the new Serious Organized Crime and Police Bill about to be implemented in the UK will oblige the police to arrest for harassment any person handing out one leaflet to a person who has previously been given a copy of that leaflet by a second person. This could stifle most public protest in the UK. The MacDonald's Two would not have succeeded in protesting against MacDonalds foods had this law been enacted then. Public complaint and protest against corporate activities impacting health is being stifled worldwide by the co-option of increasingly repressive legal means, not least by bankrupting whistleblowers trying to fight back. It is imperative that those who desire a life and freedom that is not subject to corporate control oppose repressive legislation like this, speak out against this trend, and support those, like Dr. Nicklason, who are victims of it.

Competing interests: None declared

Peaceful Public Action Needed to Prevent Gagging Public Health

28 February 2005

Anthony [illegible]egaba,
lecturer [illegible]ublic Health,
SCMR, U[illegible]versity of West In[illegible]s Cave Hill, Barbados

Se[illegible]e to jou[illegible]
Re: [illegible]ul Public Acti[illegible]d to Pre[illegible]ing Public Hea[illegible]

The action of Gunns Ltd to sue Dr Frank Nickloson and his colleagues for raising up environmental health issues is very disturbing as pointed out that it has sent a threat into health conscious activists. However, this be seen as only the beginning of a long struggle for which the following should be done:

1. Sensitise and mobilise professionals and the general public on the issues at stake;

2. Demonstrate support for freedom of speech on public health issues. Such campaigns should include - collection of signatures, funds which will help the cause during the court process and

when possible police permitted (underlined) peaceful street demonstrations.

3. Collect more evidence to document on the public health impact of activities of such companies.

For all these to occur a goal focused leadership must be in charge.

The effect will be that no company functions without public support and companies are or will be fully appreciative of that fact.

All the best in the support for the cause of public health.

Competing interests: None declared

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International Journal for Equity in Health

BioMed Central

Commentary

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Self-help: What future role in health care for low and middle-income countries?

KR Nayar*[1], Catherine Kyobutungi[2] and Oliver Razum[2]

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Abstract

In the debate on 'Third options' for health care delivery in low- and middle-income countries it is proposed that self-help should play a larger role. Self-help is expected to contribute towards improving population health outcomes and reducing government health care expenditure. We review scope and limitations of self-help groups in Europe and South Asia and assess their potential role in health care within the context of health sector reform.

Self-help groups are voluntary unions of peers, formed for mutual assistance in accomplishing a health-related purpose. In Europe, self-help groups developed out of dissatisfaction with a de-personalised health care system. They successfully complement existing social and health services but cannot be instrumentalized to improve health outcomes while reducing health expenditure.

In South Asia, with its hierarchical society, instrumental approaches towards self-help prevail in Non-governmental Organizations and government. The utility of this approach is limited as self-help groups are unlikely to be sustainable and effective when steered from outside. Self-help groups are typical for individualistic societies with developed health care systems – they are less suitable for hierarchical societies with unmet demand for regulated health care. We conclude that self-help groups can help to achieve some degree of synergy between health care providers and users but cannot be prescribed to partially replace government health services in low-income countries, thereby reducing health care expenditure and ensuring equity in health care.

Background

The paradigm of health sector reforms currently undertaken at the global level, and especially in structurally adjusting countries like India and elsewhere in the developing world, enforces a move towards privatization of medical care services. The State is often characterized as inefficient and considered ill equipped to handle social sectors such as health. This inefficiency argument is applied to both issues of financing as well as the implementation of health programs. The alternative suggested is a mix of private and public, the primary care to the government and the lucrative curative care to the private sector [1]. There are also certain options which fall between completely state-oriented services and privatized care.

Lib - Equity + Health full
Lr

One of the early such options was the Non-governmental Organization. However, a number of recent impact studies have shown that with regard to criteria such as reaching the poorest, coverage, cost-effectiveness, quality of services or policy direction, non-governmental development organizations do not have any advantage over the State [2]. As concentration of funding and projects increase, "NGOs become susceptible to bureaucratization, self-aggrandizement and imposition of standardized solutions." [3]

Another approach discussed in this context is self-help. Self-help originates from industrialized countries and was initially a bottom-up approach. Since the 1980s, however, self-help has increasingly been "prescribed" by experts with the explicit aim of reducing government health care expenditure [4,5]. We argue that such instrumentalization is about to occur again, this time in low- and middle-income countries with unmet demand for regulated health care. The WHO report on Macroeconomics and Health (2002) has identified investment in health as an effective instrument for reducing poverty in low-income countries. With their social and health systems cash-strapped, self-help is again being proposed as an allegedly less costly but effective means of improving population health.

However, the potentials and limitations of self-help in health care for low- and middle- income countries have not been sufficiently discussed. In this review paper we provide a definition of self-help groups, briefly depict their historical background, and assess scope as well as limitations of the self-help movement in Europe where it originated. In this section we demonstrate the inextricable role of the political ideology of the day in the evolution of the self-help movement and its subsequent instrumentalization by the state in industrialized countries. Whether and how this also applies to low- and middle- income countries has not yet been discussed. In the main section, we describe the political context, analyze experiences with health-related self-help groups in Bangladesh and India, and draw conclusions regarding the relevance of self-help groups for improving population health. We restrict the scope of this paper to the role of the self-help strategy in health care, which encompasses the five categories of service provision in the health sector, namely: curative, preventive, promotive, rehabilitative and palliative. Our paper does not address the broader concept of health promotion as defined by the Ottawa Charter since this is a result of inputs from various sectors, the individual effects of which are difficult to evaluate [6]. Also, we address only those aspects of self-help that have a direct effect on health through service provision in the health sector. While the self-help strategy is a long acknowledged tool for empowerment, the latter is a much more complex process that involves other methods of which self-help is just one. Kar, Pascual & Chickering (1999), for example, have aptly described the dynamic and synergistic relationship between health promotion, empowerment and quality of life [7].

Methods

We obtained the material for this review from a search covering the following databases: Medline advanced ([Webspirs 4] 1966 -), PubMed (English), International Bibliography of the Social Sciences (IBSS), Bibliography of Asian Studies, Social Sciences (including Econ-Lit, ERIC, Social Services Abstracts, Sociological Abstracts), Popline, WHOLIS and other databases of UNDP, UNICEF and UNRISD. Apart from these databases, the review also depended on government documents and conference reports relevant to the topic.

The Self-help approach

The desirability of empowering communities to take care of their health problems themselves has been raised since long. Often it is argued that self-help is an ingredient of the Primary Health Care strategy with its focus on "peoples' health in peoples' hands" [8]. The strong point could be its orientation towards action and progress; people would learn to be in the role of health care providers in the process. One of the core principles of self-help is that only those experiencing the problem can understand it [9]. This is reflected in the comprehensive and still up-to-date definition of self-help groups given by Katz & Bender 1976 [10] (cited in Katz, 1981, and in numerous other review papers):

"Self-help groups are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity."

Katz highlights that self-help groups typically start from a condition of powerlessness, and that the members spontaneously (i.e. not urged by an outside authority) agree on engaging in some actions in which they personally participate. Self-help groups create, and act within, a purposefully organized setting; this distinguishes them from

medical *self-care*, which is practiced by individuals alone or within a family [10].

Empowerment, on the other hand, is a process through which individuals gain control over matters that concern them most. It can be defined as a "multi-dimensional social process that helps people gain control over their own lives" [11]. Evidently, this concept is broader than that of self-help in health care provision. Empowerment is distinct from self-help: While self-help is (or should be) a spontaneous reaction by the affected individuals to an undesirable situation, empowerment is by connotation a proactive externally driven process. Although involvement in self-help may enhance personal empowerment, community and organizational empowerment are enhanced through other methods, as described by Kar *et al.* (1999). Empowerment can have indirect health effects that are more difficult to quantify than the more direct effects of self-help. In view of the broad concept and the indirect effects, we restrict the scope of our review to self-help groups.

Results

Self-help in industrialized countries

Historical background

By the mid-19th century, population health in Victorian England had deteriorated to an alarmingly low level; poverty, disease and death were wide-spread [12,13]. It took reformers inside and outside Government decades to devise and implement reforms that would, towards the end of the 19th century, help to control infectious disease and improve general living standards. Scientific and political debate on how to initiate social change and better society had, by that time, come to rather dissimilar conclusions. One group, the "social Darwinists", proposed to apply Darwin's theory of natural selection in the evolution of biological species to the improvement of human society. The British philosopher Herbert Spencer, for example, advocated what he called "true liberalism", an extreme economic and social *laissez-faire*. He expected that a massive restriction of the role of the state and a reliance on the principles of the market (i.e. supply and demand), would lead to the "survival of the fittest", and hence to continuing improvement of the population. Spencer expected that as his flavor of liberalism was mounting, social altruism would increase, and "voluntary associations" would replace government support and aid to the "unfit" poor.

Other social researchers followed a rather different track. Beatrice Potter (later married Webb) tried to learn from organizations that members of disadvantaged population segments themselves had created to alleviate their situation; in 1891, she published *The Co-operative Movement in Great Britain*. Peter Kropotkin, in his book *Mutual Aid* (originally 1902), did not deny the importance of Darwin's theory of natural selection; yet he argued that co-operation, and not conflict, is the chief factor in the evolution of species [14]. According to Kropotkin, mutual aid and self-help are the oldest and most natural systems to improve the situation of human beings. Like Spencer, Kropotkin reasoned against a centralized state (which he thought should be replaced by voluntary associations of mutual support), but from a libertarian rather than "truly liberal" point of view. Thus, his core ideas embraced empowerment of the weakest and not survival of the fittest. Ultimately, however, it was neither social Darwinism nor the self-help movement but the legislative work of dedicated government officials and increasing investment in water and sanitation that had brought about the major improvement in population health by the end of the 19th century [12].

Many authors trace the history of "modern" self-help groups to the foundation of *Alcoholics Anonymous* (AA) in the US in 1935, a group that became active in a field in which existing social and health services did not provide adequate support. More recently, the 1960s civil rights movement gave people the confidence to trust in their collective power, rather than in that of politicians or experts, and empowerment became a core motive in the formation of self-help groups. For example, people increasingly felt that they were being pushed in a position of childlike dependence once they became patients in the now high-tech medical sector. They began to question medical classifications of health and illness and the stigma attached to certain conditions. With the advent of the women's movement, women began to oppose the medicalization of birth and human reproduction and moved to "reclaim" these from the male dominated medical sector [15,16]. People also began to criticize what they perceived as professionalization, fragmentation and specialization of health care institutions, and started to look for alternative ways of care that were holistic and allowed patients to participate in the decision making processes that concerned their treatment. This trend was in part complimented in the late 1960s by the emergence of the community development movement especially in Britain. The working class was disillusioned with the welfare state, and had to cope with increasing levels of poverty. The upper classes thence advocated for social programs to "reach further into the community." Self-help organizations sprung up among the working class unemployed and this lay the ground for alternative means of political expression among Labour Party supporters frustrated with local state functionaries. In the post Second World War period, racial tensions arose in Britain because of unmet needs among an increasing migrant population. The establishment of the Community Development Project by the British government was therefore catalysed by the need to resolve

these growing tensions, cut spiraling welfare costs while encouraging "community care" [17]. These and other related trends, encouraged and promoted the evolution of the current self-help movement in Europe, the US, and Japan in the 1970s. Initially, self-help groups in the health field were considered as dangerous and rife with charlatans. By the mid-1980s, the movement had gained wide recognition and acceptance; national and international networks of self-help groups were established, e.g. under the auspices of WHO Europe [15-19].

In the early 1980s, the idea of self-help was again claimed by politically opposing sides, this time in West Germany. When the government cut back expenditure for health and social services because of budgetary constraints, officials proposed that self-help in groups, within families and among neighbors, together with the work of unpaid volunteers, should compensate for the resulting reduction in services. They argued that this was in line with the widely accepted principle of subsidiarity (meaning that government should perform only tasks which cannot be performed effectively at a more peripheral, local level). There was even money set aside to support self-help groups financially. The alternative health movement perceived self-help groups as a way to empower patients and to reduce the influence of professionals and bureaucrats. It soon became evident that government assistance to self-help groups tended to reduce their autonomy and could not make up for the drop in quality of social services. From this perspective, an instrument of empowerment was being turned into a tool to trim down the welfare state and promote conservative politics [4].

Scope and limitations of self-help

Self-help groups have dealt with a broad range of health-related problems where practical problems and psychological sorrows of sufferers or their relatives need to be tackled [18]. Examples are cancer post-care; addiction (self or in family, e.g., AA); common conditions like hypertension or diabetes; rare diseases (e.g., Huntington's chorea); support and social advocacy for family members of psychiatric patients; etc. [15]. There is broad agreement, however, that self-help groups cannot replace existing professional health services, but complement them [20-22]. As Lock put it, "No self-help group has ever arisen to provide a service that was already obtainable through the medical system." [18] Another reason why self-help groups cannot replace existing health services is that they are not equally appropriate for all population strata. Many groups are run and attended largely by the white middle class in distant middle class suburbs [18]. Males, minorities, the aged, the working, and lower classes are underrepresented [10]. Overall, only 6–9% of potential participants actually engage in self-help activities [23]. Kropotkin argued that self-help is a universal principle in nature [14]; it should hence be practicable in all cultures. The Western self-help groups, however, developed in a particular social and historical context. Prerequisites for their popularity were a well-educated middle class who no longer wanted to trust the experts alone [17], and high-tech medicine [24]. Not all low- and middle-income countries possess these attributes. There are examples of successful transfer of the concept across cultures, however, e.g. to Japan [25]. Ultimately, it may be more relevant that self-help is appropriate only for a minority within a country or society [23,24].

Self-help groups cannot be steered from the outside (by politicians or health experts). Crucial for the functioning of a self-help group is that its members are simultaneously givers and receivers of help; and that the bureaucracy and professionalism prevalent in the usual human service organizations is absent. The chief reason for decline of self-help groups is an autocratic leadership style of founders and a bureaucratization that preclude membership participation. The natural history of self-help groups contains this risk: self-help groups tend to move from *Origin* via *Informal Organization*, *Emergence of Leadership* and *Formal Organization* to *Professionalization* [10] – which may ultimately lead to their demise. Governmental funding often accelerates this process, as there is a danger that self-help groups lose the necessary autonomy and self-determination and are appropriated and instrumentalized by state planning [17]. The same may happen when professionals try to influence self-help groups. While mutual respect and co-operation can be productive, competition for clients, status, and power may arise [10]. As early as 1980, Jones wondered whether the self-help movement will be "able to change aspects of modern medical practice or whether groups will allow themselves to be controlled, and submerged, by the professionals" [24]. On the other hand self-help, like many other volunteerisms, is often *ad-hoc* and unpredictable, and for that reason ultimately unsustainable.

Enthusiasm about the perceived success of self-help groups in the health field can be so infectious that it replaces a systematic outcome evaluation: self-help groups are said to "mobilize new resources to provide health care" [22]; they are "the most exciting and least recognized resource for improving public health" [5]; they are a "success story" and even the "accepted fourth column of health services" [19]. Collaboration with self-help groups is deemed one of the "essential future tasks of medical activity" for medical practitioners [20]. Such enthusiasm has been questioned by Badura *et al.* (2001). They point out that since self-help groups obtain substantial amounts of public funds, their effect on the social and physical wellbeing of members should be evaluated together with the cost effectiveness, this being an

approach that seems to cater for only a small percentage of those who need it [23]. Proponents of the self-help movement, however, largely reject attempts to make self-help "evidence-based", stressing instead the need to understand health in a holistic way.

Studies of the outcomes of participation in self-help groups are notoriously difficult, and evaluation has often been less than rigorous. For example, the report "Self-help and health in Europe" published by WHO Europe frequently alludes to "initial data" and results from "early pilot studies" [13]. When it comes to evaluation, Katz observed that many self-help groups resist the involvement of outside researchers because the members question the appropriateness of outcome criteria set by outsiders – especially so when empowerment is an important aim [10]. This attitude, however, leads to criticism. Oakley points out that various other social interventions have actually been tested in a methodologically convincing way in randomized controlled trials, and many have been found to be ineffective. She worries that some researchers abandoned randomized controlled trials when they found that new "treatments" were no better than old ones. They retreated to other methods of evaluation, allegedly to prove that their favored treatment works [26].

Even proponents of self-help groups who carried out evaluative studies in the 1980s conceded that the state of research on the benefits of self help groups "is still rather unsatisfactory" [21], a verdict that is being upheld 12 years later, in particular with respect to economic evaluation [23]. There are exceptions: within the German Cardiovascular Prevention Study, groups of community members developed and implemented preventive activities without a dedicated budget. As in the model described by Moeller (1983), local doctors provided encouragement and expertise on request, but did not organize or manage the activities [20]. This approach was evaluated in a quasi-experimental design and shown to contribute towards reducing the prevalence of cardiovascular risk factor levels [27]. In summary, it is widely believed that in industrialized countries self-help groups contribute to improving the health of, and providing care for, chronically ill and disabled people [Additional File 1]. But as a prescription for improving health outcomes and saving money, self-help groups cannot yet be considered "evidence-based".

Self-help in South Asia

The background

Organizations based on the Gandhian philosophy of self-reliance had already been popularized during the freedom movement in British India. In past years, self-help groups in South Asia have been formed as part of a developmental strategy with a primary focus on poverty alleviation and empowerment of women. As governments and civil society organizations of low- and middle income countries, especially those in South Asia, have taken up the concept of self-help, the agenda and to some extent the social base have become broader and even more ambitious than in industrialized countries. Not only are self-help groups supposed to contribute towards income generation of women members and thereby their empowerment. They have to also provide psycho-social support and information (prevention, promotion) to patients and their relatives as they do in industrialized countries [28,29]; and to perform some limited form of (curative and rehabilitative) primary health care. Finally, they are expected to improve financial accessibility to ensure sustainability of social services, thus, in effect, transforming and expanding self-help groups into economically oriented co-operatives [Additional File 1]. Efforts are also on to link such groups to people living with HIV/AIDS in Asia-Pacific countries such as India, Cambodia, Nepal and Malaysia [30].

In the following, we develop a typology of self-help groups in Bangladesh and India in order to derive some preliminary conclusions on the role of self-help groups and what they have so far achieved within the health system of low-income countries, relative to the experience in industrialized countries. We base this typology on 1) the origin of self-help – did it develop from within the community or was it an exogenous prescription? 2) the approach followed by the self-help groups vis-à-vis their purpose and targets, 3) the type of activities performed by the self-help groups in health, and 4) the sustainability of the groups.

Self-help under NGO sponsorship

The 1990s marked the arrival of Structural Adjustment and economic liberalization in India. Concurrently, the number of self-help groups linked with commercial banks increased from 255 in 1992–93 to 2700 in 1995 [31]. Around eighty-five percent of these groups were formed exclusively by women in production-oriented and income generation activities such as garment making, food processing, etc., and were following a *market-oriented approach* with a narrow economic focus. These self-help groups were organized with the help of outside agencies and the support of social, religious or political leadership and were seen as alternatives in rural development to break away from the traditional bureaucracy and top-down management [32]. A number of non-governmental organizations started self-help groups mainly as savings and credit groups without any emphasis on health. This was an alternative movement due to the failure or absence of a formal rural credit system [33]. The Grameen Bank of Bangladesh is one of the earliest such movements. In most of the above cases, women were the target group under an

approach to development, which advocated micro-enterprises in the context of rolling back of the state, the removal of welfare provision and dismantling of labour protection [34]. However, available evidence shows that such an approach has failed to make any significant impact on the incomes of poor women over a sustained period and did not lead to any reduction in the gender inequality [34].

The Self Employed Women's Association (SEWA) in Gujarat, India, is a combination of self-help groups and cooperatives of women workers in the informal sector. It followed a multi-faceted *empowerment approach*, wherein all economic activities of the groups were linked to health and social issues, as against the market-oriented approach [35]. However, there continue to be intensive material and managerial inputs from the apex association in the organization and maintenance of the groups and co-operatives. SEWA has identified and trained midwives and health workers from among the self-help groups. They serve as health educators-*cum*-barefoot doctors to all the women members of different groups and help the women's groups in forging linkages with the government and private health care providers for specific services and programs. The activities of these health workers include health promotion and preventive health care through health education, immunization, micro-nutrient supplementation, family planning, provision of rational drugs, and low-cost traditional medicine [35]. Subsequently, these health workers have formed their own co-operatives in a move towards achieving sustainability. The evidence from the SEWA experience is that the self-help approach as a community based insurance scheme can prevent impoverishment through protection against catastrophic health expenditure of poor households, given the financial viability and strong administrative and management capacity of the organization [36,37].

The Mahalir Association for Literacy, Awareness and Rights (MALAR) was established in the Kanyakumari District, Tamil Nadu, India, as a women's savings group with the purpose of mobilizing women belonging to the oppressed strata of the society through a structure independent of the government [31]. The MALAR experiment, which followed an *empowerment approach*, is an entirely self-reliant movement without any external funding, but facilitated by external actors. Like SEWA, it has an organizational structure similar to co-operatives, with self-help groups forming the basis. It is also running a health campaign, apart from trying to expand the activities to women's library movement, legal aid activities, etc. Several districts in other states of India have also started such initiatives.

Some leading non-governmental organizations in Bihar, which is one of the most backward states of India, have initiated self-help groups primarily for income generation activities. However, a substantial number of these groups have been experimenting with activities in health, mostly related to health campaigns and education [38]. Many of the groups have also been giving loans for medical treatment; the level of recovery however varies.

Leading NGOs in Bangladesh have tried a self-help approach for poverty alleviation by forming organizations of poor women [39]. The activities, apart from income and employment generation, included conscientization, raising awareness for gender equity, and human resource training.

A conference organized jointly by three Red Cross Societies, UNDP and a number of other organizations revealed the renewed interest in self-help, viewing it as a cost-effective and sustainable approach to social development, especially health [40]. The papers presented were based on the experience of about 40 NGOs working in Bangladesh. The NGOs considered the self-help approach largely as a tool for community management, especially for implementation of specific project-related activities. A *project approach* is evident in this conceptualization of self-help groups: Self-help is utilized as a method of facilitating community participation or as a way of enhancing sustainability of projects conceived and implemented by NGOs. Of special significance was that among the multitude of NGOs working in different sectors of the country, some reported facing problems in phasing-out their activities from the community. In these specific cases, for example in developing a village health committee with the aim of achieving self-reliance, self-help approach was used as a phase-out strategy so that the NGOs could withdraw after the termination of the project.

Sustainability of NGO-sponsored self-help

There is limited evidence regarding the sustainability of externally sponsored self-help groups especially after the withdrawal of the mother NGOs which originally started these groups. SEWA has been able to sustain its activities, largely because of the intensive inputs and support provided for the maintenance of the groups and due to the evolution of the self-help groups to a more institutionalized form similar to co-operatives. The experience from Bihar suggests that the ability of a self-help movement to become self-sustaining is rather limited, even with financial strength and in the absence of organizational weaknesses [38]. It is premature to comment on the sustainability of the MALAR experiment, which is still in an early stage. In Bangladesh, one local NGO withdrew from a primary health care project by using the Village Health Development Committees formed in the begin-

ning of the project as a self-help mechanism [40]. Although the consequences of the phasing out are not yet clear, it is stated that a phasing out is not impossible if the people are told about it in the beginning of a project. Another NGO promoted a self-reliance strategy because it had previously experienced a sudden withdrawal of donor support. The strategy adopted was the formation of health and management committees with the participation of people. The NGO reports that the task was difficult, as people believed that government and non-government organizations should provide health care free of cost [40]. In a third case, where health was a major component, a self-sustaining, payment-based card system for free services or a reduction of fees was introduced at the village health posts [40]. One of the significant limitations identified was the inability to sustain community interest when there were other priorities such as harvesting, or when disasters occurred, for example floods. When self-help is implemented in a project mode, the motivation of the project staff also becomes important. The project staff may have apprehensions about loosing their job if the self-help project becomes too successful. In yet another case, self-help was visualized as a community support system for specific problems like obstetric care [40]. The project tried to link the support system with the local government. Although it found that this approach would potentially increase the access to health care and health information, its sustainability could not be established.

Self-help under Government sponsorship

The Government of India has adopted the self-help approach and micro-finance programs as tools for women's empowerment, employment generation and for achieving production-oriented goals. This is part of the overall strategy within the new economic policies to redefine the role of the government [41-43]. A major initiative, sponsored by the Government and known as 'Kudumbashree' (Welfare of the Family), is underway in the State of Kerala. This new scheme, based on the mentioned national strategy, is a highly formal and institutionalized approach to self-help. Kudumbashree promotes income generation activities for poor women by organizing Neighborhood Groups (NHG), which will help them to earn higher incomes, thereby enabling them to achieve economic self-sufficiency. Several other state governments in India have also initiated employment programs for women (and even public-limited companies like Women's Development Corporations) based on the concept of self-help. It is hoped that by building community structures of women drawn from poverty-stricken families and by helping them to overcome poverty, social and economic empowerment can be achieved. The empowerment of women gets the central place in the conceptualization of Kudumbashree, although it is operationalized largely through a market-oriented strategy such as micro-enterprises, thrift and credit societies, informal banks, etc.

The health component of Kudumbashree is limited to creating awareness and facilitating access of members to health services [44,45]. Weekly meetings of group members are organized to discuss issues related to hygiene, mother and child care, nutrition, immunization, etc. A Community Health Volunteer who is selected from among the members performs convergence of various programs under the Health and Social Welfare Departments and helps the members, especially women, children and the aged, to access services.

A typology of self-help in South Asia

In Bangladesh and India, three broad scenarios regarding the structure of self-help groups involved in some form of health activities are discernible. The characteristics are given in [1]. In the two countries, characterized by a hierarchical social structure and a substantial proportion of poor, there is some degree of similarity in the origin of self-help groups: they have not evolved endogenously or as a spontaneous reaction to a common cause, but have been initiated externally. The health-oriented groups in India mainly target women for their programs, resembling the purely market-oriented self-help groups. The NGOs in Bangladesh, on the other hand, are not targeted on women alone. The groups in the two countries follow different approaches and have different emphasis on health issues, from awareness campaigns and health education to primary health care activities as in Bangladesh and the SEWA initiative. However, none of the groups are involved in provision of curative health care, and may not be able to do so considering their composition and focus (except supply of drugs, as in SEWA). The SEWA initiative is characterized by its well-developed organizational structure and intensive inputs, and probably these have helped it to sustain its activities.

Evidence regarding the viability and cost-effectiveness of the self-help approach in health care is limited, partially because of its recent origin. Even SEWA, which has been able to sustain its activities over a longer period, is not a convincing example of alternate community financing in health or provision of good quality clinical care. Moreover, the evidence from Bangladesh shows that self-help has only moderate success as a rollback or phase-out strategy. To some extent, however, self-help groups may be able to increase access to, and facilitate the utilization of existing health services [Additional File 1].

Successes of self-help in health care

Notable successful self-help groups in South Asia are those which are run under huge organisations like BRAC (Bangladeshi Rural Advancement Committee), SEWA,

and Grameen Bank. They have in one way or another engaged in health related activities ranging from health education programs for child care by BRAC to training "cum-barefoot doctors" by SEWA. Hadi argues that involvement in these activities resulted in health benefits for members of self-help groups and their families like improved child care, and increased contraceptive use [46,47]. Other authors have also described a reduction in domestic violence, increased health knowledge and better disease prevention by women belonging to self-help groups [48-51]. Empowerment of women who participate in self-help groups has also been described [52] but some authors are sceptical about the reported successes in terms of meaningful empowerment, and having an effect on existing social structures that determine gender relations and health [53,54]. We found no examples where the position of self-help group members has improved to such an extent that they were capable of taking major decisions at community level in terms of resource allocation, service provision, or influencing major policy changes in health.

It is important to highlight that the few success stories noted are in the context of large organizations that incorporate self-help activities as just one component. It is therefore hard to tease out the contribution of self-help independent of other concurrent activities or the organisational infrastructure. In addition, studies that tend to subscribe cause and effect relationships between membership in self-help groups and changes in health status or health behaviour have been criticised for not taking into account sources of bias like choice based sampling and self-selection into programs [55]. Thus, there is as yet no convincing evidence that in societies with unmet demand for regulated health care, self-help groups can become a "third option" to replace ailing government health services.

Discussion and conclusions

People in Europe and the US form self-help groups to fulfil a need that is not met by existing social and health services. Their aims are multiple and often divergent: to empower themselves; to participate in decision-making; to show concern and compassion for others in an increasingly individualistic society; and to feel being treated as a dignified person, often in response to a health care system that they perceive as high-tech but de-personalized. Given the number and nature of these objectives (which, moreover, may be related to health outcomes only indirectly), the cost-effectiveness of self-help groups has been difficult to evaluate. In consequence, their role in health care provision has not been promising. For proponents of self-help groups this is not a problem – they have always insisted that this approach can complement, but never replace, existing health services.

Throughout the history of self-help, there has been a tendency to "usurp" this concept and put it to use in the interest of a conservative political agenda. The social Darwinists of the 19th century envisioned a society based on the principle of "survival of the fittest". They demanded "no money for the unfit" and promoted self-help to ease the effect on the poor. In West Germany of the mid-1980s, self-help groups were instrumentalized under a revisionist interpretation of the principle of subsidiarity, again with the outspoken aim to reduce government expenditure, and in spite of missing evidence on cost-effectiveness. Attempts like these ignore that self-help does not come for free (neither for users, nor for the social and health sector), and that it is appropriate only for a small proportion of potential users. In some cases, as in Britain, self-help groups were formed by the women's movements, unemployed youth and migrants. Overall, the aged, the working, the lower classes, the minority groups are not reached, in other words, the very people that are left most in need when funding of government social and health services is reduced.

In the international health arena today, there are attempts to appropriate the concept of self-help over again. Self-help groups are being prescribed to alleviate the effects of a utilitarian approach to priority setting in the health sector of low-income countries that resulted in "rationing by exclusion" [56]. Again, it is being overlooked that self-help is not free of cost. Potential users may not be able to afford access to information, transport to reach meetings, the required infrastructure, and clearinghouses to facilitate the formation of new groups; etc. A successful self-help approach requires that lay people not only have access to, but also learn to digest, health-related information (books, journals, Internet, etc.) that informs their activities. In summary, self-help requires political acceptance and financial support. Not only politicians, but also health care professionals have to be compliant. Doctors and nurses need to be prepared to co-operate with clients on an equal basis. This means they need to be involved early on, and be fully convinced of the advantages of self-help approaches, rather than be forced to participate.

None of these prerequisites are met in South Asia to any appreciable degree. In India [57] and Bangladesh, like in many other low- and middle-income countries, vertical, hierarchical social structures prevail, creating an environment which is not very suitable for self-help groups. We found that a prescriptive, instrumental approach to self-help is dominant, both in the NGO and the government sector. Judging from experience in Europe, the utility of an approach in which professionals attempt to steer self-help groups from outside is very limited and unlikely to be sustainable, unless continuously supported by considerable financial and organizational inputs. Self-help groups

should be voluntary, have a convincing component of service quality assurance, involve doctors early on, and agree upon outcome measures (improved health? reduced cost? equity? empowerment?) to assess cost-effectiveness.

In order to function, self-help groups require a basic enabling environment such as a stable social structure and a functioning basic health care system offering a minimum standard of quality. The presence of these two factors is a prerequisite for self-help activities; they cannot be expected to develop as a consequence of self-help in health. Self-help groups can help to achieve some degree of synergy between health care providers and users when the prerequisites mentioned above are met. As long as this is not the case, however, the transfer of a concept that originated in Western, individualistic societies to a very different societal context will bring disappointing results. As a part of the existing neo-liberal agenda, it might further result in shifting the responsibility of health care from the State to the individual, which would have serious implications for equity and justice in health.

Competing interests
None declared.

Authors' contributions
KR and OR were involved in the conceptualisation, framework, review and writing of the text. CK contributed additional reviews, definitions, and towards developing research questions. OR handled the section on industrialized countries and, KR and CK handled the sections on low and middle-income countries. All the three were responsible for the section on discussion and conclusions

Additional material

Additional File 1
Comparison of the ideal self-help model in health to the evidence from industrialized and South-Asian countries
Click here for file
[http://www.biomedcentral.com/content/supplementary/1475-9276-3-1-S1.doc]

Additional File 2
Typology of self-help groups with a health orientation in Bangladesh and India
Click here for file
[http://www.biomedcentral.com/content/supplementary/1475-9276-3-1-S2.doc]

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Indian Public Health Standards (IPHS) for Community Health Centre

Draft Guidelines

Recommendations of the Task Group-III
headed by Dr. S.P. Agarwal, DGHS

Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India

Contents

Executive Summary

The Community Health Centres (CHCs) which constitute the secondary level of health care were designed to provide referral as well as specialist health care to the rural population. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

In order to provide *Quality Care in these CHCs* Indian Public Health Standards (IPHS) are being prescribed to provide optimal expert care to the community and achieve and maintain an acceptable standard of quality of care. These standards would help monitor and improve the functioning of the CHCs.

Service Delivery

- All "Assured Services" as envisaged in the CHC should be available, which includes routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes.
- Appropriate guidelines for each National Programme for management of routine and emergency cases are being provided to the CHC.
- All the support services to fulfil the above objectives will be strengthened at the CHC level.

Minimum Requirement for Delivery of the Above-mentioned Services

The following requirements are being projected based on an average bed occupancy of 60%. It would be a dynamic process in the sense that if the utilisation goes up, the standards would be further upgraded. As regards manpower, 2 specialists namely **Anaesthetist and Public Health Programme Manager will be provided on contractual basis in** addition to the available specialists namely Surgery Medicine, Obstetrics and Gynaecology and Paediatrics.

The support manpower will include a Public Health Nurse and ANM in addition to the existing staff. An Ophthalmic Assistant will also be need to be provided in centres where currently there is none.

Facilities

The equipment provided under the CSSM is deemed adequate. Physical infrastructure will be remodelled or rearranged to make best possible use for

The child should be given only breast milk from birth to six months

optimal utilisation. New constructions will follow the specifications provided in this document.

Drugs will be as per the list provided with the document. All the support services like laboratory, blood storage etc. will be strengthened.

Human Resource Management

Capacity Building will be ensured at all levels by periodic training of all cadres.

Accountability

It is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.

Every CHC shall have the Charter of Patients' Rights displayed prominently at the entrance. A grievance mechanism under the overall supervision of Rogi Kalyan Samitis would also be set up.

Quality of Services

Every CHC shall also have the Standard Operating Procedures and Standard Treatment Protocols for common ailments and the National Health Programmes.

Social audit by involvement of the community through Consumer Forum and Rogi Kalyan Samitis is being recommended. To maintain quality of services, external monitoring through Panchayati Raj Institutions and internal monitoring at appropriate intervals will be advocated. Guidelines are being provided for management of routine and emergency cases under the National Health Programmes so as to maintain uniformity in management in tune with the National Policy.

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Introduction

Health care delivery in India has been envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units(FRUs) and the district hospitals. The CHCs were designed to provide referral health care for cases from the primary level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80,000 population in tribal/hilly areas and 1, 20,000 population in plain areas. CHC is a 30-bedded hospital providing specialist care in Medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. These centres are however fulfilling the tasks entrusted to them only to a limited extent. The launch of the National Rural Health Mission (NRHM) gives us the opportunity to have a fresh look at their functioning.

NRHM envisages bringing up the CHC services to the level of Indian Public Health Standards. Although there are already existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundwell of demands for health services and the system needs to be geared to face the challenge. Not only does the system require upgradation to handle higher patient load, but emphasis also needs to be given to quality aspects to increase the level of patient satisfaction. In order to ensure quality of services, the Indian Public Health Standards are being set up for CHCs so as to provide a yardstick to measure the services being provided there. This document provides the requirements for a Minimum Functional Grade of a Community Health Centre.

Objectives of Indian Public Health Standards (IPHS) for CHCs

- To provide optimal expert care to the community
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the community

Service Delivery in CHCs

Every CHC has to provide the following services which can be known as the *Assured Services:*

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- Care of routine and emergency cases in surgery:
  - This includes incision and drainage, and surgery for Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, etc.
  - Handling of emergencies like Intestinal Obstruction, Haemorrhage, etc.
- Care of routine and emergency cases in medicine:
  - Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue, Haemorrhagic Fever, Cerebral Malaria, etc. Appropriate guidelines are already available under each programme, which should be compiled in a single manual.
- 24-hour delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions
- Full range of family planning services including Laproscopic Services
- Safe Abortion Services
- Newborn Care
- Routine and Emergency Care of sick children
- Other management including nasal packing, tracheostomy, foreign body removal etc.
- All the National Health Programmes (NHP) should be delivered through the CHCs. Integration with the existing programmes like blindness control, Integrated Disease Surveillance Project, is vital to provide comprehensive services. The requirements for the important NHPs are being annexed as separate guidelines with the document.
  - RNTCP: CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control. (Annexure 1)
  - HIV/AIDS Control Programme: The expected services at the CHC level are being provided with this document which may be suitably implemented. (Annexure 2)
  - National Vector–Borne Disease Control Programme: The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of Malaria, Filaria, Dengue, Japanese Encephalitis and Kala-azar in the respective endemic zones. (Annexure 3)
  - National Leprosy Eradication Programme: The minimum services that are to be available at the CHCs are for diagnosis and treatment of cases and reactions of Leprosy along with advice to patient on Prevention of Deformity. (Annexure 4)
  - National Programme for Control of Blindness: The eye care services that should be available at the CHC are diagnosis and treatment of common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisaged for every 5 lakh population. (Annexure 5)

Atleast three ante-natal checkup must for pregnant women

- Under Integrated Disease Surveillance Project, the related services include services for diagnosis for Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to District Surveillance Unit. In outbreak situations, appropriate action will be initiated. (Annexure 6)

- Others:
  - Blood Storage Facility
  - Essential Laboratory Services
  - Referral (transport) Services: (details given in Annexure 7)

Minimum Requirements in CHC

The following requirements are being projected based on the assumption that there will be average bed occupancy of 60%. The strength may be further increased if the occupancy increases with subsequent upgradation.

Certain suggestions for offsetting the deficiencies in the availability of required manpower:

- Anaesthetists:
  - Diploma and MD seats for post graduation in Anesthesia to be increased across the country. However, care should be taken to only include institutions with assured quality and able to provide adequate clinical training.
  - Certificate course for one year in Anesthesia by the National Board of Examinations

- Public Health Programme Manager:
  - Diploma and MD seats for post graduation in Public Health to be increased across the country. However, care should be taken to only include institutions with assured quality and able to provide adequate field and community-based training.
  - Persons with DNB degrees in Family Medicine, Hospital Administration, Public Health, Maternal and Child Health are to be recognised for the post.
  - Persons who have completed the Professional Development Course of 3 months with a 9-month field training in recognised training institute may also be eligible for the same. This may also be seen as a career advancement avenue for Medical Officers serving in PHCs who may be eligible for the post after a stint of 3-4 years in PHC and completion of this course.

Equipment

- The list of equipment provided under the CSSM may be referred to as they are deemed to be adequate for providing all services in the CHC. (Annexure 8). Before ordering new sets, the existing equipment should be properly assessed.
- For ophthalmic equipment wherever the services are available and equipment required under various National Health Programmes are given in respective annexure (1, 2, 4, 5, 6), and Blood Storage Facilities (Annexure-10). Cold chain equipment are supplied under Immunisation Programme.

The child should be given only breast milk from birth to six months

- Maintenance of equipment: It is estimated that 10-15% of the annual budget is necessary for maintenance.
- 2 refrigerators, one for the ward and one for OT should be available in the CHC. Sharing of refrigerator with the lab should be possible.
- Appropriate standards for equipments are already available in the Bureau of Indian Standards. If standards for any equipment are not available, technical specifications for the equipment may be prepared by the technical committee for the process of tendering and procurement.

Drugs

The list of essential drugs and emergency drugs are provided as annexure 9. Programme specific drugs are detailed in the guidelines under each programme.

Clinical Manpower

Personnel	Minimum requirement	Proposed	Desirable qualifications	Justification
General Surgeon	1	1	MS/DNB, (General Surgery)	
Physician	1	1	MD/DNB, (General Medicine)	
Obstetrician/ Gynaecologist	1	1	MD/DNB/DGO (OBG)	
Paediatrics	1	1	MD/DNB/DCh (Paediatrics)	
Anaesthetist	-	1	MD/DNB/DA(Anesthesia)/ Certificate course in Anaesthesia for one year	Essential if there is to be utilisation of the surgical specialities. They may be on contractual appointment or hiring of services from private sectors on case-to case basis.
Public Health Programme Manager. He/ she will be also designated as Block Surveillance Officer.	-	1	MD/DNB/DPH/Social science with public health background/any other recognised course	Will be responsible for surveillance, coordination of NHPs, management of ASHAs, training, etc. The appointment will be on contractual basis.
Eye surgeon	-	1	MD/MS/DOMS/DNB/ (Ophthal)	For every 5 lakh population as per Vision 2020 approved Plan of Action.
Total	4	6/7		

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Support Manpower

Personnel	Existing
*Nurse-midwife	7+2
Dresser (certified by Red Cross/St.Johns Ambulance)	1
Pharmacist/compounder	1
Lab. technician	1
Radiographer	1
**Ophthalmic Assistant	0-1
Ward boys/nursing orderly	2
Sweepers	3
Chowkidar	5***
OPD attendant	
Statistical assistant/Data entry operator	
OT attendant	
Registration clerk	
Total essential	21/22+2

* 1 ANM and 1 PHN for family welfare will be appointed under the ASHA scheme

** Ophthalmic assistant may be placed wherever it does not exist through redeployment or contract basis.

*** Flexibility may rest with the state for recruitment of personnel as per needs.

Investigative Facilities at the CHC

- In addition to the lab facilities in the CHC, ECG should be made available in the CHC with appropriate training to a nursing staff.

- All necessary reagents, glassware and facilities for collecting and transport of samples should be made available.

Physical Infrastructure

The CHC should have 30 indoor beds with one operation theatre, labour room, x-ray facility and laboratory facility. In order to provide these facilities, following are the guidelines:

- **Location of the Centre:** To the extent possible, the centre should be located at the centre of the block headquarter in order to improve access to the patients. This may be applicable only to centres that are to be newly established.

However, priority is to be given to operationalise the existing CHCs.

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The building should have areas/space marked for the following:

- **Entrance Zone**
  - Prominent display boards in local language providing information regarding the services available and the timings of the institute
  - Registration counters
  - Pharmacy for drug dispensing and storage
  - Clean public utilities separate for males and females
  - Suggestion/complaint boxes for the patients/visitors and also information regarding the person responsible for redressal of complaints.
- **Outpatient Department**
  - Clinics for various medical disciplines: These clinics include general medicine, general surgery, dental (optional), obstetric and gynaecology, paediatrics and family welfare. Separate cubicles for general medicine and surgery with separate area for internal examination (privacy) can be provided if there are no separate rooms for each. The cubicles for consultation and examination in all clinics should provide for doctor's table, chair, patient's stool, follower's seat, wash basin, examination couch and equipment for examination.
  - Room shall have, for the admission of light and air, one or more apertures, such as windows and fan lights, opening directly to the external air or into an open verandah. The windows should be in two opposite walls.
  - Family Welfare Clinic: The clinic should provide educative, preventive, diagnostic and curative facilities for maternal, child health, school health and health education. Importance of health education is being increasingly recognised as an effective tool of preventive treatment. People visiting hospital should be informed of environmental hygiene, clean habits, need for taking preventive measures against epidemics, family planning, etc. Treatment room in this clinic should act as operating room for IUCD insertion and investigation, etc. It should be in close proximity to Obstetric and Gynaecology OPD.
  - Waiting room for patients
  - The Drug Dispensary should be located in an area conveniently accessible from all clinics. The dispensary and compounding room should have two dispensing windows, compounding counters and shelves. The pattern of arranging the counters and shelves shall depend on the size of the room. The medicines which require cold storage and blood required for operations and emergencies should be kept in refrigerators.
  - Emergency Room/Casualty: The emergency cases may be attended by OPD during OPD hours and in inpatient units afterwards.

Atleast three ante-natal checkup must for pregnant women

- Treatment Room
  - Minor OT
  - Injection room and Dressing room
- Wards: Separate for Males and Females
  - Nursing station– The nursing station shall be centered such that it serves all the clinics from that place. The nursing station should be spacious enough to accommodate a medicine chest/a work counter for preparing dressings, medicines, sinks, dressing tables with screen in between and pedal operated bins to hold soiled material. It should have provision for:
    - Injections,
    - Dressings,
    - Examination and dressing table,
    - Bins for waste material,
    - Wash basins,
    - Syringe destroyer
    - Needle cutter
- **Patient Area:**
  - Enough space between beds
  - Toilets; separate for males and females
  - Separate space/room for patients needing isolation
- **Ancillary Rooms:**
  - Nurses rest room
- **There should be an area separating OPD and indoor facility**
- **Operation Theatre/Labour Room:**
  - Patient area:
    - Pre-operative and Post-operative(recovery)room
  - Staff area:
    - Changing room separate for males and females
  - Storage area for sterile supplies
  - OT/Labour room area:
    - Operating room/labour room
    - Scrub area
    - Instrument sterilisation area
    - Disposal area
- **Public Utilities: Separate for Males and Females**
- **Physical infrastructure for Support Services:**
  - CSSD:
    - Sterilisation and Sterile storage
  - Laundry:
    - Storage: Separate for dirty linen and clean linen
      Outsourcing is recommended after appropriate training of washer man regarding separate treatment for infected and non-infected linen.

- **Services:** Electricity/Telephones/Water/Civil Engineering: May be outsourced. Maintenance of proper sanitation in toilets and other public utilities should be given utmost attention. Sufficient funding for this purpose must be kept and the services may be outsourced.
  - **Water Supply :** Arrangements shall be made to supply 10,000 litres of potable water per day to meet all the requirements (including laundry) except fire fighting. Storage capacity for 2 days requirements should be on the basis of the above consumption. Round the clock water supply shall be made available to all wards and departments of the hospital. Separate reserve emergency overhead tank shall be provided for operation theatre. Necessary water storage overhead tanks with pumping/boosting arrangement shall be made. The laying and distribution of the water supply system shall be according to the provisions of IS: 2065-1983*. Cold and hot water supply piping should be run in concealed form embedded into wall with full precautions to avoid any seepage. Geyser in O.T./L.R. and one in ward also should be provided. Wherever feasible solar installations should be promoted.
  - **Emergency Lighting:** Emergency portable/fixed light units should also be provided in the wards and departments to serve as alternative source of light in case of power failure. Generator back-up should be available in all facilities. Generator should be of good capacity. Use of solar energy wherever feasible may be used.
  - **Telephone:** minimum two direct lines with intercom facility should be available.

- **Administrative Zone:** Separate rooms should be available for:
  - Office
  - Stores

Capacity Building

- Training of all cadres of worker at periodic intervals is an essential component.
- Multi-skill training for paramedical workers

The child should be given only breast milk from birth to six months

Quality Assurance in Service Delivery

- **Quality of service should be maintained at all levels.**
  Standard treatment protocol for all national programmes and locally common diseases should be made available at all CHCs. Standard Treatment Protocol: is the "Heart" of quality and cost of care. All the efforts that are being made to improve "hardware i.e. infrastructure" and "software i.e. human resources" are necessary but NOT sufficient. These need to be guided by standard treatment protocols. Some of the states have already prepared these guidelines.
- **Diet:** Diet may either be outsourced or adequate space for cooking should be provided in a separate space.
- **CSSD**
  - Adequate space and standard procedures for sterilisation and sterile storage should be available.
- **Laundry**
  - Storage: Separate for dirty linen and clean linen
  - Outsourcing is recommended after appropriate training of washerman regarding separate treatment for infected and non-infected linen.
- **Services:** Electricity/telephones/water/civil engineering: may be outsourced.
- **Blood Storage Units:** The GOI guidelines as given in Annexure may be referred to. (Annexure 10)
- **Waste Disposal:** As per National guidelines on hospital waste management as applicable to 30 bed CHCs (Annexure 11) or may be outsourced to agencies trained in this.
- **Charter of Patient Rights:** It is mandatory for every CHC to have the Charter of Patient Rights prominently displayed at the entrance.
  Details are provided in the Annexure 12.
- **Quality Control:**
  - Internal monitoring:
    - Social Audit: Through **Rogi Kalyan Samitis/Panchayati Raj Institution, etc.**
    - Medical audit
    - Others like technical audit, economic audit, disaster preparedness audit, etc.
    - Patient care: This shall include:
      - Access to patients
      - Registration and admission procedures
      - Examination
      - Information exchange

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- Treatment
- Other facilities: waiting, toilets, drinking water
- Indoor patients:
  - Linen/beds
  - Staying facilities for relatives
  - Diet and drinking water
  - Toilets

- **External Monitoring:**
  - Gradation by PRI (Zilla Parishad)/Rogi Kalyan Samitis

- **Monitoring of laboratory:**
  - Internal Quality Assessment Scheme
  - External Quality Assessment Scheme

Record Maintenance

Computers are to be used for accurate record maintenance.

- Suggested innovations:
  - Water harvesting should be introduced in all new buildings
  - Computerisation is a must and would be essential for record maintenance and surveillance.
  - To maintain the hospital landscaping, a room to store garden implements; seeds, etc, should be provided.

Based on the above minimum requirements, the standards need to be developed by a professional body.

Checklists

Checklist for minimum requirement of CHCs

Services	Existing	Remarks
Population covered		
Specialist services available		
Medicine		
Surgery		
OBG		
Paediatrics		
NHPs		
Emergency services		
Laboratory		
Blood storage		

Infrastructure (As per specifications)	**Existing**	**Remarks**
Area of the building		
OPD rooms/cubicles		
Waiting room for patients		
No. of beds: Male		
No. of beds: Female		
Operation theatre		
Labour room		
Laboratory		
X-ray room		
Blood storage		
Pharmacy		
Water supply		
Electricity		
Garden		
Transport facilities		

Atleast three ante-natal checkup must for pregnant women

Checklist for Equipment

Equipment (As per list)	Available	Functional	Remarks

Checklist for Drugs

Drugs (As per Essential Drug list)	Available	Remarks

Checklist for Audit

Particulars	Available	Whether functional as per norms
Patient's charter		
Rogi Kalyan Samiti		
Internal monitoring		
External monitoring		
Availability of SOPs/STPs*		

*Standard Operating Procedures/Standard Treatment Protocols

Annexures

Annexure 1

Requirements with regard to Revised National TB Control Programme for Indian Public Health Standards at CHC Level

Diagnostic Services

- A Microscopy Centre (MC) is established for 1, 00,000 population. For hilly, tribal and difficult areas MC is established for 50,000 populations. The Microscopy Centres are established at PHC, CHC or District Hospital.

- Inputs
  i. RNTCP has provided inputs to upgrade the infrastructure through minor civil works of the existing laboratories to be able to come up to the minimum standard required to carry out sputum microscopy. At present, about 87% of the country is covered under RNTCP and it is envisaged to cover the entire country by June 2005.
  ii. Manpower: Existing Laboratory Technicians (LTs) are provided training and they function as LTs to carry out sputum microscopy. For up to 20% of the requirements of the LTs at designated microscopy centres at the District level, LTs are provided by RNTCP on contractual basis.
  iii. Equipment: Binocular Microscopes are provided to the Microscopy Centres for sputum microscopy.
  iv. Laboratory Consumables: Funds are provided to the District TB Control societies for procurement and supply of all the consumables required to carry out sputum microscopy. The list of laboratory consumables required at MC is enclosed at Annexure-I.

Treatment Services

1. Medical Officers: All Medical Officers are trained in RNTCP to suspect chest symptomatics, refer them for sputum microscopy and be able to categories the patients and handle side effects of anti TB drugs.

2. DOTS Centres: All sub-centres, PHCs, CHCs and District Hospitals work as DOTS Centres. In addition, the community DOTS providers are also trained to deliver DOT. A room of the CHC is used to function as DOTS centre. Facilities for seating and making available drinking water to the patients for consumption of drugs are provided under the programme.

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3. DOTS Providers: The Multi Purpose Workers (MPWs), pharmacists and staff nurses are trained in to monitor consumption of anti TB drugs by the patients.

4. All the DOTS providers to deliver treatment as per treatment guidelines. All the doctors to categories patients as per treatment guidelines (refer Technical Guidelines).

5. Drugs in patient wise boxes and loose drugs are provided at DOT Centres through District TB Centre (DTC). Details of the drugs given at Annexure-II.

6. Recording and reporting to be done as per Operational Guidelines (refer Operational Guidelines).

Treatment of Complicated Cases

1. For patients who require admission (Pleural Effusion, Emphysema etc.) drugs are provided in the form of prolongation pouches through District TB Centre for indoor treatment.

2. The common complications of TB can be treated by the medical officers/ specialists at CHC and side effects of drugs can also be handled by the doctors at CHC.

Quality Assurance

1. Diagnosis: The diagnostic services are supervised by Senior TB Laboratory Supervisor (STLS) for all the microscopy centres at the sub-district level (5,00,000 population or 2, 50,000 population in the hilly, difficult and tribal areas).

2. Treatment: All major drugs procured at the Centre through World Bank recommended procedures and provided to the States, thereby assuring quality of the drugs.

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List of Anti-TB drugs procured under National TB Control Programme

Sl.No	Product code number	Product description	Strength	
1.	Product Code-I Treatment box for Cat-I patient	Treatment box for Cat.I patient. Each treatment box containing 24 combi-packs of Schedule-I in one pouch and 18 multi-blister calendar combi-pack of Schedule-2 in another pouch	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 II Tabs. of 300mg each 2 E Tabs of 600mg each 2 Z Tabs. of 750mg each	Each multi-blister calender combi-pack of Schedule-2 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 4 Pyrioxine Tabs of 5mg each
2.	Product Code-2 Treatment box for Cat-II patient	Treatment box for Cat.II patient. Each treatment box containing 36 combi-packs of Schedule-I in one pouch and 22 multi-blister calendar combi-pack of Schedule-3 in another pouch	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 II Tabs. of 300mg each 2 E Tabs of 600mg each 2 Z Tabs. of 750mg each	Each multi-blister calender combi-pack of Schedule-3 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 6 E Tabs of 600mg each 4 Pyrioxine Tabs of 5mg each
3.	Product Code-3 Treatment box for Cat-III patient	Treatment box for Cat.III patient. Each treatment box containing 24 combi-packs of Schedule-4 in one pouch and 18 multi-blister calendar combi-pack of Schedule-2 in another pouch	Each combi-pack of Schedule-4 containing 1 R Cap.of 450mg 2 H Tabs. of 300mg each 2 Z Tabs. of 750mg each	Each multi-blister calender combi-pack of Schedule-2 containing 3 R Caps.of 450 mg each 6 H Tabs. of 300mg each 4 Pyrioxine Tabs of 5mg each
4.	Product Code-4 Treatment box for prolongation of intensive phase of Cat-I &Cat. II	Treatment box for prolongation of intensive phase of Cat.I & Cat.II patient. Each box containing 5 pouches and each pouch containing 12 blister combi-pack of Schedule-1	Each combi-pack of Schedule-I containing 1 R Cap.of 450mg 2 H Tabs. of 300mg each 2 E Tabs of 600mg each 2 Z Tabs. of 750mg each	

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5.	Product Code-5	Loose packs of Streptomycin vials	Each vial of 750mg
6.	Product Code-6	Blister strips pack containing	10 Rifampicin Capsule of 150mg each
7.	Product Code-7	Blister strips pack containing	10 INH Tablet of 100mg
8.	Product Code-8	Blister strips pack containing	10 Pyrazinamide Tablets of 500mg
9.	Product Code-10	Blister strips pack or foil packs containing	10 E Tabs of 800mg each
10.	Product Code-11	Blister strips pack containing	10 H Tabs of 300mg each
11.	Product Code-12	Blister strips pack containing	10 Rifampicin Capsules of 450 mg each

R= Rifampicin; H= Isoniazid; E= Ethambutol; Z= Pyrazianamide; S.M= Inj. Streptomycin.

Atleast three ante-natal checkup must for pregnant women

Annexure 2

HIV Guidelines

At present the preventive and care interventions for the control of HIV/AIDS are being provided below district level through Integrated Health Care System using the available staff. There is also a provision of training of health care providers and generating awareness through intensive IEC campaign. The programme is being further strengthened by converging the activities under NACP with RCH programme, which is underway. The following activities are being proposed to be integrated at CHC level.

S. No.	Activities	Proposed
1.	RTI/STD management services	Expansion of services up to CHC & 24 hours PHC. Basic screening test for RTI?STD to be made available at the CHCs
2.	VCTC & youth information centres	Expansion of services up to CHCs in all States.
3.	Prevention of Parent-to-Child Transmission(PPTCT)	Services to be provided at all CHCs
4.	Behaviour Change Communication (BCC)	Joint communication strategy messages & medium development to be done
5.	Condom promotion	Joint condom procurement & distribution of condoms to meet the needs of sexually active women and men as a method of dual protection
6.	Blood safety	Blood storage centres planned at FRUs will procure blood from licensed blood banks but will be supported by RCH
7.	Trainings	A specific plan will be developed jointly by both the departments to train the peripheral staff at CHC
8	Management information system	All facilities to report service performance on RTI/STI, VCTC, PPTCT as a part of routine reporting
9.	Operationalisation	A convergence facilitator to be appointed to ensure coordinated inputs between the activities implemented by NACP and RCH

Annexure 3

National Vector Borne Disease Control Programme

The National Vector Borne Disease Control Programme (NVBDCP), erstwhile National Anti Malaria Programme (NAMP) is the country's most comprehensive and multi-faceted public health activity. Directorate of NVBDCP is the nodal agency for prevention and control of major vector borne diseases of public health importance namely Malaria, Filariasis, Japanese Encephalitis (JE), Kala-azar and Dengue.

Following are the strategy for control of these diseases:

a) Malaria:
- Early diagnosis and prompt treatment of Malaria cases
- Integrated vector control
- Early detection and containment of Malaria outbreak
- Information, Education and Communication (IEC) for personal protection and community involvement for Malaria control
- Training and Capacity Building of Medical and Para-medical workers
- Monitoring and evaluation of efficient Management Information System (MIS)

b) Dengue:
- Epidemiological surveillance of Dengue cases
- Entomological surveillance of *Aedes Aegypti* mosquitoes
- Clinical management of reported cases
- Control of mosquitoes through Integrated Vector Management including source reduction, use of larvivorous fishes, impregnated bednets and selective fogging with Pyrethrum
- Behaviour change communication to change behavior of the community about prevention of breeding of mosquitoes

c) Kala-azar:
- Early diagnosis & complete treatment through Primary Health Care System
- Interruption of transmission through vector control by undertaking residual insecticidal spraying in affected areas
- Health education and community participation

d) Japanese Encephalitis:
- Vector control by insecticidal spraying with appropriate insecticide for outbreak containment

The child should be given only breast milk from birth to six months

- Early diagnosis and prompt clinical management to reduce fatality
- Health education
- Training of medical personnel and professionals

e) Filariasis:
For elimination of Lymphatic Filariasis following are the strategies:
- Annual Mass Drug Administration (MDA) with single dose of DEC to all eligible population at risk of Lymphatic Filariasis
- Home-based management of Lymphodema cases and
- Hydroceloctomy

To provide the above services under NVBDCP the PHC Medical Officers are the in-charge of PHC. The diagnosis, treatment and examination are performed at CHCs as per the pattern of PHC. In addition, CHCs are the first referral units for treatment of severe and complicated Malaria cases. To provide following services, the CHCs should be equipped with the items as mentioned at Annexure:

1. Diagnosis of Malaria cases, microscopic confirmation and treatment.

2. Cases of suspected JE and Dengue to be provided symptomatic treatment, hospitalisation and case managements.

3. Complete treatment to Kala-azar cases in Kala-azar endemic areas.

4. Complete treatment of micro-Filaria positive cases with DEC and participation & arrangement of MDA along with preparedness of management of side reactions.

Standards:

The CHC medical officer should be well-trained in the control programme of the vector borne diseases and should carry out the following activities:-

a) He will, in consultation with District Malaria Officer and the community, select FTD/DDC holders and Voluntary Link Workers for his PRIMARY HEALTH CARE

b) He will refer all fever cases to Malaria laboratory for blood smear collection and examination before giving final prescription/medicines.

c) He will supervise all Malaria Clinics and PHC laboratory in his area, see the quality of blood smear collection, staining, efficiency microscopic examination and check whether the stain is filtered daily.

d) He will also ensure/supervise that all positive cases get radical; treatment within 48 hours of examination.

e) He will also ensure that sufficient stocks of Anti-Malarials including Quinine tablets and injectable Quinine and Artemisenine are available in CHC and also PHCs

f) He will ensure that Malaria laboratory is kept in proper condition along with microscope and other equipments.

g) He will provide referral services to severe cases of Malaria

h) He will refer severe and complicated cases to District Hospital in case of emergency and drug failure.

i) He will also ensure that Filaria cases are managed at CHC and the Hydrocele cases are operated.

1. Drugs

Chloroquine, Primaquine, Sulphadoxin Pyremethamine Combination, Artemisinine Derivatives, Quinine Injections, Quinine Tablets and 5% Dextrose saline and DEC tablets

2. Equipment

Microscope, Slides, Pricking Needles, Cotton, Stains, Staining Jars, Filter Paper, Glass Marking Pencil, Lint Cloth and Glasswares for preparation of stains and storage.

3. IEC Material

- Display material like posters, banners and permanent hoardings etc.
- Distribution material like handbills, pamphlets, booklets display cards etc.
- Training materials like guidelines on programme strategies, dose-schedule cards etc.

Annexure 4

National Leprosy Eradication Programme

Minimum services to be available at Community Health Centres (CHC) are:

- Diagnosis of Leprosy
- Treatment
- Management of reactions
- Advise to patient on POD Care

1. Leprosy Case Diagnosis

- Manpower required
  - Medical Officer trained in Leprosy diagnosis
  - Pharmacist to issue medicine and manage MDT Stock
  - Health Worker trained to maintain records/reports
- Methodology
  - By following Standard National Guidelines (Annexure-I).

2. Treatment of Cases

- CHC should have MDT Blister Packs {MB(A), MB(C), PB(A), PB(C)} atleast 3 months stock against patients under treatment.
- The CHC will classify and treat Leprosy which MDT as per National Guidelines

3. Management of Reaction Cases

- The CHC should have adequate stock of prednisolone tablets for management of reaction cases as per National Guidelines (Annexure-III).

4. Advise to Patient for Prevention of Deformity and Ulcer Care.

- CHC should have a Medical Officer, Pharmacist, Health Worker properly trained for providing counselling to the patients. (Annexure-IV)

Atleast three ante-natal checkup must for pregnant women

Leprosy Case Diagnosis

1 How to Diagnose Leprosy?

Signs of Leprosy

A Leprosy patient is someone who has a skin patch or patches with a definite loss of sensation and has not completed a full course of treatment with multi-drug therapy.

Leprosy Patches

Can be pale or reddish or copper-coloured, can be flat or raised, do not itch, usually do not hurt, lack sensation to heat, touch or pain, can appear anywhere.

Other signs of Leprosy include

Reddish or skin-coloured nodules or smooth, shiny diffuse thickening of the skin without a loss of sensation.

2. Which Signs is Not Leprosy?

Skin patches ....

- Present from birth (i.e. birth marks)
- Where there is normal feelings
- That itch
- That are white, black or dark red
- With scaling or skin
- That appear or disappear suddenly and spread fast

3. How to Examine a Patient for Leprosy?

- Examine the skin in daylight or in a well-lit room
- Examine the whole body, taking care to respect the patient's privacy
- Ask the patient if the patch itches. If so, it cannot be Leprosy
- Test only one or two skin patches for sensory loss
- If there is a definite loss of sensation, it is Leprosy
- Ask about treatment received in the past
- A person who has completed a full coursed of MDT very rarely needs further treatment
- Look for any visible disability of eyes, face, hands and feet
- When in doubt about the diagnosis, always send the patient to the nearest referral centre.

4. How to Test for Sensory Loss?

- Take a pointed object such as a pen
- Show the person what you are going to do.
- Lightly touch the skin with the pen

- Ask the person to point to where they felt the pen
- Now ask them to close their eyes so that they cannot see what you are doing
- Lightly touch the centre of the most prominent skin patch and ask them to point to where they felt the pen
- Repeat the procedure on normal skin and on the same patch again.
- If the person feels nothing on the skin patch, it is Leprosy. Start treatment immediately.

5. How to Classify Leprosy?

Leprosy is classified into Paucibacillary or Multibacillary Leprosy based on the number of patches.

> 1-5 patches?

- It is Paucibacillary (PB) Leprosy
- Treatment: 6 PB Blister Packs

> More than 5 patches?

- It is Multibacillary (MB) Leprosy
- Treatment: 12 MB Blister Packs

Treatment of Leprosy Cases

MDT Regimens

MDT supply in separate blister packs for MB (Adult), MB (Child), PB (Adult) & PB (Child). Each blister pack contains treatment for 4 weeks.

1. PB Adult Treatment:

Once a month: 1 Day

- 2 Capsules of Rifampicin (300 mg X 2)
- 1 Tablet of Dapsone (100 mg)

Once a day: Days 2-28

- 1 Tablet of Dapsone (100 mg)

2. MB Adult Treatment:

Once a month: 1 Day

- 2 Capsules of Rifampicin (300 mg X 2)
- 3 Capsules of Clofazimine (100 mg X 3)
- 1 Tablet of Dapsone (100 mg)

Once a day: Days 2-28

- 1 Capsule of Clofazimine (50 mg)
- 1 Tablet of Dapsone (100 mg)

The child should be given only breast milk from birth to six months

FULL COURSE: *12 MONTHS*

It is crucial that patients understand which drugs they have to take once a month and which every day.

3. PB Child Treatment (10-14 years):

Once a month: 1 Day

- 2 Capsules of Rifampicin (300 mg + 150 mg)
- 1 Tablet of Dapsone (50 mg)

Once a day: Days 2-28

- 1 Tablet of Dapsone (50 mg)

FULL COURSE: *6 Blister Packs*

For children younger than 10, the dose must be adjusted according to body weight.

4. MB Child Treatment (10-14 years):

Once a month: 1 Day

- 2 Capsules of Rifampicin (300 mg + 150 mg)
- 3 Capsules of Clofazimine (50 mg X 3)
- 1 Tablet of Dapsone (50 mg)

Once a day: Days 2-28

- 1 Capsule of Cllofazimine every other day (50 mg)
- 1 Tablet of Dapsone (50 mg)

FULL COURSE: *12 Blister Packs*

For children younger than 10, the dose must be adjusted according to body weight.

Information for the Patient-Counselling Points

About Leprosy .....

- They will be cured of Leprosy if they take the drugs in the blister packs as advised
- They must complete a full course of treatment : 6 blisters for PB patients and 12 blisters for MB patients
- The drugs stop the disease from spreading
- Patients can lead normal lives. They can live at home, go to school, work, and play, get married, have children, and participate in social events.

Opt for hospital delivery for safety of mother & baby

Their treatment .....

- The MDT blister packs are free of charge
- They should keep the blister packs in a dry, safe and shady place and out of the reach of children
- If the drugs are spoiled (changed colour, broken), the health worker will replace them

Possible problems.....

- The medicines will turn their urine red and their skin darker.
- Patients should not worry : both will return to normal once the treatment is completed
- They must go immediately to a health centre if they have any problems (pain, fever, malaise, new lesions, muscle weakness).
- They should return for a check-up after they complete their treatment
- If they already have disabilities, tell them how to protect themselves from injuries

Important points about MDT

Safety

- MDT is very safe and effective in curing Leprosy
- MDT is safe during pregnancy
- MDT is safe for patients being treated for Tuberculosis (TB) as well as those who are HIV-Positive
- Rifampicin is common to the treatment of Leprosy and TB and must be given in the doses required for TB

Treatment

- Give MDT free of charge to all Leprosy patients
- Help ensure that patients complete their treatment
- Give patients enough blister packs to last until their next visit
- Use accompanied MDT for all patients who find it difficult to visit the health centre regularly
- If a person cured of Leprosy presents new skin patches with definite loss of sensation, consider this as a case of relapse. Re-treat with appropriate MDT regimen

MDT Supplies

Do not use MDT blister packs

- beyond the expiry date
- if the drugs are damaged, or have changed colour, or if a capsule is broken
- keep MDT blister packs in a cupboard or a wooden box.

Health worker's advice & care is best for your family's welfare

If MDT blister-packs for children are not available, remove tablets from an adult pack of the appropriate dose.

Management of Reactions Cases

1. Leprosy Reactions

Patients can develop reactions, which are part of the natural course of the disease. Reactions are not a side effect of MDT. They are the body's response to Leprosy and do not mean that the disease is becoming worse or that the treatment is not working.

2. Managing Reactions

If a patient has any of these symptoms, he or she must go immediately to a health centre for treatment. Reactions require urgent treatment with special medicines as they can lead to irreversible deformities.

Give aspirin or paracetamol to reduce pain and fever. Advise the patients to rest as that is essential.

3. Dose of Prednisolone

Maximum Dose of Prednisolone is 1 mg per kg of body weight
If you have a course of corticosteriods

(e.g. prednisolone), please administer :

40 mg daily for weeks 1 and 2,

30 mg daily for weeks 3 and 4,

20 mg daily for weeks 5 and 6,

15 mg daily for weeks 7 and 8,

10 mg daily for weeks 9 and 10,

5 mg daily for weeks 11 and 12.

Atleast three ante-natal checkup

Prevention of Deformity and Ulcer Care Services

Simple measures to prevent disabilities

Patients with insensitive hands or feet injure themselves without noticing it. These wounds can get infected and over time, lead to irreversible deformities. The patients with insensitive hands or feet should be advised as below :

a) Inspect hand/feet daily looking for blisters, warm spots, red spots and tender areas.

b) Learn how to avoid injury

Hands

- Use protective implements like gloves, towels, long sticks
- Practice safe procedure while cooking
- Bandage tool handles with cloth to make them safer

Feet

- Walk slowly, avoid running
- Do not stand at one place for long time
- Do not walk long distances, rest in between
- Use protective footwear – MCR

c) If skin has become hard & dry, keep hands/feet soaked in water for 20 minutes. Apply oil over skin afterwards. Scrape off the callused skin.

d) Do not use finger nails to remove nasal concretions.

Annexure 5

National Programme for Control of Blindness

Services and Standards at Community Health Centres

(a) Eye Care Services

(i) Basic Services: Diagnosis and Treatment of Common Eye Diseases

(ii) Refraction Services

(iii) Surgical Services including Cataract Surgery (by IOL implantation) at selected places (one per 5 lakh population)

(b) Physical Structure for Eye Care at CHC

(i) Refraction Room

(ii) Eye OT with Eye Ward (number of beds dependent on workload)

(c) Equipment

For IOL Surgery

- Operating Microscope
- A-Scan Biometer
- Keratometer
- Slit Lamp
- Auto Refractometer
- Flash Autoclave
- Streak Retinoscope
- Tonometers (Schiotz)
- Direct Ophthalmoscope

For Primary Eye Care & Vision Testing

- Tonometers (Schiotz)
- Direct Ophthalmoscope
- Illuminated Vision Testing Drum
- Trial Lens Sets with Trial Frames
- Snellen & Near Vision Charts
- Battery Operated Torch (2)

Eye Ointments

- Atropine (1%)
- Local antibiotic: Framycetin/Gentamicin etc.
- Local antibiotic steroid ointment

The child should be given only breast milk from birth to six months

Ophthalmic Drops

- Xylocaine 4% (30ml)
- Local antibiotic: Framycetin/Gentamicin etc.
- Local antibiotic steroid drops
- Pilocarpine Nitrate 2%
- Timolol 0.5%
- Homatropine 2%
- Tropicamide 1%

Injections

- Xylocaine 2% (30 ml)
- Inj Hyalase (Hyaluronidase)
- Gentamycin
- Betamethasone/Dexamethasone
- Inj. Maracaine (0.5%) (For regoinal anesthesia)
- Inj. Adrenaline
- Ringer Lacate (540 ml) from reputed firm

Surgical Accessories

- Gauze
- Green shades
- Blades (Carbon Steel)
- Opsite surgical gauze (10x14 c.m.)
- Double needle suture (commodity asstt. GOI)
- Visco-elastics from reputed firm

(d) Human Resources

1. Eye surgeon (trained in IOL Surgery)
2. Ophthalmic assistant

Annexure 6

Integrated Disease Surveillance Project

Services and Standards at Community Health Centres

(a) Services relating to Disease Surveillance:

(i) Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level.

Existing peripheral laboratories at the PHC level are capable of handling microscopic examination of sputum and blood smears and are currently undertaking this activity under TB and Malaria Control Programmes. Typhoid can be diagnosed at the periphery using 'Typhi Dot' test, which can be performed easily and has established validity and reliability. Kits are available for detecting fecal contamination of water, which can be used at the periphery and these will be made available.

Disease	Test
Tuberculosis	Sputum AFB smear
Malaria	Blood smear for Malaria
Typhoid	Rapid diagnostic test (Typhi Dot)
Water Quality	Kit for chlorination test
Water Quality	Rapid test kit for fecal contamination

(ii) **Data Management:** CHC will function as Peripheral Surveillance Unit and coallate, analyse and report information to District Surveillance Unit. In out-break situations, appropriate action will also be initiated.

(b) Physical Structure for Laboratory at CHC

	Item	No. at CHC level
1	Marble/Stone Table Top for Platform	1
2	Wash-basins (Steel/Porcelain)	1
3	Water Tapes	1
4	Electric Fittings	As per requirement
5	Office Table	1
6	Office Chairs	3
7	Revolving Stools	2
8	Almirah (Steel/Wooden)	1
9	Wooden/Steel Racks	1

Health worker's advice & care is best for your family's welfare

(c) Laboratory Equipment

1. Binocular microscope with oil immersion
2. Lancet
3. Ice box
4. Stool transport carrier
5. Test tube rack
6. Table top centrifuge
7. Refrigerator
8. Spirit lamp
9. Smear transporting box
10. Sterile leak proof containers

(d) Laboratory Supplies

1. Clean slides
2. Slide markers
3. Gloves
6. Transport medium (Cary Blair)
7. Sterile test tubes
8. Plastic vials
9. Sterile cotton wool swabs
10. Rapid diagnostic kit Typhoid
11. Rapid test kit for faecal contamination
12. Blood culture bottles with broth
13. Zeil Neelsen acid fast stain
14. Aluminium foil
15. Cotton
16. Sealing material
17. Extra plastic vials for transportation of serum

(e) Human Resources: Personnel trained in Disease Surveillance

1. Medical officer
2. Laboratory technician

Medical Record Keeper/Data Entry Operator

Atleast three ante-natal checkup must for pregnant women

Annexure 7

Round the clock functional ambulance/rural transportation – Haryana model

1. An advertisement is placed in local newspaper for leasing of ambulance by the CMO office.
2. Preference is given to Ex-Army Defence/Services personnel.
3. Ambulance is given to the driver by the CMO office. No guarantee is required.
4. Charges of transportation are fixed at Rs. 5/km.
5. Driver is on a contract basis
6. Driver is required to deposit 50 paise/km in CMO office a monthly basis. This money is kept for major repair.
7. Driver gets Rs. 4.50/km. This would cover petrol, salary and minor repairs.
8. Driver owns the ambulance after 5 years.

Complete and correct knowledge protects you from AIDS

Annexure 8

Equipment

Standard Surgical Set - I (Instruments) FRU

1 Tray, instrument/dressing with cover, 310 x 200 x 600 mm-ss 1	1
2 Gloves surgeon, latex sterilisable, size 6 12	12
3 Gloves surgeon, latex sterilisable, 6-1/2 12	12
4 Gloves surgeon, latex sterilisable, size 7 12	12
5 Gloves surgeon, latex sterilisable, 7-1/2 12	12
6 Gloves surgeon, latex sterilisable, 8 12	12
7 Forceps, backhaus towel, 130 mm 4	4
8 Forceps, sponge holding, 228 mm 6	6
9 Forceps, artery, pean straight, 160 mm, stainless steel 4	4
10 Forceps hysterectomy, curved, 22.5 mm 4	4
11 Forceps, hemostatic, halsteads mosquito, straight, 125 mm-ss 6	6
12 Forceps, tissue, all/is 6x7 teeth, straight, 200 mm-ss 6	6
13 Forceps, uterine, tenaculum, 280 mm, stainless steel 1	1
14 Needle holder, mayo, straight, narrow jaw, 175 mm, ss 1	1
15 Knife-handle surgical for minor surgery # 3 1	1
16 Knife-handle surgical for major surgery # 4 1	1
17 Knife-blade surgical, size 11, for minor surgery, pkt of 5 3	3
18 Knife-blade surgical, size 15 for minor surgery, pkt of 5 4	4
19 Knife blade surgical, size 22, for major surgery, pkt of 5 3	3
20 Needles, suture triangular point, 7.3 cm, pkt of 6 2	2
21 Needles, suture, round bodied, 3/8 circle No. 12 pkt of 6 2	2
22 Retractor, abdominal, Deavers, size 3, 2.5 cm x 22.5 cm 1	1
23 Retactor, double-ended abdominal, Beltouis, set of 2 2	2
24 Scissors, operating curved mayo-blunt pointed 170mm 1	1
25 Retractor abdominal, Balfour 3 blade self-retaining 1	1
26 Scissors, operating, straight, blunt point, 170 mm 1	1
27 Scissors, gauze, straight, 230 mm, stainless steel 1	1
28 Suction tube, 225 mm, size 23 F 1	1
29 Clamp intestinal, Doyen, curved, 225 mm, stainless steel 2	2
30 Clamp intestinal, Doyen straight, 225 mm, stainless steel 2	2
31 Forceps, tissue spring type, 160 mm, stainless steel 2	2
32 Forceps , tissue spring type, 250 mm, stainless steel. 1	1

The child should be given only breast milk from birth to six months

Standard Surgical Set - II

1. Forceps, tissue, 6 x 7 teeth, Thomas-Allis, 200 mm- ss 1	1
2. Forceps, backhaus towel, 130 mm, stainless steel 4	4
3. Syringe, anaesthetic (control), 10 ml, luer-glass 1	1
4. Syringe, hypodermic, 10 ml glass, spare for item 3 4	4
5. Needles, hypodermic 20G x 1-1/2" box of 12 1	1
6. Forceps, tissue, spring type, 145 mm, stainless steel 1	1
7. Forceps, tissue spring type 1 x 2 teeth, Semkins, 250 mm 1	1
8. Forceps, tissue spring type, 250 mm, stainless steel 1	1
9. Forceps, hemostat curved mosquito halsteads, 130 mm 6	6
10. Forceps, artery, straight pean, 160 mm, stainless steel 3	3
11. Forceps artery, curved pean, 200 mm, stainless steel 1	1
12. Forceps, tissue, Babcock, 195 mm, stainless steel 2	2
13. Knife handle for minor surgery No. 3 1	1
14. Knife blade for minor surgery No. 10, pkt of 5 8	8
15. Needle holder, straight narrow-jaw Mayo–Heger, 175 mm 1	1
16. Needle suture straight, 5.5 mm, triangular point, pkt of 6 2	2
17. Needle, Mayo, ½ circle, taper point, size 6, pkt of 6 2	2
18. Catheter urethral Nelaton solid-tip one-eye 14 Fr 1	1
19. Catheter urethral Nelaton solid-tip one-eye 16 Fr 1	1
20. Catheter urethral Nelaton solid-tip one-eye 18 Fr 1	1
21. Forceps uterine tenaculum duplay dbl-cvd, 280 mm 1	1
22. Uterine elevator (Ranathlood), stainless steel 1	1
23. Hook, obstetric, Smellie, stainless steel 1	1
24. Proctoscope Mcevedy complete with case 1	1
25. Bowl, sponge, 600 ml, stainless steel 1	1
26. Retractor abdominal Richardson-Eastman, dbl-ended, set 2 1	1
27. Retractor abdominal Deaver, 25 mm x 3 cm, stainless steel 1	1
28. Speculum vaginal bi-valve graves, medium, stainless steel 1	1
29. Scissors ligature, spencer straight, 130 mm, stainless steel	1
30. Scissors operating straight, 140 mm, blunt/blunt ss 1	1
31. Scissors operating curved, 170 mm, blunt/blunt ss 2	2
32. Tray instrument curved, 225 x 125 x 50 mm, stainless steel 1	1
33. Battery cells for item 24 2	2

IUD Insertion Kit

1. Setal sterilisation tray with cover size 300 x 220 x 70 mm, S/S, Ref IS: 3993 1	1
2. Gloves surgeon, latex, size 6-1/2 Ref. 4148 6	6
3. Gloves surgeon latex, size 7-1/2 Ref. 4148 6	6
4. Bowl, metal sponge, 600 ml, Ref. IS: 5782 1	1

Opt for hospital delivery for

5. Speculum vaginal bi-valve cusco's graves small ss 1	1
6. Forceps sponge holding, straight 228 MMH Semken 200 mm 1	1
7. Sound uterine simpson, 300 mm graduated UB 20 mm 1	1
8. Forceps uterine tenaculum duplay DBL-CVD, 280 mm 1	1
9. Forceps tissue - 160 mm 1	1
10. Anterior vaginal wall retractor stainless 1	1
11. Torch without batteries 1	1
12. Gloves surgeon, latex, size 7, Ref: 4148 6	6
13. Gloves surgeon, latex size 6 Ref. IS: 4148 6	6
14. Battery dry cell 1.5 V 'D' Type for Item 7G 1	1
15. Speculum vaginal bi-valve cusco's/Grea Ves Medium ss 1	1
16. Forceps artery, straight, Pean, 160 mm 1	1
17. Scissors operating, straight, 145 mm, Blunt/Blunt 1	1
18. Forceps uterine vulsellum curved, Museux, 240 mm 1	1
19. Speculum vaginal double-ended sime size #3 1	1

CHC Standard Surgical Set - III

Tray, instrument/dressing with cover, 310 x 195 x 63 mm 1	1
Forceps, backhaus towel, 130 mm, stainless steel 4	4
Forceps, hemostat, straight, Kelly, 140 mm, stainless steel 4	4
Forceps, hemostat, curved, Kelly, 125mm, stainless steel 2	2
Forceps, tissue Allis, 150 mm, stainless steel, 4 x 5 teeth 2	2
Knife handle for minor surgery No. 3 1	1
Knife blade for minor surgery, size 11, pkt of 5 10	10
Needle hypodermic, Luer 22G x 11/4", box of 12 1	1
Needle hypodermic, Luer 250G x 3/4", box of 12 1	1
Needle, suture straight 5.5 cm, triangular point, pkt of 6 2	2
Needle, suture, Mayo ½ circle, taper point No. 6, pkt of 6 2	2
Scissors, ligature, angled on flat, 140 mm, stainless steel 1	1
Syringe anaesthetic control, Luer - 5 ml, glass 4	4
Syringe 5 ml, spare for item 13 4	4
Steriliser, instrument 200 x 100 x 60 mm with burner ss 1	1
Syringe, hypodermic, Luer 5 ml, glass 4	4
Forceps, steriliser, Cheatle, 265 mm, stainless steel 1	1

Normal Delivery Kit

Trolley, dressing carriage size 76C, long x 46 cm wide and 84 cm high. Ref. IS 4769/1968 1	1
Towel, trolley 84 cm x 54 cm 2	2
Gown, operation, cotton 1	1
Cap, operation, surgeon's 36 x 46 cm 2	2

Health worker's advice & care is best for your family's welfare

Gauze absorbent non-sterile 200 mm x 6 m as per IS: 171/1985 2	2
Tray instrument with cover 450 mm (L) x 300 mm (W) x 80 mm (H) 1	1
Macintosh, operation, plastic 2	2
Mask, face, surgeon's cap of rear ties: B) Beret type with elastic hem 2	2
Towel, glove 3	3
Cotton wool absorbent non-sterilise 500G 2	2
Drum, sterilising cylindrical-275 mm Dia x 132 mm, ss as per IS: 3831/1979 2	2
Table instrument adjustable type with tray ss 1	1

Standard Surgical Set - IV

Vaccum extractor, Malastrom 1	1
Forceps obstetric, Wrigley's, 280 mm, stainless steel 1	1
Forceps, obstetric, Barnes-Neville, with traction, 390mm 1	1
Forceps, sponge holding, straight 228 mm, stainless steel 4	4
Forceps, artery, Spencer-Wells, straight, 180mm-ss 2	2
Forceps, artery, Spencer-Wells, straight, 140mm-ss 2	2
Holder, needle straight, Mayo-Hegar, 175 mm-ss 1	1
Scissors, ligature, Spencer, 130 mm, stainless steel 1	1
Scissors, episiotomy, angular, Braun, 145 mm, stainless steel 1	1
Forceps, tissue, spring-type, 1 x 2 teeth, 160 mm-ss 1	1
Forceps, tissue, spring-type, serrated ups, 160mm-ss 1	1
Catheter, urethral, rubber, Foley's 14 ER 1	1
Catheter, urethral, Nelaton, set of five (Fr 12-20) rubber 1	1
Forceps, backhaus towel -130 mm-ss 4	4
Speculum, vaginal, Sim's, double-ended # 3-ss 1	1
Speculum, vaginal, Hamilton-Bailey 1	1

Standard Surgical Set - V

Forceps, obstetric, Neville-Barnes, W/traction 390 mm 1	1
Hook, decapitation, Braun, 300 mm, stainless steel 1	1
Hook, crochet, obstetric 300 mm, Smellie, stainless steel 1	1
Bone, forceps, Mesnard 280 mm, stainless steel 4	4
Perforator, Smellie, 250 mm, stainless steel 1	1
Forceps, cranial, Gouss, straight, 295 mm-ss 1	1
Cranioclast, Braun, stainless steel, 365 mm long 1	1
Scissors ligature Spencer 130 mm, stainless steel 1	1
Forceps sponge holding, 22.5 cm straight – ss 1	1
Forceps, tissue, spring-type, 1 x 2 teeth, 160 mm, stainless steel 1	1
Forceps, tissue, spring-type, serrated tips, 160 mm-ss 1	1
Forceps, artery, Spencer–Wells, straight, 180 mm-ss 2	2
Forceps, artery, Spencer-Wells, straight, 140 mm-ss 2	2
Forceps, scalp flap, Willet's 190 mm –ss 4	4

Atleast three ante-natal checkup

must for p

Forceps, Vulsellum, duplay double curved, 280 mm-ss 4	4
Forceps, Vulsellum, duplay double curved, 240 mm-ss 1	1
Catheter, urethral, 14 Fr. solid tip, one eye, soft rubber 3	3
Holder, needle, Mayo-Hegar, narrow jaw, straight, 175 mm-ss 1	1
Speculum vaginal bi-valve, Cusco-medium, stainless steel 1	1
Speculum, vaginal sim's double-ended, size # 3-ss 1	1
Forceps, backhaus towel, 130 mm, stainless steel 4	4

Standard Surgical Set - VI

Forceps, sponge holding, straight, 225 mm, stainless steel 4	4
Speculum, vaginal, Sim's double-ended size # 3 - ss 1	1
Speculum, vaginal, weighted Auvard, 38 x 75 mm blade - ss 1	1
Forceps, tenaculum, Teale's, 230 mm-ss x 3 x 4 2	3x42
Sound, uterine, Simpson, 300 mm with 200 mm graduations 1	1
Dilator, uterine, double - ended hegar, set of 5 - ss 1	1
Curette, uterine, sim's blunt, 26 cm x 11 mm size # 4-ss 2	2
Curette, uterine, sim's sharp, 26 cm x 9 mm size # 3-ss 2	2
Forceps, artery, Spencer-Well's straight, 140 mm-ss 1	1
Forceps, tissue, spring-type, serrated tips, 160 mm-ss 1	1
Forceps, ovum, Krantz, 290 mm, stainless steel 1	1

Equipment for Anaesthesia

Facemask, plastic w/rubber cushion & headstrap, set of 4 4	4
Airway Guedel or Berman, autoclavable rubber, set of 6 2	2
Laryngoscope, set with infant, child, adolescent blades 3	3
Catheter, endotracheal w/cuff, rubber set of 4 3	3
Catheter, urethral, stainless steel, set of 8 in case 2	2
Forceps, catheter, Magill, adult and child sizes, set of 2 1	1
Connectors, catheter, straight/curved, 3, 4, 5 mm (set of 6) 3	3
Cuffs for endotracheal catheters, spare for item 4 4	4
Breathing tubes, hoses, connectors for item 1, anti-static 4	4
Valve, inhaler, chrome-plated brass, Y-shape 3	3
Bag, breathing, self inflating, anti-static rubber, set of 4 2	2
Vaporiser, halothane, dial setting 2	2
Vaporiser, ether or methoxyflurane, wick type 2	2
Intravenous set in box 6	6
Needle, spinal, stainless set of 4 2	2
Syringe, anesthetic, control 5ml Luer mount glass 2	2
Cells for item 3 2	2

Equipment for Neo-natal Resuscitation

Catheter, mucus, rubber, open ended tip, size 14FR 2	2
Catheter, nasal, rubber, open tip, funnel end, size 8Fr 2	2
Catheter, endotracheal, open tip, funnel end rubber, 12Fr 3	3
Stilette, curved, for stiffening tracheal catheter SS 1	1
Catheter, suction, rubber, size 8Fr 3	3
Laryngoscope, infant, w/three blades and spare bulbs. 1	1
Lateral mask, with ventillatory bag, infant size 2	2
Resuscitator, automatic, basinet type 1	1
Lamp, ultra-violet (heat source) with floor stand 1	1
Cells for item 6 (Laryngoscope) 2	2

Materials Kit for Blood Transfusion

Bovine albumin 20% testing agent, box of 10 x 5 ml vials 5	5
Centrifuge, angle head for 6 x 15 ml tubes, 240 volt 1	1
Bath, water, serological, with racks, cover, thermostate, 240 v 1	1
Pipette, volumetric, set of six 1 ml/2 ml/3 ml/5 ml/10 ml/20 ml 1	1
Test-tube without rim 75 x 12 mm HRG 12	12
Test-tube without rim 150 x 16 mm, HRG 12	12
Cuff, sphygmomanometer, set of two sizes – Child/Adult 1	1
Needle, blood collection disposable, 17G x 1-1/3 box of 100 1	1
Ball, donor squeeze, rubber, dia, 60 mm 1	1
Forceps, artery, Spencer-Wells, straight 140 mm, stainless steel 1	1
Scissors, operating, straight 140 mm, blunt/jpoints, ss 1	1
CPDA anti-coagulent, pilot bottle 350 ml for collection 20	20
Microscope, binocular, inclined, 10 x 40 x 100 x magnificant 1	1
Illuminator for item 14 (microscope) 1	1
Slides, microscope, plain 25 x 75 mm, clinical, box of 100 1	1

Equipment for Operation Theatre

Diathermy machine

Dressing drum all sizes,

Lamps shadowless:

a) ceiling lamp

b) portable type

Steriliser

Suction apparatus

Stand with wheel for single basin

Table operation, hydraulic:

a) Major

b) Minor

Trolley for patients
Trolley for instruments
X-ray view box
Wheel chairs

Equipment for Labour Room

Aprons rubber
Cradles baby
Wheel chair,
Cabinet, Instrument
Dressing drum
Shadowless lamps

Table for

a) Obstetric labour
b) Examination

Trolley for

a) Patients
b) Dressing

Torch (flash light)
Trays
Vacuum extractor
Weighing machine baby
Wheel chairs

Equipment for Radiology

Aprons lead rubber
Diagnostic X-ray Unit 200/300mA with automatic device
Dark room accessories
Dark room timer
Film clips
Lead sheets
X-ray view box
Xray protection screen
X-ray film processing tank

EQUIPMENTS under National Health Programmes (as listed under each NHP), Cold storage facility under Immunisation Programme and Blood Storage equipment as at annexure- 10.

Annexure 9

List of Essential Drugs for CHC

	Name of the Drug	Route of administration/dosage form	Strength
1	Oxygen	Inhalation	
2	Lignocaine Hydrochloride	Topical Forms	2-5%
		Injection	1-2%
3	Diazepam	Tablets	2 mg, 5 mg, 10 mg
		Injection	5 mg/ml
4	Acetyl Salicylic Acid	Tablets	75mg, 100 mg 300 mg 350 mg
5	Ibuprofen	Tablets	200 mg, 400 mg
6	Paracetamol	Injection	150 mg/ml
		Syrup	125 mg/5ml
		Tablets	500 mg
7	Pentazocine Lactate	injection	30 mg/ml
8	Chloroquine Phosphate	Tablets	150 mg
		Injection	40 mg/ml
		Syrup	50 ml/5 ml
9	Adrenaline bititrate	Injection	1mg/ml
10	Chlorpheniramine Maleate	Tablets	4 mg
11	Prednisolone	Tablets	5 mg, 10 mg
12	Promethazine HCL	Tablet/syrup	
13	Phenobarbitone	Tablets	30 mg. 60 mg
		Injection	200 mg/ml
14	Phenytoin Sodium	Capsules or Tablets	50 mg,100 mg
		Syrup	25 mg/ml
15	Albendazole	Tablets	400 mg
		Suspension	200 mg/5 ml
16	Amoxicillin Powder	For suspension	125 mg/5 ml
		Capsules	250 mg 500 mg
17	Ciprofloxacin Hydrochloride	Tablets	250 mg,500 mg
18	Co-Trimoxazole	Tablets	40 + 200 mg 80 + 400 mg
		Suspension	40 +200 mg/5 ml
19	Norfloxacine	Tablet	400 mg

Health worker's advice & care is best for your family's welfare

20	Doxycycline	Capsules	100 mg
21	Metronidazole	Tablets	200 mg,400 mg
22	Clotrimazole	Pessaries	100 mg, 200 mg
		Gel	2%
23	Sulfadoxine + Pyrimethamine	Tablets	500 mg +25 mg
24	Ferrous Salt	Tablets	60 mg
		Oral Solution	25 mg
25	Folic Acid	Tablets	1 mg, 5 mg
26	Isosorbide Mononitrate/Dinitrate	Tablets	10 mg, 20 mg
27	Amlodipine	Tablets	2.5 mg, 5 mg,10 mg
28	Digoxin	Tablets	0.25 mg
		Injection	0.25 mg/ml
		Elixir	0.05 mg/ml
29	Benzoic Acid + Salicylic Acid	Ointment or Cream	6% + 3%
30	Miconazole	Ointment or Cream	2%
31	Neomycin + Bacitracin	Ointment	5 mg + 500 IU
32	Silver Sulphadiazine	Cream	1%
33	Benzyl Benzoate	Lotion	25%
34	Acriflavin + Glycerin	Solution	
35	Gentian Violet	Paint	0.5%, 1%
36	Hydrogen Peroxide	Solution	6%
37	Povidone Iodine	Solution	5%, 10%
38	Bleaching Powder	Powder	
39	Potassium Permanganate	Crystals for Solution	
40	Furosemide	Injection,	10 mg/ml,
		Tablets	40 mg
41	Aluminium Hydroxide + Magnesium Hydroxide	Tablet	
		Suspension	
42	Domperidone	Tablets	10 mg
		Syrup	1 mg/ml
43	Local Anaesthetic,Astringent and Antiinflammatory Medicine	Ointment/Suppository	
44	Dicyclomine Hydrochloride	Tablets	10 mg
		Injection	10 mg/ml
45	Oral Rehydration Salts	Powder for Solution	As per IP
46	Dexamithasone sodium	injection	4 mg/ml
47	Ciprofloxacin Hydrochloride	Drops/Ointment	0.3%
48	Tetracycline Hydrochloride	Ointment	1%
49	Alprozolam	Tab	0.25 mg

Atleast three ante-natal checkup must for pregnant women

50	Salbutamol Sulphate	Tablets	2 mg, 4 mg
		Syrup	2 mg/5 ml
		Inhalation	100 mg/dose
51	Etophyline Anhydrous	Injection	84.7 mg/ml
52	Glucose	Injection	5% isotonic
			50% hypertonic
53	Glucose with Sodium Chloride	Injection	5% + 0.9%
54	Normal Saline	Injection	0.9%
55	Ringer Lactate	Injection	
56	Plasma Volume Expander	Injection	
57	Water for Injection	Injection	2 ml, 5 ml,10 ml
58	Ascorbic Acid	Tablets	100 mg, 500 mg
59	Calcium Salts	Tablets	250 mg, 500 mg
60	Multivitamins(As per Schedule V)	Tablets	
61	Atenlol	Tablets	50 mg
62	Floxitin	Tablets	20 mg
63	Amitryptiline Hcl	Tablets	25 mg
64	Bisacodyl	Tablets	05 mg
65	General Anaesthetic Drugs		
67	Tinidazole	Tablets	
68	Daonil	Tablets	
69	Haloperidol	Tablets	
70	Sulpacetamide Eye Drops		

Other Injections:

S. No.	Injections
1.	Cryst. Penicillin
2.	Inj.Procaine Penicillin
3.	Inj.Benzathine Penicillin (1.2)
4.	Inj. Phenytoin Sodium 50mg/ml
5	Inj. Ampicillin
6	Inj. Gentamicin
7	Inj. Soda Bicarb
8	Inj. Calcium Gluconate
9	Inj. KCI
10	Inj. Atropine
11	Inj. Hyoscine N-butyl Bromide
12	Inj. Hydrocortisone
13	Inj. Syntocinon (synthetic oxytocin)
14	Inj. Methyl Ergometrine Maleate

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15	Inj. Isoxsuprine Hydrochloride
16	Inj. Aminophyllin
17	Inj. Chloramphenicol
18	Inj. Mannitol
19	Inj. Pethidine
20	Inj. Chlorpromazine

-Drugs under various National Health Programmes(as listed under each NHP)
-Vaccines as under Immunisation Programme

Annexure 10

Extracts from National Guidelines on Blood Storage Facilities at FRUs.

1. Requirements

Space : The area required for setting up the facility is only 10 square meters, well-lighted, clean and preferably air-conditioned.

Manpower: One of the existing doctors and technicians should be designated for this purpose. They should be trained in the operation of blood storage centers and other basic procedures like storage, grouping, cross- matching and release of blood.

The medical officer designated for this purpose will be responsible for overall working of the storage center.

Electricity: 24 hours supply is essential. Provision of back-up generator is required.

Equipment: Each FRU should have the following :

1. Blood bag refrigerators having a storage capacity of 50 units of blood.
2. Deep freezers for freezing ice packs required for transportation. The deep freezers available in the FRUs under the Immunisation Programme can be utilised for this purpose.
3. Insulated carrier boxes with ice packs for maintaining the cold chain during transportation of blood bags.
4. Microscope and centrifuge: Since these are an integral part of any existing laboratory, these would already be available at the FRUs. These should be supplied only if they are not already available.

Consumables: There should be adequate provision for consumables and blood grouping reagents. The following quantities would suffice the annual requirement of an FRU with up to 50 beds.

Consumables Quantity

Pasteur pipette 12 dozens/year
Glass tubes 7.5 to 10 mm - 100 dozens/year
Glass slides 1" x 2" boxes of 20 or 25 each/year
Test tube racks 6 racks, each for 24 tables
Rubber teats 6 dozens/year
Gloves disposable rubber gloves 500 pairs per year
Blotting tissue paper As required
Marker pencil (alcohol based) As required

Opt for hospital delivery for safety of mother & baby

Toothpicks as required
Reagents: All the reagents should come from the Mother Blood Bank.
Anti-A 2-vials each per month
Anti-B 2-vials each per month
Anti-AB 2-vials each per month
Anti-D (Blend of IgM & IgG) 2 vials each per month
Antihuman Globulin 1 vial per month
(Polyclonal IgG & Complement)

Since quality of the reagents is an important issue, the supplies of these should be made from the same blood bank/center from where blood is obtained. For this purpose, State Governments/Union Territories should provide the additional budgetary requirements to the mother blood bank/center.

Disinfectants: Bleach & Hypochlorite Solution - As required

2. Suggested quantities of Whole Blood Units to be available at Blood Storage Units

5 units each of A, B, O (Positive)
2 units of AB (Positive)
1 units each of A, B & O (Negative)
This can be modified according to the actual requirement

3. Storage and Transportation

Cold chain: It is necessary to maintain the cold chain at all levels i.e. from the mother center to the blood storage center to the issue of blood. This can be achieved by using insulated carrier boxes. During transportation, the blood should be properly packed into cold boxes surrounded by the ice packs. Ice, if used should be clean and should not come in direct contact with the blood bags. The blood should be kept in blood bank refrigerator at 4°-6°c ± 2°c. The temperature of the blood should be monitored continuously.

Storage: The storage center should check the condition of blood on receipt from the mother center and also during the period of storage. The responsibility of any problem arising from storage, cross matching, issue and transfusion will be of the storage center. Any unit of blood showing hemolysis, turbidity or change in colour should not be taken on stock for transfusion. Due care should be taken to maintain sterility of blood by keeping all storage areas clean. The expiry of the blood is normally 35/42 days depending on the type of blood bags used. The Medical Officer in-charge should ensure that unused blood bags should be returned to the mother center at least 10 days before the expiry of the blood and fresh blood obtained in its place. The blood storage centers are designed to ensure rapid and safe delivery of whole blood in an emergency. The detail of storage of packed cells, fresh frozen plasma and platelets concentrate are

therefore not given in these guidelines. In case, however, these are required to be stored, the storage procedures of the mother blood bank should be followed.

4. Issue of Blood

Patients blood grouping and cross matching should invariably be carried out before issue of blood. A proper record of this should be kept.

First In and First Out (FIFO) policy, whereby blood closer to expiry date is used first, should be followed.

5. Disposal

Since all the blood bags will already be tested by the mother center, disposal of empty blood bags should be done by landfill. Gloves should be cut and put in bleach for at least one hour and then disposed as normal waste.

6. Documentation and Records

The center should maintain proper records for procurement, cross matching and issue of blood and blood components. These records should be kept for at least 5 years.

7. Training

Training of doctors and technicians, who will be responsible for the Blood Storage Center, should be carried out for 3 days in an identified center as per the guidelines. Training will include:

- Pre-transfusion checking, i.e. patient identity and grouping
- Cross matching
- Compatibility
- Problems in grouping and cross matching
- Troubleshooting
- Issue of blood
- Transfusion reactions and its management
- Disposal of blood bags

The states will have to identify the institutions where training of the staff responsible for running the blood bank is to be held. These could be the blood banks at Medical Colleges, Regional Blood Banks, Indian Red Cross Blood Banks, or any other well set up, licensed Blood Bank, provided they have the necessary infrastructure for undertaking training.

The training will be for three-days duration during which the Medical Officer and the technician from the identified FRUs will be posted at the training institution.

A "Standard Operating Procedures Manual" (SOPM) has been developed and is part of these guidelines. This SOPM will be used as the training material. A

Atleast three ante-natal checkup must for pregnant women

copy of this SOPM will be made available to the Medical Officer for use in his Blood Storage Center for undertaking storage, grouping, cross matching and transfusion.

In addition to the training of the above Medical Staff, it is considered necessary that the clinicians who will be responsible for prescribing the use of blood are also sensitised on the various parameters of blood transfusion. For this the "Clinician's Guide to Appropriate Use of Blood" has been developed. It is suggested that one-day sensitisation programme for the clinicians may be organised at the District Hospital/Medical College.

Government of India will make the expenditure for the above-mentioned trainings, available as per the norms of training under the RCH Programme. This training will, however, be coordinated by the Training Division of Department of Family Welfare. The states are required to include training as part of the overall State Action Plan for establishing Blood Storage Centers.

Equipments for Laboratory Tests & Blood Transfusion

Rod, flint-glass, 1000 x 10 mm dia, set of two 2
Cylinder, measuring, graduated W/pouring lip, glass, 50 ml 2
Bottle, wash, polyethylene W/angled delivery tube, 250 ml 1
Timer, clock, interval, spring wound, 60 minutes x 1 minute 1
Rack, slide drying nickel/silver, 30 slide capacity 1
Tray, staining, stainless steel 450 x 350 x 25 mm 1
Chamber, counting, glass, double neubauer ruling 2
Pipette, serological glass, 0.05 ml x 0.0125 ml 6
Pipette, serological glass, 1.0 ml x 0.10 ml 6
Counter, differential, blood cells, 6 unit 1
Centrifuge, micro-hematocrit, 6 tubes, 240v 1
Cover glass for counting chamber (item 7), Box of 12 1
Tube, capillary, heparinised, 75 mm x 1.5 mm, vial of 100 10
Lamp, spirit W/screw cap. Metal 60 ml 1
Lancet, blood (Hadgedorn needle) 75 mm pack of 10 ss 10
Benedict's reagent qualitative dry components for soln 1
Pipette measuring glass, set of two sizes 10 ml, 20 ml 2
Test tube, w/o rim, heat resistant glass, 100 x 13 mm 24
Clamp, test-tube, nickel plated spring wire, standard type 3
Beaker, HRG glass, low form, set of two sizes, 50 ml, 150 ml 2
Rack, test-tube wooden with 12 x 22 mm dia holes 1

Annexure 11

National Guidelines on Hospital Waste Management based on the Bio-Medical Waste(Management & Handling) Rules, 1998.

(Only relevant portions as applicable to a 30 bed CHC need to be taken in to account from this guidelines)

The Bio-Medical Waste (Management & Handling) Rules, 1998 were notified under the Environment Protection Act, 1986(29 of 1986) by the Ministry of Environment and Forest, Government of India on 20th July, 1998. The guidelines have been prepared to enable each hospital to implement the said Rules, by developing comprehensive plan for hospital waste management, in terms of segregation, collection, treatment, transportation and disposal of the hospital waste.

1. Policy on Hospital Waste Management

The policy statement aims to provide for a system for management of all potentially infectious and hazardous waste in accordance with the Bio-Medical Waste (Management & Handling) rules, 1998 (BMW,1998)

2. Definition of Bio-Medical Waste

Bio-Medical Waste means any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals, including categories mentioned in the Schedule I of the Bio-Medical Waste (Management & Handling) Rules, 1998.

3. Categories of Bio-Medical Waste

Hazardous, toxic and Bio-Medical waste has been separated into the following categories for the purpose of its safe transportation to a specific site for specific treatment. Certain categories of infectious waste require specific treatment (disinfection/decontamination) before transportation for disposal. These categories of bio-medical waste are mentioned as below:

Category No. 1 – Human Anatomical Waste
This includes human tissues, organs, body parts.

Category No. 2 – Animal Waste
This includes animal tissues, organs, body parts, carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals and colleges, discharge from hospitals and animal houses.

The child should be given only breast milk from birth to six months

Category No. 3 - Microbiology & Biotechnology Waste
This includes waste from laboratory cultures, stocks or specimens of micro organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of culture.

Category No. 4 – Waste Sharps
This comprises of needles, syringes, scalpels, blades, glass, etc. that may cause puncture and cuts. This includes both used and unusable sharps.

Category No. 5 – Discarded Medicines and Cytotoxic drugs
This includes wastes comprising of outdated, contaminated and discarded medicines.

Category No. 6 – Soiled Waste
It comprises of items contaminated with blood, and body fluids including cotton, dressings, soiled plaster castes, linens, beddings, other material contaminated with blood.

Category No. 7 – Solid Waste
This includes wastes generated from disposable items, other than the waste sharps, such as tubings, catheters, intravenous sets, etc.

Category No. 8 – Liquid Waste
This includes waste generated from laboratory and washing, cleaning, house keeping and disinfecting activities.

Category No. 9 – Incineration Ash
This contains of ash from incineration of any bio-medical waste

Category No. 10 – Chemical Waste
This contains chemicals used in production of biologicals and chemicals used in disinfection, insecticides etc.

4. Segregation of Waste

4.1 It should be done at the site of generation of bio-medical waste, e.g., all patient care activity areas, diagnostic service areas, operation theatres, labour rooms, treatment rooms.

4.2 The responsibility of segregation should be with the generator of bio-medical waste, i.e., Doctors, Nurses, Technician etc.

4.3 The bio-medical waste should be segregated as per categories applicable.

5. Collection of Bio-Medical Waste:

Collection of Bio-medical waste should be done as per Bio-Medical Waste (Management & Handling) Rules, 1998 (Rule 6 – Schedule II). The collection bags and the containers should be labelled as per guidelines of Schedule III, i.e., symbols for bio-hazard and cytotoxic. A separate container shall be placed at every point of generation for general waste to be disposed of through Municipal Authority.

The trolleys which are used to collect hospital waste should be designed in such a way that there should be no leakage or spillage of bio-medical waste while transporting to designated site.

5.1 Type of container and colour for collection of bio-medical waste:

Category	Type of container	Colour coding
1. Human anatomical waste	Plastic bag	Yellow
2. Animal waste	Plastic bag	Yellow
3. Microbiology & Biotechnology waste	Plastic bag	Yellow/Red
4. Waste sharp	Plastic bag, puncture proof container	Blue/white/ Translucent
5. Discarded medicines & Cytotoxic waste	Plastic bag	Black
6. Solid waste (Soiled)	Plastic bag	Yellow/Red
7. * Solid waste (Plastic)	Plastic bag	Blue/White
8. Liquid waste	_____	_____
9. Incineration ash	Plastic bag	Black
10. Chemical waste (solid)	Plastic bag	Black

* Those plastics which contains liquid like blood, urine. pus, etc, should be put into red colour bag for microwaving and autoclaving and other items should be put into blue or white bag after chemical treatment and mutilation/shredding.

5.2 All the items sent to incinerator/deep burial(Cat 1, 2, 3, 6) should be placed in yellow coloured bags.

5.3 All the bio-medical waste to be sent for microwave/Autoclave treatment should be placed in red coloured bags.(Cat. 3, 6, & 7)

5.4 Any waste which is sent to shredder after autoclaving/microwaving/ chemical treatment is to be packed in blue/white translucent bag.

5.5 **Location of containers:**
All containers having different coloured plastic bags should be located at the point of generation of waste, i.e., near OT tables, injection rooms, diagnostic service areas, dressing trolleys, injection trolleys, etc.

5.6 Labelling: All the bags/containers must be labelled bio-hazard or cytotoxic with symbols according to the rules (Schedule III of bio-medical waste rules, 1998)

5.7 Bags: It should be ensured that waste bags are filled up to three-fourth capacity, tied securely and removed from the site of the generation to the storage area regularly and timely.

5.8 The categories of waste (Cat. 4, 7, 8,& 10) which require pre-treatment (decontamination/disinfection) at the site of generation such as plastic and sharp materials, etc., should be removed from the site of generation only after treatment.

5.9 The quantity of collection should be documented in a register. The colour plastic bags should be replaced and the garbage bin should be cleaned with disinfectant regularly.

6. Storage of Waste

Storage refers to the holding of bio-medical waste for a certain period of time at the site of generation till its transit for treatment and final disposal.

6.1 No untreated bio-medical waste shall be kept stored beyond a period of 48 hours.

6.2 The authorised person must take the permission of the prescribed authority, if for any reason it becomes necessary to store the waste beyond 48 hours.

6.3 The authorised person should take measures to ensure that the waste does not adversely affect human health and the environment, in case it is kept beyond the prescribed limit.

7. Transportation

7.1 Transportation of waste within the hospitals

7.1.1 Within the hospital, waste routes must be designated to avoid the passage of waste through patient care areas as far as possible.

7.1.2 Separate time schedules are prepared for transportation of bio-medical waste and general waste; it will reduce chances of their mix-up.

7.1.3 Dedicated wheeled containers, trolleys or carts with proper label (as per Schedule IV of Rule 6) should be used to transport the waste from the site off storage to the site of treatment.

7.1.4 Trolleys or carts should be thoroughly cleansed and disinfected in the event of any spillage.

7.1.5 The wheeled containers should be designed in such a manner that the waste can be easily loaded, remains secured during transportation, does not have any sharp edges and easy to cleanse and disinfect.

7.2 Transportation of waste for disposal outside the hospital:

7.2.1. Notwithstanding anything contained in the Motor Vehicles Act,. 1988 or rules thereunder, bio-medical waste shall be transported only in such vehicles as may be authorised for the purpose by the competent authority.

7.2.2 The containers for transportation must be labelled as given in Schedule III and IV of BMW, 1998

8. Treatment of Hospital Waste (Please see Rule 5, Schedule V & VI)

8.1 General waste (Non-hazardous, non-toxic, non-infectious). The safe disposal of this waste should be ensured by the occupier through Local Municipal Authority.

8.2 Bio-Medical Waste

Monitoring of incinerator/autoclave/microwave shall be carried out once in a month to check the performance of the equipment. One should ensure:

j) The proper operation & maintenance of the incinerators/autoclave/ microwave

ii) Attainment of prescribed temperatures in both the chambers of incinerators while incinerating the waste.

iii) Not to incinerate plastic materials

iv) Only skilled persons operate the equipment

v) Proper record book shall be maintained for the incinerators/ autoclave/microwave/shredder. Such record book shall have the entries of period of operation, temperature/pressure attained while treating the waste, quantity for waste treated, etc.

vi) The scavengers shall not be allowed to sort out the waste

vii) Proper hygiene shall be maintained at, both the waste treatment plant site as well as the waste storage area.

viii) Categories 4, 7, 8, and 10 should be treated with chemical disinfectant like 1% hypochlorite solution or any other equivalent chemical reagent to ensure disinfection.

8.1.1 **Incineration:** The incinerator should be installed and made operational as per specifications under the BMW rules , 1998 (Schedule V) and an authorisation shall be taken from the prescribed authority for the management and handling of bio-medical waste including installation and operation of treatment facility as per Rule 8 of Bio-Medical Waste (Management & Handling) Rules,1998. Specific requirements regarding the incinerators and norms of combustion efficiency and emission levels, etc. have been defined in the Bio-Medical Waste (Management & Handling) Rules,1998. In case of small hospitals, joint facilities for incineration can be developed depending upon the local policies of the hospital and feasibility. The plastic bags made of chlorinated plastics should not be incinerated.

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8.1.2 **Deep Burial:** Standard for deep burial are also mentioned in the Bio-Medical Waste (Management & Handling) Rules 1998 (Schedule V). The cities having less than 5 lakh population can opt for deep burial for wastes under categories 1 & 2.

8.1.3 **Autoclave and Microwave treatment:** Standards for the autoclaving and microwaving are also mentioned in the Bio-Medical Waste (Management & Handling) Rules 1998 (Schedule V). All equipment installed/shared should meet these specifications. The waste under category 3, 4, 6, and 7 can be treated by these techniques.

8.1.4 **Shredding:** The plastics (IV bottle, IV sets, syringes, catheters, etc.) sharps (needles, blades, glass, etc.) should be shredded but only after chemical treatment/microwaving/autoclaving, ensuring disinfection.

8.1.5 Needles destroyers can be used for disposal of needles directly without chemical treatment

8.1.6 **Secured Landfill:** The incinerator ash, discarded medicines, cytotoxic substances and solid chemical waste should be treated by this option(Cat. 5, 9, & 10)

8.1.7 It may be noted there are multiple options available for disposal of certain category of waste, the individual hospital can choose the best option, depending upon treatment facilities available.

8.1.8 **Radioactive Waste:** The management of the radioactive waste should be undertaken as per guidelines of BARC.

8.1.9 Liquid (Cat. 8) & Chemical Waste (Cat. 10)

i) Chemical waste & Liquid waste from Laboratory: Suitable treatment, dilution or 1% hypochlorite solution as required shall be given before disposal.

ii) The effluents generated from the hospital should conform to limits as laid down in the Bio-Medical Waste (Management & Handling) Rules 1998 (Schedule V).

iii) The liquid and chemical waste should not be used for any other purpose.

iv) For discharge in to public sewers with terminal facilities, the prescribed standard limits should be ensured.

9. Safety Measures

9.1 **Personal protection:** Hospitals and health care authorities have to ensure that the following personal protective equipment is provided:

i) **Gloves**

a) Disposable gloves

b) Latex surgical gloves

c) Heavy duty rubber gloves(uptil elbows) for cleaners

ii) **Masks:** Simple and cheap mask to prevent health care workers against aerosols, splashes and dust.

iii) Protective glasses

The child should be given only breast milk from birth to six months

iv) Plastic aprons

v) Special foot wear, e.g. gum boots for hospital waste handler.

9.2 Immunisation against Hepatitis B and Tetanus shall be given to all hospital staff

9.3 All the generators of bio-medical waste should adopt universal precautions and appropriate safety measures while doing therapeutic and diagnostic activities and also while handling the bio-medical waste.

9.4 All the sanitation workers engaged in the handling and transporting should be made aware of the risks involved in handling the bio-medical waste.

9.5 Any worker reporting with an accident/injury due to handling of bio-medical waste should be given prompt first aid. Necessary investigations and follow up action as per requirement may be carried out.

9.6 Reporting accident and spillages

The procedure for reporting accidents(as per Form III of BMW Rules, 1998) should be followed and the records should be kept. The report should include the nature of accidents, when and where it occurred and which staff was directly involved. It should also show type of waste involved and emergency measures taken.

10 Training

10.1 All the medical professional must be made aware of Bio-Medical Waste (Management & Handling) Rules, 1998.

10.2 Each and every hospital must have well planned awareness and training programmes for all categories of personnel including administrators to make them aware about safe hospital waste management practices.

10.3 Training should be conducted category wise and more emphasis should be given in training modules as per category of personnel.

10.4 Training should be conducted in appropriate language/medium and in an acceptable manner

10.5 Wherever possible audio-visual material and experienced trainers should be used. Hands on training about colour coded bags; categorisation and chemical disinfections can be given to concerned employees.

10.6 Training should be interactive and should include, demonstration sessions, behavioural science approach should be adopted with emphasis on establishing proper practices. Training is a continuous process and will need constant reinforcement.

11. Management and Administration

11.1 The head of the hospital shall form a Waste Management Committee under his chairmanship. The Waste Management Committee shall meet regularly to review the performance of the waste disposal. This Committee should be responsible for making hospital specific action plan for hospital waste management and for its supervision, monitoring, implementation and looking after the safety of the bio-medical waste handlers.

Opt for hospital delivery for safety of mother & baby

11.2 The heads of each hospital will have to take authorisation for generation of waste from appropriate authorities well in time as notified by the concerned state/UT Government and get it renewed as per time schedule laid in the rules. The application is to be made as per format given in form I for grant of authorisation.(Please see page 18 of notified BMW rules)

11.3 The annual reports, accident reporting, as required under BMW rules should be submitted to the concerned authorities as per BMW rules format(Form II and Form III respectively) (Please see pages 19& 20 of BMW rules)

12. Coordination between Hospital and Outside Agencies

12.1 **Municipal authorities:** As quite a large percentage of waste (up to 90%) generated in Indian hospital belong to general category (non-toxic and non-hazardous), the hospital authorities should have constant interaction with municipal authorities so that this category of waste is regularly taken out of the hospital premises for further disposal

12.2 Coordinated efforts should be made by health authorities and municipal authorities to involve private sector/NGOs for creation of common facilities for treatment.

12.3 Health authorities in coordination with municipal authorities should facilitate optimal utilisation of waste treatment facility in the area.

12.4 Coordination with NGOs and Environmental Groups, for public awareness and education.

12.5 **Sharing of facility:** Hospital which is not on a possession of their own facility for treatment may get their waste treated in a shared facility. The hospitals having additional capacity may extend their facility to nearby smaller hospital or health care units.

12.6 There should be coordinated agencies to take care of exigencies/disruption of waste treatment equipment in a unit

Annexure 12

Model Citizens Charter for CHCs and PHCs

1. Preamble

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

2. Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

3. Commitments of the Charter

- to provide access to available facilities without discrimination,
- to provide emergency care, if needed on reaching the CHC/PHC
- to provide adequate number of notice boards detailing the location of all the facilities.
- to provide written information on diagnosis, treatment being administered.
- to record complaints and designate appropriate officer, who will respond at an appointed time, that may be same day in case of inpatients and the next day in case of out patients.

4. Component of Service at CHCs

- access to CHCs and professional medical care to all
- making provision for emergency care after main treatment hour whenever needed
- informing users about available facilities, costs involved and requirements expected of them with regard to the treatment in clear and simple terms.
- informing users of equipment out of order

Atleast three ante-natal checkup must for pregnant women

- ensuring that users can seek clarifications and assistance in making use of medical treatment and CHC facility.
- Informing users about procedures for reporting in-efficiencies in services or non-availability of facilities.

5. Grievance Redressal

- grievances that citizens have will be recorded
- there will be a designated officer to respond to the request deemed urgent by the person recording the grievance
- aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC
- to have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

6. Responsibilities of the Users

- users of CHC would attempt to understand the commitments made in the charter
- user would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- instruction of the CHC's personnel would be followed sincerely, and
- in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

7. Performance Audit and Review of the Charter

- performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified

Annexure 13
Composition of the Task Group III and the Consultation Process

Under the National Rural Health Mission, 8 Task Groups were constituted to deliberate upon various issues concerning the operationalisation of National Rural Health Mission. Task Group III under the chairmanship of DGHS comprised the following members:

1. Dr. S.P. Agarwal, Director General Health Services: Chairperson
2. Dr. Imrana Quader, JNU
3. Mrs. Brinda Karat
4. Mr. Satish Agnihotri, IAS
5. Dr. Ravi Narayan, CHC
6. Mrs. Sheela Rani Chungat, Secretary (Health, Tamil Nadu)
7. Mr. Ram Lubaya, IAS, Govt. of Rajasthan
8. Dr. Mohan Rao, JNU
9. Dr. Mira Shiva, VHAI
10. Dr. Jean Dreze, NAC
11. Mr. P.R. Krishna Kumar
12. Mr. Taradatt, JS, (AYUSH)
13. Dr. I.S.Pal, DG (FW), Uttaranchal
14. Mr. S.R. Mohanty, Madhya Pradesh
15. Dr. Abhay Shukla, CEHAT
16. Dr. S.K. Satpathy, DC (ID), Rapporteur

The first meeting of the Task Group III was held on 10th Feb.2005. The Group-III was assigned the task of preparing status papers on the following four issues:

- Setting up of Indian Public Health Standards for health care delivery in Community Health Centres
- Strengthening Public Institutions for health delivery
- Ensuring availability of doctors in rural areas
- Mainstreaming of AYUSH

As a follow-up to the meeting the DG HS reviewed the progress on a daily basis with some of the members from the Directorate and also experts from outside who were invited to join the process. The 4 papers were prepared and sent to all the members electronically and were also given print copies. The second meeting of the Task Group III was held on 26th Feb. 2005, under the Chairmanship of Dr. S.P. Agarwal, DGHS at Nirman Bhawan, New Delhi. Secretary (Health & F.W.) also participated in the discussion briefly. The list

The child should be given only breast milk from birth to six months

of Members/their representatives and various experts who participated in the meeting was as follows:

- Dr. S.P. Agarwal, Director General Health Services: Chairperson
- Dr. Imrana Quader, JNU
- Dr. Thelma Narayan, CHC
- Dr. S. Murugan, Director(FW Tamil Nadu)
- Dr. Mohan Rao, JNU
- Dr. Mira Shiva, VHAI
- Mr. S.R. Mohanty, Madhya Pradesh
- Mr. B. Venkatraman, QCI
- Dr. Abhay Shukla, CEHAT
- Mr. B.P. Sharma., JS
- Dr. S.K. Sharma, Adviser, AYUSH
- Dr. C.S.Pandav, AIIMS
- Dr. Ichhpujani (DDG (P)
- Dr. D.C. Jain, DC (CH/T)
- Dr. A.K. Harit, CMO, DGHS
- Dr. A.N. Sinha, CMO (HA)
- Dr. Sadhana Bhagwat, Consultant Cancer
- Dr. Praveena Goel, AC (UH)
- Dr. Himanshu Bhushan, AC (MH-II)
- Mrs. Mridula Das ADG (N)
- Mrs. Shubhra Singh, Director (P/RHM)
- Mr. Babu Lal Dir, (ID)
- Dr. S.K. Satpathy DC (ID), Rapporteur

These papers were discussed with the members present. Subsequent to the meeting, inputs from the deliberations were added to the papers. Further consultations were held on a daily basis with the members available at the Directorate and external experts. Another meeting with the various National Health Programme Officers and experts was also held on 7th March 2005.

The document on IPHS was prepared initially aiming at setting up Standards for the CHCs. But after discussion with Director (P/RHM), the paper was scaled down to discuss the requirements for minimum functional grading of CHCs with scope for further upgradation. Inputs were taken from the Programme Officers of National Health Programmes, consultants from accreditation agencies and also from Dept. of Community Medicine, AIIMS for preparation of the documents.

Com H-71.

AGENDA ITEM NO. 2

Health civil society in east and southern Africa: Towards a unified agenda and action for people's health, equity and justice

REPORT OF A REGIONAL MEETING
February 17-19 2005
Lusaka, Zambia

EQUINET TAC TREATMENT ACTION CAMPAIGN CWGH People's Health Movemer

HAI HEALTH ACTION INTERNATIONAL SATUCC S Af SF SEATINI Southern and Eastern African Trade Information and Negotiations Initiative

Regional Network for Equity in Health in Southern Africa (EQUINET), People's Health Movement (PHM) Treatment Action Campaign (TAC), Southern and Eastern African Trade Information and Negotiations Initiative (SEATINI), Community Working Group on Health (CWGH), Health Action International (HAI), Southern African Social Forum, Southern African Trade Union Co-ordinating Council (SATUCC)

Meeting hosted by CHESSORE Zambia
Report produced by TARSC
Support from Dag Hammerskold Foundation and Rockefeller

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Health civil society in east and southern Africa: Towards a unified agenda and action for people's health, equity and justice

REPORT OF A REGIONAL MEETING
February 17-19 2005
Lusaka, Zambia

1. Background

During 2002/3, EQUINET, Peoples Health Movement (PHM), International People's Health Council (IPHC) and Community Working Group on Health (CWGH) identified a need for closer dialogue and networking between health and related civil society in east and southern Africa to achieve common health goals.

Civil society in this region has built strong platforms and made progress in advancing peoples health in a number of areas, including around broad health rights, primary health care, patients rights, treatment access, corporate responsibilities to protect workers health, resisting damaging health impacts of globalisation, resistance to privatisation of essential services for health and protecting rights of people living with HIV and AIDS. Civil society has also through broad networks like EQUINET and PHM and through participation in the Social Forum processes, outlined policies for building equity and social justice in health and health care, particularly through a strong public sector health system. These wider platforms are, however, not strongly linked to the issue campaigns, while the issue campaigns are not necessarily all informed by the same analysis of the political and economic causes of ill health, of the health systems we are seeking to build or of the wider changes needed to achieve health goals.

A meeting held in Johannesburg South Africa on November 26 2003 involving 14 networks of health civil society (many of these with numerous individual health civil society members) identified a number of common goals and values informing health civil society work, namely:

- Common aim for equity and justice and to realize the right to health
- We all seek to bring power to the people and to strengthen people's voice in decision making through organising, uniting people and building public consciousness.
- We all work in areas that impact on health and on the wider health system
- We are all working for an alternative to the current neoliberal system, and our perspective and practice is for a system that is based on solidarity, equity, justice and public interest, from local to global level
- We act as a people's watchdog and monitor the performance of government and private sector against their commitments and the public interests, systems and values we are promoting.

To take forward this consensus vision we agreed to:

- consolidate and strengthen our influence and role as health civil society through building shared analysis and positions on health issues and strengthening our dialogue and networking; and
- identify strategic issues that we need to take up jointly and across health civil society as a whole to advance our common platform, while giving wider solidarity on specific campaign issues within wider civil society platforms.

This was taken forward through health civil society participation in the June 2004 EQUINET regional conference and by a planning committee made up of EQUINET (Secretariat at TARSC and SEATINI), PHM, Treatment Action Campaign (TAC) and CWGH. The planning committee was also joined by the Southern African Trade Union Co-ordinating Council (SATUCC) and Health Action International (HAI).

We developed a background document that outlined our common positions and analysis, and proposed to hold a regional meeting in February 2005 in Zambia. The planning committee

proposed that the meeting bring together the leadership of health civil society organisations in east and southern Africa to:

- review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ;
- build a unified and shared analysis, perspective and goals across health civil society to inform our individual and our joint platforms, strategies and campaigns;
- identify key and critical common goals and positions and the strategies for taking these forward as health civil society in the region;
- identify and agree on mechanisms for strengthening linkages, resource sharing, solidarity action and unified campaigns across health civil society in east and southern Africa; and
- identify and agree on mechanisms and processes that will strengthen and build our capabilities for ensuring mandate from, voice and agency of and accountability to communities in this process.

This report outlines the proceedings of the meeting and the resolutions and plans for future work made by the health civil society groups at the meeting. The meeting was hosted by CHESSORE, the theme co-ordinator in EQUINET on participation in health, with support from TARSC. The meeting was supported by Rockefeller Foundation and Dag Hammerskold Foundation through EQUINET, and travel contributions were made by Peoples Health Movement and Health Action International. The delegate list for the meeting is shown in Appendix 1 and the programme in Appendix 2. The report has been compiled by Rebecca Pointer and Rene Loewenson of TARSC/EQUINET.

2. Welcome, introductions

Chosani Njobvu from CHESSORE welcomed everybody to the meeting and thanked them for attending. Mwajumah Masaigana PHM and EQUINET steering committee member facilitated the introductions and everyone introduced themselves to the group.

She noted that the delegates shared a common goal of working for health equity. The meeting was designed to bring us together to strengthen ourselves, to build cohesion and linkages, and to identify strategies for working together. We need to identify areas where we agree so that we can build capacity and ensure that we are all going in the same direction.

Therefore, we need to identify who we are, what we think of ourselves, where we are now, and where do we want to go -- and how – to create a shared vision.

Mwajumah wished the meeting productive work in building a cohesive and strong movement.

Rene Loewenson TARSC/EQUINET introduced the purpose of the meeting, which was fundamentally to enhance the collective unity and purpose of health civil society around a common agenda, while enabling differences on focus in individual groups areas of action. More specifically the meeting aimed to:

- review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ;
- build a unified and shared analysis, perspective and goals across health civil society to inform our individual and our joint platforms, strategies and campaigns; and
- identify key and critical common goals and positions and the strategies for taking these forward as health civil society in the region.

Honesty, being self-critical and being mutually respectful are necessary to building trust around a shared agenda, which taps different struggle styles in working together.

The major health civil society groups hosting the process were acknowledged as present although there was still an agreed need to draw in people from the traditional health movement and land lobbies. The meeting included groups from South Africa, Zambia, Zimbabwe, Tanzania given the formative organisations noting that these networks do reach into other countries in the region, however work would now need to be done to take the dialogue to countries not represented at the meeting, including Mozambique, Namibia,

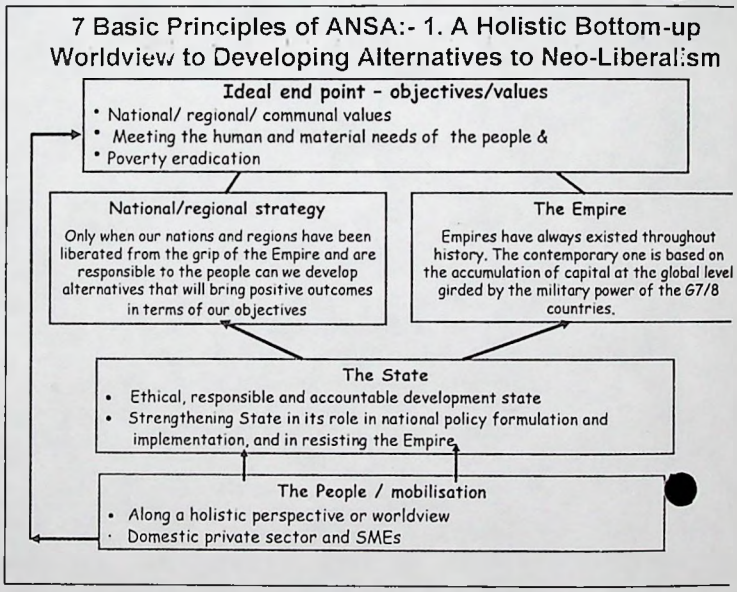
A single-issue campaign has implications for the health sector as a whole. We have had little success with addressing weak health systems as a whole, while single-issue campaigns like the Treatment Action Campaign (TAC) have had success. This raises the issue of how we balance single-issue campaigns with a broader health systems approach?

To build solidarity, can we agree to disagree, sharpen contradictions, be tolerant of diversity and share some values? We need to identify the point beyond which there is no common ground. We also need to examine how donors determine what is done, aside from what we feel is needed, and how it polarizes civil society. For example funders often have a rights-based approach to governance, but this is in a context where investors are given more rights than people, so you end up with a perverse rights-based approach. Funders also often opt for a poverty-based approach with direct budget support. This gives donors direct access to parliamentarians, and policies can become externally determined. There is also a lot of debate with funders around debt cancellation and whether it is going to create more problems than it solves.

With regard to strategies, should the state be a primary target of radicalism, or is an anti-state approach divisive? And what is the place of indigenous knowledge systems, nutrition/ promoting food security? These issues call for us to develop a sophisticated approach to the tactics and strategy we use.

3.2. Forging an alternative in east and southern Africa

Godfrey Kanyeze of LEDRIZ observed that it is now generally agreed by wide sections of Southern African society that the neo-liberal paradigm of development has failed the people. Poverty has not only entrenched but also deepened, and the gap between the rich and the poor has increased. Members of the broad trade union movement and some intellectuals in the region have been working on an alternative paradigm, as a serious effort aimed at providing the people in the region with an alternative development programme that aims at being both visionary and at the same time practical.



He presented the seven basic principles and ten essential elements for forging an alternative in east and southern Africa.

1. A *people-led strategy*, as opposed to an IMF-WB-WTO-donor led strategy. Liberations governments have appropriated people's right to determine alternatives, seeing themselves as the voice of the people without consulting the people. People should define the agenda, not the 'experts'.

2. At an economic level, an *alternative production system*. In Africa, we have a formal economic sector, which employs about 20% of the workforce. It was created by destroying the livelihoods of the peasant sector to make men – and not women – wage earners to subsidise production. Therefore poverty is a structural issue. Peasant labour is a source of cheap labour for the formal economy and also fuels the informal economy. While current economic strategies focus on trying to grow the formal economy by selling commodities, the formal sector is actually contracting by exporting raw materials at lower and lower prices to meet the needs of imperialism, which requires declining terms of trade.

3. *Grassroots-led regional integration* (as opposed to the current fragmentation in the region by Empire). Currently regional integration – through SADC and NEPAD, etc. -- is being driven by the European Union and United States, which are trying got drive the structures and determine the configurations.

4. *Selective de-linking* with globalization by focusing on regional trade, instead of international trade.

5. An *alternative strategy of science and technology*, not just importing technology from northern countries, but using our own raw materials to develop our own products.

6. A strategy of *alliance and networking* with national, regional and global progressive forces, drawing on our previous experiences of mobilization.

7. Politically governed *redistribution on wealth and opportunities.*

8. A focus on *women's rights* as the basis for a healthy and productive society.

The People, the State and the Empire

A holistic analysis requires us to look at all the following three factors in an *interconnected manner*: the global (or the Imperial Factor), the State (or the Governance or Democratic Factor) and the people (or the Social Factor).From this, three propositions follow:-

- a) Ignore SF, and you have discontent and rebellion
- b) Ignore DF, and you have suppression and opposition.
- c) Ignore IF, and you have domination by the Empire, and Resistance.

From these three, the following formula suggests itself as a *guiding principle* to achieve peace and justice. It may be written thus:

Peace and Justice = SF + DF - IF

9. A strategy where *education is linked with production.*

10. A strategy of *peoples' mobilisation* and *visible demonstrations.*

The goal of all development is to enhance *human centred values and human and social welfare.* It is customary to categorise human rights at three levels – *the political or civil rights* (or "blue rights"), *economic rights* (or "red rights"), and *social and cultural rights* (or "green rights"). However, a human rights approach on its own will not be effective; there are powerful vested interests and a certain *power configurations* at the national and global levels that need to be challenged in order to bring about necessary change.

Whilst a human rights approach is a useful starting point, important issues of *distribution* of welfare and economic well being within and between nations remain as a significant aspect of the overall value system. It is important, furthermore, to take a *livelihood approach* to human rights, because human rights are not simply *individual* rights, but also community and national rights. An important ingredient of this is the *right to national self-determination*, enshrined in the United Nations Charter. Also important is the *right of communities* at the local level to determine their own life-styles and destinies, and control over the technology and norms of production and reproduction central to their livelihoods, within the broader parameters of national and global environment. A people-oriented strategy needs to *address issues of concern to the people* (such as land reform or food security or issues of sustaining livelihood) district-by-district, village-by-village.

It is important in any alternative strategy to address the question of *agency for change*. The issue of "agency", or the motive force for change, cannot be kept out of the analysis, or deferred to a later date; it has to be integrated in a holistic manner into an alternative strategy.

He noted that within this the state is a *creation of history*, and it is a *product of struggles*. The state is *daily* configured. It *metamorphoses* on a daily basis. It is a *product of the struggle between people* on the one hand and the *forces that control the state at a particular point in time* on the other. The creation of a developmental or ethical state, thus, *is not an academic exercise*; nor is it one that can be postponed to some future date. *It is matter of daily struggle.* And, when everything is said and done, it is the people who are defenders of their own rights; it is they that are the agents of change

He further observed that "nations" as presently constituted are becoming inadequate political-geographic units for advancing the economic interests or security of the people within the nations. How "nations" will evolve in the future nobody knows. What we do know is that there is a powerful movement towards regionalism. He proposed a people and grassroots led regional integration, in contrast to the "perverse integration" crafted not by the people within the region, but externally imposed.

The ANSA-Strategy addresses a current challenge, the scenario that exists here and now, and not something in a distant future. *Struggle is a daily business; it is a continuous process.* The provision for example of the basic needs of the population and social services are *not battles of the future, postponed to some future date* (such as, for example, to 2015 in the MDG model) but parts of everyday battles. When these services are daily being privatised or commercialised in Southern Africa at the behest of the state or the IMF or the World Bank or individual donors, they become matters of concern to the people NOW, and not at some future date. An example can be seen, in the current negotiations for an Economic Partnership Agreement (EPA) between Africa and the European Union - *it is not tomorrow's battle. It is today's battle.* Tomorrow will already be too late.

In the **discussion** that followed delegates raised concerns about corruption undermining positions that seek to reinforce the role of the state. It was acknowledged that this is a collective problem that needs addressing, through tackling governance to ensure that our issues are addressed and articulated by the sate and providing adequate checks and balances. We also need to note that rich countries and powerful interests are involved in a lot of the corruption and expose and deal with it at this level as well.

Delegates also raised the issue of how we operationalise power to the people. It was noted that electoral and representative democracy where voting without the possibility of recall has led to depoliticisation, demobilization and reliance on the state. It is critical to reclaim the role of people who are the source of power and development for our leaders. We should institute the right to recall. Services should remain in the public domain. Let us define for ourselves what participation is, and push for participatory democracy, backed by the resources to implement it.

It was further noted that we need to examine our own relative emphasis between anti-imperialism and anti-capitalism. Many of our states have anti-imperialist sentiments, but are not anti-capitalist. This means that being anti-empire is not the end point for achieving social justice. It was however also noted that in the current environment we need to be clear about where the 'major determining contradictions are, so we focus on those and not undermine ourselves by division.

3.3. Agendas for global health

David Sanders, PHM, outlined recent decades of unequal progress in local health, with more rapid improvements for the rich than the poor:

* life expectancy increased from 46 years in the 1950s to 65 years in 1995;
* child deaths were reduced from 17.5 million a year to 11 million a year;
* there was substantial control of disease poliomyelitis, diphtheria, measles, onchocerciasis, dracunculiasis through immunisation and disease control programmes; and
* a decline in cardiovascular disease in males in industrialised countries.

Because of economic changes (e.g. SAPs) and the AIDS epidemic, we have seen massive reversals of these gains, and now, for example, we have seen an increase in child deaths since the 1990s. We have seen:

- the implementation of a selective PHC approach with money being pulled and programs not being sustained;
- inequitable globalization based on the trade liberalizations, removal of subsidies, currency devaluations and the debt crisis which escalated from 1970s through unfair trade practice and so SAPs were imposed; and
- health sector reform in the form of actions to improve the performance of the civil service, decentralization, actions to improve the functioning of national ministries of health, universal delivery of a core set of essential services, broadening health financing options, working with the private sector, and adopting sector wide approaches to aid rational planning.

While the World Bank denied the link between declining health and SAPs, it has now through the Macroeconomic Commission on Health generally been conclude that the effect of SAPs on health has been largely negative. However, the International Financial Institutions (IFIs) have never been held to account for their errors.

SAPS opened up current phase of globalization in favour of Transnational Corporations (TNCs) whose reach has expanded dramatically in the last decade, reinforced by WTO. Top companies have turnovers higher even than middle-income countries and countries in this region don't have negotiating clout. He quoted Henry Kissinger:

'The process of development begins by widening the gap between rich and poor in each country ... What are developing countries to make of the rhetoric in favour of rapid liberalisation when rich countries with full employment and strong safety nets argue that they need to impose protection measures to help those of their own citizens adversely affected by globalisation? ... The basic challenge is that what is called globalisation is really another name for the dominant role of the United States...'

He outlined the Health sector reforms implemented in many countries and their lack of success in achieving health equity or building health systems. Efficiency measures, through more involvement of private sector and 'cost-effectiveness' has led to private health care as a parallel system drawing on resources of the public health sector, "dual practice" of public sector human resources: "moonlighting", competition for clients and time, internal migration, and so on. Decentralization may improve democratic participation, but it is under-funded and ill prepared, without the necessary resources, training and staff, so it often increases inequities. The literature on low- and middle-income countries provides little evidence that decentralisation has resulted in creation of new posts, job re-profiling, or an improved staff mix". Human resource planning responsibilities are often transferred to local managers without providing them with adequate skills for these roles. The available literature is also quite negative about the impact of decentralisation on professional development opportunities or working conditions.

He noted that cost-effectiveness approaches had led to a range of selective primary health care packages excluding areas obviously important for health, like public provision of safe water. More recently vertical programs, such as those for HIV treatment can weaken overall health systems and through this other PHC interventions like immunization. Within PHC the role of social mobilization, civil society and the need for an intersectoral focus has often been neglected.

He called in contrast for a comprehensive approach to health and outlined the work of the People's Health Movement (PHM), guided by the People's Charter for Health. PHM is a network of civil society organizations, within which organizations can retain their own integrity. The PHM "Call for action" includes demands from local to global around health as a human right, tackling the broader determinants of health, social and political challenges, macroeconomic, environmental and a people-centred health system. The second People's Health Assembly will be held in Ecuador in 2005.

3.4. Agendas for regional health

Rene Loewenson of TARSC/ EQUINET presented the outcomes from process of regional work that was consolidated at June 2004 EQUINET conference. Health is not simply and only a sector but rather an outcome of how successfully we are addressing human needs and issues of justice and equity in all other sectors and policies. Health is an expression of and tool for organizing around other basic claims of society. Liberation movements in southern Africa recognized this and delivery on health was a powerful organizing tool. There is a wide constituency for health across the region reflected in post independence policies of equity and justice in health. While there have been diversions on this platform we are staging our struggle on active, not barren ground.

A regional agenda of equity and social justice in health means giving visibility and voice to injustices in health, and building perspective and power in a purposive manner to deal with these injustices. Visibility and profile is not an end point: we need to ensure that the issues are not co-opted by other agendas – like cough medicine for a cough rather than dealing with polluting smoke. We need to use visibility of injustice to drive a deeper agenda that goes to the causes of the causes of these outcomes.

The EQUINET 2004 conference resolutions highlight areas of this agenda for the region:

i. Calling for global relations that promote equity, social justice, people's health and public interests:

Governments, realising that poverty is a security and development threat have mobilized around poverty reduction and the Millennium Development goals. It has been estimated that $50bn annually is needed to meet these goals. This is the same amount spent each year on cigarettes by Europeans and far less than the $740 billion a year spent on arms.

Box 1: International and global relations that promote equity, social justice, people's health and public interests

Basic Education for all	**$6 billion**
Cosmetics in the USA	$8 billion
Water and Sanitation for all	**$9 billion**
Ice cream in Europe	$11 billion
Reproductive Health for all Women	**$12 billion**
Perfumes in Europe and the USA	$12 billion
Basic Health and Nutrition	**$13 billion**
Pet Foods in Europe and the USA	$17 billion
Business Entertainment in Japan	$35 billion
Cigarettes in Europe	$50 billion
Alcoholic Drinks in Europe	$105 billion
Narcotic Drugs in the World	$400 billion
Military Spending in the World	$780 billion

Source: Human Development Report, 1998

ii. ***Public interest over commercial interest in health, with rising investments in the state and public sector in health***

Responding to health needs calls for rising investment in public sector in health, with collective, population-oriented strategies for health and comprehensive primary health care. Rich countries and rich communities generally choose to invest more in their public sectors when they have the resources. Southern African public sector health systems have been seriously underfunded and need reinvestment for recovery. EQUINET has thus called for increased progressive tax-based funding of health systems as the most equitable, universal and efficient form of health financing where the rich contribute a *greater* share of their income to health than the poor. At least 15% of government spending should be spent in the public health sector, particularly to support the district and primary health care systems that address priority health needs.

iii. ***Fairer terms of trade and action around restitution for south–north flows caused by debt, unfair trade rules and human resource flows.***

We need to protect and use government authority in trade agreements to safeguard public health, such as through use of full flexibilities of TRIPS, making no health sector commitments

under GATS, act as a watchdog trade agreements and ensure that the executive is accountable to parliament and public on WTO and trade agreements. This means we need democratic and accountable states, with full authority to exercise policy measures necessary to protect the health of people. We also need to identify policies that will better retain the human resource we have and shape the forms of compensation needed to meet for regressive south-north subsidies incurred through health personnel migration. Nutrition, fundamental to health and food security, calls for policies that increase household and especially women's control over food production and consumption, including land redistribution, investment in smallholder farming and confronting monopoly control of food marketing.

Driving such policies calls for powerful and effective participatory and representative mechanisms for public contribution to decision making in health backed by a concept of human rights that addresses economic and social entitlements for health and affirms the agency of communities in claiming these entitlements.

In many countries colonial health systems were largely unreformed, preserving rural-urban, public-private segmentations, even thought these were narrowed for a period and PHC programmes added. We need to make clear the deeper transformation of our health systems needed, so that we have a comprehensive national and people's health system, that addresses the health and health care needs of the whole population, backed by a unified solidarity system of funding.

In the **discussion** that followed delegates raised debate on the role of the World Health Organisation in the UN system and its ability to bring about a more radical change in health. The fact that WHO is controlled by member states is important, but the fact that some wealthy governments have withheld contributions to exert pressure on WHO weakens this potential role. We also have the contradiction that governments themselves are buying into neoliberal policies even when they rejected them while in the struggle. Can we win people to progressive health position and understand and engage the contradictions inside the state?

Delegates observed that there is a lack of understanding among health workers and communities about the role of the state, about their roles and their working conditions. Health workers largely see themselves as responsible to the state rather than to the communities they serve. Transforming the health system also means transforming the understanding of health workers.

These wider issues need to be addressed while more immediate responses take place. We cannot stop work on food relief or immediate work to bring curative relief to people, but such campaigns need to be linked to structural changes, and ensure that they operate in a way that support and do not undermine these structural changes. Hence for example relief food in school feeding projects should aim to use local suppliers.

We need to strengthen the whole health system, including tertiary level care, and ensure that the tertiary level does not become increasingly privatized and inaccessible to people, and draw funds away from PHC. It is very important to look at how health care financing happens and what impacts on this. Also we need to think about what constitutes a public health system as often churches/ faith-based organizations have too much say in public health.

4. Priorities for health and civil society action

We then organised a participatory session to bring out the priority issues that people felt needed to be the focus of our collective future work. People raised and carried out debates in small groups recording these on flip charts in different parts of the room and moving between debates. After a period of time a number of key issues emerged, with various debate points raised around these issues:

HEALTH FINANCING

How is government going to tackle the private sector and finance national health insurance?
How can government be involved in ensuring that policies are pro-poor?
World Bank etc. propose that public health services are 'inefficient' – what is the evidence base of this and what is the 'efficiency' of the private sector?
Donor co-ordination required.
Global fund and replenishment conferences = predictable financing via an equitable contributions framework
Global fund not sustainable and should not be relied upon
Establish rules for the global fund
STOP GLOBAL FUND NOW! Global funds are weakening health systems by providing a vertical system and not co-ordinating with the people and governments.
We need to monitor financial (donor money) flows.
Industries are concerned with profit, not people!
"Africa has no skilled labour, not profitable!" – Is this true?
Government commitment to Abuja declaration – 15%
Mechanisms for protecting the vulnerable (advance risk sharing):
* national social health security must reach the targeted beneficiaries
* resources should be allocated for preventive and promotion (need driven)
National health interests vs. World Bank conditionalities and health budget ceilings.
Economic revival: how do we link this to debt?
2005 presents opportunities to get more money for healthcare: how do we engage and how do we use it?

UNITY OF HEALTH CIVIL SOCIETY

Recognise that it is "one struggle with many fronts".
While there are many fronts we should not take our eyes of the long-term objective and work to achieve that.
Single-issue campaigns give us a sense of urgency! Engage: EPAs, AGOA, Bilaterals, TB, Malaria, HIV and AIDS!
Taking advantage of the health-related aspects of MDGs to advance our cause: Wait for 2015? No, take advantage of the window of opportunity provided.
Poverty related goals interrelate with health aspects.
Without debt cancellation MDGs won't be achieved.
Reduction of maternal mortality is of the MDG goals – let us use it for advocacy on health.
Advocacy for governance that puts people's demands in the priority agenda.

FOOD SOVEREIGNTY

Food is a uniting health, production, consumption, labour, etc. issue
We are talking about food not organizing around food!
The role of agriculture and health reform in promoting access to health care.
WTO on agriculture:

- increase production
- stop north subsidy
- say 'no' to GMOs

Agricultural policies contribute to healthcare problems
Elaborate what "food sovereignty" means
Give women land in their own right.
Women's access to health.

ORGANISING PEOPLE'S POWER FOR BETTER HEALTH

CSOs must start with their community, engage their district officials and move on to national leaders. CSOs should have people's backing for their demands
Work with local communities, using local knowledge, traditional health systems.
Increase access to comprehensive PHC where communities interact with providers, government and state.
CSOs role is to demystify trade agreements and other relevant policies.
Economic literacy for mass mobilization.
Communities to be informed about policy and processes where they can participate e.g. policy discussions, parliamentary hearings, etc.
CSOs can facilitate logistical support such as childcare, transport, confidence building, etc. to enable mobilization.
CSOs must increase people's awareness on health an human rights.
Are we alone where the government representatives, private hospitals and mission hospitals are present? We need to hear about the problems they face.
Strengthen health civil society at all levels (local, regional, national and international) as it is seen to be fragmented and need to explore why this is so.
CSOs have become the new elite and lost touch with the people. How do we mend that bridge and remain relevant? We need to define who we are, remain accountable and link up, respect and mobilize grassroots organizations.

HUMAN RESOURCES FOR HEALTH

The "Brain Drain" – staff exodus and human resources for health
Perverse subsidization of south to the north undermines and weakens our responses to public health and health systems.
Which health workers do we want to support and retain? (PHC & district)
Recognition and better co-ordination of community health workers (CHWs), traditional healers, etc.
Fragmented health workers organization.
Health worker organizations are not linked to other civil society organizations.
The north should put money into training in developing countries.
Private sector to channel resources to the public sector for human resources.
Campaign for compensation to poor countries whose HR is losts.
No to GATS type free movement of labour.
Lifelong education and training funded by governments.
Work with health workers within our countries to campaign for better working conditions.
Government to narrow gaps in salary among top staff and community workers.
Funding for public health services.
Retain skilled health workers and improve conditions of employment.
Transformation of international institutions.
Promote and support the public health system.
Implementation and improvement of OH&S policies, strategies and systems.
Cost-sharing mechanisms are reducing access to healthcare for rural communities.
Trade unions should broaden their discussion beyond wage agreements/ increases and focus on globalization affecting their well-being and including health.
Build solidarity with CBOs, CSOs, etc.

The review in plenary of the flip charts and the debates that took place around them as used to raise the priority issues to take forward:

1. How do we develop **one struggle with many fronts** – single-issue and broad fronts? Can we use and advance on windows of opportunity that arise from issues to advance structural and systems issues. What are those windows of opportunity and how do we use them?
2. Civil society as an **organizer of people's power** in various forms – how, where, through what forms? This also calls for a clearer analysis of the strengths and weaknesses of health civil society in these roles. We also need to strengthen the

links between labour, community based and civil society organizations to build solidarity across these groups - What is the basis and processes of this solidarity?

3. **Human resources** are a strategic issue: There are parallel health service structures with little integration and links between health workers and health civil society. Social movements and civil society can only achieve goals by integrating the two. This has a ripple effect on service provision, as workers are the producers of services. We also need to tackle the internal brain drain.
4. **Health financing** is a further strategic issue to address at global level, between public and private sectors and within the public sector. We need to explore approaches and mechanisms for funding a more equitable public health care system. In this we need to engage in the debate and research the view – held by proponents of neoliberalism - that a public health care system is inefficient. This raises focus on our positions on stopping perverse resource flows from Africa vs increasing aid flows into Africa.
5. Resisting and reversing **trade liberalization and trade encroachment** on health, through WTO and bilateral negotiations. How do we defend the public sector within trade?
6. **Food sovereignty** means addressing the role of women as producers, and issues outside the health sector like trade, land distribution, GMOs and food production and marketing.
7. **National health systems:** These areas all imply collaboration around building a national health system. What kind of health systems do we want? How do we integrate various issues and goals into this and how do we ensure the funding and workers for it?

Within these broad issues we need to explore which struggles we take up as health civil society, and how we work around these. What are our strengths and weaknesses around these key issues and what are we currently doing around them.

5. Health in Brazil

To support the discussion of the way forward, Armando de Negri of ALAMES and WSF Brazil outlined the policies and processes of health civil society in Brazil. In the 1980s Brazil was confronting many of the challenges raised at the meeting facing southern and east Africa today. Brazil had a general idea of the kind of programme we wanted to develop with a focus on the right to health. This was strongly influenced by the health reforms in Italy in the 60s and 70s. Therefore, we built a health system around a few simple ideas:

- health is a right of all citizens;
- this universal right meant a right to all healthcare, not just primary health care (PHC); with egalitarian access to health care; and
- a strong statement about social participation in health, with real decision-making power, health councils at a city level, state and national level regarding government, health providers and health workers.

This permitted us to defend the National Health System (NHS) from privatization and gave us clear ideas in managing the relationship with work in other sectors. Since health was a duty of the state, legal actions were taken when health would be affected and the state could intervene at any time that health is tread upon. If there are bed shortages in the public health system, the state can access beds in the private health system. There is absolutely no payment for services and the constitution establishes that it is forbidden to charge for health – the same laws apply to the private health sector as the public health sector.

We have local organization of the NHS, avoiding the collapse induced by more neoliberal forms of decentralization. The research and management components are decentralized, but there is a unified system, supported by 9,8% of national tax collections: 12% of the health budget goes to state governments and 15% to local governments. There were attempt to include water and sanitation in the health budget, but we successfully prevented that.

City governments have high management responsibilities in terms of tying health planning into integrated planning. We are also now developing family health programs that cover 3000 people and can tackle counseling, medication, special care for HIV and AIDS needs.

Brazil's health system is an exception in Latin America, as other Latin America countries have not been able to face and take on global systems. However, we have proved that it is possible to have a universal system, and it is much cheaper than the fragmented private sector. Therefore we must struggle for a global right to a universal health system. We need to use this example to negotiate with funders; civil society must express what they want in terms of these programmes.

There is a need for Latin American and South American countries to build alliances to support and exchange with each other and to fight to be, not just an economical block, but also have a social agenda with a right to health, so as to eliminate inequities between countries.

6. Priorities for health and civil society action, continued...

Following through on the discussion of the first day the health civil society groups identified further the major objectives and specific issues in the five major areas of common concern:

- organizing people's power, including labour;
- building a national people's health system.
- financing a more equitable health system;
- ensuring human resources for health; and
- challenging trade liberalization and encroachment.

6.1. Organising people's power for health

Objective: Building a critical mass working together towards a common vision of the right to health for all as a constitutional right.

Sites of struggle

- Bringing unity across civil society organisations, while ensuring autonomy.
- Building an inclusive front of all stakeholders working in health and related areas.
- Demystifying and linking local, national and global struggles to co-ordinate action.
- Defining realistic priorities.
- Ensuring the survival of civil society organisations against external attacks and challenges (state and donor).

6.2. Building a national people's health system

Objective: Publicly-funded comprehensive, participatory, equitable and universal health systems.

Sites of struggle

- Lobby governments to promote, finance and provide comprehensive primary care that is participatory and involves promotion, prevention, rehabilitation and curative aspects.
- Oppose privatization of public health services.
- Promote, support and engage in actions that encourage people's power and control in decision-making on health at all levels including patient and consumer rights.
- Pressure governments to adopt, implement and enforce national health and drug policies.
- Support, recognize and promote traditional and holistic healing systems and practitioners and their integration into health systems.

6.3. Financing a more equitable health system

Objective: Increased fair, sustainable and equitable financing for health at national, regional and global level in order to secure the universal right to health.

At a national level, rising investment that strengthens the national health system through the public health sector, with mechanisms that ensure universality, solidarity and transparency and that promote public over commercial interests.

Sites of struggle

- Abuja Declaration that African governments spend at least 15% of national budgets on health, (but also need our own realistic target for funding a national health service).
- Unconditional debt cancellation.
- Increased aid for health to meet short term needs ways that strengthen health systems and that are sustainable.
- Equitable allocation of national budgets for health, with promotion of tax funding for health; national debates on health insurance; and scrapping of user fees at PHC level.
- Lifting of IMF Medium Term Expenditure Frameworks (METF) caps for increased health spending.
- Ensuring these positions are adopted in WTO, MDGs, Commission for Africa, World Bank PRSPs, SADC, EAC, etc.

6.4. Ensuring the human resources for health

Objective: Adequate, well-trained, equitably distributed and motivated health workers.
Sites of struggle

- Improved working conditions for public health workers (incentives; wages, OH&S policies), with emphasis at primary and community level.
- Lifelong training of health workers to become more problem-orientated, practice-based, including management and self-evaluation skills.
- Awareness campaign around the implications of migration of health workers, (public to private health institutions; within and outside the region) and compensation issues.
- Oppose GATS commitments that promote movement of health workers to private sector and to wealthy countries, backed by positive measures to retain health workers, to compensate for perverse south-north subsidies, and to implement codes on ethical recruitment.

6.5. Challenging trade liberalization and encroachment on health

Objective: Popular participation and transparency to ensure a fair international trade system, where people are put before profits (health over commercial interests); and where our states and governments maintain sovereignty through regulatory flexibility for development.
Sites of struggle

Access to medication

- National level: regulatory and financing frameworks.
- Regional level: make WTO powerless.
- Global level: fight against TRIPS.

Privatisation

- National level: PRSPs, GEAR and SAPs.
- Regional level: NEPAD issues and other regional trade agreements (RTAs).
- Global level: impact of GATs.

Food sovereignty

- National level: tackle GMOs, monocultures, cashcropping, and food security.
- Regional level: WTO agreements, regional agreements on national level issues.
- Global level: subsidies, commodity prices, food aid and donors, market access.

Indigenous knowledge systems and national regulation

- National level: regulation required.
- Regional level: powerlessness in Regional trade agreements.
- Global level: bio-piracy, TRIPs

Watchdog trade measures that impact on health

- National level: governments, parliaments, faith-based organizations, domestic capital, social movements and CSOs and FBOs.
- Regional level: European union EPA, United States AGOA and FTAs. Work with African social forum processes, African RTAs such as SADC and Comesa to tackle regional fragmentation.
- Global level: WTO, WIPD, WHO, WHA, UNDP, UNCTAD, WSF WEF, G8, etc.

7. *Strengths, weaknesses, opportunities and threats for health civil society*

David Sanders PHM outlined the motivation for doing a SWOT analysis of health civil society. He noted that those working to build and establish PHM in South Africa have found mobilization difficult. The experiences from this indicated the need to do a reality check around our strengths, weaknesses, opportunities and threats in building mobilization. This SWOT analysis should be in relation to the key issues identified and reflect on our country and organizational situations. A SWOT analysis will also help us prioritise a realistic set of collective actions.

The delegates carried out the analyses in groups and identified key strengths and weaknesses, opportunities and threats that need to be taken into account in shaping follow up work:

7.1. Organising people's power for health

The major concern is to increase the capacities of civil society organisations.
Strengths: CSOs have a commitment to the issue, and embrace diverse experience, skills, expertise and knowledge. There are many organisations working on health issues in the region, and successful single-issue campaigns, able to mount a quick response to issues.
Weaknesses: Civil society is fragmented, with splintered effort and lack of a joint vision. Organisations have limited resources and are donor dependent (and driven in some cases) with more funding for vertical than comprehensive programmes. Some CSOs are losing focus and lack the passion to fight for a cause. This leads to too many meetings and too little action. There is also too much work and too few people weakening our capacity.
Opportunities: There are windows of opportunity: the WTO Cancun victory created the possibility for alliance between NGOs and governments, the MDGs. The need to address health system decline creates a mobilizing opportunity to push for national public health system. Strategic alliances have formed across issues and across the region, such as the National and African Social forums, this fourm.
Threats: Exist in some government policies, such as the Zimbabwe NGO Bill and unsupportive governments. Global disasters result in the movement of policy attention and funds away from Africa, e.g. Tsunami, Iraq, etc. Donors are focusing on vertical programs such as vaccination, and prefer large established organizations over smaller ones. Civil society organisations lack finance, human resources and time.

7.2. Building national people's health systems

Strengths: There is analytical experience and organizations are working in these areas in the region.
Weaknesses: This is a complex area and patchy understanding of how to grapple with key issues in unions, CSOs. It needs a lot of work to get unions and communities on board. Ineffective and poorly resourced health committees, community organizations demobilize communities.
Opportunities: A common understanding, an interested media, global funds and increased resources, opportunities; opportunities for links with other organizations to build a popular movement.
Threats: Weak public understanding of how the health system functions; Disinterested media attitudes. Funds going to vertical programmes, over broader approaches. Unsupportive or repressive policies to civil society and lack of autonomy of health civil society.

7.3. Ensuring the human resources for health

The major concern is to improve the working conditions of health care worker, increase training and capacity, believing this will also impact on the brain drain and as a way of bringing health workers on board in fighting the brain drain and building health systems.

Strengths: Existing organisational capacity to build around this campaign by organizations which represent workers interests. A lot of work is being done around improving working conditions. It is an issue that is common across the region, from health workers to civil society. There is a felt need from health workers to build a campaign around this.
Weaknesses: This is a single-issue campaign that may again neglect health systems. It costs a lot of organizational resources, while capacity and energy are already stretched in terms of capacity, resources. There is lack of co-ordination amongst the unions, and issue is not taken up at a federation level. There are also issues of sectoral organization and conflict of interests.
Opportunities: Communities are dissatisfied with current service delivery and there is a window of opportunity through engaging around treatment access. HR has achieved a higher profile with possibility of additional funds for HRH.
Threats: Conflict between communities and health workers and the impact of HIV and AIDS.

7.4. Fair financing for a national people's health system

The key goals are increased per capita spending on health, progressive tax funding for health, debt cancellation, and appropriate external funding to support national health system
Strengths: There is consensus that current spending is inadequate. There is expertise and information in this area in CSOs in the region, solidarity from Northern CSOs, e.g.: on debt cancellation and CSOs in South America have researched models that could be adapted in Africa, such as, the Brazilian model. CSOs have the ability to track health sector funding.
Weaknesses: There is a low level of civil society/ government engagement on the issue and different opinions on strategies that could be used to address the issue e.g. tax-based delivery, health insurance, debt cancellation with or without conditionalities, MDGs, etc. There is poor SADC-CSO engagement on the issue and absence of a regional combined effort that includes governments and CSOs. There is inadequate follow-up by CSOs of gains and promises made at the global level and inadequate capacity to monitor and poor monitoring and influence on use of saving created by debt cancellation. Too many unmet needs result in disagreements on what funding should be used for.
Opportunities: All African union countries signed the Abuja declarations that African governments should spend at least 15% to be sent on health. WHO has developed recommendations on per capita spending on health. World Bank has upcoming meetings with civil society, PRSP processes in countries are engaging CSOs, as is the Global Fund replenishment conference, AU, Africa Commission and the G8 is now chaired by Britain, which has been leading the push for debt. There is potential to increase awareness among CSOs on the issue.
Threats: Low levels of public sector funding and misuse of funds weakens national advocacy, reliance on external funding with conditionalities, and external influence from financiers around, such as caps on health spending. Resistance may come from the private sector, who see solidarity financing measures as some form of control.
International processes such as WTO, Commision for Africa, SADC, EAC, Comesa can be used to dissipate energy, therefore we need to be careful what processes we engage in and how. Global funding is not being used to strengthen health systems.

7.5. Challenging trade liberalization and encroachment on health

The key issues were identified as access to medications, privatization and food sovereignty and security.
Strengths: There are visible movements and campaigns; Already developed strong positions against privatization in individual organizations; partners with an anti-privatisation agenda.
Weakness: Single-issue campaigns. Few organizations working specifically on TRIPs and health in the region. No regional programme of action, although PATAM, EQUINET initiating work. Don't have clear articulation, requiring additional dialogue, for example anti-privatisation is not articulated within EQUINET. Nutrition is not major issue that we are tackling and therefore we are weak in this area.
Opportunities: Can use single issues to move onto other platforms and build on victory for comprehensive health campaigns. Raise dialogue and campaigns around issues of private and public sector and take advantage of the dialogue on the new perceptions on the role of

the state. Information dissemination can catalyse action. Need to get traditional healers on board.
Threats: WTO, TRIPs, FTAs, EPAs, RTAs, national development plans, donors and IFIs, etc. Control of supply impacts on trade and consumption. There is a perception that governments are not efficient in delivering services and that the public health sector is weak. There is lack of knowledge on how trade agreements such as TRIPs impact on our lives and a varied level of dialogue on privatization. We are locally in conflict with government around issues that governments are advancing that were rejected in Cancun.

8. Presentations from social movements

To give background to planning of future work delegates heard further input on three major social movement processes that impact on health

8.1. African Social Forum

Thomas Deve noted that the WSF is an open space where we throw proposals and dialogue. Anyone can participate without mandates from any organization. The entry point in Africa started at the top and one of the biggest challenges we have is to explain the open space to people who are used to more bureaucratized processes. WSF has a charter of principles and is an initiative to challenge neo-liberal corporatisation and develop alternatives. WSF is for movements and organizations that want to undermine work of Davos – and it is a parallel process with those meetings.

Since it is an open space, there are many people and agendas, and debate alone will not change the world. So there have been debates around methodology of WSF. It relies on registration of organizations and events to announce their programs, but revolves around the slogans: "Our world is not for sale"; "Not in our name" and "Another world is possible".

There is now an African Social Forum (ASF) that has identified thematic areas for work such as labour, youth, gender, etc. Professional activists from NGOs are administering the process as social movements are resource poor. The sub-regions of the ASF are Southern Africa, Arab North, East Africa, and West Africa. The most vibrant region so far is southern Africa and it has the most organizations involved, with labour movements (except South Africa, students and AIDS activists. So SASF has a big niche in determining agenda of ASF. How do we organize to make sure we are everyone participates in it? In the Social Movements Indaba held in Johannesburg, organizations constantly demanded mandates, which is not how the Social Forum process works, so how do we interact with it, to what extent do we show solidarity and when do we break with it?

African attendance at previous WSFs has been disorganized, and you could easily get lost. We need to prepare a program and agenda before we even get to the venue otherwise we always face these challenges. Those of us involved in Trade issues have built people-to-people solidarity networks to bring alternative dialogue to the social forum. On the ground we have a challenge to hold SASF in Zimbabwe in October 2005 and in 2006 to have regional expressions of WSF (e.g. ASF – may be in Morocco).

The WSF on health was outlined by Armando De Negri., This meeting has a history at first WSF in 2001 when we identified the need to put people together to prepare health agenda for WSF as it is not a main issue of the WSF, although it was represented under neo-liberal umbrella. In 2001 we proposed the health WSF to take place 3 days before main event and it has been held for next 3 years until the 2004 international forum for people's health.

In 2003 PHM joined the meeting, and in 2004 PHM was responsible for organizing it. This year we ran WSF on health, as it's an important space to put together main agendas of "Another world is possible". The health forum developed a group of general agreements to develop and identify terms of about how:
* the struggle for health is linked to struggle against neoliberalism and war
* health is a fundamental human right
* this can be developed into national systems for health.
The final agreement was to generate an organizational process similar to WSF with international council to generate permanent space for dialogue. We are proposing that we are

identified and linked to WSF and will follow the dynamics and organize a health WSF wherever the WSF takes place to develop an exchange of information between regions.

Initial dialogue in health WSF sees the need to bring Africa on board, establish effective ways to touch the bases of social movement's etc in order to establish wider struggle and internationalise as much as possible. The health WSF is a coalition of coalitions, meant to reinforce wide coalitions to develop stronger international movement for human rights program. The Health WSF called for participation in PHA in Ecuador to achieve good South American participation around this event.

The dialogue on the format of WSF for 2006 is a confirmation of peoples' idea for expansion of the process, but organizing it is taking too much of energy when we'd rather be in the trenches and fighting. That is why a continental process was decided on for 2006. There are a number of different positions being developed on future of WSF.

It is hard for 150 000 people to reach common agreement, but with thematic divisions there were more that 300 different proposals as exchange of ideas within the forum. The main purpose of WSF is to generate a broader perspective, make friends, know you are not alone and know you have allies.

8.2. People's Health Assembly

Samuel Ochieng noted that the next PHA is in July 2005 in Ecuador. Civil society realized that objectives of World Health Assembly were not being met and therefore we needed to have an alternative forum to achieve the "Health for All" call. The first PHA was held in 2000 in Bangladesh; about 1500 people attended from 93 countries.

Since then PHA has been involved in a number of international forums and campaigns for health. After 5 years PHM will be holding PHA 2 in July 2005 in Ecuador. The process has begun and we have an international organizing committee. The main objective of this is to:

- strengthen and expand the PHM as a network that struggles for the revival of the original spirit and principles of "Health for All";
- launch a more concerted global action to achieve a full and universal recognition of the Right to Health as a fundamental Human Right;
- widen the debate leading to a more proactive resistance to all the forces that oppose and violate the right to health of the people-many of them enshrined in neoliberal reform policies and in the overwhelmingly unfair move towards globalization with its shift towards increasing militarisation; and
- share experiences and practices useful for the universalisation of our struggle to implement alternative models of people-centered and beneficiary controlled health care delivery systems.

Preliminary themes have been developed and we are busy developing a programme. We want to take people who have roots and who can make sufficient use of the knowledge and help us establish the network. We have resources and we ask for support in identifying candidates and developing process to ensure that Africa is well represented.

We are also seeking to develop a project called "African Dreams" within the PHC exchange. We are collecting stories, poems, posters, photos or other artistic works to create an exhibition. Please submit anything you have on this to Mwajuma Mwasaigana.
Armando extended an invitation for the southern African delegation going to Ecuador through Johannesburg and Porte Allegre, to have a two-day stop in Brazil to find out more about Brazil's health system.

8.3. WTO Ministerial, Hong Kong December 2005

Riaz Tayob outlined the process to the WTO Ministerial conference of trade ministers meeting every two years. The specific challenges we are facing at the next WTO are to review TRIPS agreements to allow countries that do not have manufacturing capacity to import generics. This agreement comes up for review and may be held over, as rich countries want to hold it over developing countries heads. Developing countries also want to prevent patenting of discovery.

The strategy inside the WTO is that nothing is agreed until everything is agreed and the GATS negotiations are also going to be included in this agenda. Key issues in the negotiations are agriculture to limit northern countries tariffs and export rights for poor countries. We are blocking out venues for African civil society and parliamentarians so that they can call ministers to account. Because Africa is underrepresented at the parallel event trying to make sure that Africa speakers are represented. We need to promote a communications system that will work for activists in Hong Kong to organize people at home and MPs.

The WTO co-ordinating group meeting – the Hong Kong People's Alliance Against WTO --- organized by Asian people will be meeting in March. The Africa Trade Network co-ordinates around a combined assault on the WTO and we still need to work how we are going to participate in this.

9. Moving forward: Fundamental principles, values and issues for health civil society

Following these discussions Rene facilitated a session that aimed to draw together the key issues raised in the previous sessions and set the platform for defining a programme of follow up work. The summary below reflects the outcomes from the session.

9.1. Guiding values

Health civil society in the region is guided by **principles and values** of:

- the fundamental right to health and to life
- equity and social justice
- people led and people centred health systems
- public over commercial interests in health: Health before profits
- people led and grassroots driven regional integration
- anti-neoliberal policies.

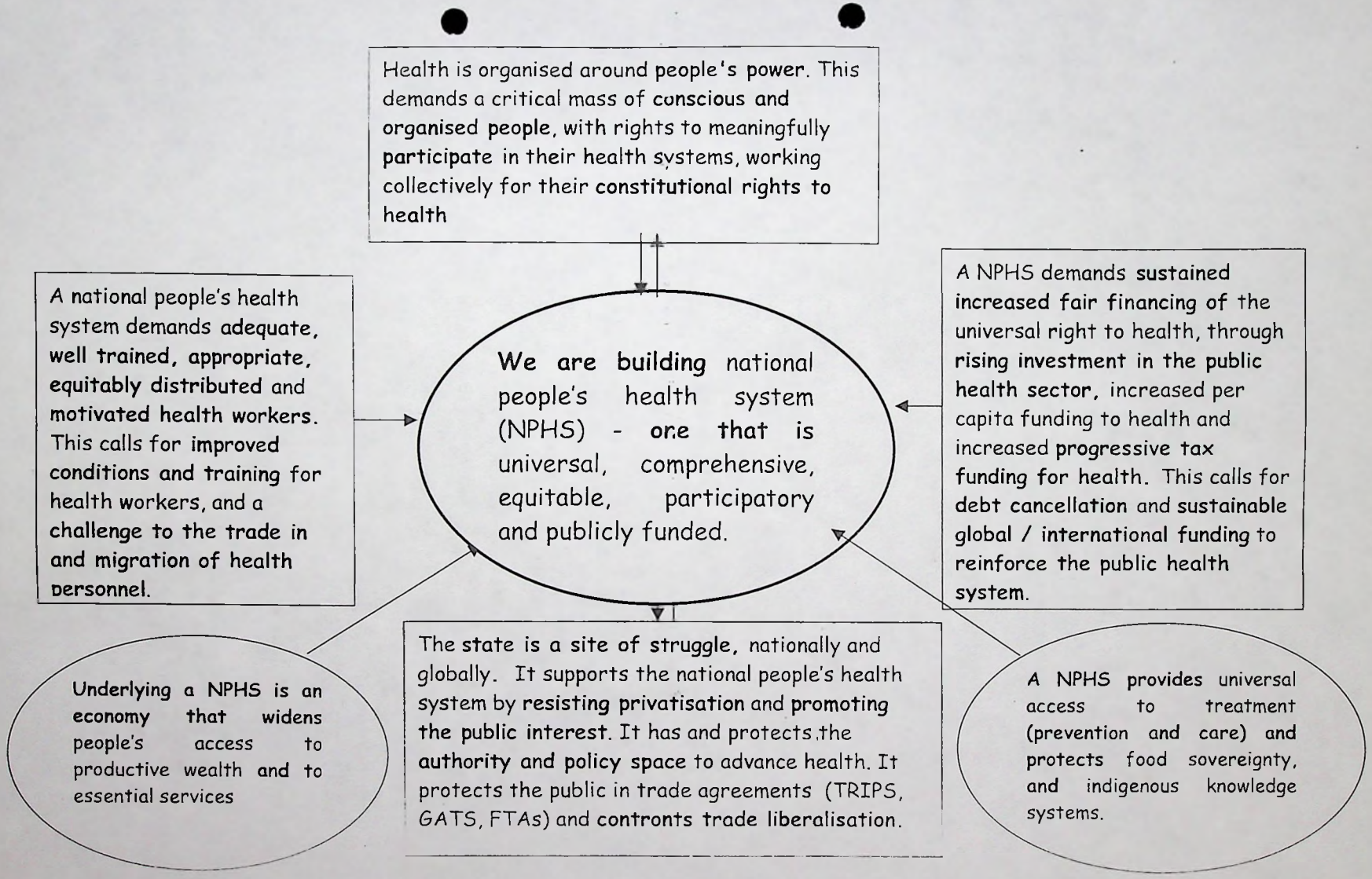
9.2. Major areas of work

We are building a national people's health system

Health civil society organisations in the region agreed that the central struggle to reflect these values and principles in 2005 is for a national people's health system.

This is the unifying goal for our various areas of struggle and the common platform around which we are all uniting, recognising the different areas of struggle around this. We understand a national people's health system to be one that is universal, comprehensive, equitable, participatory and publicly funded.

We built an understanding of how our different areas of struggle contribute and relate to this uniting goal.


Health is organised around people's power. This demands a critical mass of conscious and organised people, with rights to meaningfully participate in their health systems, working collectively for their constitutional rights to health
A national people's health system demands adequate, well trained, appropriate, equitably distributed and motivated health workers. This calls for improved conditions and training for health workers, and a challenge to the trade in and migration of health personnel.
We are building national people's health system (NPHS) - one that is universal, comprehensive, equitable, participatory and publicly funded.
A NPHS demands sustained increased fair financing of the universal right to health, through rising investment in the public health sector, increased per capita funding to health and increased progressive tax funding for health. This calls for debt cancellation and sustainable global / international funding to reinforce the public health system.
Underlying a NPHS is an economy that widens people's access to productive wealth and to essential services
The state is a site of struggle, nationally and globally. It supports the national people's health system by resisting privatisation and promoting the public interest. It has and protects the authority and policy space to advance health. It protects the public in trade agreements (TRIPS, GATS, FTAs) and contronts trade liberalisation.
A NPHS provides universal access to treatment (prevention and care) and protects food sovereignty, and indigenous knowledge systems.

Our different areas of struggle and issue campaigns in health civil society can be located within this wider unifying struggle. Each area demands and reinforces the other, once it is located within this unifying framework. We therefore carry the unifying platform of building a national peoples health system into all our issue platforms.

9.3. Organisational objectives

Health civil society in the region is guided in its mode of work by objectives of:

- ☑ Being people led and people-centred
- ☑ Being organised at grassroots, national and global level
- ☑ Having in one struggle with many fronts
- ☑ Linking single issues to the broader vision
- ☑ Being united organisationally across labour, community organisations and social movement
- ☑ Scaling up and advancing on victories
- ☑ Working in solidarity
- ☑ Taking advantage of windows of opportunity.

10. Moving forward: Follow up actions

With these key principles, areas of action and organizational objectives defined, we identified as groups and in plenary the major areas of follow up action. These are summarized below.

We identified several major areas of action as focus for follow up:

- strengthening peoples power in health
- improving the conditions of health workers
- ensuring fair financing for health
- advancing health in trade.

We also identified that issues such as access to treatment embed in all these areas of action and present opportunities through the gains achieved to advance our wider health interests.

10.1. Strengthening peoples power in health

Lead organisations for taking this area forward are: CWGH, EQUINET, MWENGO, MHEN, PHM.

- **Civic education for a NPHS:** We will develop, produce and with civil society organisations in countries widen the use of civic education materials on health that promote the NPHS (CWGH and EQUINET (TARSC) with national health civil society. We will training facilitators in how to use participatory health training materials (CWGH) and run an activist learning workshop open to health civil society in June 2005 (MWENGO).
- **People to people links:** We will make links with and strengthen community health workers understanding (PHM) and make links with parliamentarians in our work (EQUINET, CWGH, GEGA and local health civil society). We will strengthen national coalitions of health civil society with a comprehensive focus on a NPHS (HEPS, MHEN, CWGH, TANGO). We will be actively brought into, supported in and participate in social movement activities of the Social Forum and the Peoples Health Movement (SaSF, PHM).
- **Communication outreach**: We will disseminate information on issues relating to the NPHS in clear, understandeable and simple terms (PHM, MWENGO, CWGH).
- We will co-ordinate out mailing lists to share information and build common issue newsletters where we send the same messages through our editorials (MWENGO, PHM, EQUINET, PATAM). We will provide training on ICTs (MWENGO, EQUINET).

10.2. Improving the conditions of health workers

Lead organisations for taking this area forward are: SATUCC and PHM.

- **Building evidence on Health worker issues:** We will gather research evidence on the conditions of health workers including norms and losses across countries and the impact of privatisation of services and analyse the policy directions from this. (MSP; PHM; EQUINET; SATUCC, PATAM).
- **Debating and developing policy options:** We will bring our evidence from different research processes into the EQUINET regional policy forum on health human resources to be held in July 2005 to develop our policy positions and take these back to our organisations and to our dialogues at national level with health workers (EQUINET, all).
- **Advancing and engaging on our policies:** We will hold a follow up meeting to discuss our advocacy positions after the EQUINET conference and secure funding for a regional campaign that we will take forward through existing campaigns and at country and regional level (MSP, SAMWU, NEHAWU, SATUCC, PHM), Our first campaign day will be on May Day 2005. We will hold meetings in SA and in the region to build capacity on health worker issues (SATUCC, SAMWU, NEHAWU).
- **Information and media outreach:** We will disseminate media statements on the issue, such as in the SAMWU/MSP/ILRIG press conference on occupational health conditions of health workers on 7 March 2005. We will use the MSP radio show on occupational health of health workers distributed through 40 radio stations in SA and the website to take up these issues. We will build solidarity with and disseminate each other's statements and positions in line with our unified platform, including in our newsletters. We will fundraise for wider radio outreach on health worker policy positions (MSP).

10.3. Ensuring fair financing

Lead organisations for taking this area forward are: EQUINET, CIN, HAI, PHM.

- **Sharing evidence and building alliances:** We will share information through our mailing lists and newsletters in fair financing issues (EQUINET) and on global funding issues (TAC/PATAM). We will hold regional policy debates: on fair financing in April 2005 (EQUINET), in March/April in SA (TAC). We will examine how GPPIs strengthen health systems (PHM, CIN, HST, CHESSORE), explore options for fair financing in Africa (EQUINET, CIN) and investigate national health insurance schemes proposals (CIN) and private sector regulation (PHM, TAC) for their impact on fair financing.
- **Monitoring and tracking health financing:** We will track how funds for AIDS are used (HEPS; MHEN) and whether G8, Abuja and other commitments are met (EQUINET, PATAM). We will track how PRSPs are operating (CIN).
- **Campaign on fair financing and debt cancellation:** We will campaign for debt cancellation and advance this at the July G8 meeting (PATAM, TAC and all). We will advocate for an increase in health financing (All) and campaign for the abolition of user fees (TANGO, all).

10.4. Advancing health in trade

Lead organisations for taking this area forward are: ATN, SEATINI.

- **Sharing information, building literacy and building alliances:** We will share information through monthly conference calls (HAI, Oxfam, MSF, TAC, AidsLaw Project); networking meetings (SATUCC); economic literacy activities (CHESSORE, ACRN, MWENGO, ATN, SEATINI) meetings with MPs (SEATINI, CHJESSORE, EQUINET, CWGH, HEPS, HAI) . We will disseminate specific papers on issues, (HAI- medicines paper re: EPAs) . We will build capacities on trade and health isues at country and regional level (SEATINI, EQUINET, CHP)
- **Campaign and engage on trade issues:** We will campaign against EPAs (early March, ATN, MWENGO, LEDRIZ, SEATINI, ACRN), against AGOA (SATUCC); and on AU-IPR

medicines access (March SEATINI, ATN, HAI). We will engage the AU on TRIPS (April TAC/PATAM). We will participate in the Hong Kong ministers planning meeting (26-28 Feb, SEATINI) ; the MPs preparation workshop for Hong Kong (ATN August) and in the Hong Kong WTO Ministerial (MWENGO, LEDRIZ, SEATINI , EQUINET 13-18 Dec)

- **Promoting alternatives:** We will contribute to the building of alternatives to neoliberalism and locate the NPHS in the wider framework of economic and social policy for its achievement (LEDRIZ; before June).

10.5 Building one struggle from many fronts

These areas of struggle will be integrated through:

- a common and uniting position
- united health civil society in agreed common platforms
- common/ joint processes and materials.

Our common and uniting position is for a national people's health system.

The common platforms we will jointly aim at ensuring presence and engagement on the NPHS and the specific issues relevant to that platform are:

- **AU Ministers of Health meeting, April 2005:** lobby on the NPHS, fair financing, TRIPS, PATAM/TAC to lead in organizing.
- **World Health Day April 7 2005:** lobby on NPHS, link to mother and childcare (PHM to lead in organising).
- **May Day May 2005:** lobby on NPHS and health worker conditions, SATUCC to lead in organizing.
- **G8 July 2005:** mobilisation and social action on trade, financing and NPHS: Lead in organising MWENGO, SASF, TAC).
- **PHA2 July 2005**: plenary from the region on the NPHS. PHM to lead in organizing.
- **AU Ministers Meeting Sep-Dec 2005:** lobby on trade-health issues, ATN to lead in organizing.
- **SASF October 2005:** Zimbabwe, plenary on NPHS (Mwengo to lead in organising).
- **UNGASS September 2005:** lobby position on the NPHS and fair financing (lead to be finalised EQUINET?).
- **WTO Hong Kong Ministerial December 2005**: lobby and social action on trade and health. Lead in organising ATN, SEATINI).
- **ASF January 2006:** Morocco WSHF to lead in organizing.
- **WSF Jan 2007:** Nairobi WSHF to lead in organizing.

The points of co-ordination, planning and review for our work are:

- **April 2005, EQUINET:** A meeting of the health civil society lead institutions on 18 April after the EQUINET steering committee meeting in Johannesburg. EQUINET to ensure all organisations are present.
- **June 2005, CWGH:** A meeting of the health civil society institutions in June 2005 at the CWGH National Conference in Zimbabwe. CWGH to ensure relevant health civil society organisations are present.
- **July 2005 PHM:** A meeting of the health civil society led institutions in July 2005 at the PHA2 in Equador. PHM SA to attempt to ensure all organisations are present.
- **September 2005 SATUCC**: A meeting of the health civil society institutions at the SATUCC regional labour forum in Sept/Oct 2005. SATUCC to ensure that relevant health civil society organisations are present.

The processes we will use to strengthen our joint and common platforms are:

- Developing and producing materials for awareness and education on the NPHS.
- Producing and sharing materials for advocacy, lobbying etc.
- Ensuring organisations going to meetings take a joint mandate of the health civil society network, obtain d=solidarity from the network and feed back to the network.
- Setting up a joint mailing list for the health civil society network.

The co-ordinating committee for the health civil society network includes CWGH, EQUINET, HAI, PHM, TAC/ PATAM, SEATINI, SASF, and SATUCC. EQUINET will continue to provide secretariat support (to be reviewed in April) and will set up the mailing list. The April meeting will examine the secretariat roles and see how these can be devolved. EQUINET will gather existing materials from health civil society organisations and disseminate to the network.

PHM will give feedback in March to all organisations in the co-ordinating committee on their participation and support for attending PHA2 (PHM-SA to follow up) and to all organisations on the outcome of the plenary on Africa at PHA2.

The April co-ordinating meeting will review and finalise the joint platform on the NPHS that is integrated into issues platforms and discuss funding, proposals for cross cutting activities and work. In the meantime all groups will explore funding for the programme of work.

11. Closing

Delegates used the ideas of the past days to brainstorm banners, campaign messages and key messages for forums such as G8. While there was debate on the exact working there was evidence on common purpose and common passion across the groups - the objective of the workshop!

There is convergence across all groups of the key message of Building a national people's health system, and consensus on the key areas that this means engaging on.

Itai Rusike of CWGH thanked the delegates for their time and commitments, thanked CHESSORE for hosting the meeting and EQUINET/ TARSC for organizing it, the sponsors for their support and everyone who put work into the workshop. He wished everyone a good journey home and energy in carrying out the work we have agreed to undertake.

Appendix 1: List of Delegates

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Appendix 3: Program

Health civil society in east and southern Africa: Towards a unified agenda and action for people's health, equity and justice

Day one: Thursday February 17

Aims for the day:
To review our current positions and analysis, identify areas where we share perspective and analysis and debate and review areas where we differ, build shared analysis and joint platforms, strategies and campaigns.

830-930am	Welcome, introductions of delegates and groups represented
930-10am	Background to the meeting
1030-1150am	Current challenges, alternatives and issues for health civil society Challenges to common goals of health equity and social justice - R Tayob, SEATINI Forging an alternative in East and Southern Africa - G Kanyenze, SATUCC/LEDRIZ
1150-1pm	Agendas for global health - D Sanders PHM Agendas for regional health– R Loewenson EQUINET
1pm-2pm	Lunch
2-330pm	Group /plenary exercise on positions and priorities
345-445pm	Plenary review on priority issues

Day two: Friday February 18

Aims for the day:
To understand and review the strength, co-ordination and connection of health civil society to broader social movements nationally, regionally and globally. To assess the feasibility of significant co-ordinated regional activity.

830-930am	Plenary (facilitated) mapping of the strength of health civil society around priorities identified on day one. Where and in which issues is civil society pro-active? What is the strength of mobilisation around the identified issues.
1000-1130am	Group exercise: SWOT analysis
1130-1230pm	Plenary: report back
1230-145pm	Lunch
145-300pm	Plenary discussion: Issues from the analysis
315-415pm	Group work on issues raised in plenary
415-600pm	Plenary feedback on group discussions. Discussion and review of common positions and actions

Day three: Saturday February 19

Aims for the day:
To identify and agree on mechanisms for strengthening linkages, resource sharing, solidarity action and unified campaigns across health civil society in east and southern Africa.
To identify and agree on mechanisms and processes that will strengthen and build our capabilities for this
To map the way forward

0830-1000am	Group exercise: Development of a plan of action
1000 -1200pm	Plenary: report and discussion
1245-100pm	Closing
1pm-2pm	Lunch
200-330pm	Wrap up meeting of the planning committee

Appendix 3: Useful Websites

www.phmovement.org
www.patam.org
www.cwgh.org.zw
sa.indymedia.org
www.fsms.org.br
www.queensu.ca/msp/
www.equinetafrica.org
www.mwengo.org
www.tac.org.za
www.haiafrica.org
www.samwu.org.za

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www.haiafrica.org
www.samwu.org.za