HP 2.1

GROUP DISCUSSION - PROBABLE PROCESS

The group elects a Chairman and a rapporteur who will remain the same for Sessions III and IV and the rapporteur will present the deliberations of the group in session V (10/4/92 at 2.00 p.m.)

The group might like to follow the following schedule of activity:

During Session III, (9/4/92) in the afternoon

* The group goes through in detail the Policy Document
* Discusses the Policy statements referring to individual groups
* Discusses issue arising out of Policy statements
  - Present status of implementation at State/District/PHC Level
  - Are we going in line with the Policy?
  - If not, what are the areas needing strengthening? - Govt. Health Set up
  - Non-Govt. Organisation
  - What should be the approach at different levels of Health Care - State/District/PHC
  - What should be the approach by Health related sectors
  - Any other aspect group likes to discuss.

During Session IV (10/4/92) in the morning

* Starts the discussion reviewing the activities of previous day. Continue the discussion and prepares an action plan focusing on
  * Orientation of Partners in Health Care on Health Policy
  * Implementation of aspects discussed previous day at different levels of Health care by Govt./NGO and People's representatives.
  * Supervision, monitoring and evaluation of the implementation.
  * Need/otherwise of a State Health Policy

The group rapporteur presents in detail aspect of Health Policy discussed, members participating in the discussion and detailed action plan.

Group I Focusses on Primary Health Care
Group II Focusses on Health Education
Group III Focusses on Inter-sectoral co-cordination
Group IV Focusses on Health Information System

GROUP - IV HEALTH INFORMATION SYSTEMS

I. Group read relevant part of MIS in NHP statement

II. Discussion started on present system operating.

(A.) Channels of information. What information? Only statistics, or also details about programs or why info is needed?

Field Staff ⟶ PHC ⟶ DHO ⟶ DJD
⟶ Directorate HS.

with a feed back along same channel. } Both are available
∴ There is a two-way system existing. }
Feed

(B) Most important collector of HInfo. from field is by Govt. staff - ANMs.

- Voluntary agencies vary in the information they collect and supply. Also depends on request from Govt. agencies for particulars.

eg:- Vital statistics (Births/Deaths) are given to Panchayat / PHC level.
Disease profiles reports directly to Directorate once a year from Hospitals.

= There is no duplication of reports in a service like vaccination / U.I.P, while this is possible in areas of Post-partum care. - Due to different types of voluntary agencies and their different activities

FIELD LEVEL (C) Information collected is incomplete because of various problems cited below.

+ Language problems.

a) Educational level of ANM is wanting in some areas.
b) Information is 2nd hand eg. ANM collects from Anganwadi worker.
c) Too much of data. Each program has its own needs to be fulfilled. Hence the worker in the field is overburdened.
d) The reporting formats are complicated and are not easily understood by some field workers.

PHC Level:
a) Compiles reports from field
+ b) Data generated at PHC – Out patients & in-patients
Here, problems of classifying data from inadequately maintained registers.
eg: – Disease statistics Register has over 150 diseases classifications recently reduced to 27.

D.H.O. Level:
a) Compile reports from PHCs
b) Statistical officer present to compile data, and also do a 10% verification. Still the amount of data is large.
+ DHO verifies 2% of data.

General comments: (1) Vital statistics (Births & Deaths) was maintained originally by Village/Local administration. Now it is part of Health Dept. This Vital statistics reporting has improved after statutory requirements for recording is become necessary eg: Birth/Death certificates for various

(2) Notifiable Diseases / Epidemic occurrences reporting only if diseases are fatal / create problems eg: Gastroenteritis reported / Malaria - not so much

Some solutions:

1. SIMPLE FORMAT of reporting by field worker.
   IEC proforma - single sheet introduced some time back (3yrs back).
   + Adequate amount of printed material to be supplied.
   ONLY ONE PERSON/AGENCY in an area to be responsible for HHS collection preferably Govt agency.

2. SIMPLE & STANDARDISED CODING SYSTEM at PHC corresponding with W.H.O. classification to diseases to be worked out.

3. COMPUTERIZATION of INFO. SYSTEM at D.H.O. level.
   Volag. Hospital data to go directly to D.H.O. level

4. VOL. AGENCIES to attend PHC meets every months and exchange data.
   - to prevent duplication.
   - to confirm validity of data by names of individuals.

5. ~~Combination of INCENTIVES & TARGETS makes for unreliable data sometimes.~~
   ~~Incentives to work harmful for accuracy of information. The incentive funds could be utilized for other development aspect of the area.~~

6

Chair: Dr. T. Annappa Rao
Rapt: Dr S. P. Tekur

GROUP - IV - on
HEALTH INFORMATION SYSTEMS

The Group discussion started with reading the relevant parts of the N.H.P. statement focusing on this topic.

We decided to focus first on how the system is at present operating & consider the positive aspects and lacunae.

(1) Channels of Information:

Field Staff → to → PHC → to → DHO → to → DJD → to → Directorate of Health Services.

There is a feed-back system going back along the same channel.
The information transmitted is mainly in the form of figures (numbers) while the other details are also present at point of collection.

(2) The chief person collecting information from the field is from the Government - Deptt of Health & F.W. — the A.N.M. to be specific. and Male Health Assistant.

Voluntary agencies collect different types of information depending on their activities. They may transmit it to the government on request, and that too, at different levels.

eg: - Vital Statistics (Births / Deaths) are given to PHC / Panchayat level.

- Disease profiles are transmitted directly to Directorate H.S. once a year from the Hospitals

There is no duplication of reports in services like U.I.P., where vaccines are involved. It may occur in other areas.

(3) At FIELD LEVEL

The information collected is incomplete because of various problems cited below.

-a) Educational and language problems of ANM.

-b) Information may be second hand
eg: ANM Collects from Anganwadi worker.

-c) Too much of data. Each program has its own needs to be fulfilled. Hence the worker in the field is overburdened.

-d) The reporting formats are complicated and are not easily understood by some Field workers.

(4) At P.H.C. level:

-a) Compilation of reports from field

-b) In addition, data generated at P.H.C. itself from its Out-patient / Inpatient records. Here again, there are problems of classifying data from inadequately maintained registers
eg: Disease Statistics Register has 150 diseases classified.
(This has recently been reduced to 27).

(5) At D.H.O. level

-a) Compilation of reports from P.H.Cs.

-b) The data compiled undergoes ~~a~~
a 10% verification by Statistical Officer &
-2% verification by D.H.O.

The amount of data here is very large and requires about 3 days of compiling work.

(6) ☆ General comments:

(a) Vital statistics reporting (Births & Deaths) has improved after statutory requirements have made recording necessary for various reasons where Birth & Death certificates are required

(b) Notifiable Diseases / Epidemic occurences reporting is mainly if the diseases are of fatal nature, or create problems eg: in Gastroenteritis. reporting

SOME SOLUTIONS

(1) Only one person / agency in an area is to be responsible for H.I.S. collection, preferably the Govt. agency.

(2) A simple format of reporting for field worker - preferably one page.
eg: I.E.C. (MIED) proforma introduced 3yrs back of a single page - can be updated and used.
Also adequate printed material is required to be supplied.

(3) A simple and standardized coding system at P.H.C. corresponding to W.H.O. classification of diseases to be worked out for Standar Disease Statistics Register.

(4) Computerisation of information system at D.H.O level.
Hospital data from Voluntary agencies in a district to be sent to D.H.O. level.

(5) Voluntary agencies to attend P.H.C. meets every month and exchange data and information and avoid duplication.

(6) A mechanism of involving local people like in Arogya Mahila Samsthe at Mandal Panchayat level with members from each village.
Also, no incentives or honoraria should be given for helping in H.I.S. Only transfer of knowledge, especially on health takes place for the local group.

The group then decided to focus on N.H.P. guidelines and priorities it sets in the following areas.

In Nutrition – There are various programs which have gone thru' the stages of baseline survey and partial implementation.

eg: Vit. A prophylaxis / Anaemia (Iron & Folic Acid)
Goitre / ICDS - Suppl. nutrition etc.

- Concurrent evaluation of these programs is to be done for upgradation, stopping or adding on services.

Also, strengthening of Research aspect in the H.I.S. cell at State and District level for utilizing HIS data well.

Teaching, training and other Research Medical / Health Institutions to be utilized for focussing on Public Health problems with HIS degenerated.

- In areas of food / drug adulteration, incidence of Food-poisoning & unusual health effects of drugs are to be reported. Also Drug inspectorate work is to be intensified to generate data, as the people are made aware of this problem.

= It would be needed to make N.H.P priority disease areas to be reported as part of H.I.S.

= We also need Qualitative data in addition to Quantitative data. Though this cannot be done routinely, it can be done with local peoples organisations

For occupational diseases, no system for reporting or studying is available

This has to be created, with special focus on Agriculture and rural occupations.

☆ There is data generated at District Surgeon level in Cg. Hs as regards to no. of pts - treated IN as well OUT-pts. This is to be directly to Directorate for further compilation.

ALL DATA GENERATED HAS TO BE FOR RELEVANT EPIDEMIOLOGICAL NEEDS OF HEALTH OF THE PEOPLE.

- Data from Pvt. N. Homes & Hosp. & Pvt. sector. -

- One nodal agency at PHC & Dist. Level.

- Lacunae in information system.

HP 2.2 (1)

The Bangalore Workshop on National Health Policy, organized by the
Voluntary Health Association of Karnataka,
Voluntary Health Association of India, and
Department of Health and Family Welfare, Karnataka,
with participants drawn from the Governmental and Voluntary Health Sectors, at the Institute of Economic and Social Change on 9th to 11th April, 1992
Having had the benefit of well-searched presentations on
Overview of the National Health Policy,
Current Health Status of India,
National Health Policy from the point of view of the Government of Karnataka, and
National Health Policy as seen by Voluntary Organisations,
Deliberating in groups on various issues in health and especially focussed on
Primary health care,
Health Education,
Inter-sectoral co-ordination and
Health Information System,
Reflecting in the plenary session on the various suggestions, and further recommendations,
Have come to the following conclusions:

* Taking note of the possible impact of the New Economic Policy on Health

1. There is need for increasing the allocation of budget to Health Sector giving due importance to population Coverage (urban and rural) proportionately in urban and Rural areas.

2. Decentralisation of planning, implementation and evaluation of Health and Health related programmes to District level is to be fostered to facilitate effective functioning.

3. The existing facilities at primary health centres should be improved before embarking on expansion of Services.

4. National Drug policy and implicit recommendations should be part of National Health policy. The use of essential drugs in adequate quality is to be recommended at all levels of health delivery.

5. Indigenous System of medicine should be incorporated into Modern medicine and Comparative research in this area is to be promoted.

6. Health Insurance as a concept of health policy document may be promoted among the people to participate economically for utilisation of available Health services provided by the govt.

7. To improve the inter Sectoral Coordination in Health Care delivery inter Sectoral Committees be set up at State / District / PHC / Sub-Centre / village levels which should identify the health problems, implement the health and health related problems with a wholistic approach giving due importance to Creating awareness among the people and monitoring and evaluating the programmes periodically.

8. The available infrastructure for training in govt. set up should be made available to train Health personnel from voluntary organisations.

9. Health education is needed to make people health Conscious, become aware of health problems and develop, Knowledge, Skills and attitude to take action for better health by the people.

10. There is need for improvement in Communication Strategies utilising the mass media, Street theatre and folk arts as also inter personal Communication.

11. Committees should be constituted or revitalised at the block, District and State level for identifying and taking action for Health.

12. The Structure of the Health Information System and reporting channels are adequate to generating valid data. The functioning can be improved by

- Simplified reporting systems
- use of Computerisation and
- involvement of voluntary agencies.

and village level people's Committee taking responsibility and helping the system.

13. All data generated in the Health Information System should focus on giving epidemiological information relevant to health need of the people. There is a necessity to establish one Epidemiologic Unit in each district.

We further recommend ~~that~~

1. There is need for professionals, voluntary organisations and ~~and~~ peoples representatives and others at the State/District/Taluka levels to discuss the policies and ~~to~~ develop understandable, workable programmes ~~and evaluation~~ implement them and evaluate them.

2. A State level committee consisting of all partners in health care from Governmental and voluntary sectors be formed to monitor progress in the implementation of the policy and to help in removing bottlenecks and constraints. The committee will work out the indices for monitoring ~~and~~ progress.

3. The Committee be also entrusted ~~to~~ the task of formulation of a Health Policy for Karnataka within a time frame of one year ~~taking~~ into account from now.

4. A committee of five members of this workshop be entrusted with the responsibility of preparing the ~~final~~ draft report of this workshop, which will be circulated to all the participants, ~~and~~ who will be given one months time to respond to the draft. The same committee will then prepare the final report which will be submitted to Government by August 1992 and copies sent to all members.

(as there may be matters to be sent to DHS)

HP 2.3

CURRENT HEALTH STATUS OF INDIA

(By Dr.J.P.GUPTA, Regional Director (H&FW) Bangalore)

According to WHO, "the process of continuous progressive improvement of the health status of a population reflects the health development of the nation". It is a product of rising of the level of human well-being marked by containment of diseases and attainment of positive physical and mental health related to satisfactory economic functioning and social integration.

It is based on the fundamental principle that Governments have responsibility of their people and simultaneously people should have the right as well as the duty, individually or collectively to participate in the development of their own health.

The health status depends upon the over all social and economic development of the country.

There are a number of indicators to gauze health status of the community to the extent to which the objectives and targets of a programme are being attained.

Characteristic of indicator -

The ideal indicators scientifically should be Valid, Reliable, Sensitive, Specific and Quantifiable. There is presently no available definition (including WHO definition) containing all the ideal indicators as criteria for measuring the health. Only the measurement of health have been dubbed in the frame work of illness, the consequences of ill health (morbidity or disability) and economic, occupational and domestic factors that promote ill health.

Since health is multidimensional and each dimension is influenced by numerous factors (known or unknown); thus the health status may cover the following indicators:-

Mortality indicators, Morbidity indicators, Nutritional status indicators, Health care delivery indicators, Utilisation rates, Indicators of social and mental health, Environmental indicators, Socio-economic indicators, Health policy indicators, Indicators of quality of life and Other indicators.

- oOo -

REFORMULATED GLOBAL INDICATORS

(As adopted with amendments by the Executive Board by Resolution EB 85.R5)

No.1 - The number of countries in which health for all is continuing to receive endorsement as policy at the highest level.

No.2 - No. of countries in which mechanism for involving people in the implementation of strategies are fully functioning or are being further developed.

No.3 - The percentage of gross national product on health.

No.4 - The percentage of National Health Expenditure devoted to local health services.

No.5 - The No. of countries in which resources for Primary Health Care are becoming more equitably distributed.

No.6 - The amount of International Aid received or given for health.

No.7 - The percentage of the population covered by Primary Health Care, with atleast the following -

(a) Safe water in the home or with reasonable access and adequate excreta disposal facilities available.

(b) Immunization against Diphtheria, Tetanus, Whooping-cough, measles, Poliomylitis and Tuberculosis.

(c) Local Health Services, including availability of essential drugs, within one hour's walk or travel.

(d) Attendance by trained personnel for pregnancy and child birth and caring for children upto atleast one year of age.

(e) The percentage of each element should be given for all identifiable subgroups.

(f) The percentage of women of child-bearing age using family planning.

No.8 - The percentage of newborns weighing at least 2500 grams at birth and the percentage of children whose weight-for-age and/or weight-for-height are acceptable.

No.9 - The IMR, MMR and probability of dying before the age of 5 years (U5MR), in all identifiable subgroups.

No.10 - Life expectancy at birth, by sex, in all identifiable subgroups.

No.11 - The adult literacy rate, by sex, in all identifiable subgroups.

No.12 - The per capita Gross National Product.

NATIONAL GOALS OF HEALTH

(Source: National Health Policy Document)

	GOALS	ACHIEVEMENT
* INFANT MORTALITY RATE (combined) (per 1000 live births)	60	80 (1990-prov.)
UNDER-5 MORTALITY (per 1000 live births)	70	146 (1990)
MATERNAL MORTALITY (per lakh birth)	200	400 (1990)
PERINATAL MORTALITY	30-35	50.1 (1987)
*CRUDE DEATH RATE (Combined)	9/1000	9.6 (1990-Prov.)
*CRUDE BIRTH RATE (Combined)	21/1000	29.9 (1990-Prov.)
**EFFECTIVE CPR	60%	44.1 (1991-Prov.)
@@ N.R.R	1.0	1.6 (1981)
@@ FAMILY SIZE (Rural & Urban combined)	2.3	4.1 (1987)
@ EXPONENTIAL ANN GR.RATE	1.2	2.11 (1991) (Source Census Report 1991)
@% NEWBORN WITH 2500 Gms Birth Weight.	10%	30% (1990)
@ % OF ANTENATAL CARE	100%	40-50%
@ % DELIVERIES BY TBA	100%	40.5% (1987)
** IMMUNIZATION - TT(PW)	100%	79% (1991)
"TT School Children	100%	55.6% (1989)
DPT	100%	82% (1990)
POLIO	100%	82% (1990)
BCG	100%	89% (1990)
DT	85%	80% (1990)
** MEASLES	100%	90.1% (1991)

OTHER INDICATORS

	GOALS	ACHIEVEMENT
LIFE EXPECTANCY AT BIRTH (persons)	64.0	59.0 (1990)
@@ LEPROSY (% of Disease arrested out of those detected)	100%	55% (1989)
@@ T.B.(% of Disease arrested out of those detected)	75%	65% (1989)
@@ INCIDENCE OF BLINDNESS (%)	0.3	0.7 (1990)

Female Literacy (1991) =39.4

@ % of children suffering from underweight (0-4 yrs.) (By Gomez - 8 States)

Moderate & severe = 61 (1980-91)

severe = 9 (1980-91)

@ Average index of food production per capita (1979-81=100) = 118 (1990)

@ Daily per capita calorie supply as % of requirements (1988) = 95

@ % of household income (1980-85)

Spent on - All foods = 52

Cereals = 18

@ % of Population with access to safe water (1989-90)

Total = 75

Urban = 79

Rural = 73

@ O.R.T. use rate (1987-89) = 13

@ GNP per capita (in US $) (1989) = 340

Sources -

* - SRS Report 1990

@ - The State of the World's children 1992 - UNICEF

** - MCH&FW Quarterly report

@@ - 2nd Evaluation - Country report on strategies for Health for all by the year 2000-1991

LEVEL OF ACHIEVEMENT OF SOME NORMS
ALL INDIA POSITION AS ON 30.09.1991

Sl. No.	Parameters/indicators	National Norms	Norms achieved/ established (Approximate)
1	2	3	4
1.	Population covered by a Sub-centre	3000-5000 Pop.	4576
2.	Population covered by a PHC	20,000-30,000 Pop.	27168
3.	Population covered by a Community Health Centre	About 1 lakh Pop.	3.10 lakhs
4.	No.of Sub-centres for each PHC	6 sub-centres	6.0 sub-centres
5.	No.of Primary Health Centres for each Community Health Centre	4 PHCs	11.4 PHCs
6.	Trained Village Health Guide	One for each village/1000 population	1.42 villages/ VHG 1442 population/ VHG
7.	Trained Dai	Atleast one for each village	1.00 villages 1002 population
8.	Population served by Health Workers (Male and Female)	M:3000-5000 F:3000-5000	7632 4953
9.	Ratio of HA(M):HW(M)	1:6	1:3.4
10.	Ratio of HA(F):HW(F)	1:6	1:5.4
11.	Average area covered by Sub-Centre	-	24.00 sq.km.
12.	Average Area covered by a PHC	-	142.45 sq.km.
13.	Average area covered by a CHC	-	1626.93 sq.km.
14.	Max.radial distance covered by a PHC (in km.)	-	6.73 km.
15.	Max.radial distance covered by a Sub-centre (in km.)	-	2.76 km.
16.	Max.radial distance covered by a CHC (in km)	-	22.81 km
17.	Average number of villages covered by a sub-centre	-	4-5
18.	Average number of villages covered by a PHC	-	26-27
19.	Average number of villages covered by a CHC	-	304

Source: Quarterly Bulletin on Rural Health Statistics -Sep. 1991.

HEALTH INFRASTRUCTURE - As on 30-9-91.

A.

	Total functioning.	In Govt. Building.	Building under construction.	Buildings to be constructed.
Sub-Centres	130983	51985 (39.7%)	7905	71093 (54.3%)
PHCs	22065	12500 (56.6%)	1389	8176 (37.0%)
CHCs	1932	1179 (61.0%)	284	469 (24.3%)

B. No.of PHCs & Sub-Centres required and in position in Tribal Area -

= Total Population in TSP Area = 776.84 lakhs
= Total Population in Tribal pocket = 403.02 lakhs
= Total PHCs required for Tribal Area = 3507
= Total PHCs in position in Tribal Area = 3198 (91.2%)
= Total Sub-Centres required in Tribal Area = 23586
= Total Sub-Centres in position in Tribal Area = 18996 (80.5%)

C. Primary Health Centres with or without Doctors -
(Information available for 10787 PHCs. (48.9% only)

= PHCs with 4 or more Doctors = 427
= PHCs with 3 Doctors = 450
= PHCs with 2 Doctors = 3875
= PHCs with 1 Doctor = 5048
= PHCs without Doctors = 987

D. = PHCs without Lab.Technician = 3787
= PHCs without Pharmacist = 311

E. = Total No.of ANM Schools = 476
= ANM admission capacity =20337
= Total No.of LHV promotional schools = 46
= ANM admission capacity = 3863

F. = Total Dais trained since inception (as on 30-9-91) = 597761

= Village Health Guide Scheme

-PHCs covered under VHG Scheme = 4220
-Villages covered under VHG Scheme = 531009
-Total VHGs Trained (including 948 AHGs) = 416672
- No.of working VHGs = 335590

G. = Medical Care Statistics - As on 1-1-1990
(Source - Health Information India - 1990)

	Rural	Urban	Total
- No.of Hospitals	3167	7005	10172
- No.of beds	95722	506768	602490
- No.of Dispensaries	12747	15557	28304
- No.of Beds	13642	9286	22928

H. = Disabled population (as per 1981 Census report)
- Disabled persons in Rural Area = 969401
- Disabled person in Urban area = 149547
- Total Disabled person =1118948

I. =Percentage of Population below poverty line (1987-88 Prov.)
(Source - Health Information India - 1990)

- Rural = 32.66%
- Combined = 29.23%

J. HEALTH MAN POWER IN RURAL AREAS -

Category	No.Sanctioned	No.in Position	Vacant (%)
1. Surgeons	914	676	25.1
2. Obs.& Gyn.	627	362	42.4
3. Physicians	535	406	24.2
4. Paediatricians	512	274	46.4
5. Doctors at PHCs	25062	21278	15.1
6. Block Extn. Educators	6154	5763	6.4
7. Health Asstts. (Male)	24891	23273	6.5
8. Health Worker (Male)/MPW	86713	78538	9.4
9. Health Asstts.(Fem)/LHVs	25044	22282	11.1
10.Health Workers (Fem)/ ANMs	132449	121016	8.7
11.Pharmacists	19172	17578	8.4
12. Lab.Technicians	10189	8629	15.4
13. Nurses Mid-wives	13790	11969	13.3
14. Radiographer	658	509	22.7
Total category 1 to 4	2588	1718	33.6
Total of category (5 to 14)	344122	311835	9.7
Grand total of all (1-14)	346710	312553	9.9

PERCENTAGE OF GROSS NATIONAL PRODUCT SPENT ON HEALTH -

Estimation of total expenditure on Health and Family Welfare have been taken into consideration on the following basis:-

(1) Expenditure of Ministry of Health and Family Welfare (Centre and State - both Plan and Non-plan)

(2) Expenditure on Health and Family Welfare by other Government Departments (except Defence, Paramilitary Forces, Local bodies and P & T etc - since data are not available).

(3) For estimating private expenditure on Health and Family Welfare, the basic assumption is that the private expenditure is double the amount of Public Sector Expenditure (on the basis of National Sample Survey findings).

The findings are -

(A) During Sixth and Seventh Plan the total expenditure on Health and Family Welfare (from Departments of Health and Family Welfare of States, UTs. and Centre only) as percentage of GNP is between the rate of 0.98% (1986-87) to 1.32% (1984-85)

For year 1984-85

$$\frac{\text{National Health Expenditure}}{\text{GNP}} \times 100$$

$$= \frac{\text{Rs.3018.36 Crores}}{\text{Rs.228,118 Crores}} \times 100 = 1.32\%$$

(Source - Planning Commission)

(B) As percentage of HNP, the total public sector expenditure (as per above information) has remained within the range of 1.32% (1984-85) and 1.07% (1986-87).

(C) The total expenditure on Health and Family Welfare including the Private Sector is within the range of 4.08% (1984-85) to 3-2% (in 1986-87).

PERCENTAGE OF NATIONAL HEALTH EXPENDITURE ON LOCAL HEALTH SERVICES

Only outlays of Minimum Need Programmes (below district level) has been considered. Therefore the following figures are not showing realistic picture - rather it is an under estimate -

For 1985-1990

National Health Expenditure elevated

$$= \frac{\text{to local services}}{\text{National Health Expenditure (including F.W.)}} \times 100$$

$$= \frac{\text{Rs. 1063 Crores}}{\text{Rs. 2495 Crores}} \times 100 = 42.6\%$$

(Source - Planning Commission)

(It excludes Central Health outlay of Rs.897 crores, Family Welfare outlay of Rs.3256 crores and outlays for National Health Programmes - because expenditure below district level is not available).

Duplicate

CURRENT HEALTH STATUS OF INDIA

(By Dr.J.P.GUPTA, Regional Director (H&FW) Bangalore)

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- oOo -

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(b) Immunization against Diphtheria, Tetanus, Whooping-cough, measles, Poliomylitis and Tuberculosis.

(c) Local Health Services, including availability of essential drugs, within one hour's walk or travel.

(d) Attendance by trained personnel for pregnancy and child birth and caring for children upto atleast one year of age.

(e) The percentage of each element should be given for all identifiable subgroups.

(f) The percentage of women of child-bearing age using family planning.

No.8 - The percentage of newborns weighing at least 2500 grams at birth and the percentage of children whose weight-for-age and/or weight-for-height are acceptable.

No.9 - The IMR, MMR and probability of dying before the age of 5 years (U5MR), in all identifiable subgroups.

No.10 - Life expectancy at birth, by sex, in all identifiable subgroups.

No.11 - The adult literacy rate, by sex, in all identifiable subgroups.

No.12 - The per capita Gross National Product.

NATIONAL GOALS OF HEALTH

(Source: National Health Policy Document)

	GOALS	ACHIEVEMENT
* INFANT MORTALITY RATE (combined) (per 1000 live births)	60	80 (1990-prov.)
UNDER-5 MORTALITY (per 1000 live births)	70	146 (1990)
MATERNAL MORTALITY (per lakh birth)	200	400 (1990)
PERINATAL MORTALITY	30-35	50.1 (1987)
*CRUDE DEATH RATE (Combined)	9/1000	9.6 (1990-Prov.)
*CRUDE BIRTH RATE (Combined)	21/1000	29.9 (1990-Prov.)
**EFFECTIVE CPR	60%	44.1 (1991-Prov.)
@@ N.R.R	1.0	1.6 (1981)
@@ FAMILY SIZE (Rural & Urban combined)	2.3	4.1 (1987)
@ EXPONENTIAL ANN GR.RATE	1.2	2.11 (1991) (Source Census Report 1991)
@% NEWBORN WITH 2500 Gms Birth Weight.	10%	30% (1990)
@ % OF ANTENATAL CARE	100%	40-50%
@ % DELIVERIES BY TBA	100%	40.5% (1987)
** IMMUNIZATION - TT(PW)	100%	79% (1991)
"TT School Children	100%	55.6% (1989)
DPT	100%	82% (1990)
POLIO	100%	82% (1990)
BCG	100%	89% (1990)
DT	85%	80% (1990)
** MEASLES	100%	90.1% (1991)

OTHER INDICATORS

	GOALS	ACHIEVEMENT
LIFE EXPECTANCY AT BIRTH (persons)	64.0	59.0 (1990)
@@ LEPROSY (% of Disease arrested out of those detected)	100%	55% (1989)
@@ T.B. (% of Disease arrested out of those detected)	75%	65% (1989)
@@ INCIDENCE OF BLINDNESS (%)	0.3	0.7 (1990)

Female Literacy (1991) =39.4

@ % of children suffering from underweight (0-4 yrs.) (By Gomez - 8 States)

Moderate & severe = 61 (1980-91)

severe = 9 (1980-91)

@ Average index of food production per capita (1979-81=100) = 118 (1990)

@ Daily per capita calorie supply as % of requirements (1988) = 95

@ % of household income (1980-85)

Spent on - All foods = 52

Cereals = 18

@ % of Population with access to safe water (1989-90)

Total = 75

Urban = 79

Rural = 73

@ O.R.T. use rate (1987-89) = 13

@ GNP per capita (in US $) (1989) = 340

Sources -

* - SRS Report 1990
@ - The State of the World's children 1992 - UNICEF
** - MCH&FW Quarterly report
@@ - 2nd Evaluation - Country report on strategies for Health for all by the year 2000-1991

LEVEL OF ACHIEVEMENT OF SOME NORMS
ALL INDIA POSITION AS ON 30.09.1991

Sl. No.	Parameters/indicators	National Norms	Norms achieved/ established (Approximate)
1	2	3	4
1.	Population covered by a Sub-centre	3000-5000 Pop.	4576
2.	Population covered by a PHC	20,000-30,000 Pop.	27168
3.	Population covered by a Community Health Centre	About 1 lakh Pop.	3.10 lakhs
4.	No.of Sub-centres for each PHC	6 sub-centres	6.0 sub-centres
5.	No.of Primary Health Centres for each Community Health Centre	4 PHCs	11.4 PHCs
6.	Trained Village Health Guide	One for each village/1000 population	1.42 villages/ VHG 1442 population/ VHG
7.	Trained Dai	Atleast one for each village	1.00 villages 1002 population
8.	Population served by Health Workers (Male and Female)	M:3000-5000 F:3000-5000	7632 4953
9.	Ratio of HA(M):HW(M)	1:6	1:3.4
10.	Ratio of HA(F):HW(F)	1:6	1:5.4
11.	Average area covered by Sub-Centre	-	24.00 sq.km.
12.	Average Area covered by a PHC	-	142.45 sq.km.
13.	Average area covered by a CHC	-	1626.93 sq.km.
14.	Max.radial distance covered by a PHC (in km.)	-	6.73 km.
15.	Max.radial distance covered by a Sub-centre (in km.)	-	2.76 km.
16.	Max.radial distance covered by a CHC (in km)	-	22.81 km
17.	Average number of villages covered by a sub-centre	-	4-5
18.	Average number of villages covered by a PHC	-	26-27
19.	Average number of villages covered by a CHC	-	304

Source: Quarterly Bulletin on Rural Health Statistics -Sep. 1991.

HEALTH INFRASTRUCTURE - As on 30-9-91.

A.

	Total functioning.	In Govt. Building.	Building under construction.	Buildings to be constructed.
Sub-Centres	130983	51985 (39.7%)	7905	71093 (54.3%)
PHCs	22065	12500 (56.6%)	1389	8176 (37.0%)
CHCs	1932	1179 (61.0%)	284	469 (24.3%)

B. No.of PHCs & Sub-Centres required and in position in Tribal Area -

= Total Population in TSP Area = 776.84 lakhs
= Total Population in Tribal pocket = 403.02 lakhs
= Total PHCs required for Tribal Area = 3507
= Total PHCs in position in Tribal Area = 3198 (91.2%)
= Total Sub-Centres required in Tribal Area = 23586
= Total Sub-Centres in position in Tribal Area = 18996 (80.5%)

C. Primary Health Centres with or without Doctors -
(Information available for 10787 PHCs. (48.9% only)

= PHCs with 4 or more Doctors = 427
= PHCs with 3 Doctors = 450
= PHCs with 2 Doctors = 3875
= PHCs with 1 Doctor = 5048
= PHCs without Doctors = 987

D. = PHCs without Lab.Technician = 3787
= PHCs without Pharmacist = 311

E. = Total No.of ANM Schools = 476
= ANM admission capacity =20337
= Total No.of LHV promotional schools = 46
= ANM admission capacity = 3863

F. = Total Dais trained since inception (as on 30-9-91) = 597761

= Village Health Guide Scheme

-PHCs covered under VHG Scheme = 4220
-Villages covered under VHG Scheme = 531009
-Total VHGs Trained (including 948 AHGs) = 416672
- No.of working VHGs = 335590

G. = Medical Care Statistics - As on 1-1-1990
(Source - Health Information India - 1990)

	Rural	Urban	Total
- No.of Hospitals	3167	7005	10172
- No.of beds	95722	506768	602490
- No.of Dispensaries	12747	15557	28304
- No.of Beds	13642	9286	22928

H. = Disabled population (as per 1981 Census report)
- Disabled persons in Rural Area = 969401
- Disabled person in Urban area = 149547
- Total Disabled person =1118948

I. = Percentage of Population below poverty line (1987-88 Prov.)
(Source - Health Information India - 1990)

- Rural = 32.66%
- Combined = 29.23%

J. HEALTH MAN POWER IN RURAL AREAS -

Category	No.Sanctioned	No.in Position	Vacant (%)
1. Surgeons	914	676	26.1
2. Obs.& Gyn.	627	362	42.4
3. Physicians	535	406	24.2
4. Paediatricians	512	274	46.4
5. Doctors at PHCs	25062	21278	15.1
6. Block Extn. Educators	6154	5763	6.4
7. Health Asstts. (Male)	24891	23273	6.5
8. Health Worker (Male)/MPW	86713	78538	9.4
9. Health Asstts.(Fem)/LHVs	25044	22282	11.1
10.Health Workers (Fem)/ ANMs	132449	121016	8.7
11.Pharmacists	19172	17578	8.4
12. Lab.Technicians	10189	8629	15.4
13. Nurses Mid-wives	13790	11969	13.3
14. Radiographer	658	509	22.7
Total category 1 to 4	2588	1718	33.6
Total of category (5 to 14)	344122	310835	9.7
Grand total of all (1-14)	346710	312553	9.9

PERCENTAGE OF GROSS NATIONAL PRODUCT SPENT ON HEALTH -

Estimation of total expenditure on Health and Family Welfare have been taken into consideration on the following basis:-

(1) Expenditure of Ministry of Health and Family Welfare (Centre and State - both Plan and Non-plan)

(2) Expenditure on Health and Family Welfare by other Government Departments (except Defence, Paramilitary Forces, Local bodies and P & T etc - since data are not available).

(3) For estimating private expenditure on Health and Family Welfare, the basic assumption is that the private expenditure is double the amount of Public Sector Expenditure (on the basis of National Sample Survey findings).

The findings are -

(A) During Sixth and Seventh Plan the total expenditure on Health and Family Welfare (from Departments of Health and Family Welfare of States, UTs. and Centre only) as percentage of GNP is between the rate of 0.98% (1986-87) to 1.32% (1984-85)

For year 1984-85

$$\frac{\text{National Health Expenditure}}{\text{GNP}} \times 100$$

$$= \frac{\text{Rs.3018.36 Crores}}{\text{Rs.228,118 Crores}} \times 100 = 1.32\%$$

(Source - Planning Commission)

(B) As percentage of HNP, the total public sector expenditure (as per above information) has remained within the range of 1.32% (1984-85) and 1.07% (1986-87).

(C) The total expenditure on Health and Family Welfare including the Private Sector is within the range of 4.08% (1984-85) to 3-2% (in 1986-87).

PERCENTAGE OF NATIONAL HEALTH EXPENDITURE ON LOCAL HEALTH SERVICES

Only outlays of Minimum Need Programmes (below district level) has been considered. Therefore the following figures are not showing realistic picture - rather it is an under estimate -

For 1985-1990

$$= \frac{\text{National Health Expenditure elevated to local services}}{\text{National Health Expenditure (including F.W.)}} \times 100$$

$$= \frac{\text{Rs. 1063 Crores}}{\text{Rs. 2495 Crores}} \times 100 = 42.6\%$$

(Source - Planning Commission)

(It excludes Central Health outlay of Rs.897 crores, Family Welfare outlay of Rs.3256 crores and outlays for National Health Programmes - because expenditure below district level is not available).

VIEW OF PEOPLES' REPRESENTATIVE IN NATIONAL HEALTH POLICY

By

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Presented in the workshop on National Health Policy by Voluntary Health Association of Karnataka, Bangalore.

on 9-10 April 1992

Held at Institute for Social and Economic Change, Nagarbhavi, BANGALORE-560 072

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C O N T E N T S

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INTRODUCTION

The charter for India's Socio-Economic Development through specific programmes, as a Health Policy was approved in 1983 by Parliament, Lying greater stress on MCH care following targets by 2000 A.D. were fixed.

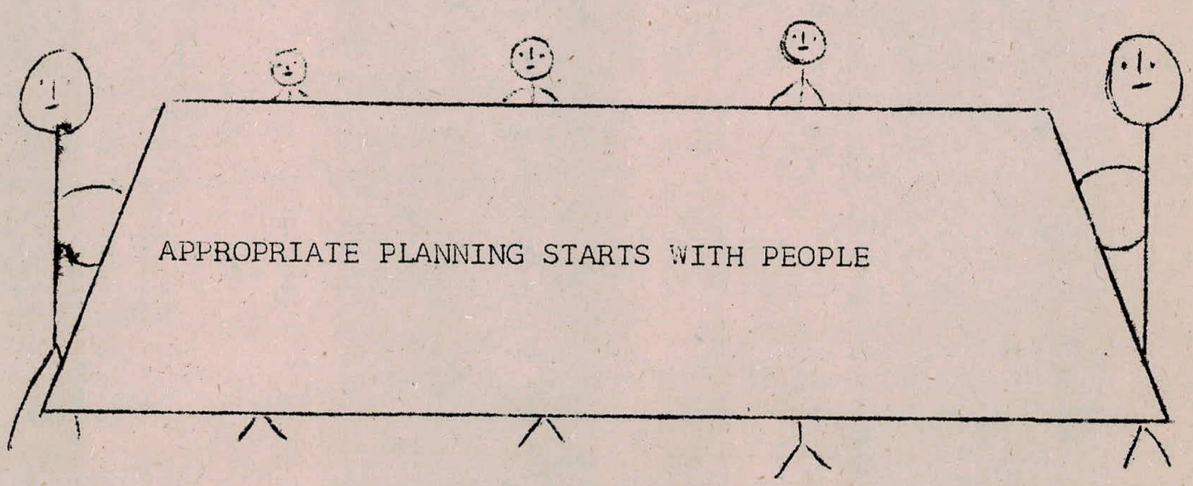
I.M.R. - below 60	-
Perinatal Mortality Rate	- 30-35
Pre-School child mortality (1 - 5 years)	- 10
M.M.R.	- Below 2
Babies with Birth weight below 2500 g	- 10%
Birth rate	- 21
Family size	- 2.3
ANC to pregnant women	- 100%
Deliveries by TBA	- 100%
Immunization	- 100%

We have seen integration of Family Planning with other sector and also a change in the Organisational pattern of MCH & FP Services, both in Rural and Urban areas. Training of Dais, ICDS and UIP have been best examples of effert in this regard.

People's Representatives main objection has been that NHP never takes Social Justice and only talks about poverty alleviation and health care. Further, they are also of opinion that there is no spirit of partnership by agencies.

People have the right and duly to participate in the process for the improvement and maintenance of their health.

Dia - 1



They should recommend the Government encouraging and ensuing their participation.

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Small political units or communities can take care of 'Whole Person's needs' rather than by a Government which take compartmentalised bureaucratic activities.

2. FUNDAMENTAL POLICY

The Fundamental policies for health that are to be considered are as follows;

1. Health is a fundamental right and is a social goal
2. Inequality in Health is a concern.
3. People should participate in planning implementing Health care.
4. Government is responsible for adequate health of people
5. Self reliance is possible by peoples active participation
6. Intersectoral co-ordination is the backbone.
7. Utilisation of available resources for health

3. ELEMENTS TO BE CONSIDERED

The elements that are to be mentioned for the people's Representative are;

1. Awareness of health problems
2. Means to solve health problems
3. Safe water, sanitary latrines affordable by the people
4. Diverting rural quota to rural instead of to an urban area
5. Legislative support gathering for above items there is a need of more sub-centres, community health centres, Trained Health guides and trained Dais.

Involvement of all category of People's Representatives from the existing infrastructure have been there from time immemorial. These are (a) Corporation (b) Muncipality (c) Boards (d) Village Panchyat (e) Mandal Panchyat (f) Zilla Parishat (g) Religious Bodies (h) Co-operative bodies (i) District Health and F.W.Offices (j) Director of Health and Family Welfare (k) State Ministry (l) Union Ministry (m) Voluntary Health Organisation.

People representatives should have a note of the following elementaries.

1. All people in every country will have at least ready access to essential health care and to first level referal facilities.

2. All People will be actively involved in caring for themselves and for their families as far as they can and in community action for health.

3. People shall share responsibility with Government for health care of their members.

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4. Government should assure overall responsibility for health of their people.

5. Safe drinking water and sanitation facilities will be availabel to all.

6. All people to be adequately nourished.

7. All children and pregnant mothers to get immunised

8. Communicable diseases shall no more be a public health problem

9. Look into non communicable diseases and Mental Health by controlling life style and psychosocial environment.

10. Availability of essential drugs.

Successful pursuit of health policy will depend on authority being responsible for it, on behalf of Government. At present those being (a) Ministry (b) Directorate (c) Corporation and Municipality (d) Zilla Parishat at different levels. Here ensuring political commitment is to channelling health activities to the people.

4. EXISTING PROBLEMS IN THE AREA

Our great problems is not that of promoting the pursuit of new knowledge, it is the suitability and adoptability of existing structure and functioning of Health Services at large that matters in Health for All.

It is still being observed that --

a) Raising cost of Medical Treatment
b) No aminities for safe water and sanitation
c) Over reliance on Mass Media is becoming dangerous
d) Poor education becoming carrier for utilisation of knowledge.

A) PROBLEMS IN APPROACH:

- LACK OF CLEAR NATIONAL HEALTH POLICY
- POOR LINKAGE OF HEALTH SERVICES WITH OTHER NATIONAL DEVELOPMENT
- LACK OF CLEAR PRIORITY
- SOCIAL ASPECT OBSTRUCTS NATIONAL HEALTH POLICY
- NO COMMUNITY INVOLVEMENT
- INAPPROPRIATE TRAINING OF HEALTH PERSONNEL

B) PROBLEMS IN RESOURCE:

- INADEQUACY AND MALDISTRIBUTION
- NON-UTILISATION OF ACTUAL AND POTENTIAL RESOURCES
- RESTRICTED USE OF PUBLIC HEALTH WORK
- INCREASING COST

C) PROBLEMS IN GENERAL STRUCTURE:

- NO EFFECTIVE PLANNING
- WEAK DEVELOPMENT OF CONCEPT OF TOTAL SYSTEM.

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D) PROBLEM IN TECHNICAL ASPECT:

- NO HEALTH EDUCATION
- NO BASIC SANITATION
- NO COMMUNICATION
- NO TRANSPORT
- NO HEALTH INFORMATION

5. GENERAL FORCE INVOLVED:

Support by other related sectors viz., Agriculture, Housing, Water supply, Sanitation, Public Works and Communication, Education, Mass Media are at most important.

People's Representatives in Local Government can ensure that community interests are properly taken into account in planning and implementation of programmes. Public services should be accountable to the communities. The desirability of co-ordinating at the local level, the activities of various sectors involved in Socio-economic development and the crucial role of community in achieving them, make peoples representatives as an essential and effective component.

A clear national health policy is needed which will promote community cohesion around efforts for health and related development, will foster the co-ordination at the local level of all sectors' programmes that have a bearing on Health Care, will build up the capacity of communities to make up their health and other social aspirations known, and will ensure that the community controls both the funds it invests and personnel providing it. Mutual support between Government and people, reinforced by mutual information feedback. It is the responsibility of Government to stimulate this kind of support to set up necessary intersectoral co-ordination and different administrative level to pass legislation, to provide sufficient human, material technical and financial resources.

For public reach, it needs easy access to the right kind of information concerning their health situation and how they themselves can help to improve it. In certain area or situation, peoples participation can be legislated.

Non-Government Organisations can make a very useful contribution to health services, precisely because of working within the community. They have same responsibility as Government Agencies in the sense that they provide Technical and financial support to nation and would do well to ensure that these are channelled into the Health Service System.

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6. WOMEN FORCE INVOLVED:

Women a force for renewal of Health Activities in a nature of policy is attributed. Women influence health care in many ways, as mothers bearing the main responsibility for family health, as Agricultural workers, as Primary Health Centre, Workers birth attendants, Educators and members of community groups. If an educational programme does not recognise women as important agents of change and learning, it will not succeed in developing full community involvement and cannot obtain the people's responsibility.

7. NATIONAL PICTURE:

In India, at least 3 forms of influential environment can be seen. They are (a)Political environment (b) Religious environment and (c)Social reform environment.

High technology, medicine is getting quite out of hand and leading health systems in the wrong direction, i.e., away from health promotion for the many, towards expensive treatment for the few.

Modern Medicine, is not accessible to the poorer social classes. And most forms of disease are more prevalent among people living in poverty. This show the link between health and socio-economic conditions.

Among the organisations that have been used or suggested for mobilising support for Primary Health Care as National Health Programme are (a)Political parties (b)Women Organisations (c)Youth organisations (d) Trade Unions and (e)Religious or Ethnic bodies.

Whenever possible, local plans and priorities should be based on informations about the actual health needs and problems of all members in the community. Groups at risk can be identified along with special needs and priorities can be established and progress monitered on the basis of information.

Individuals and families should assume responsibilities for their own health and welfare. This entails penetration of services to target population.

In our Society, stress is laid on overall political and economic context. Power, Finance decision making all not by people, but normally by people's representatives. Hence countryside effert is necessary for a common setting of peoples representatives

Elected bodies of citizens have been put incharge of local health and social services at District and Regional levels.

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Here wide involvement of people, in the improvement of their own health will not be there. Appointment of representatives to the advisory board of local health facilities is to be geared up.

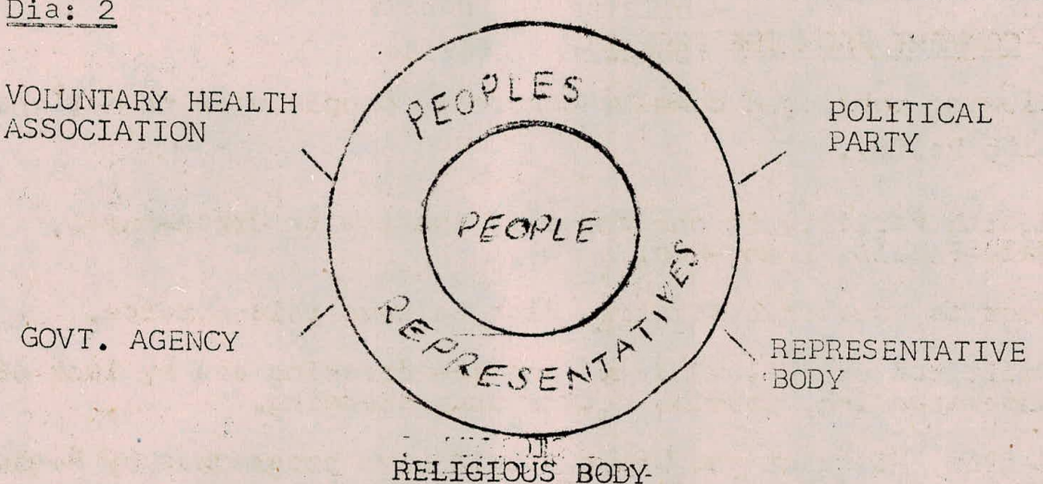
The financial contribution by voluntary organisation is relatively small, but their contribution to health is often significant. These local, National and International Organisations have their own motives and provision in the allocation of resources. This factor should be carefully considered when assessing that role in health care. They direct their limited resources to the most needy segment of population.

8. COMMUNITY EFFORT:

Cultural, Economic, and political circumstances of India influence all aspect of support to Health services. There is a need for understanding of the relations between effective community involvement and propitious political and economic conditions.

The mobilisation of people for health development require their participation.

The collective organisation in India has been as follows:
Dia: 2



In British ruling without any contribution people used to get services. Now also that strong tradition has been seen in our country. We have organisational disharmony. Various social and political forces play in every Mandal Panchyat and Zilla Parishad hampering the participation. Hence peoples involvement is slow and halting. What people see as their real need are not seen by service givers. This amounts to ignoring peoples need. A professional man always says that he is better qualified and that he knew better than any one.

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9. INTEGRATED ACTION:

Discussions and conclusions at the Joint Conferences of the Central Councils of Health and Family Welfare and the National Development Council have always been directed towards a common pattern of infrastructure in Health and Family Welfare Services in India. Whether it is in Medical Education, Legislation, Standard maintenance of vaccine or drug; there has been common consensus for a common pattern. Evolution of National Health Policy is one such major step for an integrated action in achieving this goal.

Communication strategies to motivate a positive attitude could have been another step in achieving a goal of National Health Policy.

Thus all over departments, which contribute for socio-economic development of India, relay upon intimately related sectors of administration and politics. It is vital importance to ensure effective co-ordination between Health and People's Representatives. Contents and priorities of programmes are to be viewed by people or people's Representatives in their effective implementation. Integrated Programme of Rural Development (IRDP) is a standing example in this regard.

10. COMMENT FROM THE PEOPLE:

Following upbridged comment demarcate people view in National Health Policy.

- Health Facility to one and all, equal with Urban-Rural, Male-Female, Young-Old.
- Poor to have free service, Rich to have paid service.
- Political unrest, violence and law breaking are by lack of understanding, provide better understanding.
- Region, District and Urban should have programmes by Regional, District and Corporation Offices.
- Without potable water and sanitation is it health facility?
- India is not poor, money is going down the drain, use for proper health care.
- Older have struggled. Younger are yet to realise the importante of sweat and toil.
- Administrators both Government and elected body have done considerable harm by undermining the concept and need of excellence in every sphere of action.
- Democracy run on present election procedure puts a premium on powers.
- No Co-operative community care by Zilla Parishat
- No copying from USA or UK Make Health available to all in their economic status.

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- Health care is not just by doctors. But by others also. Say Health Board.
- Hospital admission criteria is priority to certain groups. Why not policy common to all?
- Allow us to have Home, Herbal or Nature even. Do not insist with chemicals.
- Field workers of all department to help Health services.

11. CONCLUSION AND REMARKS:

National Health Policy is an expression of our Health. Hence national strategy should include broad lines of action in all sectors involved to give effect to that policy, what has to be done? Who has to do it? During what time? With waht resources? It is a framework leading to more detailed programming, budgeting, implementation and evaluation.

We mean Health that begine at home, schools, factories. It is there, where people live and work that health is made or broken. It does mean people will use better approaches then they do now for preventing diseases and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully.

Let this mean even distribution among population whatever resources for Health are available.

Peoples Representative in Health Policy is a sober one. But related strategy appears good, clear cut and defined. They deserve giving effect to these action. Here achieving acceptable level of health as part of socio-economic development in the spirit of social justice is to be indicated.

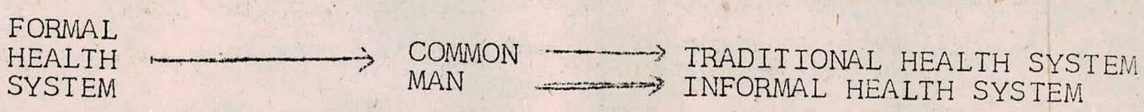
Why should we not involve General Practioners and Link Insurance Scheme? This can be answered in the policy

Simplified Medicine programme or elementary health by any body should be envisaged in the policy.

Two way Radio scheme for advice and supervision seems to be very good.

Dia: 3

RELATIONSHIP BETWEEN MAN AND HEALTH SYSTEM



In the above figure it is pointed out how we are driving behind man, whereas Man is running behind Traditional and informal s...

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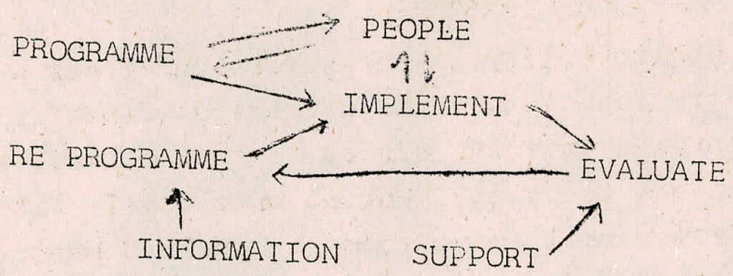
Hence we should think of

a) Co-operative Rural Despensary
b) Family Survival Assurance Plan
c) Integrated Child Care
d) Integrated Health Nutrition
e) Integrated Maternal Care
f) Integrated Family Care

Dia: 4 PROCESS OF HEALTH DEVELOPMENT



In each action involvement of people and/or peoples Representative has an effect on any policy making.

In view of problems posed, we should make an endevour to provide basic aminities, to provide essential drugs, to provide basic education.

Women force and community force is an asset in our endevour of uniform pattern of Health Services.

Integrated Action is an injectable solution, which has a miracle in community healing.

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"OVERALL VIEW OF NATIONAL HEALTH POLICY"

* Dr.(Mrs.)M.K.Vasundhara

Introduction

Since independence the nation has taken forward stride to improve the health of its citizens. There has been a substantial success in lowering the death rates and raising the life expectancy. Smallpox has been eradicated. Plague almost eliminated and the incidence of malaria is reduced. However, the surmounting health problems still post a challenge. Our current infant mortality rate (IMR) is 94 which does not compare favourably with that of Japan which is 4. It is estimated that 3 deaths occur every minute from dehydration due to diarrhoea while tuberculosis claims one life. At any one time, 12-15% of the population is sick mostly due to communicable diseases. The major brunt of these illnesses is borne by women and children. It is all the more tragic because most of this morbidity and mortality is preventable as 75% of the illnesses are related to poor hygiene and lack of sanitation. The resurgence of the repressed diseases like kalazaar or malaria and emergence of new diseases like AIDS pose a further challenge. To top it all, the rapidly expanding population takes its own toll. It is estimated that on the economic front, for every 5 points gained, 2 points are lost due to minimum demands of the growing population. It is "tight rope walk exercise" to check the slide down and balance the development because for the overall development, health is a critical factor.

Need for National Health Policy

The Government's concern regarding current situation and its commitment to achieve "Health for All by 2000 A.D." led to evolvement of the National Health Policy in 1983. The enunciation of policy highlights the Government's efforts at removing inequity in the health care delivery by reaching out to the "voiceless" vulnerable population with a health care technology which is appropriate, affordable and acceptable to the community. For the first time, the time as an important resource was realised and targets to be achieved by 2000 A.D. have been clearly spelt out.

Strategy

The Strategy suggested for implementation of this policy is the same as that evolved for Primary Health Care. i.e.

1. Equity in distribution of health care
2. Appropriate Health Technology
3. Multisectoral Approach
4. Community Participation

Equity: had to be considered because the health care services were concentrated in urban areas catering only to the minority of the population. The vulnerable population were often neglected. Inadequate referral services led to consumer inconvenience, congestion, duplication and fragmentation of the services leading to increased cost.

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Appropriate Health Technology: The curative bias led to wastage of resources in treating over again the diseases which were preventable. A comprehensive health care consisting of preventive, curative, promotive and rehabilitative services was envisaged. The specialisation and hospital based services engulfed the major chunk of the budget favouring the few while denying the essential care to the majority of the community.

Appropriate Health Technology: The shift is now from specialisation to services which are appropriate, effective, simple and feasible. Such technology promotes self reliance eg. Oral rehydration therapy to combat dehydration.

Multisectoral approach: Health cannot be viewed in isolation as both health and development are interdependent. Therefore, a multisectoral approach with intersectoral co-ordination between health and allied sectors like food and agriculture, education, water supply and sanitation, social welfare etc., is required for balanced development. This calls for horizontal integration of services at all levels.

Community Participation: Sir Joseph Bhore in 1946 indicated the need for community participation. This critical need is not yet realised. There have been some sporadic unorganised ventures which have been shortlived. The dialogue between the planner and the consumer is lacking. Therefore, the envisaged community participation in planning, implementation and evaluation of health care services is minimal.

Broad Guidelines

Certain broad guidelines have been identified in the National Health Policy. They are:

1. Strengthen the health care services,
2. Develop referral linkages
3. Restructure medical education
4. Exploit the potential of Traditional Systems of Medicine
5. Promote action oriented health service research
6. Develop Health Information System
7. Attempt Population stabilisation
8. Provide for environmental sanitation
9. Involve Non-Governmental Organisation in health care delivery
10. Highlight the role of health education
11. Reform health legislation

Health Services: In order to make health care services appropriate, the stress is on shifting the bias from "somewhere to everywhere" by establishing a network of services to reach the remotest of the areas. This takes into consideration the population density, topography, transport and priority criteria like tribal, hilly and endemic areas. The curative bias is shifted to comprehensive health care.

The lack of referral services leads to consumer inconvenience, congestion at the specialist centres, duplication and fragmentation of services which adds to the cost of the already constrained resources. Therefore, "Back-up support" is provided for by establishing Community Health Centres (C.H.C) with specialist services. Each CHC will be catering to the needs of 4 to 5 Primary Health Centres.

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The policy also envisages elimination of private practioners by Government doctors. It focuses attention on the much neglected occupational health services.

Critical analysis reveals that the above objectives are not yet realised though there has been considerable expansion of health infrastructure. Essential drugs are not yet available within one kilometer walking distance. The drug policy is topsy turvy with a bias on its the price line than the health needs. Control is still vested with Ministry of Petroleum and Industries though drugs are critical for health care needs.

Medical Education: Due to accultration, the Medical Education had been "Western oriented" creating a "Culture gap" between the training and health demands. The Policy indicated a need for restructuring the syllabi and revise the training programmes.

Health Service Research:

In order to seek optimal solutions to the existing problems the stress is to be shifted from the fundamental research to operation research.

Health Information System: Hard factual data are needed for planning, evaluation and understanding of epidemiological trends of diseases. Monitoring and evaluation process would permit "midterm corrections" in the programmes and also ring a timely warning bell in the event of emergence of a new problem. This is how AIDS was detected in U.S.A. Our reporting system needs revamping as the date available is often incomplete and irrelevant. The person who gathers the data and the one who transmits it are not oriented in the process and the relevance of data generation. Further, there is lack of "feed back" of data to the grass root level though communication is one of the fundamental principles of management.

Involvement of Traditional Systems of Medicine: A vast potential of available health manpower already practicing traditional system of medicine as well as general practitioners of allopathio medicine remain unexploited in the implementation of National Health Programmes. Their contribution is neither recorded nor recognised. It is hightime this manpower availability is exploited to draw them in to national health stream in order to achieve the Goal of Health For All by 2000 A.D.

Non-Government Organisations (NGOS): have voluntarily contributed a lot towards community health by extending their services to outreach areas, educating the community; facilitating research; sensiting Government about health needs of community e.g.Family Planning Programme was first activated by the voluntary organisations. It is indeed a welcome change that the Government is now inviting NGO's to extend their role in National Health Programmes.

Health legislation: needs to be reviewed and revised to be relevant in context of the current knowledge. It needs to be implemented uniformly throughout the country because diseases or health problems recognise no geographical boundries.

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Health Education: The unfortunate loss of limbs and life is avoidable if the community is educated about ways and means to prevent the same. In any case, people have right to information. Therefore the messages have to be meaningful to promote self reliance. People have to realise their rights, role and responsibilities for their health care. Health education therefore should be the foundation stone on which health care services should be built.

The "Count Down 2000 A.D." has already begun. It is hightime, therefore, that we critically review our progress, remove the impediments and reinforce our activities on war-footing basis to convert the cherished "dream" of National Health Policy into a reality.

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HP 2.6

Some Policy Reflections

in the context

of

a) Health Policy for Karnataka

b) Perspective Planning for Health Services

c) Approach Document for 8th Plan

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Presented at a Dialogue of NGOs including Community Health Cell Team, with Director of Health and Family Welfare Services and Joint Director (Planning), Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

July 1990
Bangalore

By

Dr.Ravi Narayan
Community Health Cell, Bangalore.

"PERSPECTIVES IN HEALTH POLICY AND STRATEGIES" FOR THE STATE OF KARNATAKA.

-- a response from the Community Health Cell, Bangalore.

A. GENERAL PERSPECTIVE

1. As a background it is important to keep in mind that the health of people and populations is largely determined by broader factors such as:

   employment;
   adequate income and purchasing power;
   adequate food, housing and clothing;
   availability of sanitation facilities and safe water;
   education and opportunity for skill development;
   accessible and effective health care services.

   This is examplified by the documented experience of several developed countries where major public health problems like tuberculosis, leprosy, cholera and other diseases were on the decline prior to the medical are of antibiotics and vaccines. It is accepted that this change was due to general socio-economic development.

2. At an operational level, acceptance of the above ideas call for effective intersectoral linkages in terms of planning and coordination between the Departments of Health, Education, Water supply and Sanitation, Housing, Town and Country Planning, Agriculture and Industries.

   Keeping in mind the decentralised system adopted by the state, this planning and coordination could be done at the zilla parishad level.

3. Regional Health Planning

   At present, in the health sector, we have national health policies, programmes and targets for the country as a whole, while overall policies and thrusts are important, keeping in mind the vastness and diversity of the country and even within single States, health programmes and plans need to be evolved at a more local level at District level to start with. Two important factors to consider in this are:

   a. the special needs of certain groups, who are socially and economically marginalised -- dalits, tribals, slum dwellers, women and children, the handicapped;

   b. the dynamic nature of the health status of populations which keeps changing in response to factors in society--eg., environmental, economic, cultural changes, life style changes etc., We are faced simultaneously with the diseases of poverty for large sections of the population, viz., malnutrition, tuberculosis, leprosy, water related diseases etc., and diseases resulting from industrialisation and modernisation--eg., cancers, cardio-vascular diseases and ill-defined new symptom complexes that are presenting in areas of environmental pollution.

   Health planning needs to move from a rather adhoc, centralised, top down method to a more scientific basis. For this, it is necessary to have good quality health information, collected on an ongoing basis from different geographical, social and economic strata of society. Presently health statistics are largely

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compilations from various administrative reports. Greater emphasis needs to be given to quality of information, its validity and analytical interpretation of the date. Quantitative or hard data reflect some of the physical factors but an interactive, participatory approach with people would indicate the live social/human processes taking place.

There are presently more than 400 voluntary agencies working in the field of health in the State. Involving them in planning exercises would provide a 'window' to what is happening at the grass root level. Involving members of gram sabhas, mandal panchayats and zilla parishads would play the same role--they would in the process get better equipped to monitor the functioning of the health care services.

4. The budgetary allocation for health, education and welfare services needs to be critically analysed in the context of the health needs of the people. This could also be the subject of wider debate at various levels--State, District, Zilla Parishad, Mandal Panchayat, Gram Sabha etc.,

   Broadly there could be --

   a. a larger allocation to health - eg., 6-8%

   b. a reduction in the present urban/rural bias in health expenditure--eg., Rs.30000 spent on drug purchases per annum, per primary health centre presently covering a population of 60-80000 (or even the prescribed 30000 population) is grossly inadequate, In contrast the annual budgets of specialised, elite institutions at State and District head quarters is excessive.

5. The Indian Systems of Medicine (Aurveda, Siddha, Unani, Yoga etc.,) and other systems like homeopathy are widely prevalent throughout the country. They are culturally more acceptable and economically and geographically more accessible. Though official recognition has now been given to them, they are very marginalised in terms of State financial resources and in involvement with health planning. By recognising them as partners, we would increase the health infrastructure many fold.

6. During the past decade and particularly so in the past 4-5 years, there is a very rapidly increasing trend towards privitization of medical services. Corporate sector business houses are getting involved with the running of diagostic centres, hospitals and even with medical education. Though conducted under the name of increasing accessibility to the latest in medical care and of self-reliance etc., the basic logic is one of making profits. Unfortunately, they are also receiving State encouragement. It is resulting in the commercialization of medicine with the 'selling' of high technology diagnostic and therapeutic services not all of which are beneficial and some of which are positively hazardous and harmful to health.

B. SPECIFIC ISSUE/STRATEGIES

1. Public health approach/training

   Over the years, there has been a gradual erosion in the role played by public health specialists in the sphere of health planning. The discipline itself has unfortunately slid into disrepute and has not been attracting the best. This is in contrast to the increasing role being played by such trained specialists in health

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planning and organization and evaluation of health services in several other countries to their benefit. This situation needs to be rectified by providing better training facilities and job opportunities.

It would be benefical if all Govt. Medical Officers could undergo some basic training in practical public health (more than that in the undergraduate course), management, team work etc.,·as in their future role, they are also expected to function as team leaders and planners. In the absence of such a "staff college" type training, they in effect offer only curative services to those who manage to reach their clinics.

At the primary health centre level, 'team training' orienting all members as one group to the overall objectives of the work, programmes, team functioning itself could be given. This could be followed by regular meetings for sharing and feed back of experiences, problem solving, team building and continuing education. At present these exercises are more of a beaurocratic, policing nature mainly checking out on target coverages.

2. As mentioned earlier, regional planning for health based on a knowledge of the regional patterns of health indicators is necessary.

3. There is a great need for continuing education for doctors, nurses and paramedical staff on an organized basis. Teaching and research institutes from different disciplines including sociology, management, economics etc., could be involved. This should be a two-way dialogue--much feed back from the field level is necessary to suitably modify teaching curriculum and research priorities.

These experiments are also going on in teaching institutions and coordinating bodies among voluntary agencies involved with health, teaching, service and research.

4. Recently, there is a trend emphasising vertical health programmes - eg., immunization, oral rehydration, child survival, leprosy etc., as time bound, targetted efforts. This is going full circle back to the days of malaria cradication and unipurpose workers. India, infact has historically contributed the concept of an integrated community based health care approach and the wisdom of this should not be lost sight of in spite of professional bodies.

5. There is an urgent necessity to evolve a rational drug policy. This would ensure an adequate supply of essential drugs to meet the health needs of people and in fact would also help conserve scarce resources.

6. The system of medical education itself needs critical reappraisal. Several governmental committees have given very relevant recommendations regarding this aspect of health personnel training. But as yet no major dent has been made on the system.

In Karnataka, private enterprise in medical education is playing a questionable role. These money oriented practices are detrimental to a profession which is so closely associated with life and health of people.

7. Studies (some in Karnataka as well) have reported poor utilization of government health services. In the face of this a mere expansion of structures and numbers will not yield results. There is a need to consolidate and strengthen the qualitative aspects of the service.

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8. As in many other spheres, there is corruption at many levels of the health service. This factor has to be addressed seriously by all concerned if the goal of public service is to be realised.

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"PERSPECTIVES IN HEALTH POLICY AND STRATEGIES" FOR THE STATE OF KARNATAKA

A SUMMARY

A. Perspective Planning in Karnataka for health services must keep in mind the goal for 'HEALTH FOR ALL BY 2000 A.D.' and in this context reorient its focus:

a. From HEALTH as a medicalized PROVISION of curative Services to Health as an enabling/empowering process in the community increasing individual, family and community's autonomy over health related means, opportunities, knowledge and structure.

b. From Health Policy as infrastructural development to Health Policy as 'quality of life' and 'quality of care' development.

c. From Health Planning as a top down bureaucratized procedure to a participatory, community based, bottoms up exercise. This is particularly relevant in the context of the decentralised system of Panchayat Raj ushered into the State.

B. In keeping with the overall perspectives of the Ministry of Health & Family Welfare Services outlined in their March 1988 Perspective Plan and the discussions with Sri.L.C.Jain, we wish to highlight the following key issues:

1. Health Policy must be closely interlinked with policy of socio-economic development.

2. Health Policy must explore multi-sectoral linkages.

3. Health Policy must evolve regionally from local level upwards taking into account--

   a. Special needs of certain groups - dalits, tribals and slum dwellers;

   b. Changing status of health, environment, socio-economic status;

   c. Reliable and good quality health information.

   d. Interaction with community perceptions and needs.

4. Health budgets should be increased substantially and rural urban disparity tackled seriously.

5. All systems of Medicines and existing alternatives and options available to the community must be involved and included in an attempt to create an integrated Indian System of Medicine and Health Policy.

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6. Privatization and commercialisation of medicine must be curbed and the State must continue to bear the major responsibility to providing people with affordable and accessible services, NGO, Volags and the private sector must be welcomed to complement the services but not replace it.

7a. Public Health reorientation of all medical staff is an important strategy organized through a staff college process and oriented to team training and participatory approaches.

7b. Continuing Education programmes for doctors, nurses and para-medicals based on multi-disciplinary and participatory approaches are crucial investments for the future. A community/social reorientation of medical education and all existing h alth manpower training programme is important.

8. Stress on integrated community based health care approaches and movement away from vertical unipurpose health programmes is necessary.

9. A Rational Drug and Technology Policy needs to be outlined and implemented.

10. Health Practice Research geared to important basic issues such as:

    a. Poor utilisation of government health services;

    b. Corruption in health services; and

    c. Participatory approaches in planning/management should be organised.

HP 2.7

NATIONAL HEALTH POLICY STATEMENT - 1982

From the viewpoint of Voluntary Agencies.

by

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NATIONAL HEALTH POLICY STATEMENT - 1982

From the viewpoint of Voluntary Agencies.

The Government of India's National Health Policy Statement 1982 recognises the importance of community participation and its role and relationship with voluntary agencies in the following areas -

a) for identification of health needs and priorities, as well as in the implementation and management of various health and related programmes. (P-4)

b) for providing universal comprehensive primary health care services relevant to the actual needs and priorities at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organized involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector. (P-4)

c) at the community level, to devise arrangements for health and all other developmental activities to be coordinated under an integrated programme of rural development. (P-17)

d) for offering organised logistical, financial and technical support to voluntary agencies, while adequately utilizing and enlarging the services rendered by them, and intermeshing it with governmental efforts in an integrated manner. This, especially for those which seek to serve the needs of rural areas and urban slums. (P-6,9,10)

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e) for initiating organised measures to enable development of various indigenous and other systems of medicine and a phased integration in the overall health care delivery system, specially in regards to preventive, promotive and public health objectives. (P-10,11)

The policy clearly emunciates what is desirable. It also calls for

- decentralization of services like MCH services to the maximum possible extent (P-14)

- efforts to establish herbal gardens and encourage low-cost, indigenous herbal medicine which is easily available and of certified quality (P-15); and

- for mobilising additional resources for health promotion, ensuring that the community shares the costs of the services. (P-16)

All these, for providing adequate care and treatment to those entitled to free care. (P-9)

The policy refrains from providing advice on how this can be done, beyond the pointers it puts out. This gives us a wonderful opportunity to initiate measures to

- take into account local realities in the area of health and development;

- understand peoples priorities in health and the reasons thereof;

- consider available resources and constraints, while designing a flexible process suitable for implementation.

Voluntary agencies and their federations have been interacting with the Government of Karnataka at meetings and workshops at various levels, and different times, initiated both by the voluntary agencies as well as the government. our experience in Karnataka in the last 5 years has shown that with adequate openness and enthusiasm on both sides, this is a creative possibility and can be operationalised. Even though this may not have brought any miracles in Karnataka,

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as yet, the stage is set for a close and meaningful collaborative effort in the decade ahead. Some aspects of this collaboration are:

1. The Formation of a Consultative Committee by the Ministry of Rural Development and Social Welfare comprising of secretaries of all key government departments and representatives of NGOs in Community Development, Education & Health. This was formed at the initiative of the Planning Commission and has been sustained by the enthusiasm of a series of Development Commissioners and Rural Development Secretaries.

   The Consultative Committee has sub committees including one on Health in which NGO's dialogue with the Director of Health Services and his colleagues on health programmes .....

2. Dialogue of NGO's with Perspective Planning Committee of Government of Karnataka on Health, Welfare and Educational Programme.

3. Dialogue with NGO's by Director of Health Services at various levels

   a) Sub committee of consultative committee

   b) 8th plan document preparation

   c) Dialogue on government programmes organised by Voluntary Health Association of Karnataka.

4. Steps to prepare a comprehensive directory.

5. There are steps to increase such dialogue at the district level.

6. Exploration of collaborative efforts are also under way.

The key process in all this is frank discussion, feedback from grassroots and mutual consultation in a non-threatening interactive ethos and a general commitment to exploring the idea of working together.

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At this juncture, a purposefully critical collection of impressions of voluntary agencies in their interactions with the Government are called for to understand the varying levels of success in the process of Government-Voluntary agency collaboration.

a) Participation sought of Volags in government initiated meets are at very short notice, on matters which have been already decided upon and more for purposes of form than actual concern. Also, when government officials attend Volag sponsored meets, the response is desultory, condescending and defensive if at all.

b) Voluntary agencies are seen by the government as only alternative service providers or associates for implementation of their programmes. The voluntary agency's roles as issue-raisers, demand creators, builders of awareness and alternative planners are largely ignored if not also seen as threats to the Government plans.

c) The Government's understanding is that involvement of voluntary agency's representatives in consultations automatically means 'peoples involvement' or 'community participation'.

It ignores the feedback and the elaborate process the voluntary agency initiates to bring about peoples participation, since it may mean modification of plans to suit peoples needs.

d) The Government tends to off-load many of its responsibilities on to voluntary agencies, and puts demands and pressures beyond voluntary agency resources and capabilities without adequate support. The top-down planning and issue of operation guidelines stifle voluntary agency innovations and creative approaches. Also, vertical programs and focus on selective primary health care programs are at the cost of comprehensive primary health care.

e) The people's image of the P.H.C. and Governmental Health staff is very poor. Corruption, inefficiency, political interference and mismanagement are seen to hold sway. They are unhappy with

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functioning, attitudes, and quality of services at Government Health Centres.

The voluntary agency plea to tone up the existing governmental system and bring in greater accountability as well as qualitative improvement in their services is largely ignored.

A fall-out of this was seen in the negative experiences of the government health services with the Panchayat Raj system.

The Governmental Health Services has also been pre-occupied for too long in infra-structural development, resulting in mere structures and no useful function.

f) There has been no change in the Government's perceptions about people working outside the system (NGOs/Volags) or about peoples capabilities in planning and implementation of programmes.

The Village Health Workers, Health Guides, Anganwadi workers and others who were possibilities in peoples participation have been co-opted by the system and become lackeys in the governmental process, demanding recognition, more salaries, perks, etc.

g) Diversity of local culture and traditions and respect for it has never been a string point in Governmental bureaucratic processes. So, have the traditional and indigenous systems of health care suffered and failed to be recognised for their potential in the dominance of the Allopathic approach to health care.

Is it any wonder, then, that people do not participate as much as desired?

- that privatisation and commercialization of medical services is the norm?
- that people have to take up the call for a Rational Drug and Technology policies?

and that Health policies designed for the poor and marginalised do not reach them?

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If community participation as envisaged in the National Health Policy is to make an impact on peoples health, it needs to include processes that enhance -

a) Information transfer and awareness building programmes for the people - probably the most important and credible step, considering that this is the weakest link of the present system.

People need to know the whys and hows of each programme, and also to discuss them to explore ideas of how to do them better. Voluntary agencies have something to offer to the Government in ways of interacting with the community as well as creative low-cost communication, which considers people as participants in a process of development rather than 'target-groups' or ' 'beneficiaries'.

b) Understanding that people are not a homogenous mass, and are stratified by class, caste, education, culture, gender and other factors. Positive discrimination towards groups who do not benefit from existing programmes, because they do not participate in local decision making should be a focus. Voluntary agencies have experience in working with such groups and find that supplementing participation with Education efforts could strengthen building of healthy communities.

c) Peoples perceptions of the working of projects and programmes or their own responses to problems must be seen as equally important as statistical/professional/technical situation analysis. This can be sought for by informal focus group discussions rather than formal surveys. When facts are placed before people in an understandable manner, it is seen that education/technical expertise is not a precondition to evolve innovative solutions. These methodologies used by Voluntary agencies in their work can easily be shared with governmental agencies.

d) Increasing involvement of voluntary agency sector in the role of monitors, evaluators, issue raisors, demand creators and trainers- and not just 'programme implementors'.

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e) Reorientation programmes for staff at all levels of the existing infrastructure about this alternate concept of people as participants, where voluntary agencies could share the approaches they adopt.

f) Monitoring and record-keeping systems that are not only quantitative, but also qualitative and allow feedback from people and from lower level functionaries of the system who are in closer contact with the people. The motivation of health staff at the lower levels is at a low ebb as they face practical difficulties in their work with people, which they do not seem to have the required continuing education and support to deal with effectively. Voluntary agencies could help re-orienting them.

All these call for moving away from top-down models to more decentralized and flexible approaches to the diversity of options likely to emerge. We can share the positive and negative experiences of both Governmental and Voluntary agency efforts especially in the past two decades, learn from each other and evolve more effective methods towards health.

To conclude, we have

- a positive approach to the National Health Policy,
- an opportunity to make our approaches flexible to meet peoples needs,
- a rich experience between us to learn from, and,
- in Karnataka, a healthy trend of collaboration.

Let us make use of these and get down to making HEALTH FOR ALL by 2000 A.D. a reality in Karnataka.

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HP2.8

CONCLUSIONS

The Bangalore Workshop on National Health policy, organised by the

Voluntary Health Association of Karnataka

Voluntary Health Association of India and

Department of Health and Family Welfare, Govt. of Karnataka;

with participants drawn from the Governmental and Voluntary Health Sectors,

at the Institute of Social and Economic Change on 9 and 10 April 1992;

having had the benefit of well Searched presentations on

Overview of the National Health policy,

Current Health Status of India,

National Health policy from the point of view of

Govt. of Karnataka and

National Health policy as seen by Voluntary organisations;

taking note of the impact of the New Economic policy on Health;

deliberating in groups on various issues in Health especially focussed on

PRIMARY HEALTH CARE

HEALTH EDUCATION

INTER SECTORAL CO-ORDINATION and

HEALTH INFORMATION SYSTEM;

reflecting further in the plenary Session on the various Suggestions and recommendations;

have come to the following conclusions:-

* Distortion in allocation of expenditure to preventive Rural Health Care on one hand and to Medical education and urban Curative Services on the other hand is to be avoided.
There is need for proportionate allocation of budget to urban and Rural areas; apart from increasing the allocation.

* Decentralisation of planning, implementation and evaluation of Health and Health Related programmes to District level — attempts towards this end by the State through Zilla parishads has appreciated.
The workshop concluded that there is much scope for intensified efforts in this area to foster and facilitate effective functioning.

* The existing facilities at primary Health centres Should be improved before embarking on expansion of Services.

* The use of essential drugs and in adequate quantities is to be made fostered at all levels of Health Care.

* The National Drug policy and implicit recommendations Should be part of the National Health policy.

* Indegenous System of medicine Should be integrated / incorporated into Modern Medical practice; comparative research in this area is to be fostered.

* Health insurance as a Concept of Health policy Document may be promoted among the people to participate economically to utilisation of available Health Services provided by the Govt.

* To foster and improve the intersectoral co-ordination in Health Care Delivery, intersectoral committees be set up at State/District/PHC/Sub-centre/village levels which should identify the health problems, implement the health and health related solutions; Due importance need to be given for ensuring wholistic approach; for creating awareness among the people; and for evaluating and monitoring the programme periodically.

* The available infrastructure for training in governmental set up should be made available to train health personnel from voluntary organisations.

* Health education is needed to make people health conscious, become aware of health problems and develop knowledge, attitude and skills to take action for better health. We should enable people. Poor Sentence Construction

* There is need for improvement in communication strategies utilising the Mass Media, Street theatre and Folk arts as also inter-personal communication.

* Committees should be constituted/reactivated at the block, District and State level for identifying and taking action for health.

* The structure of the health information system and reporting channels are adequate for generating valid data. The functioning can be improved by
  - Simplified reporting system.
  - use of Computerisation, and
  - involvement of voluntary agencies.

Village level people's committees to take responsibility, and helping the system.

* priority areas in National Health policy are to be identified and made part of Health information Systems for routine reporting. A training module for Health information Systems is to be developed.

* All Data generated in the Health information Systems should focus on giving Epidemiological information relevant to Health needs of the people. There is a necessity to establish one epidemiologic unit in each District.

* (M.E)

We further recommend that

(i) There is need for professionals, Voluntary organisations, peoples representatives and others at the State / District and Taluka levels to discuss the policies and develop understandable, workable programmes, implement them and evaluate them.

(ii) A State level Committee Consisting of all partners in Health Care from Governmental and Voluntary Sectors be formed to monitor progress in the implementation of the policy and to help in removing bottlenecks and Constraints. The Committee will workout the indices for monitoring progress

(iii) The Committee be also entrusted the task of formulation of a Health policy for Karnataka within a time frame of one year from now.

(iv) A committee of five members of this workshop be entrusted with the responsibility of preparing the final draft Report of this workshop, which will be circulated to all the participants, who will be given one months time to respond to the draft. The same Committee will then prepare the final Report which will be Submitted to Government by August 1992 and Copies Sent to all members. (As there may be changes, it may be Sent to DHS)

TENTATIVE PLAN OF PRESENTATION : HP2.9

PART I — PROLOGUE

PROGRAM DETAILS

PROCEEDINGS — (A) Inaugural session.

(B) Session - II - Presentation by Invited Speakers

(C) Group Discussion in the afternoon of DAY I and Morning of DAY II

(D) plenary session.

CONCLUSIONS

PART II (A) Full papers - presented by -

DR. V.S. QADRI

SRI. T. R. SATHISH CHANDRAN

Dr. (Mrs) M.K. VASUNDHARA

Dr. J. P. GUPTHA -

Dr. S. P. TEKUR

Dr: M.V. Kulkarni and Dr. G.N. Prashakar

(B) Recommendations of Individual Groups along with the list of participants. I / II / III / IV

(C) List of Names of working group and Resource -

(D) List of Members of Executive Committee of VHAK.

(E) Short description of activities of VHAK / VHAI

(F) ACKNOWLEDGEMENT.

PROLOGUE

To-day we have a comprehensive National Health policy. Needless to say that this comprehensive document is important and relevant to all involved in Health Care. Among other things, the Statement of the policy highlights the role of voluntary agencies in Health and emphasises the govt's desire to involve, support and enhance this role.

The very fact that we have a National Health policy, it is an indication that there is political will towards better Care of the populace. There is a need for a careful Study of this policy to determine (1) in what direction we are going ahead and (2) How to operationalise this policy into improved practice than what it is to-day. Such a Study will help people involved in planning Health Care at District level to orient their approach and decisions towards elements of the policy. This exercise will help formulation of a State Health policy at a later date.

Voluntary Health Association of Karnataka made a beginning towards this end by initiating discussion on National Health policy at St. philomena's Hospital, Bangalore during 1984.

It is pertinent at this juncture to recall and remember with gratitude initiatives by Voluntary Health Association of India. When the Voluntary Health Association of India first printed the Statement on National Health policy, there were requests from individuals and institutions from all over the Country for the copies. In some cases bulk Supplies were requested. This widespread interest inspired VHAI to plan a Systematic dissemination and discussion of the policy document. The first National Seminar on National Health policy was held at New Delhi on April 23 1983. State level Seminars were to follow this.

following the workshop at St. philomina's Hospital during 1984; and in recognition of the crucial need to facilitate an active and Constructive dialogue among all groups for continuing identification of progress or lack of progress in this regard and to seek participatory measures to accelerate this process towards progress a group of experts in the field of health both from govt. and voluntary Sector met at St. johns Medical College, Bangalore on oct. 31 1991 under the auspices of VHAK. After an elaborate discussion it was felt that a clearent and intimate dialogue among District Health Officers, people's representatives (Presidents of Zilla parishads and chairmen, Standing Committee, Health of Zilla parishads) Voluntary Organisations and Media persons along with experts in the field will help in the Study of the Health policy and to determine which way to go.

The group of experts mentioned above (who formed the workin ~~group and~~ Committee and the Resource) also felt that as an initial Step there is a need for Creating awareness of the document itself among the participants. To meet this aspect, it was planned to invite papers on the document itself.. The group, realising the impossibility of discussing the National Health policy in entirity within a Span of 2 days decided to focus the discussion on four Specific issues:

(a) PRIMARY HEALTH CARE

(b) HEALTH EDUCATION

(c) INTERSECTORAL CO-ORDINATION

(d) HEALTH INFORMATION SYSTEM

In the phase of pre-planning itself it was felt that it is imperative to promote a relationship of partnership between the Govt. and voluntary organisations. It was very strongly expressed that such an exercise will help District level planning.

PROGRAM DETAILS:

DAY I 9th APRIL 1992

[MORNING] INAUGURAL FUNCTION

1. Invocation – Mrs. Joyce ~~[illegible]~~ Jayaseelan.
2. welcome – Dr. Sudarshan, Treasurer VHAK
3. Lighting of the lamp – Sri. J.R. Sathishchandran Director, ISEC.
4. Key note address – Dr. V.S. Badri, Population Centre, Bangalore.

~~Lighting of the lamp~~

6. ~~[illegible]~~ inagural Address – SRI. J.R. Sathishchandran Director, ISEC, B'lore
5. Representing Govt. of Karnataka – Dr. Ranganathachar, Director, H and FW Services
7. Representing VHAI – Dr. Mira Shiva, VHAI
8. Representing VHAK – Dr. Upendra Shenoy
9. Vote of Thanks – Dr. Sona Kalyanpur Rao, Hon. Secretary VHAK.

SESSION II

Moderator : Dr. C.M. Francis
Director, St. Martha's Hospital, Bangalore.

'Overview of National Health policy'
Dr. (Mrs) M.K. Vasundhara
I/c and HOD, Com. Medicine, BMC, Bangalore

'Current Health Status of India'
– Dr. J. P. Guptha
Regional Director, H and FW Services, GOI

'National Health policy – View point of Govt'
– Dr. C.R. Krishna Murthy
Addl. Director, H and FW Services, Govt. of Karnataka

'National Health policy – view point of Voluntary Agencies'
– Dr. S.P. Tekur
Consultant paediatrician
Community Health Cell, Bangalore.

... Contd.

DAY I [Afternoon]
9th April 1992

SESSION II Continued
DISCUSSION - in response to presentations.

SESSION III

GROUP DISCUSSION

GROUP I "Primary Health Care" — facilitators:
Dr. J.P. Guptha
Dr. Sudarshan
Dr. Mira Shiva
Dr. S. Pruthvish

~~[illegible]~~ :

~~[illegible] and friends, followed [illegible] Dr. Sudarshan, VHAK welcomed the honourable guest and participants. Hon. Guest was presented [illegible] for the occasion.~~

GROUP II 'Health Education' — facilitators:
Dr. C.M. Francis

GROUP III 'Intersectoral Co-ordination' — facilitators:
Sri. S.M. Subramanya Shetty
Dr. C.R. Krishnamurthy
Dr. Safruddin.

GROUP IV 'Health Information System' — facilitators:
Dr. Annapurna Rao
Dr. S.P. Tekur

DAY II [Morning]
10th April 1992

Session IV
Group Discussion Continued
Preparation and presentation of report within the group.

[Afternoon]

Session V
Plenary Session.
Moderator : Dr. C.M. Francis

Presentation of Groups I and II
Presentation of Conclusions and Recommendations : Dr. S. Pruthvish.
Valedictory : Sri. G. Puttaswamy Gowda
Hon'ble Health Minister

Remarks by : Dr. Ranganathachar
Dr. C.R. Krishnamurthy
Dr. C.M. Francis
Participants

Vote of Thanks : Dr. Sona Kalyanpur Rao
Hon. Secretary, VHAK.

Presentation of Group III and IV
Formation of Committee to draft the proceedings.

The pleasant morning of first day started with Prayer Song by Mrs. Joyce. Jayaseelan (4)

RAC ON

① Dr. Sudarshan, Treasurer, VHAK welcomed the guests. Honourable guests were presented Garlands. Smt. T.R. Satheeschandran, Director, ISEC lighted the lamp to make the inauguration of the workshop

② Dr. V.S. Badri of the population Centre, Bangalore delivered the Key note address. Referring to progress made in the control of cholera, Tuberculosis Malaria and other Communicable diseases; reduction in death rate; grave picture of high infant and Maternal Mortality rate; Proceeded to touch upon certain factors which promote the Health Status of our population. He Stressed the urgent need to move away from the expensive western model and encourage and promote the indegenous and other Systems of Medicine, especially in the rural areas.

DR. Badri further Commenting upon Village Health guide Scheme Suggested that Voluntary Health Organisations help the Village Health guide in mobilising the Community for active participation in Health Tasks. He further Suggested that One voluntary organisation be identified for each Taluk and Supported with Suitable grants.

He Concluded by mentioning that Village Health Committees be provided with Orientation training at primary Health Centres.

(4) The group had the privilage of enlightenment by Sri. T. R. Sathish chandran Director, Institute of Social and Economic change and former chief Secretary of Govt. of Karnataka. Sri. T. R. Sathish chandran delivered the inaugural address.

Mr. Sathish chandran Complimenting the Voluntary Health Association of Karnataka in organising this workshop which has brought together representatives of the Voluntary Organisations and Govt. officials and other professionals interested in the area of public health.

Starting with our failure in translating the laudible Sentiments and eminently reasonable Recommendations contained in the policy documents into concrete action in the area of Science, Technology, education, specifically Commented that neither at National level nor at State level do we see any innovative changes in the Health Strategy in the last ten years. He further mentioned that India still figures prelly low among the list of Countries became of its low human development index. He further mentioned that 'development' is more important than 'growth'. Mentioning that India undoubtedly has made progress in the area of Health Since independence, Observed that foundation has been laid long before the National Health policy was enunciated.

Refering to reduction in the annual compound growth rate of population during the decade 1981-91 to 1.9 per cent Complemented the good work done by the Health Sector of the State. On further analysis, he Specifically observed that Share of Health expenditure in Karnataka is lower than in Tamil Nadu which is further ~~distorted~~ affected by ~~allocation~~ distortion in allocation of expenditure for preventive Rural Health Care on one hand and for Medical education and urban Curative Services on the Other.

Mr. Sathish chandran further observed that the State having taken a step forward in decentralisation of planning through Zilla parishads ~~expenses~~ is

currently taking two steps backwards in weakening the structure it not wholly dismantling it.

~~Restructuring the~~ :

Explaining the possible indirect impact on the health sector by the new economic policy, Specifically touched upon effect of abolition of subsidies on the Social Service Sector of which Health forms one Major Component.

He Concluded by expressing happiness over involvement of many voluntary agencies in the area of health and their representation in the workshop. He hoped for Constructive ideas and Suggestions which will help to Shape the health policy in future.

⑤ Dr. Mira Shiva of the Voluntary Health Association of India Conveyed greetings from Mr. Alok Mukhyopadhyay, Executive Director of VHAI. In her short, but thoughtful words pointed to the participants that in India, unfortunately Drug policy is not part of the National health policy document and there is need for working towards this end.

⑥ Dr. Upendra Bhonoy Member, Executive Committee of VHAK representing the President and Executive Committee of VHAK apprised the participants about the activities of Voluntary Health Association of Karnataka and the Context of the Workshop.

⑦ Dr. Sona Kalyanpur Rao Hon. Secretary of VHAK proposed vote of thanks.

⑧ Dr. Ranganathaiah, Director of K and FW Services, govt. of Karnataka Spoke about the Context of the workshop and its importance

SESSION - II

Following the inaugural function, the first session focussed on recalling and reviewing the Statement on National Health policy. This was contemplated by presentation of four well searched papers by different resource persons. The Session was chaired by Dr. C.N. Francis Director of St. Martha's Hospital, Bangalore.

Dr. (Mrs) M.K. Vasundhara Prof and Head, Dept. of Community Medicine of Bangalore Medical College presented an "Overview of National Health policy". Introducing the participants into the topics to be discussed over the next two days She specifically mentioned that 'TIME' as an important resource was realised and targets to be achieved by 2000 AD have been spelt out in the National Health policy. Apart from identifying (a) Equity in distribution of health care, (b) Appropriate Health Technology (c) Multisectoral approach (d) Community participation as the Strategy for implementation of National Health policy (and of course, primary Health Care) She deliberated on broad guidelines identified in the National Health policy, namely

(i) Strengthening the Health Care Services.
(ii) Developing Referral linkages.
(iii) Restructuring Medical Education
(iv) Exploiting the potential of Traditional Systems of Medicine
(v) promoting action Oriented Health Service Research.
(vi) Developing Health Information Systems
(vii) Attempting Population Stabilisation
(viii) providing for Environmental Sanitation
(ix) Involving NGOs in Health Care Delivery
(x) Highlighting the role of Health Education
(xi) Reforming Health Legislation.

Dr. J. P. Gupta, Regional Director, Health and family welfare Services, Govt. of India presently the 'Current Health Status of India' introduced the participants to the issue by deliberating on Social and Economic facets of Development and Characteristics of indicators to measure Health Status. In his thought provoking presentation, he reviewed the Health Status of India focussing on

(i) Reformulated global indicators as adopted with amendments by the Executive Board by Resolution EB 85.R5.

(ii) National Goals of Health.

(iii) Other indicators

(iv) Level of achievement of Some norms as on Oct 1991.

(v) Health Manpower in Rural areas

drawing Statistics from National Health policy Document, SRS report of 1990, Unicef - State of world's children - 1992; Quarterly report of H & MF Dept, Govt. of India and Country Report on Strategies for Health for All by the year 2000 - (1991).

He deliberated on basis for estimation of GNP Spent on Health and Percentage of National Health Expenditure on Local Health Services. It was observed that During Sixth and Seventh plan, the total Expenditure on Health and family welfare (from Departments of Health and family welfare of States, Union Territories and Centre only) as percentage of GNP is between the Rate of 0.98% (1986-87) to 1.32% (1984-85).

Dr. C.R. KrishnaMurthy, Additional Director, Health and family welfare services, Govt. of Karnataka reviewed the Strategies & Current Health Status of Karnataka drawn Inferences from available data in his eloquent and detailed presentation.

Dr. Shirdi Prasad Tekur Consultant Paediatrician from the Community Health Cell presented the viewpoint of Voluntary Agencies with respect to National Health policy Statement of 1982. Identifying the areas wherein community participation and its role and relationship with Voluntary Agencies is highlighted in the National Health policy, pointed out that the policy refrains from providing advice on how this can be done beyond the pointers it puts out. Dr. Tekur further cited instances of interaction between Voluntary Agencies, their federations and Govt. of Karnataka at meetings and workshops at various levels and different times, initiated both by the Voluntary Agencies as well as the Government. He specifically mentioned that adequate openness and enthusiasm has been observed on both sides which is a creative possibility and the same can be operationalised. Also, presenting a series of purposefully critical Collection of impressions of voluntary Agencies in their interactions with the government.

Concluding his presentation, Dr. S.P. Tekur mentioned that Voluntary Agencies have a positive approach to National Health policy, and in Karnataka there is a healthy trend in Collaboration between Voluntary Agencies and the Govt.

Paper on "View of people's representative in National Health policy" by Prof. M.V. Kulkarni and Dr. G.N. Prabhakar of Dept. of Community Medicine of Mysore Medical College was Circulated among the participants as the authors could not come to the workshop. The paper made an analysis of people's representative's possible view point. The authors rightly pointed out that 'we' are behind 'Man', but Man is running behind Traditional Systems of medicine. They have suggested

(a) co-operative Rural Dispensary

(b) family Survival Assurance plan

(c) Integrated child care
(d) Integrated Health and Nutrition
(e) Integrated Maternal Care
(f) Integrated family care

as possible Solutions.

This Session evoked much interest among the participants. It appeared as if participants were looking forward for a discussion on certain issues raised by the Resource persons. The critical impressions of Voluntary Agencies presented evoked little unrest among State Health Officials. Chairperson Dr. C.M. Francis made room for discussion for about 45 minutes after lunch in response to the presentation of Resource persons. The discussion was very revealing and useful for all the participants. Some of the points brought out follow: These are not conclusions. They are comments and individual responses.

* voluntary organisations operate more in urban areas than in rural areas.
* Voluntary organisations are not fully utilising the facilities available with the Govt.
* Zilla parishath is a strong link and they have to be actively involved in Health Care.
* Is there any need to expand Health Services? or.. should we improve the existing infrastructure.
  Trend of the people presently is to go away from govt institutions.
* How are we going to match the discussed policy with the existing budget?
* Have we developed the organisation in Health Dept. to implement the policy?

* People are not Health Conscious. We Should educate members of 'Grama Sabha'.
* District Health Committees Should be constituted along with Representation of Voluntary Health Agencies.
* Nothing much could be achieved by March 31st allocation.
* People expect Something from the agency involved in Health care - whether it is Govt. agency or a NGO.
* We Should move to enable people.
* If we take the example of major Govt. Maternity Hospitals, by and large, women come only for Delivery.
* There is necessity for decentralisation of financial aspects too at District level.
* People from Govt. Agency and People from Voluntary Organisation are here. What all of us want to do needs political Support.
* Idea of expressing critical impression is to discuss and learn from.

Dr. C.M. Francis Complemented the Resource Persons for their well searched presentations and remarked that participation from Govt. and Non-Govt. Organisations is simply wonderful.

GROUP DISCUSSION - SESSIONS II and IV

Group Discussion were held during the afternoon on Day I which Continued till afternoon on Day II. Four groups with representations from both Govt. and voluntary Sector were formed. The issues discussed in the four groups were:

GROUP	Issue Discussed	Facilitators.
I	Primary Health Care	Dr. J.P Gupta / Dr. Meera Shiva Dr. Sudarshan / Dr. S. Prathish
II	Health Education	Dr. C.M. Francis.
III	Intersectoral Co-ordination	Dr. C.R. Krishna Murthy, Dr. S.M. Subramanya Shetty, Mr. Mohammed Sheriff, Dr. Annapa Rao
IV	Health Information Systems	Dr. S.P. Tekur

The probable process expected in the discussion among the groups was briefed to the participants. Specially the groups were suggested to discuss as follows:

Afternoon of Day I : (a) Group goes through the policy Document
(b) Discusses the policy Statement referring to topics of individual groups.
(c) Discusses issues arising out of policy Statement - identify areas needing Strengthening.

Morning of Day II : (a) Review of activities of previous day.
(b) Implementation of the policy
(c) Supervision, monitoring and evaluation of implementation
(d) Need/otherwise of a State health policy:
(e) Prepare action plan/recommendations.

The group consisting of State Health officials; Divisional joint Directors / their representatives; District Health and family welfare officers; representatives of the various voluntary organisations; Resource persons from varied background deliberated in a most healthy and congenial atmosphere. Equal opportunity for expression from individual members was encouraged in the group discussion. Both the NGO and Govt. Sector representatives found the exercise rewarding to each other.

Each grp prepared report of discussions and presented the same in their groups before its presentation for the whole group in the plenary Session.

PLENARY SESSION

The plenary Session moderated by Dr. C.M. Francis began at 2 p.m on Day II. Individual groups presented the observations / recommendations and conclusions of each Group.

Proceedings of Grp I was presented by _____

Proceedings of Grp II " " " Dr. G.V. Nagaraj
State immunisation officer.

Proceedings of Group III was presented by Dr. S.M. Subramanya Shetty,
Asst. Prof. in Health Education
NIMHANS.

Proceedings of Group IV was presented by Dr. S. P. Tekur.
Community Health cell
Bangalore.

Hon. Health Minister of the Govt of Karnataka Sri. G. puttaswamy Gowda joined the plenary session. Dr. Sudarshan, Treasurer VHAK welcomed the Hon. Health Minister. Dr. S. Pruthvish, Member VHAK presented the Conclusions arrived at the workshop, on behalf of the participants and organisers.

After the presentation of Conclusions, the Hon. Health Minister asked for clarifications on the issue of Decentralisation of planning, implementation and evaluation being mentioned as one of the recommendations. The participants deliberated for a few minutes on this issue and it was observed that Karnataka is one of the States which has attempted to decentralise planning to District level. Appreciating this aspect; the group felt that there is much scope to improve in this area. Dr. Ranganathachar, Director of H and FW Services, Dr. C R Krishnamurthy, Addl. Director, H and FW Services; and Dr. C.M. Francis, Director St. Marthas Hospital and Dr. Sudarshan, Treasurer VHAK provided clarifications to the Hon. Health Minister.

Hon. Health Minister Sri. G. puttaswamy Gowda addressed the gathering. This attempt by ~~Karnataka Association of~~ VHAK, VHAI and ~~Dept~~ of Health and Family Welfare Services in organising this two day workshop and forwarding these recommendations to the govt. is Commendable.

Role of Voluntary organisations in Health care assumes major importance. This is a model as well as guiding example. Since both Govt. and NGOs are involved in similar type of activities, Confusion in mandatory. Keeping

this in mind, it is advisable that Voluntary Agencies decide their area of work and concentrate on the same.

At field level there is necessity for local officers of Health Dept. to join hands with the voluntary Organisations and identify the local needs and help the Govt.

Lack of thought and conscience appears to be evident among people concerned with import of Banned/Banned drugs. In this situation it is difficult to implement the policy recommendations. But, not impossible. There is necessity of Service mind.

Benefits are required to reach rural populace. The Administrative Structure needs to be more active.

There are attempts at Decentralisation and District Health and family welfare Officers are independent to a large extent. ~~Consequently~~ Their duties and responsibilities with respect to administration of Health is to be exercised Consciously.

The Drug policy Unfortunately is in the fold of Multinationals. There is need for amendments in the same for the good. The State govt. intends to Communicate to Central Govt. in this regard.

The Hon. Minister hoped that the ~~recommendations~~ ~~Conclusio~~ outcome conclusions and recommendations be Supportive to the powers of the Society.

Dr. Ranganathachar, Director of Health and family welfare Services, Dr. C.R. Krishnamurthy, Addl. Director, Health and family welfare Services and Dr. Sona Kalyanpur Rao, Secretary VHAK thanked the Hon. Health Minister.

Presentations of the next two groups continued and it was a rewarding Experience for both Voluntary Sector as well for Govt. Sector.

A Committee of ~~Rotary~~ five members was constituted with the responsibility of preparing the final draft Report of this workshop which will be circulated to all the participants, who will be given one month time to respond to the draft. The same Committee will then prepare the final draft which will be

Submitted to Govt. by August 1992 and Copies sent to all members (to DHS if there may be transfers). The members of this Committee are:

(a) Dr. C.M. Francis — Director, St. Marthas Hospital, Bangalore.

(b) Dr. C.R. Krishnamurthy, Addl. Director, Health and family welfare Services Govt. of Karnataka.

(c) Dr. Sudarshan, ~~VGKK~~, B.R. Hills, Mysore District. Treasurer VHAK

(d) Dr. G.V. Nagaraj, Joint Director, Health and fw Services, Govt. of Karnataka.

(e) Dr. S. Premavirh, Programme Adviser, Disability Division, Action Aid, India and Member, VHAK.

Contribution of Dr. C.M. Francis, Director of St. Marthas Hospital; Members of the working group and Resource group; Dr. C.R. Krishna Murthy, Addl. Director of Health and family welfare services; Dr. Ranganathan Acher Director, Health and family welfare Services; Mr. AKM Nadir, Secretary - II, Health and family welfare Services; VHAI; all participants was acknowledged and profusely thanked for the same.

~~Material and System Support provided by~~

Sri. T.R. Satheeshchandran, Director, ICEC was profusely thanked for providing the Venue for the workshop.

~~The System Support provided by~~

The Staff of VHAK Mrs. Neerajakshi, the dynamic promotional Secretary and Sri. Ramappa, the Coolum Co-ordinator were appreciated and thanked for the hard work put in by them.

The System Support extended by Mr. Premananda Thambi, Member, VHAK was remembered with gratitude.

HP 2.10

VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA. (VHAK)

Rajini Nilaya, No.60, Ramakrishna Mutt Road Cross
Ulsoor, Bangalore -8.

During 1969 the leaders of Voluntary Hospitals and Health care Institutions of this country met at Bangalore and in their deliberations they recomended formation of Voluntary Health Association to bring in all the Voluntary Health Institutions of State in to its fold to supplement and augment the Primary Health Services for the unreached community. It is with this background the VHAK was established in 1974 as a non-Governmental, non-sectarian registered under Karnataka Society's Act 1960.

After its formation VHAK started its activities intensively to enroll all the Voluntary Health Institutions both in urban and rural including teaching Hospitals in the Voluntary Sector as members to bring them together on various platforms through regional meetings, seminars, workshops, training programmes for all levels of Health functionaries to enable them to perceive Health as a movement and to strengthen the existing Health care delivery system. The VHAK started with 25 Institutions and has grown to a big institution with a membership strength of 150 institutions covering all the regions, all the districts of Karnataka emphasising the need for developing the most underdeveloped communities of such districts. It has taken such programmes which would directly benefit the common man in the remotest part of the country side through Dai Training programme, Teachers Training programme, Health Volunteers Training Programme, Traditional Medical healers Training programme, Health Workers Training programme, RDT for Practicing and Teaching Medical personnel, Seminars for personnel of Developmental Organisations and designing programmes to the needs of the member institutions.

- VHAK is federal constituent of VHAI, New Delhi.
- Membership is open to all Health & Developmental Institutions which are registered under Society's Act or any other act with a motive of no profit and non-sectarian.
- VHAK has divided Karnataka into four regions Bangalore, Mysore, Mangalore and Dharwad for convenience of bringing the respective institutions together and closer for geographical convenience.
- The funds of VHAK are received from Membership fees & Donations.

GOALS & OBJECTIVES

The main goal of VHAK is to create a healthy community. It believes that health can became a reality for all people of the country by ensuring social justice, equitable distribution and reaching the unreached for prevention, promotion, curative and rehabilitative Primary Health Care through concerted effort both by Government and Voluntary Sector. This needs a Comprehensive health plan enunciating all the basic principles of justice dignity and human values woven into the fabric of the 'comprehensive' policy emphasising on Primary Health Care. This may be ensured through mutual understanding and defining the policy clearly both by Government and Voluntary Sector for effective implementation of the programme to achieve the enshrined goals of the health policy.

The Main objective of the VHAK is:

--To act as a liaison between the Voluntary and Government Agencies at both Central and State levels.

--To aid in co-ordination of health care activities in the Voluntary Sector.

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--To help Member Institutions to collaborate wherever feasible in order to conserve resources.

--To help in organising training programmes for different levels of Institution Staff

--To encourage preventive and promotive health care activities

--Diffusing information and recent trends in health care policies, Management and Technology.

--Studying, documenting and promoting alternative systems of medicine and Traditional medicine.

---Promoting health care activities

-- To mobilize the resources of both Government and Voluntary for effective utilization of available resources

Apart from conducting various programmes the sharing of Health information related to the programmes and latest developments in the field of Health is an important task and to achieve this goal circulars and bi-monthly newsletters are brought out.

ACTIVITIES:

-- VHAK organizes refresher and short term training programmes according to the felt needs of member institutions from time to time for Doctors, Nurses, Para-medical workers and others.

-- Training programmes have been organized in the field of Community Health, School Health, Rational Drug Therapy, T B A (MCH) etc.,

Some of the programmes to mention that were organised both intensively and extensively are as follows:

1. Community & Health Care
2. Problems encountered by Health Care institutions and suggestions to over come the same.
3. Materials Management
4. Community Health Care for the needy
5. New approaches to community Health Planning & Implementation
6. Visions of Health Care
7. Refresher course for Balasevikas
8. Health priorities and difficulties in the practical implementation of these priorities.
9. Hospital Health education programmes
10. T.B.in context to community health
11. National Health Policy & Role of Voluntary Health Institutions.
12. School Health & School Health education
13. Role of Nurses in community health
14. Management of Diarrhoeal Diseases

.....3

15. Innovative methods of Nutrition education in schools

16. Participatory dialogue on Government Health Programmes - Government & Voluntary Organisation, Etc.,

VHAK has envisaged the following training programmes for the years 1991 to 1994; The major areas are:

1. Training of Traditional Birth Attendants:

This is a five days programme, since the age old practices of conducting deliveries by the untrained Dais give way for high rate of infant mortality, morbidity and other complications in some places leading to death, it is necessary that they undergo training to conduct safe deliveries and acquire knowledge to educate on various aspects of Maternal & Child Health.

2. Traditional Systems of Medicine:

This is three days workshop on Traditional Systems of Medicine to develop a system of Health Care in which all the different systems can make their own uiique contribution and promote the same.

3. Training of Village Health Workers:

This is ten days Training Programme. Identify and train dedicated, committed and service minded local personnel who would take the initiative in a broader prospective to improve the health status of the community.

4. School Health:

The role of the School in the Community is to provide a means for future development and growth through creative education of its future citizenary. The emphasis of this programme is Training the Teachers. This includes one day orientation and 3 days Intensive Training Programme.

5. Health for Non-Health:

Most of the Voluntary Organisations working in the field of development do not have either doctors, nurses or any other so called Health personnel; all the same, in one way or other they are contributing to health in all rural masses with whom they are working. This 2 days programme aims at strengthening their knowledge on Health, broaden their definition of Health and help them incorporate components of health so that, their developmental programmes will be more comprehensive and successful.

6. Rational Drug Therapy:

VHAK Objectives regarding this are

a) To collect and disseminate the right information on Drugs and Drug related issues.

b) To create awareness among masses

c) To involve health, education departments, lawyers Medical workers and Journalists in the awareness compaign.

d) To pressurise Medical Professionals and the authorities of Pharmacy & Pharmaceutical companies to realise the irrational policies and practices existing.

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LIAISON WORK WITH THE GOVERNMENT:

--VHAK maintains fruitful dialogue with the Health Ministry and Directorate of Health Services on all matters of common interest. It has good rapport with the Education department and Forest department also.

--The cause of Voluntary health sector has been effectively represented with the Government through meetings and presentation of memoranda.

--VHAK encourages member institutions to co-operate with Government agencies at local levels in a collaborative and supportive manner with a view to maximize health care services.

--In light of the VII & VIII five year plans the Karnataka Government is also involving Voluntary Organisations as partners. A consultative committee has been constituted under the Development Commissioner, representatives of Voluntary Organisations and different heads of the Government departments, VHAK is very much part of this consultative Committee.

--Helping the Member Organisations to have dialogue with district level Health personnel.

--Collecting & disseminating various Government Orders, Circulars related to Voluntary Organisations to the member institutions.

--Helping the Members utilise the Government resources such as training programmes and health education materials etc.,

LIAISON WITH OTHER VOLUNTARY AGENCIES:

--VHAK has good collaborative relationship with many other Voluntary agencies engaged in diversely specialized yet allied fields of activity such as FEVORD-K and the DAF-K etc.,

RELATIONSHIP WITH VHAI, NEW DELHI.

VHAK is a federal constituent of Voluntary Health Association of India and being committed to common goals and philosophy, maintains a special relationship with it in all spheres of activity.

PUBLICITY AND INFORMATION SHARING:

Through our bi-monthly Newsletter and circulars, we keep our members informed about latest developments in the health services in areas of legislation, innovative projects, research discoveries, refresher training programmes etc.,

ASPIRATIONS:

- To strengthen Collective fellowship of Voluntary Health Sector
- To strive for increased liaison and collaboration with the Government for mutual benefit.
- To publish a health resources manual containing information on local resources, Government facilities to voluntary sector etc.,
- To publish simple, health education material such as posters and slides on good health, hygiene and nutrition.
- To offer on-the-field consultancy for developing community based innovative health care programmes involving local resources.
- To establish a legal consultancy service on all matters of legislation affecting voluntary hospitals.
- To become financially self-sufficient with indigenous public support through self-supporting services and fund-raising programmes.
- To organise disaster relief from amongst its constituents.
- To offer consultancy service to organizations and companies who wish to add health activities as a service.

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VOLUNTARY HEALTH ASSOCIATION OF KARNATAKA, BANGALORE

VOLUNTRY HEALTH ASSOCIATION OF INDIA, NEW DELHI

AND

DEPARTMENT OF HEALTH AND FAMILY WELFARE

GOVERNMENT OF KARNATAKA

WORKSHOP ON NATIONAL HEALTH POLICY

Date : 9 & 10, April 1992 Venue : I S E C

Bangalore - 72

PROGRAMME

FIRST DAY 9.4.1992

Inagural Function :

Session - I

8.30 to 9.30 a.m	-	Registration
9.30 to 9.35 a.m	-	Invocation by Mrs.Joyce
9.35 to 9.45 a.m	-	Welcome by Dr.H.Sudarshan, Treasurer V H A K
9.45 to 9.55 a.m	-	Role of VHAI in health & Context of the workshop by Dr.Mira Shiva, Head Public Policy Division VHAI, NEW DELHI.
9.55 to 10.15 a.m	-	Lighting of the lamp & Inagural address by Sri.Puttasame Gowda Hon.Health Minister, Govt. of Karnataka.
10.15 to 10.30 a.m	-	Key Note Address Mr.V.S.BADARI, Asst. Director Population Centre.
10.30 to 10.40 a.m	-	Presidential address
10.40 to 10.45 a.m	-	Vote of thanks - Dr.Sona Kalyanpur Rao, Hon.Secretary, VHAK
10.45 to 11.00 a.m	-	Coffee

Session II

Chair person	-	Dr.C.M.Francis
Co-Chair person	-	Dr.S.V.Rama Rao

Presentations :

11.00 to 11.15 a.m	-	Over view of NHP Dr.M.K.Vasundhara Prof. & Head, Dept of P&SM Bangalore Medical College
11.15 to 11.30 a.m	-	Current Health status of India Dr.J.P.Gupta, regional Director (H & FW) Bangalore
11.30 to 11.45 a.m	-	NHP - Point of view of Govt. Dr.C.R.Krishnamurthy Addl. Director - MCH &FWZ Govt. of Karnataka.
11.45 to 12.00 noon	-	NHP - point of view of people's representative Dr.M.V.Kulkarni - Prof. & Head Dept. of P & SM - Govt. Medical College, Mysore.

P T O

12.00 to 12.15 p.m	-	NHP - Point of Voluntary Organisations Dr.S.P.Tekur, Community Community Health Cell, Bangalore.
12.15 to 1.00 p.m	-	Remarks & Reflection from Chair person & Co-chair person
1.00 to 1.45 p.m	-	LUNCH

Session - III

GROUP DISCUSSION :

2.00 to 4.30 p.m	-	Study & Analyse NHP Identifying lacunae & its implementation

SECOND DAY - 10.4.1992

Session - IV

8.00 to 9.00 a.m	-	Breakfast
9.00 to 9.15 a.m	-	Briefing of the Group Discussion Report held the previous day.
9.15 to 11.00 a.m	-	Group discussion continued (How to strengthen the implementation)
11.00 to 11.30 a.m	-	Tea Break
11.30 to 1.00 a.m	-	Action Plan (towards effective implementation of NHP)
1.00 to 2.00 p.m	-	Lunch

Session V

2.00 to 4.00 p.m	-	Gist of the deliberations to be presented to the Health Secretary
	-	Presentation of Group reports
	-	Remarks
	-	Vote of thanks
	-	Tea

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HP2-11

VOLUNTARY HEALTH ASSOCIATION, KARNATAKA

ANNUAL GENERAL BODY MEETING

DATE: Sunday 5, July 1992

VENUE: Conference Hall
St.Martha's Hospital
Nrupathunga Road
BANGALORE - 560 009

P R O G R A M M E

WORKSHOP ON - 'NATIONAL HEALTH POLICY - A DECADE AFTER.....'

9.00 to 9.30 a.m. - Registration

9.30 to 11.00 a;m. - INAGURATION
- Invocation - By Students, School of Nursing St.Martha's Hospital
- Welcome - Fr.Bernard Moras, President, VHAK
- Lighting of the Lamp & Inagural Address - Mr.A.K.M.Naik, Secretary, Health & Family Welfare, Govt. of Karnataka
- Key Note Address - Dr.Ranganath Achar, Director, H & F.W. Govt. of Karnataka
- Report of N H P - By Dr.H.Sudarshan, Treasurer, VHAK
- Vote of Thanks - Dr.(Mrs) Sona Kalyanpur Rao, Hon. Secretary, VHAK

11.00 to 11.30 a.m. - T E A

11.30 to 12.30 p.m. - Group Discussion
- Operationalisation of National Health Policy Strategy at District level
- Moderates
  - Dr.C.M.Francis
  - Dr.S.V.Rama Rao
  - Dr.C.R.Krishna Murthy
  - Dr.C.Prasanna Kumar

12.30 to 1.30 p.m. - Presentation of Group reports

1.30 to 2.30 p.m. - L U N C H

2.30 to 4.00 p.m. - ANNUAL GENERAL BODY MEETING.

A G E N D A

1. Prayer
2. Roll Call
3. Approval & Review of the Minutes of the previous E.C.Meeting
4. Points arising out of the minutes
5. Annual Report
6. Audited Statement of Accounts - 1991-92
7. Appointment of Auditors
8. Review of the Constitution
9. Appointment of Nomination Committee
10. Release of the Book 'STATE OF INDIA'S HEALTH'
11. Future programmes
12. Any other matter with the permission of the Chair.

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Duplicate

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STATEMENT
ON
NATIONAL HEALTH POLICY

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NEW DELHI

1982

Introductory

1. The Constitution of India envisages the establishment of a new social order based on equality, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and illhealth and directs the State to regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of workers, men and women, specially ensuring that children are given opportunities and facilities to development in a healthy manner.

1.2 Since the inception of the planning process in the country, the successive Five Year Plans have been providing the frame work within which the States may develop their health services infrastructure, facilities for medical education, research etc. Similar guidance has sought to be provided through the discussions and conclusions arrived at in the Joint Conferences of the Central Councils of Health and Family Welfare and the National Development Council. Besides, Central legislation has been enacted to regulate standards of medical education, prevention of food adulteration, maintenance of standards in the manufacture and sale of certified drugs, etc.

1.3 While the broad approaches contained in the successive Plan documents and discussions in the forums referred to in para 1.2 may have generally served the needs of the situation in the past, it is felt that an integrated, comprehensive approach towards the future development of medical education research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health Policy.

Our heritage

2. India has a rich, centuries-old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical skills enunciated by Charaka and Shusharuta bear testimony to our ancient tradition in the scientific health care of our people. The approach of our ancient medical systems was of a holistic nature, which took into account all aspects of human health and disease. Over the centuries, with the intrusion of foreign influences and mingling of cultures, various systems of medicine has, in a relatively short period of time, made a major impact on the entire approach to health care and pattern of development of the health services infrastructure in the country.

Progress achieved

3. During the last three decades and more, since the attainment of Independence, considerable progress has been achieved in the promotion of the health status of our people. Smallpox has been eliminated; plague is no longer a problem; mortality from cholera and related diseases has decreased and malaria brought under control to a considerable extent. The mortality rate per thousand of population has been reduced from 27.4 to 14.8 and the life expectancy at birth has increased from 32.7 to over 52. A fairly extensive network of dispensaries, hospitals and institutions providing specialized curative care has developed and a large stock of medical and health personnel of various levels, has become available. Significant indigenous capacity has been established for the production of drugs and pharmaceuticals, vaccines, sera, hospital equipments, etc.

The existing picture

4. In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The high rate of population growth continues to have an adverse effect on the health of our people and the quality of their lives. The mortality rates for women and children are still distressingly high; almost one third of the total deaths occur among children below the age of 5 years; infant mortality is around 129 per thousand live births. Efforts at raising the nutritional levels of our people have still to bear fruit and the extent and severity of malnutrition continues to be exceptionally high. Communicable and non-communicable diseases have still to be brought under effective control and eradicated. Blindness, Leprosy and T.B. continue to have a high incidence. Only 31% of the rural population has access to potable water supply and 0.% enjoys basic sanitation.

4.1 High incidence of diarrhoeal diseases and other preventive and infectious diseases, specially amongst infants and children, lack of safe drinking water and poor environmental sanitation, poverty and ignorance are among the major contributory causes of the high incidence of disease and mortality.

4.2 The existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas. Furthermore, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of the health care. The existing approach instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, at various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes have, by and large, failed to involve the individuals and families in establishing a

self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes.

Need for evolving a health policy -the revised 20-point programme

5. India is committed to attaining the goal of "Health for all by the year 2000 A.D." through the universal provision of comprehensive primary health care services. The attainment of this goal requires a through overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure. Furthermore, considering the large variety of inputs into health, it is necessary to secure the complete integration of all plans for health and human development with the overall national socio-economic development process, and specially in the more closely health related sectors, e.g. drugs and pharmaceuticals, agriculture and food production, rural development, education and social welfare, housing, water supply and sanitation, prevention of food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs and the conservation of the environment. In sum, the contours of the National health Policy have to be evolved within a fully integrated planning framework which seeks to provide universal comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the health sector.

5. 1 It is also necessary to ensure that the pattern of development of the health services infrastructure in the future fully takes into account the revised 20-point programme. The said programme attributes very high priority to the promotion of family planning as a people's programme, on a voluntary basis, substantial augmentation and provision of primary health facilities on a universal basis; control of leprosy, T.B. and Blindness; acceleration of welfare programmes for women and children; nutrition programmes for pregnant women, nursing mothers and children, especially in the tribal, hill and backward areas. The programme also places high emphasis on the supply of drinking water to all problem villages, improvements

in the housing and environments of the weaker section of society; increased production of essential food items; integrated rural developments; spread of universal elementary education, expansion of the public distribution systems, etc.

Population stabilisation

6. Irrespective of the changes, no matter how fundamental, that may be brought about in the over-all approach to health care and the restructuring of the health services, not much headway is likely to be achieved in improving the health status of the people unless success is achieved in securing the small family norm, through voluntary efforts, and moving towards the goal of population stabilisation. In view of the vital importance of securing the balanced growth of the population it is necessary to enunciate, separately, a National Population Policy.

Medical and health education

7. It is also necessary to appreciate that the effective delivery of health care services would depend very largely on the nature of education, training and appropriate orientation towards community health of all categories of medical and health personnel and their capacity to function as an integrated team, each of its members performing given tasks within a coordinated action programme. It is therefore, of crucial importance that the entire basis and approach towards medical and health education, all levels, is reviewed in terms of national needs and priorities and the curricular and training programmes restructured to produce personnel of various grades of skill and competence, who are professionally equipped and socialy motivated to effectively deal with day-to-day problems, within the existing constraints. Towards this end, it is necessary to formulate, separately, a national medical and health education Policy which (i) sets out the changes required to be brought about in the curricular contents and training programme of medical and health personnel, at various levels of functioning; (ii) takes into account the need for establishing the extremely essential inter-relations between functionaries of various grades (iii) provides guldelines for the production of health personnel on the basis of realistically assessed manpower requirments; (iv) seeks to resolve the existing sharp regional imbalances in their availability; and (v) ensures that personnel at all levels are socially motivated towards the rendering of community health services.

Need for providing primary health care with special emphasis on the preventive, promotive and rehabiliative aspects :

8. Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres-dispensaries, hospitals, instituticns for specialist treatment—the large majority of which are located in the urban areas of the country.

The vast majority of those seeking medical relief have to travel long distance to the nearest curative centre, seeking relief for ailments which could have been readily and effectively handled at the community level. Also for want of a well established referral system, those seeking curative care have the tendency to visit various specialist centres, thus further contributing to congestions, duplication of efforts and consequential waste of resources. To put an end to the existing all-round unsatisfactory situation, it is urgently necessary to restructure the health services within the following broad approach :

(1) To provide within a phased, time-bound programme a well dispersed network of comprehensive primary health care services, integrally linked with the extension and health education approach which takes into account the fact that a large majority of health functions can be effectively handled and resolved by the people themselves, with the organised support of volunteers, auxilliaries, para-medicals and adequately trained multi-purpose workers of various grades of skill and competence, of both sexes. There are a large number of private, voluntary organisations active in the health field all over the country. Their services and support would require to be utilised and intermeshed with the governmental efforts, in an integrated manner.

(2) To be effective, the establishment of the primary health care approach would involve large scale transfer of knowledge, simple skills and technologies to health volunteers, selected by the communities and enjoying their confidence. The functioning of the front line of workers, selected by the community would require to be related to definitive action plans for the translation of medical and health knowledge into practical action, involving the use of simple and inexpensive intervention which can be readily implemented by persons who have undergone short periods of training. The quality of training of these health guides/workers would be of crucial importance to the success of this approach.

(3) The success of the decentralised primary haalth care system would depend vitally on the organised building up of individual self-reliance and effective community participation; on the provision of organised, back-up support of the secondary and tertiary levels of the health care services, providing adequate logistical and technical assistance.

(4) The decentralisation of services would require the establishment of a well worked out referral system to provide adequate expertise at the various levels to the organisational set-up nearest to the community, depending upon the actual needs and problems of the area, and thus ensure against the continuation of the existing rush towards the curative centres in the urban areas. The effective establishment of the referral system would also ensure the optimal utilisation of expertise at the higher levels of the hierarchical structure. This approach would not only lead to the progressive improvement of comprehensive health care services at the primary level but also provide for timely attention being available to those in need of urgent specialist care, whether they live in the rural or the urban areas.

(5) To ensure that the approach to health care does not merely constitute a collection of disparate health interventions but consists of an integrated package of services seeking to tackle the entire range of poor health conditions, on a broad front, it is necessary to establish a nation-wide chain of sanitary-cum-epidemiological stations. The location and functioning of these stations may be between the primary and secondary levels of the hierarchical structure, depending upon the local situations and other relevent considerations. Each such station would require to have suitably trained staff equipped to identify, plan and provide preventive, promotive and mental health care services. It would be beneficial, depending upon the local situations, to establish such stations at the Primary Health Centres. The district health organisation should have, as an integral part of its set-up, a well organised epidemiological unit to coordinate and superintend the functioning of the field

stations. These stations would participate in the integrated action plans to eradicate and control diseases, besides tackling specific local environmental health problems. In the urban agglomerations, the municipal and local authorities should be equipped to perform similar functions, being supported with adquate resources and expertise, to effectively deal with the local preventable public health problems. The aforesaid approach should be implemented and extended through community participation and contributions, in whatever form possible, to achieve meaningful results within a time-bound programme.

(6) The location of curative centres should be related to the populations they serve' keeping in view the densities of population, distances, topography, transport connections. These centres should function within the recommended referral system, the gamut of the general specialities required to deal with the local disease patterns being provided as near to the community as possible, of the secondary level of the hierarchical organisation. The concept of domiciliary level and the field-camps approach should be utilised to the fullest extent, to reduce the pressures on these centres, specially in efforts relating to the control and eradication of Blindness, Tuberculosis, Leprosy, etc. To maximise the utilisation of available resources, new and additional curative centres should be established only in exceptional cases, the basic attempt being towards the upgradation of existing facilities, at selected locations, the guiding principle being to provide specialist services as near to the beneficiaries as may be possible, within a well-planned network. Expenditure should be reduced through the fullest possible use of cheap locally available building materials, resort to appropriate architectural designs and engineering concepts and by economical investment in the purchase of machineries and equipments, ensuring against avoidable duplication of such acquisitions, It is also necessary to devise effective mechanisms for the repair, maintenance and proper upkeep of all bio-medical equipments to secure their maximum utilisation.

(7) With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirments and potentials, to encourage the establishment of practice by private medical professional, increased investment by non-governmental agencies establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in health field.

(8) While the major focus of attention in restructuring the existing governmental health organisations would relate to establising comprehensive primary health care and public health services, within an integrated referral system, planned attention would also require to be devoted to the establishment of centres equipped to provide speciality and super-speciality service, through a well dispersed net work of centres, to ensure that the present and future requirements of specialist treatment are adequately available within the country. To reduce governmental expenditures involved in the establishment of such centres, planned efforts should be made to encourage private investments in such fields so that the majority of such centres, within the governmental set up, can provide adequate care and treatment to those entitled to free care, the affluent sectors being looked after by paying clinics. Care would also require to be taken to ensure the appropriate dispersal of such centres, to remove the existing regional imbalances and to provide services within the reach of all, whether rural or the urban areas.

(9) Special, well coordinated programmes should be launched to provide mental health care as well as medical care and the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, infirm and the aged. Also, suitably organised programmes would require to be launched to ensure against the prevention of various disabilities.

(10) In the establishment of the re-organised services, the first priority should be accorded to provide service to those residing in the tribal, hill and backward areas as well as to endemic disease affected populations and the vulnerable sections of the society.

(11) In the re-organised health services scheme, efforts should be made to ensure adequate mobility of personnel at all levels of functioning.

(12) In the various approaches, set out in (1) to (11) above organised efforts would require to be made to fully utilise and assist in the enlargement of the services being provided by private voluntary organisations active in the health field. In this context, planning encouragement and support would also require to be afforded to fresh voluntary efforts, specially those which seek to serve the need of the rural areas and the urban slums.

Re orientation of the existing health personnel

9. A dynamic process of change and innovation is required to be brought in the entire approach to health manpower development, ensuring rhe emergence of fully integrated bands of workers functioning within the "Health Team" approach.

Private practice by governmental functionaries

10. It is desirable for the States to take steps to phase out the system of private practice by medical personnel in government service, providing at the same time for payment of appropriate compensatory nonexisting allowance. The State would require to carefully review the existing situation, with special reference to the availability and dispersal of private practitioners, and take timely decisions in regard to this vital issue.

Practitioners of indigenous and other systems of medicine and their role in health care

11. The country has a large stock of health manpower comprising of private practitioners in various systems, for example, Ayurvedic, Unani, Sidha, Homoeopathy, Yoga, Naturopathy etc. This resource has not so far been adequately utilised. The practitioners of these various systems enjoy high local acceptance and respect and consequently exert considerable influence on health beliefs and practices. It is, therefore, necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Simultaneously, planned efforts should be made to dovetail the functioning of the practitioners of these various systems and integrate their services, at the appropriate levels, within specified areas of responsibility and functioning, in the over-all health care delivery system,

specially in regard to the preventive, promotive and public health objectives. Well considered steps would also require to be launched to move towards a meaningful phased integration of the indigenous and the modern systems.

Problems requiring urgent attention

12. Besides the recommended restructuring of the health services infrastructure, reorientation of the medical and health manpower, community involvement and exploitation of the services of private medical practitioners, specially those of the traditional and other systems, involvement and utilisation of the services of the voluntary agencies active in the health field. etc., it would be necessary to devote planned, time-bound attention to some of the more important inputs required for improved health care. Of these, priority attention would require to be devoted to:

(i) **Nutrition:** National and regional strategies should be evolved and implemented, on a time-bound basis, to ensure adequate nutrition for all segments of the population through a well developed distribution system, specially in the rural areas and urban slums. Food of acceptable quality must be available to every person in accordance with his physical needs. Low cost, processed and ready-to-eat foods should be produced and made readily available. The over-all strategy would necessarily involve organised efforts of improving the purchasing power of the poorer sections of the society. Schemes like employment guarantee scheme, to which the government is committed could yield optimal results if these are suitably linked to the objective of providing adequate nutrition and health cover to the rural and the urban poor. The achievement of this objective is dependent on integrated socio-economic development leading to the generation of productive employment for all those constituting the labour force. Employment guarantee scheme and similar efforts would require to be specially enforced to provide social security for identified vulnerable sections of the society. Measures aimed at improving eating habits, inculcation of desirable nutritional practices, improved and scientific utilisation of available food materials and

the effective popularisation of improved cooking practices would require to be implemented. Besides, a nation-wide programme to promote breast feeding of infants and eradication of various social taboos detrimental to the promotion of health would need to be initiated. Simultaneously, the problems of communities afflicted by chronic nutritional disorders should be tackled through special schemes including the organisation of supplementary feeding programmes directed to the vulnerable sections of the population. The force and effect of such programmes should be ensured by delivering them within the setting of fully integrated health care activities, to ensure the inculcation of the educational aspects, in the over-all strategy.

(ii) **Prevention of food adulteration and maintenance of the quality of drugs:** Stringent measures are required to be taken to check and prevent the adulteration and contamination of foods at the various stages of their production, processing, storage, transport, distribution, etc. To ensure uniformity of approach, the existing law would require to be reviewed and effective legislation enacted by the Centre. Similarly the most urgent measures require to be taken to ensure against the manufacture and sale of spurious and sub-standard drugs.

(iii) **Water supply and sanitation :** The provision of safe drinking water and the sanitary disposal of waters, human and animal wastes, both in urban and rural areas, must constitute an integrated package. The enormous backlog in the provision of these services to the rural population and in the urban agglomerations must be made up on the most urgent basis. The provision of water supply and basic sanitation facilities would not automatically improve health. The availability of such facilities should be accompanied by intensive health education campaigns for the improvement of personal hygiene, the economical use of water and the sanitary disposal of waste in a manner that will improve individual and community health. All water-supply schemes must be fully integrated with

efforts at proper water management, including the drainage and disposal of waste waters. To reduce expenditures and for achieving a quick headway it would be necessary to devise appropriate technologies in the planning and management of the delivery systems. Besides, the involvement of the community in the implementation and management of the systems would be of crucial importance, both for reducing costs as well as to see that the beneficiaries value and protect the services provided to them.

(iv) **Environmental protection:** While preventive, promotive, public health services are established and the curative services re-organised to prevent, control and treat diseases, it would be equally necessary to ensure against the haphazard exploitation of resources which cause ecological disturbances leading to fresh health hazards. It is, therefore, necessary that economic developmeat plans, in the various sectors, are devised in adequate consultation with the Central and the State Health authorities. It is also vitally essential to ensure that the present and future industrial and urban development plans are centrally reviewed to ensure against congestions, the unchecked release of noxious emissions and the pollution of air and water. In this context, it is vital to ensure that the siting and location of all manufacturing units is strictly regulated through legal measures, if necessary. Central and State Health authorities must necessarily be consulted in establishing locational policies for industrial development and urbanisation programmes. Environmental appraisal procedures must be developed and strictly applied in according clearance to the various developmental projects.

(v) **Immunisation programme :** It is necessary to launch an organised, nationwide immunisation programme, aimed at cent percent coverage of targetted population groups with vaccines against preventable and communicable diseases. Such an approach would not only prevent and reduce disease and disability but also bring down the existing high infant and child mortality rate.

(vi) **Maternal and child health service :** A vicious relationship exists between high birth rates and high infant mortality, contributing to the desire for more children. The highest priority would, therefore, require to be devoted to efforts at launching special programmes for the improvement of maternal and child health, with a special focus on the less privileged sections of sections of society. Such programmes would require to be decentralised to the maximum possible extent, their delivery being at the primary level, nearest to the doorsteps of the beneficiaries. While offorts should continue at providing refresher training and orientation to the traditional birth attendants, schemes and programmes should be launched to ensure that progressively all deliveries are conducted by competently trained persons so that complicated cases receive timely and expert attention, within a comprehensive programme providing ante-natal, intra-natal and postnatal care.

(vii) **School health programme :** Organised school health services, integrally linked with the general, preventive and curative service, would require to be established within timelimited programmes.

(viii) **Occupational health service :** There is urgent need for launching well-considered schemes to prevent and treat diseases and injuries arising from occupational hazards, not only in the various industries but also in the comparatively un-organised sectors like agriculture. For this purpose, the coverage of the Employees State Insurance Act, 1948, may be suitably extended ensuring adequate coordination of efforts with the general helth services. In their respective spheres of responsibility, the Centre and the States must introduce organised occupational health services to reduce morbidity, disabilities and mortality and thus promote better health and increased welfare and productivity on all fronts.

Health education

13. The recommended efforts, on various fronts, would bear only marginal results unless nation-wide health education programmes, backed by appropriate communication strategies are launched to provide health information in easily understandable form, to motivate the development of an attitude

for healthy living. The public health education programme should be supplemented by health, nutrition and population education programmes in all educational institutions at various levels. Simultaneously, efforts would require to be made to promote universal education, specially adult and family education, without which the various efforts to organise preventive and promotive health activities, family planning and improved maternal and child health cannot bear fruit.

Management information system

14. Appropriate decision making and programme planning in the health and related fields is not possible without establishing an effective health information system. A nation-wide organisational set-up should be established to procure essential health information. Such information is required not only for assisting in planning and decision making but to also provide timely warnings about emerging health problems and for reviewing, monitoring and evaluating the various on-going health programmes. The building up of a well conceived health information system is also necessary for assessing medical and health manpower requirements and taking timely decisions, on a continuing basis, regarding the manpower requirement in the future.

Medical industry

15. The country has built up sound technological and manufacturing capability in the field of drugs, vaccines, bio-medical equipments, etc. The available know-how requires to be adequately exploited to increase the production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirement, specially in regard to the national programmes to combat Malaria, TB, Leprosy, Blindness, Diarrhoeal diseases, etc. The production of the essential, life saving drugs under their generic names and the adoption of economical packaging practices would considerably reduce the unit cost of medicines bringing them within the reach of the poorer sections of society, besides significantly reducing the expenditures being incurred by the governmental organisation on the purchase of drugs. In view of the low cost of indigenous and herbal medicines, organised efforts may be launched to establish herbal gardens, producing drugs of certified quality and making them easily available.

15. 1 The practitioners of the modern medical system rely heavily on diagnostic aids involving extensive use of costly, sophisticated biomedical equipment. Effective mechanisms

indigenous manufacture, for such devices being readily available, at reasonable prices, for use of the health care centres.

Health education

16. Besides mobilising the community resources, through its active participation in the implementation and management of national health and related programmes, it would be necessary to device well considered health insurance schemes, on a State-wise basis, for mobilising additional resources for health promotion and ensuring that the community shares the cost of lhe services, in keeping with its paying capacity.

Health legislation

17. It is necessary to urgently review all existing legislation and work towards a unified, comprehensive legislation in the health field, enforceable all over the country.

Medical research

18. The frontiers of the medical sciences are expanding at a phenomenal pace. To maintain the country's lead in this field as well as to ensure self—sufficiency and generation of the requisite competence in the future, it is necessary to have an organised programme for the building up and extension of fundamental and basic research in the field of bio-medical and allied sciences. Priority attention would require to be devoted to the resolution of problems relating to the containment and eradication of the existing, widely prevalent diseases as well as to deal with emerging health problems. The basic objective of medical research and the ultimate test of its utility would involve the translation of available know-how into simple, low-cost, easily applicable appropriate technologies, devices and interventions suiting local conditions, thus placing the latest technological achievements, within the reach of health personnel, and to the front line health workers, in the remotest corners of the country. Therefore, besides devotion to basic, fundamental research, high priority should be accorded to applied, operational research including action research for continuously improving the cost effective delivery of health services. Priorities would require to be identified and laid down in collaboration with social scientists, planners and decision makers and the public. Basic research efforts shouid devote high priority to the discovery and development of more effective treatment and preventive procedures in regard to communicable and tropical diseases—Blindness, Leprosy, T.B., etc. Very high priority would also have to be devoted to contraception research, to urgently improve the effectiveness acceptability of existing methods as well as discover more effective and acceptable devices. Equally high attention would

should be established to identify essential equipments required for extensive use and to promote and enlarge their require to be devoted fo nutrition research, to improve the health status of the community. The overall effort should aim at the balanced development of basic, clinical problem-oriented operational research.

Inter-sectoral cooperation

19. All health and human development must ultimately constitute an integral component of the overall socio-economic developmental process in the country. It is thus of vital importance to ensure effective coordination between the health and its more intimately related sectors. It is, therefore, necessary to set up standing mechanisms, at the Centre and in the States, for securing inter-sectoral coordination of the various efforts in the fields of health and family planning, medical education and research, drugs and pharmaceuticals, agriculture and food, water supply and drainage, housing, education and social welfare and rural development. The coordination and review, committees to be set up, should review progress, resolve bottlenecks and bring about such shifts in the contents and priorities of programmes as may appear necessary to achieve the overall objectives. At the community level, it would be desirable to devise arrangements for health and all other developmental activities being coordinated under an integrated programme of rural development.

Monitoring and review of progress

20. It would be of crucial importance to monitor and periodically review, the success of the efforts made and the results achieved. For this purpose, it is necessary to urgently identify the base line situation and to evolve a phased programme for the achievement of short and long term objectives in the various sectors of activity. Towards this end, the current level of achievement as well as the broad indicators for the achievement of certain basic health and family welfare goals are set out in the annexed tabular statement. These goals, as well as other allied objectives, would require to be further worked upon and specific targets for achievement established by the Central and the State governments in regard to the various functioning.

GOALS FOR HEALTH AND FAMILY WELFARE PROGRAMMES

Sl. No	Indicator	Current level	GOALS		
			1985	1990	2000
1.	Infant mortality rate	Rural 136 (1978)	122		
		Urban 70 (1978)	60		
		Total 125 (1978)	106	87	below 60
	Perinatal mortality	67 (1976)			30-35
2.	Crude death rate	Around 14	12	10.4	9.0
3.	Pre-school child (1-5 yrs) mortality	24 (1976-77)	20-24	15-20	10
4.	Maternal mortality rate	4-5 (1976)	3-4	2-3	below 2
5.	Life expectancy at birth (yrs)	Male 52.6 (1976-81)	55.1	57.6	64
		Famale 15.6 (1976-81)	54.3	57.1	64
6.	Babies with birth weight below 2500 gms (Percentage)	30	25	18	10
7.	Crude birth rate	Around 35	31	27.0	21.0
8.	Effective couple Protection (Percentage)	23.6 (March 82)	37.0	42.0	60.0
9.	Net Reproduction Rate (NRR)	1.48 (1981)	1.34	1.17	1.00
10.	Growth rate (annual)	2.24 (1971-81)	1.90	1.66	1.20
11.	Family size	4.4 (1975)	3.8		2.3
12.	Pregnant mothers receiving ante-natal (%)	40-50	50-60	60-75	1.00
13.	Deliveries by trained attendents (%)	30-35	50	80	100

14.	Immunisation status (%) coverage				
	TT for pregnant women	20	60	100	100
	TT for school children				
	10 years		40	100	100
	16 years	20	60	100	100
	DPT (children below 3 yrs)	25	70	85	85
	Polio (infants)	5	50	70	85
	BCG (infants)	65	70	80	85
	DT (new school entrants 5-6 years)	20	80	85	85
	Typhoid (new school entrants 5-6 years)	2	70	85	85
15.	Leprosy - percentage of arrested cases out of those detected	20	40	60	80
16.	TB - percentage of disease arrested cases out of those detected	50	60	75	90
17.	Blindness Incidence of (%)	1.4	1	0.7	0.3

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