Health Policy Is Our Concern Too!

Health policies affect us all very much and we, too, should have a role in helping to evolve them, argues* Dr. Thelma Narayan *of Community Health Cell, Bangalore.

Whether recognised or not, health and related policies greatly affect health work. They affect nurses, multi-purpose workers, doctors and all allied health professionals working in rural nd urban, health centres and hospitals.

More importantly, they affect patients and the population in general. This could be for better or for worse. Therefore, health policies concern all of us!.

A policy can be defined as a broad statement of goals, objectives and means that creates the framework for activity. Policies often take the form of explicit written documents, but they may also be implicit or unwritten.

National Health Policies are guiding principles for efforts by the health sector of the State or Government.

Independent India evolved health policies and plans with inputs by expert Committees, the Planning Commission, the Central Council of Health and Family Welfare and the Ministries of Health and Family Welfare at the centre and states.

Bhore Committee and others

The Bhore Committee (1946) and others initiated this phase. It gives detailed findings and conclusions of a process that lasted two years.

The working of the Health Survey and Development Committee, appointed by the Government of India in 1943 stressed the importance of preventive health work "if the nation's health is to be built".

It gave a call to medical education to prepare "social physicians" for the future.

It set forth a bold vision of a country-wide system of primary health centres, secondary hospitals and district hospitals. However, almost fifty years later, we have yet to achieve the recommendations of this Committee.

Since this landmark report, other expert committees too submitted reports. They deal with different aspects of the development of health services in India. The main reports are highlighted in Box 1

As a result, several national health programmes were developed to address special problems like different communicable diseases, nutritional problems, mental health etc. The concept of Primary Health Centres with sub-centres covering a defined population, as part of the Community Development Programme, was accepted. The first Primary Health Centre was started in 1952. Taluk and district-level hospitals were developed; so also specialist and medical college hospitals.

The year 1977 saw the launching of the Rural Health Scheme. This included:

- training of community health workers;
- re-orientation of medical education to meet the needs of the majority, underserved rural population; and
- the reorientation of multi-purpose workers.

The common thread throughout has been the expressed need to make health a reality for the entire population of the country.

This was to fulfill Article 23 of the Constitution of India, which "aims at the elimination of poverty, ignorance and ill-health and directs the State to regard the raising ot the level of nutrition, the standard of living of its people and the improvement of public health as among its primary duties, securing the health and strength of the workers, men and women, especially ensuring that children are given opportunities and facilities to develop in a healthy manner".

This Constitutional statement could be taken as the overall goal of national health effort.

Alma Ata (1978): Health For All

India is a signatory, along with all other nation states, to the now-famous Alma Ata Declaration of the World Health Organisation.

The stated goal has since been Health for All by 2000 AD with Primary Health Care as its main strategy.

Equity in the health status of people, globally or within countries, was accepted as being vitally important.

Primary Health Care was defined by the Alma Ata Conference as "essential health care made universally accessible to individuals and acceptable to them, through their full participation, at a cost the community and country can afford".

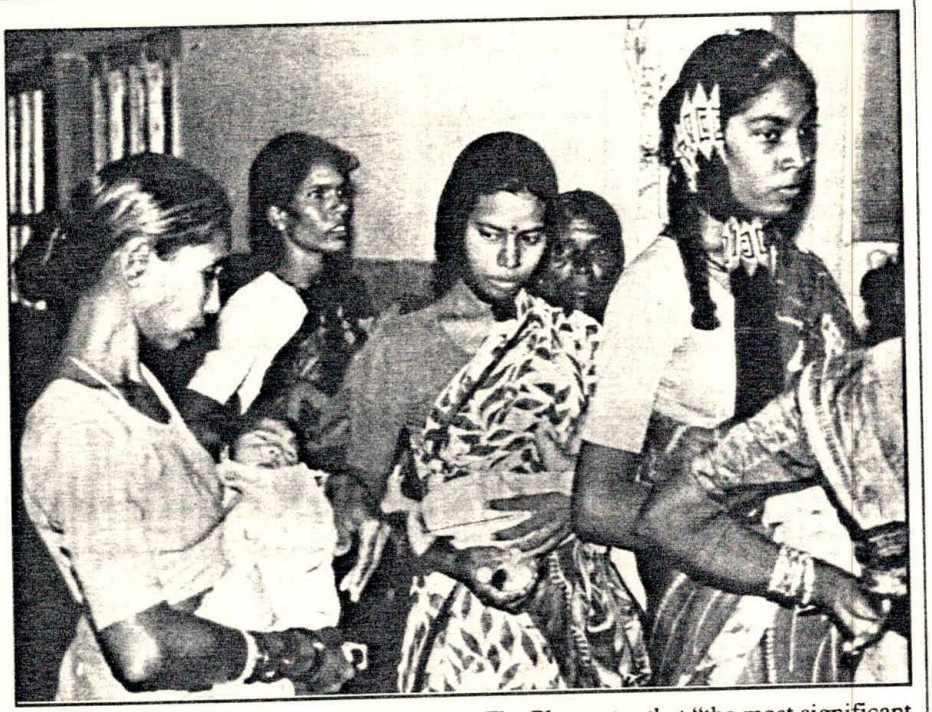
Essential principles of Primary Health Care:

- ◆ equitable distribution of health services/equitable access to health services;
- ◆ community participation;
- ◆ Inter-sectoral coordination; and
- ◆ use of appropriate technology.

A working group of the Indian Council for Medical Research and the Indian Council for Social Science Research, in 1981, brought out an important document, "Health for All : An Alternative Strategy". It stressed the need for a people-based health care system.

It also recognized that poverty is a major cause of ill health in India. The urgent need for social justice in health and health care was reinforced.

This document was used in formulating the Sixth Five Year Plan.



National Health Policy

The National Health Policy was brought out by the Government in 1982 and passed by Parliament in 1983. It reviewed progress made thus far, analysed the prevailing health situation and identified key areas for health efforts in the future. It emphasised -

- ◆ the preventive, promotive, public health and rehabilitative aspects of health work and the need for country-wide comprehensive primary health care services;
- ◆ the need for a decentralized system of health care; and
- ◆ maximum community and individual self-reliance and participation.

A time framework, for the achievement of specific goals was laid down (see box 2)

The Sixth Five-Year-Plan and the 20-Point-Programme gave shape to ways by which the National Health Policy and its goals could be achieved.

The Eighth Plan (1992-97)

Coming to the present and the future, it is useful to look at the Eighth-Five-year-Plan covering the period 1992-97. The Plan states that "the most significant goals for the plan" are:

- ◆ improvement in the level of living,
- ◆ health and education of people,
- ◆ full employment,
- ◆ elimination of poverty, and
- ◆ a planned growth in population.

This include

- ◆ the building up and strengthening of peoples' participatory institutions;
- ◆ the provision of safe drinking water, and
- ◆ primary health facilities to all

Health, here, forms part of the total development effort. Health and population control are listed as two of the six priority objectives of this Plan. Special note should be made that in the Eighth Plan Document "Health for the Underprivileged" is to be "promoted consciously and consistently", through community-based health systems. This is seen as the key strategy for Health for All.

The Plan document states; "The structural framework for the delivery of health programmes must undergo a meaningful reorientation in a way that the underprivileged themselves become the subjects of the process and not merely its objects. This can only be done through emphasising community-based systems. Such systems must provide the base and basis of health planning. The ethos and culture of the communities

BOX 1 – Expert Committees to Government of India on Health

Mudaliar Committee, 1962	–	Health Survey and Planning Committee
Chadha Committee, 1963	–	Maintenance phase of National Malaria Eradication Programme; Basic Health Workers.
Mukerji Committee, 1965	–	Review of Strategy of Family Planning Programme
Mukerji Committee, 1966	–	Details of Basic Health Services
Jungalwalla Committee, 1967	–	Integration of Health Services
Kartar Singh Committee, 1973	–	Multipurpose Workers under Health and Family Planning.
Srivastav Committee, 1975	–	On Medical Education and Support

must provide the scaffolding for such community-based systems".

A major role is envisaged for practitioners of Indian systems of medicine. There is an intention to move more strongly from curative medical care towards building positive health. Preventive and promotive methods and practices would get greater emphasis. This include meditation, yoga and other traditional practices.

Need for further analysis

This quick review covers the major explicit policies. However, a deeper analysis of several factors is necessary to assess how effectively the policies are followed up and implemented. We could look for instance at

- the total budget allocation, its trend over time and its rural-urban distribution;
- the availability and quality of government health services, geographical and social accessibility and the utilization of services;
- the quality and relevance of training in health sciences, the distribution of health personnel; and
- the recognition and support given to indigenous systems of medicine.

BOX 2 – National Health Policy Goals For Health And Family Welfare

Sl.	Indicator	Goals 1990	Goals 2000
01.	Infant Mortality Rate	87	60
02.	Perinatal Mortality Rate	–	30-35
03.	Crude Death Rate	10.4	9
04.	1-5 year Mortality Rate	15.2	10
05.	Maternal Mortality Rate	2.3	< 2
06.	Low Birth Weight Babies (% < 2,500 gms)	18.0	10.0
07.	Life Expectancy : Female	57.1	64.0
08.	Crude Birth Rate	27.0	21.0
09.	Annual Growth Rate	1.66	1.20
10.	Family Size	3.88	2.3
11.	% mothers receiving AN care	60-75	100.00
12.	% deliveries by trained attendants	80.00	100.00

Source: National Health Policy Document, 1983.

Ground realities

We find continued disparities and inequalities.

The total health budget allocation has been decreasing over the decades in terms of percentage of total budget (from 5.9% in the First Plan to 3.7% in the Seventh Plan).

There is a major urban-rural difference in budget allocation. This is reflected in the services.

In Kerala (KSSP Study, 1991) 75% of hospital beds and 66.6% of doctors were urban-based. Only 5% of the budget is allocated to the Indian Systems of Medicine and Homeopathy though a large proportion (approx 50%) of trained medical personnel are in this sector.

The utilization of Government health services is relatively poor e.g., 5.6% in rural Maharashtra (Malshiras Study, FRCH, 1993) and 15-20% in rural Karnataka (1992-93).

Inadequate coverage of the urban poor by basic Mother and Child Health care has been recently reported from Delhi.

Performance of national health programmes are also below par as shown by evaluations, e.g., of the Family Welfare Programme (stagnant birth rates) and the National TB Control Programme (ICORCI, 1987).

There continues to be a disproportion in the type of health personnel trained. Smaller numbers of nurses are trained, as compared to doctors. There are inadequate numbers of dentists, pharmacists, physiotherapists and other allied health professionals. The urban rural disparity also persists here.

Questions of relevance of training to community needs and community health problems are being raised: e.g., CHC medical education study.

The mushrooming of the 'private sector' in the training of health professionals is also taking place with insufficient social and professional accountability.

These realities could be said to reflect implicit, unstated policies that also govern the actual functioning of health services. They are not a negation of the sev-

eral real achievements in this field made by the country so far.

They, however, are important pointers to the need to understand ground realities and their underlying forces more deeply.

While the present system could and should be improved, much could be learnt from alternative approaches, that have been tried at various levels by voluntary health organisations. A constructive and critical spirit can support the further evolution of health policies and services, so that health for the underprivileged becomes a reality.

Could policies be more data-based in the future?

Data from the decadal census, the National Sample Survey, the Sample Registration Scheme and from various research organizations provide us with indicators of the health status of the population. While there is an overall improvement occurring, disparities between states and districts in a state are very evident. This is indicated in Box 3.

Differences by social class are also increasingly being studied. These data have to be used more effectively and translated through policies and plans into strategies for action. Information, in an understandable form, also needs to be made more available to the public. To respond meaningfully to diverse health problems and needs, and equally importantly, as a crucial democratic step towards putting people's health into people's hands, the planning process needs to be decentralised.

Decentralisation – a possible future scenario

The current debate on the recent Panchayat Raj Bill raises important issues. The need for decision-making power and for greater social and financial control at the village/mandal level over development, health and education is being expressed.

How will this intermesh with the more centralised, bureaucratic system that has developed in the health sector? How can the interests of the less powerful and less articulate sections of society be safeguarded and promoted? How will conflicts of interest between professional groups, powerful groups and the emerging peoples' consciousness through the process of decentralisation be resolved? And what are the actual steps that need to be taken?

BOX 3 – Health Indicators In Different States

State	Birth Rate (1990)	Death Rate (1990)	Infant Mortality Rate (1990)	Life Expectancy in females (1986-91)	Total Fertility Rate (1985)
Andhra Pradesh	25.60	8.70	70	62.23	3.70
Bihar	32.90	10.60	75	57.00	5.40
Gujarat	29.50	8.90	72	61.49	3.70
Harayana	31.80	8.50	69	61.97	4.60
Karnataka	27.80	8.10	71	63.31	3.60
Kerala	19.00	5.90	17	73.80	2.40
Madhya Pradesh	36.90	12.50	111	54.71	4.60
Maharashtra	27.50	7.30	58	64.30	3.50
Orissa	29.90	11.60	123	55.15	3.80
Punjab	27.60	7.80	55	65.30	3.50
Rajasthan	33.10	9.40	83	58.69	5.50
Tamil Nadu	22.40	8.70	67	60.80	2.80
Uttar Pradesh	35.70	12.00	98	49.64	5.60
West Bengal	27.30	8.10	63	59.53	3.70
INDIA	29.90	9.60	80	59.10	4.30

Source: Eighth Five Year Plan (1992-97), Vol. I.

There are no ready-to-use packages or easy solutions to these questions.

Micro-level experiments and projects by voluntary groups, using participatory methods, have been effective in evolving policies and strategies that not only provide low-cost health care responsive to peoples' needs, but also improve health status.

Larger level planning at the state, district and national level, is also necessary. Here, a possibility is to use an optimum mix.

This would include time-tested methods:

- an epidemiological approach;
- provision of vision and broad directions;
- allowing much flexibility;
- promoting and strengthening local initiative and capacities in the management of health problems and issues;
- progressive equitable improvement in health and quality of life, and accountability and social justice in health care would be indicators of effective policies.

Can we contribute?

At the level of individuals and groups of hospitals, health centres and health/development projects, there are policies that determine the direction of work. Staff members could collectively review the policies at regular intervals. Are priority disease problems/health issues being addressed? What are our criteria for deciding what is considered "priority"? Can the national health policy be discussed? Are there specific regional/local problems that need to be addressed? Do we interact adequately with the governmental health system? Can people be involved more in the process of decision-making? The process goes on.

Of course the most crucial part of a policy is its implementation. Could we be sentinels regarding the implementation of national health policies which are essentially our health policies? Could we create greater awareness among people about the various policies and programmes? Could we also help the health system to be more functional? Health Policy then is certainly our concern, too!. ■

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Health Care Policy and Delivery Methods*

by
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Introduction

Public Health in British India mainly concentrated on legislation and measures for the prevention of epidemics in the civil population to safeguard the health of the British Army. In 1943, a rapid stride was however made by the British India Government in the wake of the constitution of the famous Beveridge Committee in Great Britain, by the appointment of 'The Health Survey and Development Committee (Bhore Committee)' to survey the existing position in regard to health conditions and health organisations in the country and to make recommendations for the future development. The Bhore Committee Report, as it is popularly known, came out in 1946, which recommended a short term and long term programme for the attainment of reasonable health services based on the concept of modern health practice.

India became independent in 1947. A democratic regime was set up with its economy geared to a new concept, the establishment of a "Welfare State". The burden of improving the health of the people and widening the scope of health measures fell upon the National Government.

The Constitution of India came into force in 1950 and India became a Republic in the Commonwealth. Article 246 of the Constitution covers all the health subjects and these have been enumerated in the Seventh Schedule under three lists - Union List, Concurrent List and State List. Article 47 of the Constitution under the Directive Principles of State Policy states "that the State shall regard the raising of the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties'. The Planning Commission was set up in the same year by the Government of India which set to work immediately for drafting the First Five Year Plan and subsequent plans. Paradoxically, the policy frame for health services of Independent India was to be the blue print of health services drawn up by the Bhore Committee for post war British India.

The Bhore Committee formulated its recommendations on the basis of certain remarkably progressive guiding principles listed below:

1. Medical Services should be free to all without distinction
2. The Health programme must from the very beginning lay special emphasis on preventive work
3. Suitable housing, sanitary surroundings and a safe drinking water supply and adequate nutrition are pre-requisites of a health life
4. Health services should be placed as close as possible to the people
5. Health education should be provided on a wide basis
6. Doctor of the future should be a social physician

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*Paper read at the Plantation Medical Officers' Conference organized by UPASI during 21-22 December 1978 at Coonoor.

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7. The training of the basic doctor should be designed to equip him for playing an effective role as a social physician

It is significant that even at such an early period when the country was still under colonial domination and the members of the Committee were British and native health administrators and public men of that period, they could develop such profound insights into the issues involved in the formulation of a national health policy.

The Bhore Committee had categorically stated that it is "fundamental that development of the future health programme should be entrusted to Ministries of Health at Centre and in the Provinces which will be responsible for the people and sensitive to public opinion. The need for developing the programme in the closest possible cooperation with the people has already been stressed". The Committee had also emphasised that in drawing up a health plan, certain primary conditions essential for healthful living must in the first place, be ensured. Suitable housing, sanitary surroundings and safe drinking water supply are pre-requisites of a healthy life. The Committee enjoined that "the provision of adequate protection to all, covering both its curative and preventive aspects, irrespective of their ability to pay for it, the improvement of nutritional standards qualitatively and quantitatively, the elimination of unemployment, the provision of a living wage for all workers and improvement in agricultural and industrial production and in means of communication, particularly in the rural areas, are all facts of a single problem and call for urgent attention. Nor can a man live by bread alone. A vigorous and healthy community life in its many aspects must be suitably catered for. Recreation, mental and physical, plays an important part in building up the conditions favourable to sound individual and community health and must receive serious consideration. Further, no lasting improvement of the public health can be achieved without arousing the living interest and enlisting the public cooperation of the people themselves.

The Prime Minister Jawaharlal Nehru in enunciating the health policy of Independent India to the first Conference of the Provincial Health Ministers held in 1946, endorsed the views expressed by the Bhore Committee and stated that in the past, little attention was paid to health which was "the foundation of all things". He asserted that economy in this sphere might mean greater expense in the long run and that "the health of the villagers required special attention as the country derived its vitality from that and hence benefits of health must be extended to the whole country side". The aim according to Shri Nehru was to develop a "National Health Scheme which would supply free treatment and advice to all those who require it".

Five Year Plans and the Health Status of the Indian People

Although policy decisions have been taken from time to time to evolve a sound National Health Policy over the last 28 'planned' years, we seem to have drifted further and further away from the goal of "total health for all" envisaged by the Bhore Committee. Every five year Plan document contains a brilliant rhetoric for expanding health programmes for more and better equipped Primary Health Centres and for better implementation of programmes. The recommendations of the Chadha Committee and Kartar Singh Committee were aimed towards this end. Even more recently in 1975, the Shrivastav Committee, brought out a blue print for major policy changes giving a social orientation to the entire system of medical education and in rural health programmes of India.

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As stated by the Shrivastava Committee on development of a national programme of health services for the country based on the Bhore Committee Report-"During the last 30 years, sustained efforts have been made to implement its recommendations as well as those of other important Committees in this field. In spite of substantial investments made and the impressive results obtained particularly in the production of medical manpower, the health status of the Indian people is far from satisfactory. The sheer magnitude of the tasks that still remain is so great and the additional resources available for the purpose appear to be so limited that one almost despairs of meeting our health needs or realising our aspirations on the basis of the broad models we seem to have accepted. A time has, therefore, come when the entire programme of providing a nation wide net work of efficient and effective health services needs to be reviewed de novo with a view to evolving an alternative strategy of development more suitable for our conditions, limitations and potentialities".

There is no doubt that all the while manpower, material and economic resources drained inexorably away from the country's real needs. They flowed towards establishing a sophisticated, individualistic, expensive, illness service for the privileged, rather than towards a simple community based and inexpensive primary service for the deprived who form the bulk of the population. The W.H.O. Regional Director, Dr V T H Gunaratne has termed as "Disease Palaces" the present day hospitals. According to him, what we now have in India and other developing countries is an incredibly expensive health 'industry' not for the promotion of health but for the unlimited application of "disease technology" to the affluent section of society.

He further adds that consequence of the present high technological pitch of therapeutics is that the very treatment of one illness may produce another, either through side effects or iatrogenesis. He goes on to say that "this distortion of health work is self-perpetuating. The whole un-healthy system finds its most grandiose expression in buildings, in disease palaces, with their overgrowing need for staff and sophisticated equipment. In medical research too, the main thrust is towards pursuits of disease oriented establishment. Even in the less developed countries probably more than 90% of the research now going on concerns problems, the solution of which would benefit less than 10% of their populations".

Dr Gunaratne made these observations to highlight the need for a shift in favour of the 'Primary Health Care' concept, which envisaged integration, at the community level, of all the elements required to make an impact on peoples' health. This concept was explained by him thus 'It is an expression of what a person should do in order not to fall ill and what he should do when he falls ill'.

A Revised National Health Policy and Health Care Delivery System

The Bhore Committee had visualised that health services would percolate down from the teaching hospitals to the taluq hospitals and then to the Primary Health Centres, Sub-Centres and ultimately to the villages. But it never worked like that. The health services got clustered around the apex institutions - hospitals - instead of percolating to the peripherals. In the new national health policy of our government, this trend is sought to be reversed and a deliberate decision taken to spend 75 per cent of the planned allocation for health in the rural areas.

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I find that in your plantations (a primary rural industry) too, the trend of expenditure has a similar pattern. With the introduction of the Plantation Labour Act, the Government placed the responsibility of providing medical care in the Planters while stipulating the minimum requirements. This was based on the concept of the Western model. Garden Hospitals and dispensaries with personnel were prescribed on the basis of the labour force. On some estates these hospitals developed to provide sophisticated medical care. In an analysis of the morbidity and mortality undertaken by Dr (Mrs) V Rahmathullah, Medical Adviser, UPASI, we find that only 3% of out-patient require admission into the Garden Hospital. The estate budget runs to about Rs.75/- per worker per annum and 85% of this budget is spent on the Garden Hospital which looks after only 3% of the out patients. This lopsided expenditure and inadequacy of health care system in plantations need to be given serious consideration. In conformity with the national health policy, it is desirable that 75% of budget is allocated for expenditure on peripheral health services ie., a shift in favour of the primary health concept is necessary. The change is imperative.

If the Infant Mortality Rate is accepted as a good index of the socio-economic progress of a country, then we have one of the highest rates in the world as far as rural areas are concerned, ranging from 90 to 138 per thousand. In some rural areas 80% of the children are undernourished and only 3% have normal body weight. Fifty per cent of the deaths in our country are of children under four.

Nearly 60% of our people who live below the poverty line, lack the purchasing power to secure health services. They constitute about 378 million people whose health care is being neglected. Let us consider this matter in terms of 'health economics' ie., the loss to the national economy due to the ill health of the poorer rural and urban people. If 40% is taken roughly as the number of able bodied people in our population, then the lowest 60 per cent of our population (approximately 378 millions) provide a work force of 151.2 million. If even 10 per cent of them are ill at a time, then 15.12 millions are away from work every day for the whole year. At the current per capita income rate of Rs.1400/- (I am quoting the lowest rate) we are losing at least Rs.2006 crores a year in Gross National Product alone due to ill health. If there are epidemics of any sort, we lose much more. This huge national loss occurs because we do not have a clear cut and firm national policy.

A major shift in the emphasis in the health services was necessary from a curative to a curative-preventive approach, from urban to rural population, from the privileged to the under-privileged and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development. Health had to be given a high priority in the Government's general development programme.

Health services are only one factor contributing to the health of the people. Economic and social development activities often have a positive influence on a community's health status. Sanitation, housing, nutrition, education and communications are all important factors contributing to good health by improving the quality of life. In other absence, the gains obtainable with the disease-centred machinery of health services cannot go beyond a certain point. Two kinds of integration are, therefore, necessary. The first is the integration of various aspects of health policy into economic and social development. The second is the welding of the different parts of the health services into a national whole.

A firm national policy of providing total health care for all will involve a virtual revolution in the health care delivery system. It will bring about changes in the distribution

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of power, in the pattern of political decision making, in the attitude and commitment of the health professionals and administrators and in people's awareness of what they are entitled to. To achieve such far reaching changes, political leaders will have to shoulder the responsibility of overcoming the present inertia as well as the well entrenched vested interests. Though the framing of health policy belongs to the domain of politicians, the medical profession has a responsibility that goes beyond protecting its own interests and the interest of individual patients, to protecting the health of the whole community. Plantations will no doubt have to adopt the national policy of health care delivery. In a captive population (labour force) in plantations, greater advances are possible, with an enlightened management and an effective medical service. Managements must accept this new philosophy and make greater investments towards providing comprehensive medical care to its labour force, with a sound peripheral health delivery system. Through your Comprehensive Labour Welfare and Link Workers Schemes, some advances have been made but a great deal is still to be done.

The new rural health programme launched in October last year by the present Government, has in my view provided the necessary break through. "Instead of waiting and waiting indefinitely for the health services to percolate down from the teaching hospitals and district hospitals and getting obstructed and lost somewhere on the way, it is a bold attempt to build from the bottom upwards using the village itself as the base", as stated by the Health Secretary to the Government of India.

The rural health and development programmes launched on the basis of the Bhore Committee Report and subsequent Community and Panchayati Raj Development Programmes, may not have made the impact expected of them to bring about an all round development of the rural areas, but the necessary infrastructure has been built up. There are now 5400 Primary Health Centres (with an equivalent number of Blocks) and 38,115 sub-centres with a large number of para medical staff (now Multipurpose Workers) trained in the delivery of the different components of the package of services required.

By the end of the sixth plan, there would be one sub-centre for a population of 5000 compared to one for 10,000 now. Each sub-centre would have one male and one female Multipurpose Worker. The day to day health care at the village level will be provided by the new category of Community Health Workers/Village Level Workers (CHW/VLW), similar in a way to the Link Workers introduced by your Medical Adviser. There will be one CHW for a population of 1000. According to the information given by the World Health Organization, at least six other countries in South East Asian Region (Bangladesh, Burma, Tailand, Indonesia, Nepal and the Maldives) have adopted this scheme.

More than any other part of this scheme, it is the deployment of CHWs that has met with opposition from the medical profession, on the ground it would promote quackery. Before the Government embarked upon this on a national scale, several projects were undertaken by hospitals and voluntary bodies. The ICMR and ICSSR reviewed these projects and the consensus was that in addition to the existing health infrastructure, front line health workers should be deployed at the rate of one per 1000 population. Twelve different duties were contemplated for them, including treatment of minor ailments. All States except Tamil Nadu, Karnataka, Kerala and Jammu and Kashmir opted for this scheme. An evaluation of the scheme within nine months of its launching was undertaken by the

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ICMR and important Health and Management Institutions in the country. There has been in general, massive support for the scheme from all sections of respondents - Community Leaders, Block Development Officers, Zilla Parishads etc.

The Government of Karnataka has now accepted the Community Health Workers Scheme.

Health Delivery through Auxilliary Health Personnel

Our Government hopes that in due course of time, when recommendations of the Shrivastava Committee on Health Services and Medical Education are fully implemented and internship training in rural areas is increased to two years, adequate number of doctors may be available for deployment in rural areas on the basis of one doctor per 10,000 population. There is a great reluctance on the part of doctors to serve in rural areas. For many years Governments and Health Administrators have been attempting to coerce, induce, persuade or even compel young doctors to go to the rural areas and we are astonished that they evince signs of reluctance. May be we should, instead, be astonished that we succeed in getting any physicians to go to these areas. One school of thought is that we are training a person in the science of Clinical Medicine and the academic pursuit of knowledge to attain excellence and then attempt to place him in a position where his whole education is negated. In short, we are attempting to place the physician, an elegantly trained professional in a somewhat inelegant position. The obvious end is dissatisfaction and frustration of the young doctor. To a large extent this may be due to defects in our medical education system or more correctly, lack of implementation of accepted educational policies by Medical Colleges, to produce the type of Social Physicians, envisaged by the Bhore Committee.

All countries want a physician-manned health service and this no doubt will ultimately be achieved in the under-privileged areas. Under-developed countries cannot immediately attain this objective, for they cannot afford to pay for a health service that gives satisfaction to its personnel, which means providing the buildings, equipment, operational funds, and supporting staff that comprise the physician's working environment. There is also a need to provide such as educational facilities for the physicians children, adequate remuneration and housing, and means to overcome intellectual isolation. All these are very expensive, which an under-developed country can ill afford.

But perhaps a physician is not needed to the extent that we imagine in rural areas and many of his functions can be undertaken by the lesser trained and much less costly personnel. What we need to do is to apply the concepts of big business-market research, job analysis or the breakdown of the job into components that require a lesser degree of skill than demanded for the whole, and organisation and management. It is partly the image of medicine that is wrong. The emphasis has been all along on clinical aspects and not the management, to-day medicine demands competent management and this applies particularly to Plantation Medicine.

Better health is desired, as stated by me earlier from the combination of many factors - not merely curative medicine and community health programmes, but also higher incomes, more education, agricultural reform, better animal husbandry, and improved sanitation. There is therefore a need to approach health from a broad ecological view point. Change can only be accepted at a certain rate. Further more, health services must have a total outreach to all the people and not merely to a small privileged urban minority, if they are to have a substantial impact on progress.

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Underdeveloped countries have several common factors. These are limited economic resources, a paucity of educated man power, rapidly expanding populations, conservative traditional cultures, a prevalence of communicable diseases and undernutrition. The use of auxiliary health workers offers a means of achieving a balanced programme of curative, preventive and promotional medicine.

Three essential distinctions have to be borne in mind in the delivery of health services.

First is the distinction between human medical wants and scientific health needs. Human medical wants are very simple. They are for relief when hurt, care when sick, and reassurance and help during maternity. The majority of people in the underprivileged countries have not yet reached the stage of interest in health as such, but only want an absence of sickness. The scientific health needs are equally clear. They are control of the common cummunicable diseases including those of childhood, the parasitic diseases, and the vector borne diseases; the need for planned fertility patterns, for, as Enke said, "the equivalent sum used to reduce births can be 100 times more effective in raising per capita incomes in underdeveloped countries than if invested in traditional development projects", and the relief of protein calorie malnutrition, which could be furthered by the marriage of agriculture and medicine.

The second distinction in the delivery of health services is that between the minor and major ills with the implication of minor and major solutions. I classify diseases into five categories for the purpose of distinguishing between minor and major ills. The symptomatic illnesses are the headaches, sore throats, bronchitis, flatulences, dyspepsias, colds, neuralgias, rheumatisms, aches and diarrhoeas. A second classification is the visible ailments, including wounds, snakebites, tropical ulcers, scabies, eczemas, impetigos, burns, conjunctivitis, caries, and goitres. A third group are those commonly known to the local population, the local entity diseases tapeworm, roundworm, anemia, malaria, and gonorrhea. A fourth group are the infant and toddler diseases, such as marasmus, kwashiorkor, whooping cough, measles, and chickenpox. The final group are the suspect and referral diseases--those which must be referred to more highly trained persons for diagnosis and treatment.

The third essential distinction in delivering health services is in the training and use of auxiliaries in the assistant role, when they are working directly subordinate to a more highly tained person and in the substitute role with supervision remote at best and completely absent at worst.

There are broadly speaking, two methods of delivering rural health services and achieving total outreach. One is to develop an absolute standard for medical and health personnel. As time goes by, the number of persons meeting these standards increases and their reach spreads from the center to the periphery, to cover the whole population. The other is to commence at the economic and educational level which the country can afford, train personnel on a less rigid standard, begin with total outreach, and over a period of time raise the standard of education until professional quality is reached. At a distant end point, both these methods will achieve the same result of quality care to all the people all the time. It is what happens to the people during the interim until this objective is reached that matters.

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A combination of these two methods offers much better prospects for this interim period. Experience dictates that the demand for physicians and other high level manpower always exceeds supply. The use of auxiliaries, working through a few dedicated physicians and para-medical personnel, offers a much greater prospect for improving the health of the populations in the underprivileged territories, than either of the two alternative methods.

'Primary Health Care' and 'Health by the People'

Health for all by the year 2000 A.D. This is the call, given by Dr Halfdan Mahler, Director General of the World Health Organization at the World Health Assembly in May 1977. Dr Mahler has advocated resort to 'Unorthodex way like increased use of auxiliary health personnel to correct the situation even through this might be disagreeable to some policy makers". Both the developed and developing countries have expressed dissatisfaction about their health service. This was highlighted by W.H.O. as early as 1973. The Director General had frankly admitted that the most signal failure of W.H.O. and its Member States has been the inability to promote development of basic health services and to improve their coverage and utilisation.

In January 1975, the W.H.O. Executive Board underlined the plight of rural populations and recommended priority attention to "Primary Health Care" at the community level.

Over 700 delegates from all over the world met for a week in September '78 at Alma Ata, the capital of Soviet Kozhakhstan, to discuss ways and means of providing health care for all peoples in the world. There was an exchange of experience among member countries on the development of "Primary Health Care" as part of the National Health Services. India was one of the nine countries whose experience with community involvement in the health sector had triggered international action in favour of the 'Primary Health Care' approach. Besides India, the other countries whose experience has been drawn upon by W.H.O. in advocating "health by the people", were China, Cuba, Guatemala, Indonesia, Iran, Niger, Tanzania and Venezula. Based on the experience of these countries, W.H.O. brought out a book in April 1975, "Health by the People" and following that, the Executive Boards of UNICEF and W.H.O. adopted a new health policy which underscored the need for combined curative, preventive, educational and social approach and for simplified technology.

As India has accepted in principle the 'primary health care' approach as a national policy, it is worthwhile clearly defining this approach.

According to the WHO, the seven basic principles of 'primary health care' are:

a) it should be shaped around the life patterns of the population it is to serve and should meet the needs of the community;

b) it should be an integral part of the national health system, and other echelons of service should be designed to support it;

c) it should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications)

d) the local population should be actively involved in the formulation and implementation. Decisions as to the community's needs should be based on a continuing dialogue between people and the services;

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e) health care offered should place maximum reliance on available community resources, especially those that have remained untapped, and should remain within the strictest cost limitations;

f) primary health care should use an integrated approach of preventive, promotive, curative, and rehabilitative services. The balance between these services should vary according to community needs; and

g) the majority of health interventions should be undertaken at the most peripheral level possible, by suitably trined workers".

We may briefly state that Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community. In short, medicine has rediscovered the community at large. It is rather amazing and ironical that a profession which began in the community should suddenly need to rediscover it!

Since primary health care is a component of integrated rural development, participation in community development activities must remain one of the concerns of the health team in addition to other 'management' tasks such as registration, notification, health reports, or referrals, depending on local circumstances. These activities call upon many disciplines: nursing, obstetrics, health education and especially education in healthy and balanced nutrition, elementary medical diagnosis, therapeutics, environmental sanitation, dental health, mental health, community development, health management etc.

In the frequently presented diagram of the pyramid of health services, the organisation of Primary Health Care can be organised through a three tier system - Health Centre, Sub-Centre and Community Health Worker. At the base of the pyramid are the CHWs/VLWs, with their emergency kit boxes. A CHW/VLW is selected and supported by the local community and looks after a population of about 1000. They are given adequate training to carry out a limited number of specific curative, preventive and health promotional activities with the aid of the emergency kit and elementary sources. These workers, however, will not be able to solve the more complex but at the same time less frequent problems.

At the sub-centre level are the two Multipurpose Workers (male and female) looking after a Community of 5000, who are more experienced and have had sound training in maternity, child health and welfare programmes, national health programmes and other aspects of community health work. They will supervise and assist the community health workers, improve their skills and supplement their activities. The work of Multipurpose Workers will be supervised by the Multipurpose Worker Supervisors from the Primary Health Centre.

At the apex of the primary health care pyramid, will be the Primary Health Centre with 6 beds. A Primary Health Centre will, therefore, look after a population of about 80,000 through 16 sub-centres each with a population of 5,000 and 80 CHWs at the village level, each CHW looking after a population of 1000. The staffing pattern and functions of a Primary Health Centre are well known to you. Three medical officers will now be available at each Primary Health Centre for preventive, promotive and curative work. From the Primary Health Centre, referrals will go to the Taluq or District Hospitals.

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It will be observed the present concept of Primary Health Care delivery System is almost the same as advocated by the Bhore Committee in 1946. Let us hope that now with the strong backing of WHO, UNICEF and National Governments, the call of Dr Mahler, Director General, WHO, "Health for all by the year 2000 A.D." will come true and not sound to many as an utopian dream or wishful thinking.

In your own plantations with dispersal of labour, distance and terrain, the three tier system of primary health care could be organised through Garden Hospitals, Dispensaries (Mini Health Centre) and Link Workers, but adequately supervised by medical officers. I know that your Medical Adviser is already planning on the basis of one Garden Hospital for 10,000 population with four mini health centres, each looking after 2500 population and Link Workers (each Link Worker looking after 20-40 families)

10 point Declaration on Health (WHO/UNICEF)

I would like to conclude with the 10-point declaration on health taken at the Alma Ata Conference of WHO, which calls for urgent and effective international and national action to develop and implement primary health care, throughout the world and particularly in developing countries.

(1) Health, which is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, is a fundamental human right.

(2) The existing gross inequality in the health status of the people, particularly between developed and developing countries is economically unacceptable and is, therefore, of common concern to all countries.

(3) Economic and social development, based on a new international economic order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.

(4) The people have the right and duty to participate individually and collectively in the planning and implementation of their health care

(5) Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of Governments, international organisations and the whole world community in the coming decades, should be the attainment by all peoples of the world by 2000 A.D. of a level of health that will permit them to lead a socially and economically productive life.

INTEGRAL PART

(6) Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the over all social and economic development of the community.

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(7) Primary Health Care reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and includes at least education concerning prevailing health problems and the methods of preventing and controlling them

(8) All Governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system in coordination with other sectors

(9) All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people, since the attainment of health by people in any one country directly concerns and benefits every other country.

(10) An acceptable level of health can be attained for all the peoples of the world by 2000 AD through a fuller and better use of world's resources, a considerable part of which are spent on armaments and military conflicts.

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D R A F T

NATIONAL HEALTH POLICY

GOVERNMENT OF INDIA

MINISTRY OF HEALTH & FAMILY WELFARE

NEW DELHI

PREAMBLE

1.1. Health is a positive attribute of life. It is characterised by a state of complete physical, mental and social well-being and not merely the absence of disease. Maximally attainable and acceptable levels of health for all people is out goal. Every citizen should be enabled to attain a level of health necessary to develop his mental and physical faculties to their full genetic potential. Health cannot be viewed in isolation from the overall goals and policies of national development. Development implies progressive improvement in the living conditions and quality of li e enjoyed by the society and shared by its members and the central focus of such development is 'man'. Thus, health is both an important pathway to development as well as a desirable end-product of development.

1.2. Any re-organisation of the health services should be in response to the needs of the situation. Improvement in the health status of the population is achievable if there is a shift from the current emphasis on hospital-based, disease-oriented approach, depending heavily on sophisticated technology, to an approach where the attitudes, skills and methods of the trained personnel are in tune with the needs and aspirations of the common man and where the facilities available are equitable accessible to the population in physical, social, cultural and financial terms. The adoption of modern methods of medicine without adaptation to our cultural ethos has only brought in dependency and weakened the community's capacity to cope with its own problems. A wise use of the manifest and latent resources of the community can play a key role in supporting organised health services. A community achieves the highest l level of health when it reaches a stage of least dependence on professionaly intervention and maximum reliance on its own resources and action.

1.3. Growth of medical technology has equipped man with increased ability to cure and decreased sensitivity to 'care'. This has created distortions in medical treatment and has led to ineffectiveness of the health system. If we can make the concept of 'care' a social reality, it would ensure the total health of the individuals as well as of the community.

PRIMARY HEALTH CARE

2.1. Active involvement of people in the health system is a sine qua non for at-taining the goal of 'Health For All'. At the International Conference on Primary Health Care held at Alma Ata in September 1978, the Nations of the world have given unto themselves the objective of attaining an acceptable level of health for all the people of the world by the year 2000. As a signatory to the Alma Ata Declaration and in a spirit of service to our own people, we have to take active steps through Primary Health Care to attain this objective.

2.2. Primary Health Care is a practical approach in making essential care universally accessible to individuals and families in the community in an acceptable and affordable manner and with their full participation. Decentralisation and self-reliance are the corner-stones of this approach. The goals of Primary Health Care are attained by social means such as acceptance of increasingly greater responsibility for health by communities and individuals and their active participation in attaining it. This approach involves large scale transfer of simple skills and knowledge to people slected by the com- their confidence and willing to serve it

compassion and spirit of service. The translation of much of medical and health knowledge into practical action involves use of simple and inexpensive inventions which can be readily implemented by ordinary people with ininimal training leading to the greatest benefit to the society.

2.3. Primary Health Care can only succeed if the organised health services provide full logistic and professional support to the voluntary workers residing within the community. Such a system would result in optimal utilisation of the knowledge and expertise at higher levels and in the long run, it can be expected to relieve the overburdened curative services in the urban and semi-urban areas. The development of an effective primary health care system both for rural and urban areas would ensure would ensure the following:-

i. A greater awareness among the community and population of the health problems and ways to tackle them at their own levels;

ii. Intervention at the lowest practicable levels by a worker more suitably trained;

iii. Optimal utilisation of khowledge and expertise by higher level technical experts, be they health workers, physicians or specialist

iv. Increasingly less dependence on hospitals and thus optimal utilisation of such facilities for cases where they are actually needed.

PREVENTIVE AND PUBLIC HEALTH SERVICES

3.1. The emphasis on public health services has slowly decreased in the last 30 years, yielding its own rightful place to curative services. The trend has to be arrested to reversed. The coverage of public health services and provision of preventive services are now spatially very limited. Municipal and local authorities responsible for such services generally suffer from a lack of will and resources to implement them effectively. It is rational and economical to deal with a cluster of causes for poor health conditions on a broad front in the form of integrated package of services which are more than a mere collection of health interventions. There is, therefore, an urgent need to set up a chain of sanitary-cum-epidemiological stations throughout the length and breadth of the country, manned by suitably trained and equipped staff. Such stations can conveniently take care of environmental health problems, detection and control of epidemics, handle checks on quality of food, water, etc. Investments on such stations now will have a relatively high pay-off in the long run.

3.2. The pattern of diseases in developed countries has changed radically in the last 50 years. The range of vaccines, sera, etc., is ever increasing Our aim on the preventive front should be achieve 100% coverage of the total population by the year 2000 in terms of inoculation, vaccination, etc. The wherewithal is within our technical competence.

WATER SUPPLY AND SANITATION

3.3. Provision of safe water supply to the population and improvement in sanitation is basic for improving the health status of the people. This need to be done at a cost and with a technology which the nation can afford. We should, therefore, aim at providing safe drinking water and improved sanitation to all population within a given time-frame.

PROMOTIVE SERVICES

4. For a meaningful involvement of the community in the health care system, education about the advantages both immediate and long-term are necessary. It is, therefore, in the interest of the health system itself to take on the responsibility for explaining, advising and providing clear information about the favourable and adverse consequences of interventions available or proposed as well as their relative cost. As part of promotional services, it would be necessary to educate people about food habits,

nutrition, breast-feeding, etc., which are themselves not costly if properly adopted and which could lead to substantial savings in terms of human misery. In view of the large-scale widely prevalent malnutrition, the question of proper nutrition assumes special importance and requires concerted action. There would also be a difficult but pressing need to overcome religious and social taboos which often-times prevent people from adopting healthy habits.

FAMILY WELFARE AND POPULATION POLICY

5. A reduction in birth rate is part of the National Family Welfare Policy, a Statement on which was adopted in June 1977. Health and family welfare are; so intimately intertwined that, without an active and vigorous implementation of the Family Welfare Policy, the National Policy on Health or, for that matter, any policy of national development, cannot even be conceived of.

MATERNAL AND CHILD HEALTH SERVICES

6.1 The future of any nation is the future of its children. If the limited reso rces in the health s ector are to be preferentially applied to any segment of population, it should logically flow to children and mothers. Infant mortality, child mortality and maternal mortality in this country are stark figures signifying our inability to achieve a break-through in this field. Bold attempts need to be made to ensure 100% health coverage in the ne next 10 to 15 years for all children in the age group 0-5 and by the year 2000 of all children up to the age of 15.

6.2 Maternal services are sparsely distributed. Our dependence on professional birth attendants will continue for a long time. While there may be an addition in the institutional facilities for deliveries - particularly to provide for complicated cases - we should ensure that all deliveries are handled by competently trained persons. This would reduce signficantly the maternal mortality and morbidity.

6.3 Along with vigorous steps needed to achieve deduction in the birth rate, we need to improve the facilities availabeltto mothers and children to assure the families of the safety of their progeny. This, by itself, will have a psychological impact and would over the period favour a reduction in the birth rate.

CURATIVE SERVICES AND HOSPITALS

7.1 We have inherited a system of health services and medical education from the colonial days which has a large emphasis on treatment in hospitals and cure of diseases. With increasing sophistication, we are now devoting 80% financial and manpower resources in the health sector to this segment of health services which is more or less concentrated in urban areas. With the public sector, private sector and voluntary sector operating jointely and sometimes at cross-purposes, there is avoidable disorganisation in the provision of curative services. Even the general hospitals run by Government do not provide equality of access to the poor. There is often-times duplicate and triplicate utilisation of facilities in an effort to get second and third medical opinions. A method should be developed to avoid this wastage of scaree resources. The urge of the common man to get quick and effective medical treatment, particularly when he is at the physical and psychological nadir is understandable. The pace of investment in hospitals and curative services has to be slowed down, linking it rationally to a national policy on urbanisation. One can, however, hope that extensive provision of preventive promotive, public health services would go a long way to relieve the burden of curative health system to a large extent.

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7.2. Even so, there would be a need to provide an increasing number of hospital beds; firstly to take care of some of the under_served, semi-urban and rural population and secondly, as part of the referral system. Construction of hospitals on traditional methods is a costly proposition, most of the money going into brick, mortar and equipment. We need to explore ideas on new type of hospitals in which modern construction is restricted only to essential areas such as theatres, wards, etc.; the rest being of simple structures using local materials with provision for members of the family to stay and provide basic nursing services.

7.3. We have, in addition to themodern system of medicine, indigenous systems like ayurveds, unani, siddha, naturopathy and homoeopathy in wide use. There has so far been no coordination among all these systems, either in terms of education or in terms of services, not to speak of integration. We should now begin an attempt on a co-ordination of the services offered by all these systems so as to obtain optimal economic utilisation.

7.4. The trend is towards increased application of sophisticated modern technology, be it auto-analysers, linear accelerators, EMI scanners or intensive care equipment and the like. Very often these provide a cultural shock for the average Indian. In any case, they tend to increase competition amongst professionals to acquire more of these sophisticated techniques at great cost and thereby increase the distance between the patient and the doctor We must learn to use increasingly appropriate health technology replicable with scientific, technical and managerial resources available within the country.

MEDICAL EDUCATION AND HEALTH MANPOWER

8.1. Medical Education has suffered as a result of cultural dichotomy coupled with parallel development. The modern medical system has kept pace with developments in the rest of the world but the type of education imparted particularly at the under-graduate level is heavily hospital-oriented with little relevance to Indian situations. This makes a fresh graduate unsuitable to handly situations in the community and unable to appreciate the problems and dilemmas of the community. The indiegenous (traditional) systems of medicine have, after years of neglect, started coming into their own. The earlier attempts to integrate the modern medicine with the traditional systems have failed. While no attempt to forcibly integrate any system of medicine should be made, all the systems should realise, in the Indian conditions, the limits and potentials of other systems and draw inspiration from them and should support each other mutually. This can be done only by a concern for other systems and understanding of their functioning.

8.2. The training of agents of health care in sufficient numbers at appropriate levels, with right attitudes, outlooks and functioning in an orchaestrated manner, holds the key to success of any health system. The hierarchical structure of the presat day health manpower and the roles allocated to each level in the hierarchy are the outcome of a historical process. A dynamic process of change and innovation is needed. The concept of health team is important in this context. The national medical education policy aims at qualitative and quantitative development of adequately trained health personnel of all categories in a reorganised structure keeping in view the training of a composite health team. To help in innovative development of medical education al processes and ensure a continuous input of properly trained manpower, it would be necessary to set up a Medical and Health Education Commission embracing all systems of medicine and all categories of medical and para-medical personnel.

HEALTH PLANNING AND HEALTHE INFORMATION SYSTEM

9. The need for an effective information system in the Health field at all levels providing for collection, processing, storage, and retrieval as a tool actively actively aiding appropriate decision making and programme plan[illegible] field of Health is well recognised. We have [illegible]

set up a dynamic information system to support the Health Planning and decision-making machinery.

MENTAL HEALTH

10. Mental well-being is an essential component of the state of good health. With increasing industrialisation and greater strains in the community, mental health problems are on the increase. Here again, a primary health care approach would enable isolation of the problem at an early stage and handling of the same in an appropriate manner. Traditional Indian practice such as yoga, sadhana, etc., need to be strengthened and made universally available to attempt non-medical methods of handling mental health problems.

REHABILITATION

11. Rehabilitation forms the fourth side of the health square, the other sides being prevention, promotion and cure. Medical rehabilitation services are not fully available to those in need of the same. Here again appropriate technology should be increasingly used. Medical rehabilitation also needs to be coupled with social rehabilitation in certain circumstances like 'burnt out leprosy cases', etc.

BIO-MEDICAL ENGINEERING

12. Developments in this field are occurring every day and at a rapid pace. However, particularly due to miniaturisation occurring in electronics it should be possible to take advantage of the electronic industry in the country to make available such advances to a multitude of istitutions. This branch of medical science has so far not been adequately attended to. The industrial capability of this country is of a high order and it should be possible, with some attention, to keep pace with developments in this field and transfer them in an appropriate manner to Indian conditions.

PHARMACEUTICALS

13.1 It would not be far wrong to say that the pharmaceuticals industry dominates the health sector and the doctors are deeply influenced by the drug industry. Instead of being able to dictate to the drug industry, the medical profession is in fact dependent on the drug industry of whatever continuing education it receives in the form of literature. Over-utilisation of drugs so as to increase the profits of the drug industry, has become the end and hospital and the medical profession are used as a means towards this end. This problem has been deliberated upon by various committees, essentially to ensure that the drug industry plays a subordinate and not a dominant role, without, however, minimising the plenitude of good that it brings to millions of people. The medical profession should have a greater say in determining the direction of growth of the drug industry.

13.2 Reliance on synthetic chemicals and antibiotics is a growing world-wide phenomenon. Greater utilisation of drugs tends to increase the cost of the health system. On the other hand, vaccines and sera which are used in preventive medicine need to be encouraged and new vaccines need to be developed.

13.3 In so far as the medicines belonging to the traditional systems are concerned, the age-old practices of local preparation of such drugs have slowly vanished leading to greater commercial preparation of such such drugs. It might be worthwhile and necessary to encourage local manufacture of such durgs in small communities wherever such treatments are in vogue. Further use of herbs and meicinal plants, particularly for common ailments wherever practicable, needs to be encouraged. It is expected that the local growing of such herbs and plants, harvesting, storing and preparation of medicines out of the,, at the community level, would go a long way towards self-reliance.

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13.4. In keeping with the concept of community participation and self-reliance it is also necessary to reduce dependence of the population on the formalised medical system for the use of medicines. While on the one hand it would be necessary to guide the population in the use of medicines particularly those which are toxic or have reactions, it is also necessary to depend on the people themselves for knowledge of their own conditions and use of appropriate remedies. Thus, consistent with our concern for overuse of drugs and professional supervision on the use of drugs having toxic or side-effects, we should liberalise the idea of self-medication. This will imply strict control on the quality of medicines available in the market.

RESEARCH

14. No nation can afford to neglect the support of fundamental and basic research, for without it there can be no proper teaching of science and no national capability for solving unresolved problems, meeting changing situations and for adopting, in certain instances, known technology to suit local conditions. And yet, highest priority should be given to applied research, in particular health services research, if the technological achievements of medicine are to be placed within the reach of those who need them most. Health services research is holistic, multi-disciplinary in character involving the the joint participation of bio-medical sciences and social sciences. Such research should be carried out within the health service system and research priorities determined as a result of joint discussion between researchers, administrative decision-makers and the public, The whole ethos of such research should be based on discovery of simple, low cost, appropriate health technology, the results of which are replicable under routinised settings. We also need to devote ourselves to basic research, particularly with a view to developing solutions to problems plaguing our country. We are yet to develop effective cures or vaccines, for such diseases as malaria, leprosy, etc. Likewise, there is immense scope for research in matters relating to Human Reproduction. Research in the field of medicine should be relevant to the needs of the community.

LEGISLATION, INSURANCE AND COORDINATION

15. Health being a State subject, the approaches to legislation in the health field would necessarily vary from State to State. A variety of legislation s already on the statute book, be it on the national level or State level. It would be necessary to review these items of legislation and work towards a single comprehensive legislation applicable to the health field. The services provided by government are generally free. This leads to a situation where there is not enough appreciation that the services do cost money to the nation and, therefore, should be utilised only where it is essential and unavoidable. A realisation of the utility of such services can be brought about by educating people as also by levying nominal charges for all services. The possibility of introducing some form of national health insurance, at least in the future, to provide for guaranteed health services to all segments of population needs to be pursued. In the present system since there is a co-existence of the private sector, voluntary sector as also the public sector, it is essential to coordinate the services by these sectors. The possibility of setting up coordination committees to regulate the services available in each of these sectors needs tobe explored. Secondly, in the private sector and to a limited extent in the voluntary sector, sometimes the fees charged are rather high. While this drawback will continue as long as the private sector exists, an attempt needs to be made to ascertain whether there can be any self-regulation. As part of this exercise bold attempts need to be made to end the system of private practice by doctors in Government service and in Medical Colleges.

INPUTS IN HEALTH-RELATED FIELDS

16. Developments in health come not merely as a result of inputs and activities in thehealth field, but also due to developments in health related fields such as agriculture, water supply and drainage, communication etc.

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At the community level, all health activities must be coordinated with and in fact, form part of, total rural development. To the extent decentralisation of resources, planning and implementation can be achieved, there will be greater efforts and development in all field and thus in health also. Such decentralisation should, therefor , be actively pursued and supported. Even at State and national levels, health activities and inputs should benefit from investments in health-related fields and to that extent, coordination with other sectors of development have to be volunatrily sought for and achieved.

CONCLUSION

17. The following should, therefore, be the short-term and long-term goals of the national health policy:-

17.1. Short-term goals

i. to eradicate/control communicable diseases in the country;
ii. to provide adequate infrastructure for primary health care in the rural areas and in urban slums;
iii. to utilise all availabrlmethods for health education and spread the me-ssage of Health and Family Welfare;
iv. to utlise knoledge from different systems of medicine for profiding quick and safe relief from sickness and debility at the cheapest possible cost;
v. to reorient medical education to be in tune with the needs of the community;
vi. to provide increasing maternal and child health coverage.

17.2. Long-term goals

i. to improve public health services by setting up a chain of sanitary-cum-epidemiological stations;
ii. to ensure 100% coverage of all segments of population with preventive services;
iii. to create a self-sustaining system of health security so that earnings of the individual are not affected adversely during periods of illness;
iv. to impart medical education in a medium which is an integral part of our culture and life-style and thus remove the foreign concepts associated with foreign languages which are major factors inhibiting people from understanding the true and proper role which medicine plays in the development of a healthy community;
v. to utilise available knowledge from the ancient and modern systems of medicine in an effort to develop of composite system of medicine, thus obliterating the caste system prevailing in the field of medicine;
vi. to inculcate a sense of self-reliance and discipline in all segments of population so that all four sides of the health square, namely, prevention, promotion, cure and rehabilitation are effectively handled at the local level consistent with the developments in the field of medicine.

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HINDU, September 1, 1978.

In Quest of a

NATIONAL HEALTH POLICY

> Our health services need a major shift-from curative to curative-preventive, from urban to rural population, from the privileged to the underprivileged. The health policy has to be an integral part of the planning for economic development.

Over the last 26 "planned" years, we have drifted further and further away from the goal of "total health for all". Every Plan document contained brilliant rhetoric for expanding health programmes for more and better-equipped Primary Health Centres and for better implementation of programmes. But all the while the development and allocation of medical care resources, viz, manpower, material and economic resources drained inexorably away from the country's real needs. They flowed towards establishing a sophisticated, individualistic, expensive, illness service for the privileged, rather than towards a simple community-based and inexpensive primary service for the deprived who form the bulk of the population.

Nearly 60 per cent of our people, who live below the poverty line, lack the purchasing power to secure health services. They constitute about 378 million people whose health care is being neglected. It is necessary to consider the loss to the national economy due to ill health of the poorer rural and urban people. If 40 per cent is taken rougly as the number of able-bodied people in our population, then the lowest 60 per cent - 378 millions - provide a work force of 151.2 million. If even 10 per cent of them are ill at a time, then 15.12 million are away from work everyday for the whole year. At the current per capita income rate of Rs. 1,400, we are losing at least Rs. 2,006 crores a year in GNP alone due to ill health. If there are epidemics of any sort of any area, we lose much more.

This huge national loss occurs because we do not have a clear national health policy. What is therfore urgently needed is a national health policy based on health priorities. The Government of Inida has not so far evolved such a policy incorporating primary health care for all citizens nor has it felt the necessity to consider it as a part of total planning. A national plan, with health goals to meet the mass needs, the required personnel, their training and allocation of functions, development of necessary institutional base and establishment of objectives, strategies and priorities among competing demands for health services should be identified for planning proper health services to the people.

An effective health approach requires the co-ordinated efforts of all those sectors that can contribute directly or indirectly to the promotion of people's well-being. This is not only at the central level but also at the intermediate and above all the peripheral level, where policies should have their roots. Moreover, health should be considered an integral part of development with clearly defined goals, policies and plans.

FRAGMENTARY EFFORTS

The efforts made now are fragmentary, not necessarily related to those of other sectors and not directed towards supporting national growth on a broad scale by fostering human well-being and resources.

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Health activities often become stagnant and health development projects collapse for lack of proper budgetary support. Clear, concise and logical priorities within the health care system are not laid down. Realistic criteria for the development of priorities are not formulated.

For example, scant attention is given to the balance between curative, preventive and promotional activities and the division of resources among them. Priorities between primary care and hospital services are not defined. A balance is not always established on objective grounds between personal health services, environmental health services and community-oriented activities. Again, not enough is done to assess alternative methods of combating communicable diseases, while the use of measures not directly related to but generally affecting health is frequently neglected.

The shortage of human material and financial resources is often complicated by faulty utilisation and maldistribution of resources. The shortage of financial resources affects the larger, needier rural population more than the urban dwellers. The health sector is often hospital-based, relies on relatively sophisticated technology and places emphasis on specialised medicine. The national health needs should be defined to plan the manpower development of various categories.

The training of health personnel is frequently irrelevant to or falls short of local health needs and aspirations. Our medical graduates have a "trained in-capacity" to meet the pressing health needs of the people and are more inclined to remain in the protective hospital setting in which they have received their training. To products of such a system, the problems of preventive, promotive and rehabilitative health care are fields which are fit only for the auxiliaries to practise. Changes in the curricula, intensive field training, problem-oriented instruction, an emphasis on the acquisition of necessary skills and above all training in organisation and leadership in health care have been rightly identified as steps required to be taken.

Equally the training of auxiliaries usually leaves much to be desired. Seldom is it planned according to priorities and the job to be done. The auxiliaries with limited basic education and brief preparation require continuing on the spot training. The development of primary health workers raises a new set of problems related to their selection, training and administration. Critical importance is attached to the technical aspects of the activities of primary health workers, who form the entry point to the health system for the majority of the population. If they give improper or wrong treatment and do not refer patients when they should, the system will be a failure, Consequently their tasks must be clearly defined and the training programmes must be efficient.

That the basic health workers of the new Janata health scheme will not be equal to the task and responsibilities is obvious from the basic qualification and the short duration of training in allopathy, ayurveda, homoeopathy, naturopathy, unani, family planning, child care, modern hygiene, etc. The responsibilities of these workers are heavy and varied as they are expected to deliver a package of health services - preventive, promotive, curative and educational at the door-step of the villagers. The future of the scheme depends on the quality of the workers enlisted,

their education, ability, mobility, competency, attitude and skill. If it does not succeed, it will be one million quacks let loose on the rural community and nearly Rs. 300 crores going down the drain.

The problem of health care cannot be solved by a combination of different systems of medicine. Qualified and registered practitioners of indigenous systems of medicine should be utilised through separate schemes within medley of different systems should be discouraged. Indigenous medicine is certainly in great favour among the rural population. But its practitioners should be compelled to confine themselves to their own system and not dabble in modern allopathic treatment. The Government policy should be clear in this regard. It is necessary to study the role of practitioners of different systems of medicine and their contribution to the health care of the community. There should be need-based research to provide cheaper medical care to the people.

High morbidity and high mortality, particularly among infants and children, are an index not only of a community's low health level but also of inadequate health education. A large number of diseases could be prevented with little or no medical intervention if people are adequately informed and if they are encouraged to take the necessary precautions in time. Health education is particularly needed where the network of services is weak, where people must learn to protect themselves from disease and to seek help only when needed.

It is therefore necessary to plan and guide health information activities to suit the health culture and psychology of the masses. There is an imbalance between environmental sanitation should aim at safe drinking water, sanitary collection and disposal of human wastes, control of pollution, uncontaminated food and a decent place to live in. A major problem is the lack of a competent service infrastructure to carry out a comprehensive range of functions effectively.

Many statistical services fail to provide public health authorities with the information they need for sound decision making. The collection of data of doubtful validity and utility serves neither the decision-makers nor the community. Information services should be recast according to the priorities of health system and should be aimed strictly at problem-solving.

The objectives of a national health policy should therefore be :

1. To create the infrastructure for integrated and comprehensive health services.
2. To integrate the family planning and health programmes at the grass-roots level.
3. To provide well-organised health care programme for infants, children and mothers, with a view to reducing infant and maternal mortality.
4. To ensure effective prevention and control of communicable diseases and to organise epidemiological services supported by well-equipped public health laboratories.
5. To establish well-organised industrial health services for workers, to provide protection against industrial health hazards, to create a healthy environment to places of work and to provide workers and their families with medical care.

6. To [illegible]

6. To provide hospital facilities in rural areas by having 25 beds at each primary health centre.
7. To create adequate undergraduate and postgraduate teaching and training facilities for medical and auxiliary personnel and to ensure proper service conditions enabling the staff to be used to the optimum extent.
8. To ensure the availability of all essential and life-saving drugs at reasonable cost and of immunising agents for the prevention and control of communicable diseases.
9. To ensure intersectoral co-operation and co-ordination in improving environmental sanitation, housing, potable water supply, etc., at home and at places of work.
10. To plan and guide health education activities.

Overall health policy requires a policy requires a political will to provide the resources necessary and an effective executive structure to implement the decisions. The machinery for national health planning is lacking with the result the plans that are formulated are unrealistic and not presented in terms attractive enough to appeal to the cost-benefit and cost-effectiveness minded planners. This is a serious shortcoming and leads to neglect, relatively, of social sections and health in particular.

The outlay for health should be considerably increased. The annual percapita expenditure is less than Rs.10 and the total is about one per cent of GNP as compared to about six per cent in developed countries like the U.K., the U.S., and Canada. Investment in health is investment in human capital and this realisation is yet to dawn on our planners. Health care delivery systems - public and private, curative and preventive, peripheral, intermediate and central must be considered as a whole.

BANE OF OVER-CENTRALISATION:

In a health service, overcentralisation of authority and executive responsibility may prevent effective and adequate delivery at the periphery. It tends to maldistribution of resources. Any plan or programme is first planned, then put in operation, then evaluated. A strict and impartial assesment of the utilisation of the services rendered should be made to know if the aims have been achieved.

The evaluation results would enable the necessary adjustments to be made in the programme. In our planning, we encounter many shortcomings. Operation is the only continuous area of most programmes. Planning is often sporadic. Evaluation is relatively rare. So the cycle is not operating in a continuous manner in many programmes.

A major shift in the emphasis in the health services is necessary - from a curative to a curative-preventive approach, from urban to rural population, from the privileged to the underprivileged and from vertical mass campaigns to a system of integrated health services forming a component of overall social and economic development. Health has to be given a high priority in the Government's general development programme.

Health services are only one factor contributing to the health of the people. Economic and social development activities often have

housing, nutrition, education and communications are all important factors contributing to good health by improving the quality of life. In their absence, the gains obtainable with the disease-centred machinery of health services cannot go beyond a certain point.

Two kinds of integration are, therefore, necessary. The first is the integration of various aspects of health policy into economic and social development. The second is the welding of the different parts of the health services into a national whole.

A firm national policy of providing total health care for all will involve a virtual revolution in the health care delivery system. It will bring about changes in the distribution of power, in the pattern of political decision-making, in the attitude and commitment of the health professionals and administrators and in people's awareness of what they are entitled to.

To achieve such far reaching changes, political leaders will have to shoulder the responsibility of over-coming the inertia as well as the well entrenched vested interests. Though the framing of health policy belongs to the domain of politicians, the medical profession has a responsibility that goes beyond protecting its own interests and the interest of individual patients to protecting the health of the community.

The needs of our people warrant a clear national health policy. In this, there are two important factors: 1. Health planning should be an integral part of socio-economic planning; 2. Most health work is carried out at the State level. Under these circumstances, it is essential that there should be co-ordination and co-operation between the Central and State Ministries of Health if planning is to be successful.

Dr: T.M. Kumaraswami.

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 evolved and have continued to be practised widely. However, the allopathic system 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, nospital 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 0.5% 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 thorough 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, at 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 guidelines 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 rehabilitative aspects :

8. Presently, despite the constraint of resources, there is disproportionate emphasis on the establishment of curative centres-dispensaries, hospitals, institutions 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-medics 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 interventions 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 of 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 care 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 in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in the 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 services, 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 residing in the 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 services, 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 (i) 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 needs 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 the 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 nonpractising 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 laws 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 waste 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 to the 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 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 services, 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 requirements 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

should be established to identify essential equipments required for extensive use and to promote and enlarge their indigenous manufacture, for such devices being readily available, at reasonable prices, for use of the health care centres.

Health insurance

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 should 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

and acceptability of existing methods as well as to discover more effective and acceptable devices. Equally high attention would require to be devoted to 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 areas of 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	100
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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POSITION PAPER ON NATIONAL HEALTH POLICY

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POSITION PAPER ON NATIONAL HEALTH POLICY

The National Health Policy as planned may remain only a policy document unless all of us make a commitment to it, and try to implement it at all levels. Each of us must carefully analyse the health problems, keeping in mind the country's capacity to deal with them. The goals and priorities will be fixed accordingly. Strategies to achieve them need to be based on social justice and equity, intrasectoral linkage and self-reliance as far as possible.

The ill-conceived and inadequate health services currently provided to the vast majority of the population has created a feeling of social injustice and given many voluntary organisations the impetus to act as natural leaders of their communities. They have the responsibility to lead movements for the change. For this they need to identify the strategies to develop their full leadership potential. They should look beyond the traditional system of health care and develop a deeper understanding of the philosophy of primary health care and a commitment to achieve health for all by 2000 A.D.

1. PROVISION OF HEALTH SERVICES TO ALL

For those who live in remote areas and belong to the lower income groups, health care can be provided only through a system which creates a broad base of functionaries and provides health care to the maximum number of people. The training of new community health workers at the village level has only duplicated the existing system and has not proved very helpful in the long run. Wherever the traditional health functionaries have been involved, the infrastructure has become stronger. The health care system may continue to be lopsided, unless efforts are made to improve the training and supervision of CHW's and Dais.

2. REFERRAL SYSTEM AND PRIMARY HEALTH CARE : A STRATEGY

The bottlenecks that exist between the village and a health sub-centre are again a matter of concern. The health assistant is no better equipped with the skills and will to deal with certain health problems than a CHW. So unless there is a way to reach Primary Health Centres very little can be done at these levels.

Another important point is that the referral system does not allow for any planned way to go from one to another. There is no geographical or political boundary which one cannot cross. Unless the screening is done at all levels, the political and the social linkage is established between a specialist hospital to a Primary Health Centre of the block, from there to the village sub-centre and back from village to the specialist hospital; the congestion, duplication and the parallel system will continue to exist. The suggested change of effective links between primary health centres and medical colleges and hospitals in order to harness and provide specialised skills is no doubt progressive thinking for re-orientation of medical education and better health service, but its implementation has been held up due to many administrative difficulties. As a result, neither are the Block Administrators taking responsibility for the better functioning of these Primary Health Centres nor have the medical college hospitals established a proper linkage with them. Very few specialists from these hospitals like to go out to the Primary Health Centres. In fact the person who goes there is only a junior or senior resident working in those specialised units. Most of the time they treat these trips as holiday excursions. There is no continuity of ties nor any feedback from such hospitals to the Primary Health Centre doctor.

3. INFORMATION SUPPORT

To estalish a proper information support, there must be a well-defined referral system. General practitioners, indigenous practitioners and all others who are involved in any way with the health care system should become a part of the information support. The Epidemiological Cell in each State may not be essential but it should have a computerised system for collecting and processing information from different units. Without information, support evaluation and monitoring of any programme is not possible.

4. RE-ORIENTATION OF HEALTH PERSONNEL

To equip health personnel with appropriate and scientific techniques we must provide a system of continuous education. Inservice training programmes are essential to develop the skill to do the job better. Certain managerial skills which are never imparted to medical professionals in their undergraduate courses must become a part of the orientation training programmes. All courses could be so planned that NGO/Govt. officials attend the courses together and can interact with each other.

The voluntary organisations have a greater sense of dedication and commitment to social causes and are more open to change. This gives them an enormous advantage in the field. They provide care at all levels in all kinds of settings to the poorer section. They frequently act as links between the individuals, community and the rest of the health care system.

5. INTERSECTORAL COORDINATION

That various sectors have influence on health is well understood, but intra or intersectoral coordination remains most of the time only in the minds of people or as words on paper. Actual coordination at various levels is possible only if the planning of the two sectors are done at one place, and from bottom to top. The possibility of removing the bottlenecks is maximised if two sectors, well connected like water and sanitation, nutrition and education, are planned together. Again, regarding the educational status of woman and her acceptance of family planning, both must be worked out together, and receive the same importance. The administrative blocks also need attention. There is a need to define the job responsibility of various people at different levels, as well as a policy of delegation of authority at each level. If decision making is confined to the planners' level, the implementing functionaries find it very difficult to carry out their day-to-day duties.

6. ALTERNATIVE SYSTEMS OF MEDICINE

There is a need for integrating the training programmes of different personnel in different systems. The policy has recommended the use of indigenous systems of medicine like Ayurveda, Unani, Sidha and Homeopathy. It also emphasises introducing Yoga and Naturopathy into the overall Health Care Programme. But when it comes to putting this into practice, none of the Primary Health Centres or the dispensaries is equipped to give advice on any of the traditional systems of medicine.

Traditional systems of medicine have always had a place in our culture. They are both less expensive than modern medicine and more easily accessible to the majority of our population. To allow them to stagnate will only increase existing inequalities in the health care system. Therefore, ways of integrating the modern with traditional system of medicine must be thought of.

7. REGIONAL IMBALANCES OF THE HEALTH CARE SYSTEM

It is of vital importance to correct the regional imbalances that exist in health care systems today. The policy cannot be successfully implemented unless sustained political, social and administrative support is obtained from everyone concerned. Here the local communities play a very important role and it is our duty to make them aware of the facilities they are entitled to, so that they demand the care they need. The concept of preventive and promotive services is still lacking all through.

8. MEDICAL EDUCATION

We need not go into the details of formal medical education as we all know that it is not tailored to meet the requirements of the type of medical practitioners who work

in Primary Health Centres. If more clear and effective strategies could be specified, the wasted resources could be harnessed. The re-orientation of medical education has been talked about for the last several years but very little has been done to make education community-oriented and problem-based. Most of a medical graduate's time is spent in hospitals. The type of knowledge and skills that he/she acquires are the ones from the hospital itself, when almost 80% of the ailments are preventable and can be cured by simple remedies. But these cases never reach the hospital for their attention.

The National Health Policy is aimed at taking services to the doorstep of the people ensuring fuller participation of the community and improvement in the quality of their life. It is intended to restructure the health care services on the preventive, promotive and rehabilitative aspect rather than on cure only. Therefore to provide trained personnel with the right attitude and outlook is more important for proper functioning of the services talked of in the policy document.

9. MEDICAL RESEARCH

It is the opinion of various experts that today there is a lot of money being wasted on basic research which could be well shared by the developed world. The technical know-how can be easily obtained from them.

Special research on health care system, problem based medical education and need-based para-medical education at various levels, require a lot more attention than is being given in this country. In my opinion "behaviour problem" of the recipients of health services should form the priority for the research grant in India. There is also a need for a constant feedback on the new findings and advances in medical research and their application to health services. The dissemination of this information to the proper levels both upward and downward are equally important. Unless we keep informing our workers at the grassroots level of what is happening at the central level, the implementation of the programmes become difficult.

10. THE TARGETS

The National Health Policy paper gives the targets to be achieved according to the time frame. These targets are not comprehensive nor have they been worked out on any realistic terms. The exercise only tells what future achievements can be expected provided the base is known. No doubt it is better to work on some frame, to measure the milestone and progress being made but the baseline information is of crucial importance.

The target sets are based on certain information that was available at one point of time: perhaps as far as 1975 or 1976. Unless the relevant data is available from different states it is of no use setting up targets to reduce the incidence. A few studies

carried out by big institutions like the All India Institute of Medical Sciences or PGI Chandigarh tell us very little about the overall health status of our country. Lack of vigilance in reporting and collecting of information will hinder us from reaching our targets.

11. ROLE OF NGO's

The role of voluntary agencies has been very well spelt out by the Alma Ata Declaration. It includes:

1. Identification of the needs and problems of the people.
2. Development and innovative programmes for Primary Health Care, in the context of comprehensive human development.
3. Promotion of full participation by individuals and communities in the planning, implementation and control of these programmes.
4. Training of health workers, supervisors, administrators, planners and various agricultural and development workers, along with training schemes, build on the skills of traditional healers and midwives.
5. Creation of new and effective methods of health education.
6. Recognition of the essential role of women in health promotion and in the full range of community development concerns.
7. Contribution to the search for greater social justice.
8. Development of locally appropriate health technologies and use of resources.

Most of the voluntary organisations are working for both health and development. The standards of health cannot be improved unless there is an improvement in the general quality of life. The NGO's are more willing to go to the most difficult areas where nothing exists as far as the health system is concerned. Still they find it difficult to be recognised and get little or no help from the government system. It is time we all realised that to achieve health for all by 2000 AD, the involvement of the voluntary sector is essential.

THE DILEMMA—NATIONAL HEALTH PROGRAMME

Most of the time the doctor faces a very big dilemma in his day-to-day functioning. He is unable to find what to do and how to get started with diverse programmes like TB, Leprosy, Prevention of Blindness, Malaria control, Family Planning, Immunization, School Health, Nutrition and MCH, as well as to keep evaluating the programmes from time to time. Only if the planning process, information system, resources, supervision, coordination and training is adequate can the

doctor use his energy as a team leader to build up the team, organise the community, keep proper records, monitor the programmes and do a follow up review, as well as initiate certain changes in the programme when the need arises.

The bring about any change is a very complex task. The people who are striving to reach the goal of health for all must have a clear understanding of the National Health Policy, the critical issue required for its implementation and the broad principles involved in it.

In these three days let us together work out an action plan for our own areas keeping all the elements of the National Health Policy in mind and evolve our own strategies to reach the goal of health for all by 2000 AD.

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Simplistic Approach to Health Policy Analysis

World Bank Team on Indian Health Sector

Debabar Banerji

A World Bank report on the health sector has set out to offer an alternative policy framework to cushion the impact of structural adjustment programmes on health services. But by choosing health financing as a tool for policy analysis it has arrived at highly questionable conclusions.

THE secretive World Bank Report: *India: Health Sector Financing*, has been widely commented upon in the national press. A World Bank team paid a five-week visit in March-April last and claimed that the analysis and the policy outcomes were generally endorsed by senior health sector personnel in India (p 3). Indeed, based on a 'vigorous' discussion at a meeting of "India's most eminent health policy researchers, chaired by the Secretary of Health", the team claims that the report in many ways is a joint statement of the two sides (p 3). It is worthy of note that a substantial majority of those who attended the meeting were not even acquainted with some of the basic literature concerning growth and development of public health practice in India, not to sepak of health policy research with its political, administrative, technological, epidemiological and sociological dimensions. That might be the reason why the distinguished participants of the meeting failed to note that health financing is a part of the wider academic field of health economics, which in turn forms only one component of health systems research for developing effective public health practices under given conditions. Health economics has interest, among others, in the complex questions of identifying more effective uses of given resources. A health service system is a complex entity, where a large number of variables, derived from a large number of disciplines, are in complex interaction with one another. The interaction determines the output of the system. This output needs to be optimised, using the methodologies of operational research and systems analysis. In this sense, research in health economics becomes a component of the even larger field of health systems research. Optimisation of complex systems in order to get the maximum returns from a given quantum of resources thus becomes the cornerstone of research in public health practice and health policy research [Banerji 1985: 362-64]. For instance, in considering a programme for containment of malaria in India, it is important to ensure that adequate inter-disciplinary research has been carried out to have the optimal solution of the problem. The question of financing comes after the problem of optimisation of the system is attended to. There is, indeed, a likelihood that the current approach adopted for malaria control is not cost-effective [Banerji 1985: 142-44]. In such an eventuality, clamour for a mere increase in the funding of the malaria programme may result in increase of waste of resources. Health human-power development, National AIDS Control Programme, the health service system, as a whole or in the form of its components (e g, hospitals, medical colleges or PHCs), are other examples of systems that need optimisation, before the question of financing is considered. The heading on page 13 of the report, 'Enhancement of Efficiency through Redirection of Funds' is a good example of the narrow and obviously distorted approach adopted in the report: as if lack of redirection of funds is the only cause of inefficiency. The focus on health financing, to the exclusion of the wider issues of optimisation has sharply distorted the problem analyses and the solution suggested by the World Bank team. It has put the issues upside down.

The team is expectedly simplistic in making policy analysis. The report makes a sharp contrast with the National Health Policy of India (NHP) of 1982 [GOI 1982]. It did not occur to the team to identify the factors which have come in the way of implementing the NHP over the past decade and more. In addition, apart from the numerous gaping holes in the analysis of epidemiological, technological and organisational and management issues that need to be considered for policy analysis, the team is deafeningly silent on the political and sociological dimensions of the analysis. Is it because the team itself is a creature of international politics of the World Bank and the affluent countries that dominate it? How could the team ignore the wealth of literature available on politics of family planning, immunisation, health systems research and of course, the World Bank's own National AIDS Control Programme [see, for example, Banerji 1990a; 1992a; 1993]? There is moreover the politics of capitation fees in medical colleges which has led to the recent overthrow of the governments in Karnataka and Andhra Pradesh. The savage 42 per cent cut in the malaria programme in the 1992-93 budget by the finance minister, and its restoration apparently at the insistence of the World Bank in 1993-94, provides yet another chilling instance of the way politics literally decides issues of life and death of a large number of people of this country.

The Report

The main purpose of the report is to initiate dialogue between the government of India and the World Bank to clarify issues of direction and policy in the face of structural adjustment, which will influence the pattern of co-operation in the health sector for the next few years (p 3). The purpose is to ensure that budgetary constraints do not reduce the scale, equity, and quality of health services by encouraging health administrators to take difficult decisions. The major concern ought to be to make reallocation of expenditures to achieve greater effectiveness in solving national health problems, specially for the poor, who suffer disproportionately from poor health and high mortality.

The most significant aspect of the health services is that it has undergone rapid expansion while it was receiving slowly declining share of public budgets for health in the 1970s, with a precipitous decline occurring in the 1980s. The plan expenditure has steadily declined from 0.08 per cent of GDP to a low of 0.04 per cent in the revised 1991-92 budget. This has caused, what the report says 'a double squeeze'. The infrastructure stretches the existing budget very thin. This has caused marked inefficiencies, which has made it almost ineffective. Over and above came a sledgehammer approach to the budget cut to bring about structural adjustment. The central health budget was slashed by

a massive 20 per cent in 1992-93, without even accounting for inflation—from Rs 302 crore in 1991-92 to Rs 244 crore in 1992-93. There was also a massive 30 per cent cut for rural drinking water and 40 per cent cut in rural sanitation. An across the board of cut of 20 per cent in all expenditure heads will obviously be a lacerating way of making the reduction. However, apparently to placate the rich, already privileged urban classes, there was indeed an increase of 13 per cent in the allocation for hospitals and dispensaries and, correspondingly, the malaria programme which caters to the large masses of the population of the country received a savage 42 per cent cut. In effect, there is some rise in expenditure towards programmes with what the report terms as 'relatively few externalities' at the expense of programmes with larger externalities and benefits to the poor.

The selected neglect of the health services which were of greater relevance to the poor has precipitated a serious crisis. The report quotes an NCAER survey of 1990 (p 9) to state that the poorest 40 per cent of rural households spend, on an average, Rs 157 per illness episode, when receiving care from government doctors and Rs 131 when purchasing care from private doctors. The richer 60 per cent of the population paid less for government doctors, Rs 137, and more for private doctors, Rs 215. A similar pattern was observed in the 42nd round of the NSS, completed in 1987. Thus, those who are least able to pay are bearing the heaviest burden when they go to a government doctor. The poignancy of this finding is underlined by another finding of the survey, which indicated that medical care cost is next only to dowry as a cause of rural indebtedness. This is a shocking situation in itself. However, more shocking is the utter callousness of the political leadership, both at the centre and in the states, which has created the present state of affairs. The draconian cuts in the budget is only one such episode in the long story of almost criminal neglect of the health services by the political leadership.

The report notes that public health financing in India is characterised by an emphasis on 'hospitals' (all institutions above community health centres (CHC)), rather than 'primary care' (all services from CHCs down); urban rather than rural populations; medical officers rather than paramedics (again with an urban bias); services that have larger private rather than social return; and family planning and child health to the exclusion of wider aspects of female health (p vi). The report maintains that structural adjustment can facilitate flexible, imaginative strategies and operational changes that will redirect public spending to ameliorate disparities and increase efficiency. It offers a chance for the health sector to emerge from the period of financial stringency stronger, more effective and better targeted. The current budget shows that the central government has missed the opportunity to raise spending on health and family welfare during adjustment as a part of the safety net (p 12). The report urgently calls for evolution of a positive policy before fiscally driven cuts, with little regard for the efficient functioning of the health service system, effect severe damage to the quality and equity of services that can be delivered. The report has presented an alternative policy framework (p viii): (a) expand spending on primary care and communicable disease programme; (b) redirect public resources to health activities with broad benefits to the nation as a whole; (c) improve efficiency and effectiveness of service delivery primarily through adequate blend of inputs; and (d) redouble efforts to address inter- and intra-state equity problems through the redistribution and targeting of public expenditure to raise the primary health care services to an acceptable minimum standard. It makes the interesting suggestion of making poverty levels as a basis for distribution of grants to states, rather than using the general population-based formula.

The team has defined some specific short-term health policy responses to the structural adjustment (pp xiii-xv): (a) Enhancement of efficiency through redistribution of funds; (b) Restoring cuts to the malaria and tuberculosis programmes; (c) Increased spending on communicable disease control; (d) Increase selective spending on non-salary inputs for what the report calls 'primary health care services'; (e) Develop a health economics unit in the department of health; and (f) Begin policy development for increasing cost recovery in hospitals and medical education.

Precisely because the team has provided quite a convincing argument for a re-evaluation of the health services, for the reasons mentioned earlier, the recommendations come as an anti-climax. They amount to a prescription for a vivisection of the health services so painstakingly built and nurtured over more than six decades.

India's health policy is rooted in the vision of a new India during the anti-colonial freedom movement [Banerji 1985: 13-24]. It was articulated in the report of the National Health Sub-Committee of the National Planning Committee (1948) and the Bhore Committee [GOI 1946]. Despite severe resource constraints and colossal dimensions of the health problems, after independence the country launched the very ambitious programme of setting up primary health centres as an integral component of the broader community development programme. At around the same time, a massive health manpower development drive was launched, which also included social orientation of education and training of physicians and other categories of health workers. In 1977, there was the programme to entrust 'people's health in people's hands'. Later, there was the programme of rapid expansion of the infrastructure with PHCs and its sub-centres and CHCs [Banerji 1990b: 37-42]. Data have been collected by the team to demonstrate vividly how this rich heritage has been frittered away due to unpardonable acts of omissions and commissions of the political leadership and the bureaucracy of the country. Nevertheless, it should be realised that the health services is a live, organic entity, despite its many serious problems. The remedy does not lie in the vivisection of this organic entity. The 'hospitals' (from above CHC level right up to the super-sophisticated ones and the medical colleges) are integral parts of this organic structure. Hypothetically, even if they are dissected away from the main body and are conceived as autonomous bodies, making 20 per cent cost recovery, it will also mean laceration of the entire health service workforce. Further, where will the poor, who form the overwhelming majority of the patients, go? What about the urban poor? What will happen to community health activities of the hospitals—family planning, referral support to PHCs, immunisation, social paediatrics, education and training of health workers, and so forth?

The team is similarly vague and equivocal about strengthening of what it calls 'primary care' institutions and communicable diseases programmes. This is reflected indirectly in the team's confusion in the use of the term 'primary care' with the concept of primary health care of the Alma-Ata Declaration [WHO 1978] and primary health centre of the Bhore Committee. Besides, what will happen to the World Bank's own National AIDS Control Programme on the UNICEF's Universal Programme of Immunisation and the Polio Plus Programme, which have all been shown to be not cost-effective [Banerji 1990a; Gupta and Murali 1989]? Then, over and above, is the critical question of optimisation of other programmes and institutions.

Other Conceptual Gaps

The team had done commendable work in mobilising data on different aspects of health financing and develop insights concerning the three important areas of efficiency, equity and disparity. However, a number of issues concerning the study c

health policy through analysis of health financing have been raised earlier which call into question the basic policy recommendations made by the team. It is contended that such an analysis of health financing ought to have been associated with wider analyses of the health service system and its numerous sub-systems, sub-sub-systems, and so on. This required a much wider inter-disciplinary scholastic base for optimising systems of different sizes and complexities. Due to excessive preoccupation with aspects of financing, the team has missed discussion of some of the key variables within the health service system, which have profound policy implications. Some of these are briefly mentioned below:

(1) *Social Dimensions of Health and Health Services:* India has been a pioneering country in promoting social science studies in health fields as an integral component of inter-disciplinary efforts for health service development [Banerji 1993]. That is why it is all the more striking that the team should have ignored this very critical input in health policy research. The Alma-Ata Declaration on primary health care is also anchored on social science considerations: increasing community self-reliance through increasing their own coping capacity in health field, social orientation of technology and intersectoral action in health. The concept of community-felt need, developed on the basis of imparting sociological dimensions to the epidemiological parameters of health problems, is yet another important area of interest for study of health policy [Banerji 1993].

There is, moreover, the important concept of interaction of health behaviour with access of services of various kinds and of cultural meaning and perception of health problems in a community. These ideas are of particular importance as the team has laid so much of stress on equity and disparity. Indeed, the team has paid attention to the NCAER and NSS studies, showing how tragic it is for those who are poor to pay higher amounts for the same services in government institutions than the rich and how often the loans taken for meeting such catastrophies become a major burden on them in the form of debts incurred. Social analysis of India's experiences of the community health worker scheme ought to have raised important issues concerning rural power structure [Banerji 1985: 306-16].

(2) *Centralisation and Decentralisation:* Closely connected with the social science dimensions, including the issue of community participation and the nature of power structure in rural populations, is the desirability or otherwise of decentralisation in administration of health serivces. This acquires even greater significance in view of the recent constitutional change, empowering the panchayati raj institutions. This opens up exciting possibilities of bringing the health services nearer to the people by making suitable policy changes. However, the team finds itself in the opposite camp. Throughout the report, its recommendations lean heavily on a strong centre which can serve as a conduit for bringing about the changes desired by it (see, for example, p xvii of the report). There then is a clear political issue: should the World Bank's interest in strengthening the leverage capacity of the centre receive precedence over the dictates of the national parliament and of the Constitution?

(3) *Regional Variation:* The team is seized of the serious nature of regional variation in health service development. It also advocates allocation of support on the basis of poverty, an issue which has also been discussed in the National Development Council. However, one misses a more detailed policy frame for reducing the disparity, based on actions already initiated.

(4) *Inadequate Public Health Inputs:* As a result of the preoccupation of the team with financial aspects, it has almost totally omitted some key considerations related to public health practice. Interestingly, if the team had used an epidemiological approach to community diagnosis and solution to a community health problem, the concept of natural history of a disease in an individual would have almost logically led it to the identification of the strategic points in the natural history where intervention in the form of an optimised package of programmes would have yielded the maximum returns from a given investment. This would have been particularly relevant because of the team's deep concern about communicable diseases and about women's health.

(5) *The National Health Policy of 1982:* This important document has received virtually no attention in the report. This is surprising, because an analysis of the factors which came in the way of its implementation would have provided valuable leads to the team. The NHP strongly endorsed the principles embodied in the Alma-Ata Declaration, including the key issues of community self-reliance and decentralisation of health administration to promote it. An interesting point stressed in the document was to "bridge the cultural gap that exists between the providers of the health services and the community".

(6) *Management of Health Services:* This is by far the most critical, because the managers and their political leaders are key elements in policy formulation and its implementation. Even though the team's Indian contacts were predominantly secretaries, commissioners and joint secretaries at the centre and in the states, it did not strike them that most of them were literally not fit for the job. They lacked the public health competence needed for policy research, because as generalist administrators, their posting in a health ministry is a mere episode in their long career span, which takes them to many other ministries. So, they cannot be held accountable either. The team does not seem to be aware that some 15 years back India had a competent cadre of public health physicians, with long experience in policy formulation and public health practice. This heritage is now lost. Along with the domination of the generalist administrators, there are many key public health positions at the centre and in the states which are filled by physicians who do not have the needed qualifications and training [Banerji 1990b: 91-99]. One reason for the present crisis among the physician-administrators is the nature of the cadre structure, which does not have a clear-cut career plan for the making of physicians who have the managerial, epidemiological, sociological and political competence (managerial physicians) to effectively deal with questions of health policies and programmes. Besides, the relatively 'inferior' positions given to even top technical persons in comparison with the generalist administrators of corresponding seniority has its deleterious impact on the morale of the health workers [Banerji 1990b: 143-50].

The responsibility for the present state of affairs rests squarely on the political leadership, because all the decisions which have precipitated the present crisis were taken with their active consent [Banerji 1990b: 143-50]. The macabre slashing of funds in the 1992-93 budget is an example. Here the finance minister acts even holier than the pope. The donor agencies asked for a pound of flesh as a price for their 'help'; the finance minister insisted on giving them two pounds of flesh! While pampering the rich by making massive reductions in excise and customs duties, the finance minister did not show any mercy for the poor. He allowed them a free fall, steadfastly refusing the offer of a safety net by the kind-hearted donors (p xii)!

(7) *Impact of the Family Planning Programme:* The team has not done justice to the analysis of the damage done to the infrastructure of the health services as a result of according the highest priority to the target-oriented, time-bound family planning programme. Ironically, the damage was maximum in the regions where the infrastructure was weak.

(8) *Consequences of Imposition of Internationally Sponsored Health Programmes:* The Universal Immunisation Programme sponsored by the UNICEF, the WHO and other international and bilateral agencies was brought in as another target-oriented, high priority pro-

gramme. As in the case of family planning, it further pushed down other rural health programmes in the order of priority [Banerji 1990a]. Tragically, the programme was very poorly designed, but the Indian health administrators were in no position to recognise this. Worse still, even when a review [Gupta and Murali 1989] showed conclusively that it had miserably failed in attaining the objectives set for it, the programme was pursued nevertheless and claims continued to be made about its remarkable 'achievements' [Banerji 1992a]. The National AIDS Control Programme promoted by the World Bank also suffers from a number of infirmities [Banerji 1992a]. It is still being pushed nevertheless. These are glaring instances of how international politics works in a country like India. Is the current World Bank team a harbinger of yet another international initiative? The loan-intoxicated finance minister has again welcomed such an initiative with open arms. This is another facade to obscure the plight of the wretched poor.

Taking into account the crisis generated by structural adjustment, the World Bank team has set out to offer an alternative policy frame to cushion its impact on the health services. By making it more efficient and equitous, the team attempts to convert the crisis into an opportunity. However, by choosing health financing as a tool for policy analysis, it has arrived at highly questionable conclusions. Health financing is one component of health economics, which, in turn, is a component of the wider field of health systems research which is based on inter-disciplinary studies to optimise the highly complex health service system or its smaller components. This 'upside down' study has led the team to advocate a lacerating vivisection of a live organisation which has been so painstakingly nurtured and build up over more than six decades. An astonishing feature of the report is that it does not take into consideration the powerful political and socio-economic forces which are critical for conducting a policy analysis. Other critical inputs for health service developments, such as social science inputs, epidemiological analysis, public health competence of the key decision-makers in India, the damage caused to the health services by imposition of vertical programmes like the target-oriented time-bound family planning programme and Universal Programme of Immunisation, are missing. The team calls for still greater centralisation of health services at a time when the country has opted for a major programme of decentralised administration. This is not a policy alternative the country can look forward to.

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AN APPRAISAL OF THE IMPACT OF EIGHT YEARS OF NATIONAL HEALTH POLICY

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AN APPRAISAL OF THE IMPACT OF EIGHT YEARS OF NATIONAL HEALTH POLICY

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Introduction

Based upon the framework indicated by the Bhore Committee, the government of India, over the last four decades have embarked upon the process of development of health infrastructure, so that Primary Health Care services are made available as near the people as is possible.

Though the initial emphasis was on the development of basic health services, several individual disease oriented programmes have been given importance in view of the higher prevalence resulting in high morbidity and mortality among large sections of population. In the long run, this strategy of simultaneous encouragement to vertical health programmes has contributed to the non-development of health infrastructure for the delivery of comprehensive and integrated basic health services. This strategy also has taken away the much needed resources - men, material and money, from the health services.

Several Committees like the Health Survey and Planning Committee, the Chadha Committee, the Mukherjee Committee, the Jangalwalla Committee, the Kartar Singh Committee, and the Srivastav Committee have emphasised the role of Primary Health Care and suggested various mechanisms for achieving the same. It was not until the eighties that any concerted attention was paid to the meaningful development of infrastructure. The AlmaAta declaration, the ICMR/ICSSR Committe report, the Working Group of Ministry of Health and Family Welfare, the successive Twenty-point programme have all focussed attention on the need for development of comprehensive and meaningful health services nearer the door steps of the households.

In this back-ground, the National Health Policy of 1982 can be regarded as the first conscious effort of the Government for laying down a policy frame for achievement of a reasonable level of health service in the community. The National Health Policy while reiterating the major issues highlighted in the twenty-point programme and major recommendations of the Working Group of Ministry of Health has laid down certain specific guide-lines.

A policy is not static and does not stand still. It is dynamic and is prone to constant change. The policy is formulated in the context of changing goals, shifting environments and varying situations. Seckler-Hudson regards it as a 'moment in a process'. Policy formulation is a continuous oblication and the re-formulation of policy in the light of experience is as important as its formulation., In the words of Gladden, four different levels in the policy making may be distinguished: "(1) Political or general policy framed by the parliament, (2) executive policy framed by the Cabinet, (3) administrative policy, that is, the form in which the administrator carries out

the will of the government, and (4) technical policy, that is, the day-to-day policy adopted by officials in the working out of the administrative policy."

A policy is only a guideline. Its efficiency and success will depend upon the speed and energy with which it is implemented. It will also depend upon understanding of the same at various levels of political, administrative and technical hierarchy. The constitution, the legislature, the Cabinet, have to a certain extent, done job in giving a policy direction. The advisory role of planning commission, advisory committees, working groups, task forces, pressure groups, political parties, professional association and the press will have to play a vital role in focussing attention on specific issues in policy and should point out the lacunae, if any, and help in remodelling the policy if needed.

The technical and the bureaucratic wings should understand the spirit and content of the policy and help in wide dissemination of the content. They should also set an example by implementing the policy in right earnest and taking it to a logical condusion to enable the benefits reach largest section of the populations in the quickest possible time.

Professional bodies and associations like Indian Medical Council, Indian Medical Association and the Voluntary Health Association of India have an important role to play by disseminating the information and acting as an interface between the Government and the community as well as by playing the role of advocacy etc.

The present conference would have played a more than a useful role if it can focus attention on some of the key issues in the implementation of National Health Policy.

I now propose to examine some specific issues in terms of their impact and current status.

FOLLOW-UP OF NATIONAL HEALTH POLICY

1. Development of Health Infrastructure

The Health Policy envisages a phased time-bound programme of well dispersed comprehensive Primary Health Care services giving priority to tribal and hilly areas as well as to vulnerable sections of society. Improvement of health status for facilitating the achievement of reasonable level of health; knowledge and simple skills and technology are to be transferred to health volunteers. The existing health personnel are to be re-oriented for the integrated delivery of primary health care. The siting of the curative centres is to be related to the population they serve. For higher levels of medical care the health policy wanted a good referal system to be built up.

Now let us take a look at the development of health infrastructure in the country.

a. Hospitals and Dispensaries

	Hospital	Dispensary	Total
Government	4042	10845	14887

Local Bodies	292	3071	3363
Pvt. and voluntary	5497	13579	19076
Total	9831	27495	37326
Hospital population ratio	.. 1:1351		

b. Hospital and Dispensary beds

	Hospital beds	Dispensary beds	Total beds
Government	390552	18987	409539
Local Bodies	20220	2672	22892
Pvt. and voluntary	175117	2187	177304
Total	585889	23846	609735
Bed population ratio	.. India - 1:1426		
	UK - 1:127		
	USA - 1:171		

c. Doctor population ratio

India - 1:2600
UK - 1:711
USA - 1:750

d. Nurse population ratio

India - 1:4564
UK - 1:207
USA - 1:190

e. Rural infrastructure

		Required by 2000 AD
Community Health Centres (1,00,000 pop.)	1253	7650
Primary Health Centres (20,000 - 30,000 pop.)	14609	25500
Sub Centres (5000 pop.)	102674	255000
Village Services	387472	765000

f. Tribal health infrastructure

	Required	In position	% short fall
Primary Health Centres	3322	1792	53.94
Sub Centres	21948	12610	57.45

This is a priority item as stated in the Health Policy. Roughly a decade after the policy we still have only 50% coverage in this item.

It is very obvious that we have taken a quantum jump in the matter of laying down the health

infrastructure. This lead is not supported by improvement in quality of the services provided. Though comprehensive job descriptions have been laid down for various levels of health functionaries, due to operational inefficiency, the quality of care at their hands is continuously suffering. The chief problems contributing to the poor quality are inadequate pre-service and in-service training, bad and ineffective supervision, inadequate direction from the higher-ups, lack of managerial capability of medical officers, political interference, lack of resources, rigid administrative control, red tapism etc.

Even though every committee from the Master Plan onwards have talked of the need for building up of a referal system, not much has been achieved in this sphere. Inadequate planning, aided by poor communication and transportation facilities at times of need, non development of health records, and non-attachment of the families to an identified institution for first contact and building up of referal chain from that point onwards are the chief problems that have to be tackled in this arena.

It appears that greater attention should have been paid to location planning and site selection of health facilities that have been and are being established.

2. Control of Communicable Diseases

The Health Policy envisages establishment of nationwide chain of sanitary cum epidemiological stations and an organised programme for building up fundamental and basic research in problems like blindness, leprosy and tuberculosis.

The current status of the various communicable diseases are as under:

Tuberculosis - **currently** 9 lakhs cases
(Prevalence 15 to 25/1000 pop.)

Leprosy - **currently** 40 lakhs cases
(prevalence 13 to 19/1000 pop.)

	Cases/lakh	CFR
Whooping cough	21.12	0.02
Tetanus	4.28	12.32
Measles	191.05	0.34
Polio	2.72	2.14
Malaria	2.2 (1987)	API-2.2%
Filaria estimated	3.0 million (342 M population are at risk)	
Guinea worm	1.10	0.08
Diarrhoeal diseases	1281.95	0.09
STD	117.83	-
Rabies	13.30	0.69

As regards tuberculosis there is poor case identification consequent to the policy of case detection by sputum microscopy. Even if 100% efficacy is ensured in exhausting all the available sputa in the community only 25% of the prevalence can be detected. The remaining 75% are in

the early stages before tissue breakdown could occur.

As regards leprosy, I feel it is too pre-mature to claim reduction in the case load and attribute the success to the multi drug therapy programme in a mileu where the portal of exit, the portal of entry, the incubation period, the immunological deficit and the assured efficacy of the regimen followed are not very well understood.

Elsewhere I have made a plea, on the need atleast now, to build a base-line so that we can compare the effect of the Universal Immunisation Programme on the six-killer diseases. It is not late even now, to embark upon a systamatic survey using the existing health infrastructure to gather vital information regarding the incidence of these diseases.

The current tempo of educational activities is expected to have some impact on the prevention and cure of the diarrhoeal diseases. With the possible continuance of the same socio-economic conditions and the state of environmental sanitation any appreciable reduction in these diseases may be too much to expect.

The prevalence and incidence of non communicable diseases like mental disorders, diabetes, hypertension, heart attacks and cancer instead of showing any decline is showing upward trend not only because of increase in exciting factors but also because of increased tempo in case detection and better awareness among the massess. The gap between anticipation and achievements which is very likely to be more in the coming decades will certainly contribute to the occurrence of these diseases in greater numbers. It is alarming to note that these diseases are occuring in young individuals as against comparatively older individuals in other countries.

3. Maternal and Child Health

The Maternal and Child Health programmes are being delivered from the sub centres through multipurpose workers (female) mainly and to a certain extent by multipurpose workers(male). Even today 80% of the deliveries are being conducted by the traditional birth attendants. Though figures are being furnished in the matter of Dais trained it is not very clear as to how many of the traditional birth attendants who are practising the profession have been trained.

Scientific data is lacking as regards the impact of the type of antenatal care that is being provided, the so called registration, palpation and auscultation. To my knowledge, identification of high risk mothers and providing them needed services at time of delivery by proper communications and transportation to higher level care will go a long way in preventing maternal morbidity and mortality. The supervisory staff seem to be wasting time in counting the number of antenatal visits which are not made. Certain programmes for MCH care contemplated in the health policy like growing and distribution of low cost nutritious food can be expected to have a good impact if proper supervisory control in equitable distribution to really vulnerable women and children is ensured.

4. School Health

Though the Policy envisages organised school health services, school health examinations are not conducted in the spirit with which the programmes have been organised. A lot of improvement in both the quality and in follow-up is required, for early diagnosis and taking remedial action.

5. Health Information

The Health policy contemplates a nationwide set-up for procuring essential health information. We are singularly lacking in health information as there is no uniform data collection system. Even when information is available, expertise is lacking on the management of the available information.

6. Health Eduction

The Policy says that health education programmes must be backed by communication strategies and adult education and non formal education. To my mind even today this is the most neglected sector. Drawbacks seem to be identification of good and acceptable messages; testing their usefulness; modifying them identifying the means for the delivery; training in the process of delivery; and follow-up of the impact. Though adult and non formal education are useful programmes for health education inadequately trained animators can easily be a source of disinformation.

7. Intersectoral Co-ordination

The Policy lays down the development of intersectoral co-ordination between health, family planning, medical education and research, drugs, agriculture, food, water supply and drainage, housing, education, social welfare and rural development for greater impact of health programmes.

Most of the problems of present inequalities arise from factors outside the scope of health service system. Social and economic factors like income, work, environment, education, housing, transport, and what are today called'life-styles' all affect health and all favour better off and yet these have largely remained outside the national health policy.

There is a greater need for intrasectoral co-ordination before we talk of co-ordination at the inter-sectoral level. There is so much of duplication and lack of information within the health sector.

Co-ordination is required not only in over-all planning but also at the practical level at health centres. Needless to say that health programmes are only a part of the over-all social and economic development.

8. Role of voluntary organisations

Even in the past top level politicians and administrators realising the magnitude of the health problems, vastness of the area and inadequacies of the official effort, have called for voluntary participation in the matter of provision of health services to supplement the governmental efforts.

The National Health Policy has envisaged a key role to voluntary organisations in the two most vital components of health and family welfare programme i.e. population stabilisation and Primary health Care.

8.1 What the VII Plan expects of voluntary sector

The Seventh Five Year Plan has given a pride of place to voluntary organisations. It says, "There has been inadequate recognition of the role of voluntary organisations in accelerating the process of social and economic development. These agencies have been known to play an important role by providing a basis for innovation with new models and approaches, ensuring feedback and securing the involvement of families living below the poverty line. Therefore, during the Seventh Plan, serious efforts will be made to involve voluntary agencies in various development programmes, particularly in the planning and implementation of programmes of rural development. Voluntary agencies have developed expertise and competence in many non-traditional areas to plan their own schemes instead of expecting the Government to do so".

The Seventh Plan suggests the following as the possible roles for voluntary organisation:

i. To supplement government efforts so as to offer the rural poor choices and alternatives.

ii. To be the eyes and ears of the people at the village level.

iii. To set an example. It should be possible for the voluntary agency to adopt simple, innovative, flexible and inexpensive means with its limited resources to reach a larger number with less overheads and with greater community participation.

iv. To achieve the delivery system and to make it effective at the village level respond to the felt needs of the poorest of the poor.

v. To disseminate information.

vi. To make communities as self-reliant as possible.

vii. To show how village and indigenous resources could be used, how human resources, rural skills and local knowledge, grossly rural skills and local knowledge, grossly under utilized at present, could be used for their own development.

viii. To demystify technology and bring it in a simpler form to the rural poor.

ix. To train a cadre of grassroots workers who believe in professionalising voluntarism.

x. To mobilise financial resources from within the community with a view to making communities stand on their own feet.

xi. To mobilise and organise the poor and generate awareness to demand quality services and impose a community system of accountability on the performance of village level government functionaries.

It urges the voluntary organisations to extend their programmes to rural hilly and backward areas. Their role in health education and for spreading rural sanitation was emphasised.

8.2 The Positive lead of Tamil Nadu Government

It must be mentioned that successive Tamil Nadu Governments have been quite progressive in realising the value of the NGOs and in supporting the voluntary organisations involved in several health and welfare activities. They have shown a lead in supporting the voluntary organisations without waiting for approval or a matching grant from the Central Government. They are supporting the mini health centre programme evolved by the Voluntary Health Services. This programme

is not being run by several voluntary organisations throughout Tamil Nadu.

The voluntary agencies depend on government and official agencies for funds, equipment, supplies such as drugs, vaccines, sera and health education materials.

In Tamil Nadu voluntary organisations receive two thirds share promised by the Government under the scheme of financial assistance to organisations running mini health centres. It is distressing to note that due to procedural and administrative bottlenecks several organisations including the Gandhigram Institute of Rural Health were forced to close down their centres and give up the idea of running such programmes, especially when more and more agencies should have come forward to run mini health centres.

Constraints to voluntary work

The bulk of the limited financial support available to the NGO sector is locked into patterns of assistance that are centrally designed. The funding constraints kill the initiative and innovative spirit that are the hallmarks of the most successful NGO efforts. The need for NGOs to secure clearances/recommendations for undertaking programmes and projects from the governmental machinery, most often is a tedious and frustrating process stemming from the lack of understanding and due to adherence to established rules by the lower levels in the administrative ladder.

8.3 Most recent developments

A. Regional review committee meeting

The author was invited to be a member of the Regional review committee regarding implementation of Primary Health Care for Southern States and Union Territories held at Bangalore on February 22-23, 1990. This meeting was convened by the Directorate General of Health Services, Ministry of Health, Government of India and World Health Organization.

The following unanimous recommendations were made at the meeting:

i. "Committed and reputed Voluntary Organisations (VOs) may be involved in the development of primary health care system by handing over certain proportion of infrastructure facilities namely, sub centre or Primary Health Centre along with buildings, funds and staff with relatively more management freedom to VOs/NGOs depending upon their capability of funds, staff etc. after ascertaining their credibility.

ii. Willing VOs may be involved and encouraged to take up the primary health care work in backward areas.

iii. Community must be involved to choose the site of primary health centre(PHC) & sub centres (SC) by involving local youth in particular, in constructive activities. In this direction, Government as an institution should take leading part in involving the VOs and NGOs in primary health care work and not vice-versa.

iv. 2.5% of total health outlay amount be allowed to flow through VOs after assessing their credibility. This percentage may gradually be increased.

v. Voluntary sector may be encouraged especially in areas where the

need is high.

vi. Village level VOs must be involved in infrastructural organization.

vii. Health planning maybe decentralised to States and Districts with due involvement of VOs and NGOs.

viii. Lessons must be learnt from successful VOs/NGOs for evaluation.

ix. VOs/NGOs may also be involved in such training programmes by making use of training materials and journals produced by them."

B. Workshop organised by the Ford Foundation.

I had the privilege of attending a workshop organised by the Ford Foundation a week ago, which was attended by the Union Health Secretary, Advisor to Planning Commission, representatives of the Central Government and voluntary organisations. This workshop has agreed on the following as the roles of voluntary sector:

I. Net working

1. Interface with Government
   a. National level
   b. State/Regional level
2. Linkage with other institutions
3. Roles of intermediary organisations
   a. Networking among NGOs
   b. Clearinghouse (collection / dissemination of NGO experiences) and news letter
   c. Legal advice
   d. Budgeting/accounting
   e. Proposal development
   f. Fund-raising
   g. Information on sources of funding
   h. Technical assistance
      - research
      - management
      - computers
      - social marketing
      - finance
   i. Lobbying/applying political pressure locally
   j. Site visitation coordination

II. Future Role

1. Professionalism and human resource requirements
2. Support services
3. Expanding role of action research education, documentation
4. Place of voluntarism

8.4. Some issues in policy towards voluntary organisations

It is realised that consequent to the National Health Policy the governments are establishing sub centres one each for a population of 4000 to 5000 Primary Health Centres for 30,000 population and Community Health Centres for 1,00,000 population.

The following questions crop up on the role of voluntary organisations in the changing scenario:

i. Should the existing voluntary agencies wind up their innovative experiments and service programmes?

ii. Should no new voluntary effort be made?

iii. Should voluntary organisations refrain from doing any service programmes and concentrates only on community arousal by way of education and motivation?

iv. Should voluntary organisations be only theoreticians taking part in workshops, seminars, symposia, working groups, task forces etc.?

v. Will the government restrain from

opening sub-centres and primary health centres in areas already under the care of voluntary organisations?

vi. Will the Government by suitable orders handover subcentres and primary health centres to accredited voluntary organisations to continue their service programmes and innovative activities? There are precedents in this area.

vii. Will the National Front Government and the DMK Government in Tamil Nadu show the way for a meaningful dialogue at the Central and State levels which should form the basis of the discussion in the Eighth Plan?

viii. Will the new Planning Commission examine the model presented here with particular reference to the four essential requisites for primary health care and resource mobilisation from community?

9. Some key areas for strengthening for a better impact of National Health Policy:

a. Awareness and implementation of Policy.

i. Increased awareness of National Health Policy and its goals down the health hierarchy.

ii. An increased awareness among legislators on the health policy and in health financing as they are the ultimate controllers of the purse strings:

iii. Creation of a committed band of individuals as health administrators, who are wedded to the profession of public health, at various levels.

iv. Introduction of scientific tools in health care management.

v. Net-working along with the voluntary organisations and professional bodies.

vi. Creation of a watch-dog mechanism for over-seeing the implementation of the policy at State and District levels. This mechanism should have an equal share of official and non-official members.

b. Accessibility of the services

Attention will have to be paid to locate the health infrastructure so as to be accessible to all the sections of the community. Today the sub centres and other health facilities are not ideally located. Most of the buildings have been constructed with lack of basic facilities including water supply with the result, the female worker does not find it convenient and safe to live there, so as to be accessible to the community during their hour of need. It is no wonder under such circumstances that 80% of the deliveries are being conducted by the traditional birth attendants most of whom are untrained.

c. Optimisation of work potential of staff

Consequent to the bureaucratic system of functioning and target oriented time bound approach and inadequacies of the supervisory mechanism, a number of records have been prescribed. Several studies have revealed that most of the time of the MPWs is consumed for maintenance of records and in travel. Consequently very little time is available for actual services. They are unfortunately subjected to pressures from both within the community and from outside by the official hierarchy. That is largely due to the gap between the training they receive, which is heavily hospital oriented, and actual job description and job experience at the field level. This disorientation has contributed to the poor quality of work in terms of maternal

and child health care and other prescribed activities.

If health care programmes have to have the desired impact, the optimisation of work potential by suitable studies to analyse the work load and simplification of record system will become absolutely essential.

d. Supervisory Support

Today the supervisory cadre is thoroughly inefficient in carrying out the prescribed duties. The machinery that is existing today for enforcing better quality care does not seem to move and for any programme to succeed supervision of good quality is a must. Somebody remarked that in our country even God requires supervision. The supervisors of the Primary Health Care programme are not oriented to practical supervision. The whole exercise of supervision at various levels is confined to perusal and rather inadequate scrutiny of reports submitted and records maintained without any scope for field verification. Supportive guidance of the staff is lacking consequent to the value orientation, cultural differences pressures of long distance travel, coupled with plurality of programmes and inadequate direction from their own supervisors. This explains the ills of this cadre. Separate training and retraining modules will have to be thought of to correct this unfortunate system.

e. Training and retraining

As already stated the training programmes in the country today at both medical and para-medical levels are not tuned to community health work. Though certain statutory provisions have been made for compulsory services in rural areas, they have indeed failed to generate the necessary enthusiasm. The training is not need based and flexible. The training programmes have to be directly related to the real function in a particular country rather than copy the traditional duties carried out elsewhere in the world. The technical knowledge of trainees must be upgraded constantly by refresher courses and information flow.

The present training of doctors is examination-oriented, clinical and curative in emphasis. While social aspects of diseases are recognised, students are not given experience in community interaction nor a role or responsible leadership of a health team, nor managerial competence; medical colleges have often interpreted community health services as their own outreach operation, rather than as a supportive of the responsibility for the health of a defined population group. This must be immediately rectified.

The same factors operate in the matter of training of paramedical workers. The training is more weighted towards hospital nursing. Only one semester is devoted to community health and two semesters to hospital work in the curriculum of MPW(F). Even during this semester there is no guided programme of community health care. There is a serious shortage of qualified and committed training manpower.

As scientific knowledge is increasing every day it is necessary to keep all the staff engaged in the programme upto date with information. The creation of a machinery is absolutely essential to give orientation training in a systematic manner to every staff member so that each of them receives an orientation atleast once in two or three years.

f. Financing of Health Care

While the Bhore Committee in 1946 recommended an out-lay to the tune of 15% of the total expenditure; the Central Council of Health in 1952 favoured 10% the same

Council in the year 1989 recommended 7%; the financial allocation for the health sector in our country as a percentage of over all public sector out-lay has been between 2.9 to 3.9% in the successive Five Year Plans.

It is understood that the working group on "Health Financing and Management" set-up by the Government of India for the formulation of eighth plan has recommended a minimal raise of allocation for the health sector to 5%.

It might be of interest to note that in United States it is 10.81% of their much higher income; in Australia it is 9.99% Even in Kenya and Mauritius it is more than 7% and in Burma it is 6.96%.

Per Capita expenditure

Calculating the per capita expenditure on health by simple arithmetic is obviously a misleading information. According to Planning Commission the per capita expenditure on health has been 46.23 and on Family Welfare 7.19. As 80% of the health services are in the urban areas, 80% of the expenditure naturally goes to urban areas and a greater proportion of this goes to the maintenance of multimillion, chromium plated, ivory tower institutions.

The following table highlights the per-capita expenditure of Maharashtra State:

Total	- Rs.156 million	
3 cities: Bombay	- Rs.14.6	
Poona	- Rs.12.17	80.0%
Nagpur	- Rs. 6.09	
District towns		6.2%
Other miscellaneous centres		9.3%
Villages		4.5%

A perusal of the table reveals that in the rural areas a mere 13 paise is available per person.

Break-down of Health Rupee

A perusal of the expenditure pattern indicates that more than 85% of the expenditure goes to maintenance of staff and only 14% goes to drugs. The question that crops up is-how much of this expenditure really results in accrual of benefit and of what kind to the ultimate recipients of the services for whom the entire health hierarchy exists.

Is it possible for the benefits to be quantified in economic terms?

Will a mere increase in the allocation of rupees and consequent increase in the per capita health expenditure result in tangible benefits in terms of reduction of morbidity and mortality? If yes for how long?

The determining factors seem to be minor ailments which keep on recurring, higher threshold for suffering; Low priority to health. What would be the proportional costing of health rupee? Salaries Vs Services/ Benefits, Preventive Care Vs Curative Care.

I am sure that NGOs and Government will rise to the occasion in a spirit of understanding, co-operation, mutual support for the furtherance of the common goal of making health services meaningful to the community especially to the underprivileged in rural areas and urban slums.

The Voluntary Health Services - M.A.Chidambaram Institute of Community Health will be happy to network with any agency in developing an action programme.

INDIA SELECTED HEALTH AND SOCIO-ECONOMIC INDICATORS

Sl. No.	Item	Year of reference	Particulars
1	2	3	4
1.	Population (000) as on 1st March, 1981 Census:--		
	(i) Total		6,85,185
	(ii) Male		3,54,398
	(iii) Female		3,30,787
2.	Decennial Growth Rate (%)	1971-81	25.0
3.	Sex-ratio (No. of females to 1000 Males)	1981 Census	933
4.	Area in Sq. Kms. (000)	1981 Census	3,287.3
5.	Density of Population per Sq. Km.	1981 Census	216
6.	Proportion of Urban Population to total population	1981 Census	23.31
7.	Number of Districts	1981 Census	412
8.	Number of towns*	1981 Census	3,949
9.	Number of Developments Blocks	1980-81 Census	5,011
10.	Number of Villages (inhabited)	1981 Census	5,57,137
11.	Broad Age distribution of population (Percentage to total population) & Age Groups:		
	0-14	1981	39.6
	15-59	1981	53.9
	60+	1981	6.5
12.	Crude Birth Rate (SRS)	1987	32.0
13.	Crude Death Rate (SRS)	1987	10.8
14.	Natural Growth rate (SRS)	1987	21.2
15.	Infant Mortality rate (SRS)	1987	95
16.	Expectation of life at birth--		
	Persons	(1986-91)	58.6
	Male		58.1
	Female		59.1
17.	No. of Medical Colleges	1987-88	125**
18.	No. of Hospitals and beds	1-1-1989	
	(i) Govt	Do.	4,504/4,21,025
	(ii) Private	Do.	5,641/177,034
	(iii) Total	Do.	10,145/5,98,059
19.	Area Served per hospital (sq. Kms.)	1-1-1989 (Range)	(19-491)
20.	Population served per hospital	Do.	(14,236-1,27,000)

21.	Population served per bed.	Do.	(775-2,540)
22.	Hospital beds per 1000 population	1-1-1989	0.74
23.	No. of PHCs	31-12-1988	16,756
24.	Number of Sub-Centres	31-12-1988	1,12,004
25.	Number of Community Health Centre	31-12-1988	1,468
26.	Number of Doctors (registered with Medical Council of India) . .	1988	3,31,630
27.	Number of Registered Nurses (with Nursing Council of India) . .	1987	2,19,299
28.	Plan outlay on Health Family Welfare and Water Supply etc. (Rs in crores)	1988-89	3,168.42
29.	Per capita expenditure on Health and Family Welfare (Rs.) .	1986-87	53.06/7.31
30.	Proportion of Scheduled Castes & Scheduled Tribes population to total population	1981 Census	
	(i) Scheduled Castes		15.75%
	(ii) Scheduled Tribes		7.76%

**Included 19 unrecognised Medical colleges.

*Excluding Assam.

@Quick Estimation.

Source: Health Information 1989
CBHI, DGHS New Delhi

GOALS FOR HEALTH AND FAMILY WELFARE PROGRAMMES IN TERMS OF 'HEALTH FOR ALL' BY 2000 AD

Sl. No.	Indicator	Current Level	Goals		
			1985	1990	2000
1	2	3	4	5	6
1.	Infant Mortality Rate				
	Rural	104 (1987)	122		
	Urban	61 (1987)	60		
	Combined	95 (1987)	106	87	Below 60
2.	Perinatal mortality	53.8 (1985)			30-35
2.(a)	Crude Death Rate	10.8 (1987)	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	58.1 (1986--91)	55.1	57.6	64
Female	59.1 (1986--91)	54.3	57.1	64
6. Babies with birth weight below 2500 gms (percentage)	30	25	18	10
7. Crude birth rate	32.0 (1987)	31	27.0	21.0
8. Effective couple protection (Percentage)	39.9 (March, 88)	37.0	2.0	60.0
9. Net Reproduction Rate (NRR)	1.48 (1981)	1.34	1.17	1.00
10. Growth Rate (annual)	2.12 (1987)	1.90	1.66	1.20
11. Family size	4.4 (1975)	3.8		2.3
12. Pregnant mothers receiving ante-natal care (%)	60 (1988)	50--60	60--75	100
13. Deliveries by trained birth attendants (%)	40--50 (1988)	50	80	100
14. Immunizations Status (%) cover-age TT (for pregnant women)	86.3 (1987--88)	60	100	100
TT (for School children) 10 Years	88.7 (1987--88)	40	100	100
16 Years	86.45 (1987--88)	60	100	100
DPT (children below 3 years)	96.0 (1987)--88)	70	85	85
Polio (infants)	83.5 (1987--88)	50	70	85
BCG (infants)	94.3 (1987--88)	70	80	85
DT (new School entrants 5--6years)	87.5 (1987--88)	80	85	85
Typhoid (New school entrants 5--6 years)	62.6 (1987--88)	70	85	85
15. Leprosy-percentage of disease arrested cases out of those detected*	20 (1988-89)	40	60	80
16. TB percentage of disease arrested cases out of those detected	62 (1987--88)	60	75	90
17. Blindness-Incidence of (%)	1.4 (1987--88)	1	0.7	0.3

Note: Cases cured after 1983, out of the 4 million estimated Leprosy cases

Source: National Health Policy--1983

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Original Article on Health Policy and Underdevelopment

THE MANDWA PROJECT: AN EXPERIMENT IN COMMUNITY PARTICIPATION

Noshir H. Antia

The project at Mandwa was designed to study the problems of health in rural India and the delivery of health care by the existing public and private health systems. The results demonstrate the important role of socioeconomic and political factors not only in vital areas such as nutrition, water supply, sanitation, and housing, but also in the delivery of health services. The private sector showed a predominantly curative and monetary orientation, while the public sector demonstrated a lack of accountability to the people it was designed to serve. Under these conditions, an attempt was made to test the possibility of training local women in self-help with a minimal supportive service. The results reveal that adequate knowledge and technology exist for most of the prevalent problems of health and illness in developing countries, and that semiliterate villagers have the capacity to use these effectively if they are provided in a simple manner. This experiment also demonstrates the opposition from local vested interests to any change of the status quo, even in the relatively noncontroversial field of health.

INTRODUCTION

In 1947, a newly emergent independent India resolved that the benefits of development, inclusive of health, henceforth would reach all our people and not be restricted to a select few. In their enthusiasm for rapid advancement and modernization during the prevalent postwar euphoria of science and technology, it was not unnatural that our leaders, many of whom had received their education in the Western tradition, opted for the ad hoc adoption of the Western model for the country's development. To them, modern science and technology provided the necessary means to leap from the bullock cart to the jet age.

Unfortunately, unlike Gandhi, distanced from the masses the leaders failed to appreciate the socioeconomic and above all the cultural problems that this would involve. If any shortcuts were to be tried, the regimented discipline and hardships of a closed society would have to be borne by the leaders as well as by the people. Instead, while adopting the planned approach of the socialist countries, they sought to achieve their goals through a "mixed economy" with ample room for the free play of market forces. This "free" or what may be more aptly termed "free for all" approach has resulted in a patchwork type of development that has chiefly benefited the upper two deciles while 50 percent of the population continues to remain below the poverty line.

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Table 1

Health status: India and China[a]

	India		China	
	1960	1983	1960	1983
Per capita GNP (US$, 1981)	–	260	–	300
Life expectancy at birth (years)	43	55	41	67
Infant mortality rate (per 1000 live births)	165	110[b]	165	39[b]
Child mortality rate (per 1000 population aged 1–4 years)	26	11	26	2
Crude birth rate (per 1000 population)	44	34	39	19
Crude death rate (per 1000 population)	22	13	24	7
Adult literacy rate (percent, 1980)[c]	28	36	43	69

[a]Source (except as noted below): World Development Report 1985, World Bank.
[b]From UNICEF, State of the World's Children 1982–83.
[c]From World Development Report 1983, World Bank.

This is the result of a lack of accountability and remarkably poor performance by the public sector and a highly exploitative private sector devoid of the trusteeship concept of Gandhi. The performance of the health sector can only be appreciated in the context of the overall political economy of the country. Unfortunately, the medical profession working in splendid isolation has failed to perceive health in its wider perspective and hence been unable to diagnose what ails the people as well as itself.

India has always had a rich tradition of its own indigenous systems of medicine which has been a part of the health culture of its people. But it is the allopathic system that has dominated the health scene since independence. This was partly because it was a legacy of the British Raj and as such had been adopted by the local elite, and also because of its inherent superiority in the relief of acute illness, the treatment of communicable disease, and the use of surgery.

In 1947, India had 15 allopathic medical colleges and 47,500 doctors trained in the Western system of medicine. It was also fortunate in having in the Bhore Committee's report (1) a document of unrivaled clarity which analyzed in great detail the problems of delivery of health services to the common person in a country with a large and predominantly rural population and with limited financial resources. The report contains the original concept of primary health care, of which we hear so much today, with a clear advocacy of a decentralized service based within the local community and involving the people in their own health care.

Considering all the facts, it is not surprising that the founding fathers of our nation placed the responsibility for the planning as well as the operation of our health services entirely on the shoulders of the allopathic medical profession.

Four decades later, we realize that though there has been considerable improvement in the health status of our people as measured by the increase in life span and fall in

Table 2

Comparison of Punjab and Kerala[a]

	India	Punjab	Kerala	Target for 2000 A.D.
Birth rate (per 1000)	33.9	30.3	26.0	21.0
Death rate (per 1000)	12.5	9.4	6.9	9.0
Infant mortality (per 1000, 1980)	114	89	40	<60
Per capita income at current prices (Rs.)	1758	3164	1447	
Female literacy (percent)	24.7	34.1	64.5	

[a]Source: Government of India. *Health Statistics of India.* Ministry of Health and Family Welfare, New Delhi, 1984.

infant mortality (IMR) and crude death rates, statistics have also shown (Table 1) that our achievements have fallen far short of our expectation. This is especially true when we compare India with China, a country that gained independence in about the same period and has similar and probably much greater problems to overcome.

Even in our own country, the differences between the poorest state of Kerala (before the Gulf boom) and the richest state of Punjab are remarkable, as shown in Table 2. Even though Kerala received the same health services as the other states of India, the health of its population has already reached the targets set for the rest of the country for the year 2000 AD.

It is evident from the above figures that the health of the people does not merely depend on the income level of the people or medical services; the Punjab per capita income is 2.4 times that of Kerala. John Ratcliffe (2) has attributed the success of Kerala on the health front to mass education and political will. Education, especially of women, is probably the most important factor in improving the health of the family and community. The causes for the inadequacies of the health services have been examined in detail in the 1980 joint report of the Indian Council of Medical Research (ICMR) and the Indian Council of Social Science Research (ICSSR) (3). These causes have also been remarkably well summarized in the government's own statement of its National Health Policy of 1983:

> The demographic and health picture of the country still constitutes a cause for serious and urgent concern. 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. . . . 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 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 of 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 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 the implementation and management of the various health and related programmes.

It is evident that the failure to deliver health care, especially to the rural poor who form the majority of the population, is the result of a lack of professional and political will to look after the underprivileged and share the benefits of development; this is no different from the other fields. Despite protestations to the contrary, the chief beneficiaries of such a system are those who are supposed to deliver the goods. Welfare, including health care, has become another large and profitable business.

Two decades in the public as well as the private sector were more than adequate to convince the author that the medical profession had neither the desire nor the training and capability to deliver health care to our people. Even the sophisticated urban services, which were chiefly monopolized by the elite, left much to be desired, for in the absence of a generalized scientific culture and with an archaic administrative infrastructure they generally ended up as poor imitations of their Western role model and often only a caricature. Even worse, I was convinced that those of us educated in urban medical colleges were totally unaware of the actual problems of health and disease of the common person in our own country, even in the urban slums let alone the villages. What we saw and learned in big hospitals was only the tip of the ice-berg, as represented by the few "interesting" cases of advanced pathology that reached us, often in extremis. The emphasis of medical training was almost entirely on cure and not prevention.

PLANNING OF THE MANDWA PROJECT

Being an observer as well as a part of this scene, I made a decision in the early 1970s to try to understand the actual problems of the health of our people and, if feasible, to explore new avenues whereby the benefits of modern medical science could reach the common person. Since 80 percent of the population of the country is rural, a community comprised of 30,000 population distributed in 30 villages across the harbor of Bombay was chosen for the study, now popularly known as the Mandwa project. Though only 15 kilometers by sea from the great metropolis with all its sophisticated medical services, Mandwa represented a typical undeveloped rural community along the coastal belt of Western India with hardly any worthwhile medical services.

The first two years were spent in trying to understand the problems of health and disease of the people by meeting, observing, and discussing these problems with the people and their leaders in the villages. Also, we observed the functioning of the

Primary Health Centre,[1] which was located 40 kilometers away, and of the District Hospital with 250 beds, which was at a distance of only 20 kilometers. The findings of this exploratory phase can be summed up as follows:

1. The village is as much a stratified community as is the city. The interface between the village and the external world is a few "leaders" who exert financial as well as political control and are the self-appointed trustees of the silent majority, which is virtually unapproachable without going through this local power structure.

2. Health, and especially the preventive aspects, is of little significance to the vast majority whose main preoccupation is to provide the next family meal. Even illness and pain are not adequate reasons to seek medical aid unless they interfere with earning the daily bread. Early detection of disease and regularity of treatment, let alone prevention, were a luxury the villagers could ill afford. What they sought was quick temporary relief, which was provided by the doctor in the form of an injection of a broad spectrum antibiotic and analgesic, a bottle of tonic, and injection of vitamin B complex to which they were now hooked.

3. The commonest problem was malnutrition, which together with the lack of water supply and hygiene and the tensions of survival took an extraordinarily heavy toll on the health of the population. Yet the extensive load of chronic ill health was considered only as the norm.

4. Despite their poverty, villagers incurred considerable expenditure in emergencies such as obstructed labor, accidents, or terminal stages of dehydration, often by resorting to the moneylender.

5. The Government Primary Health Care service was virtually nonexistent despite the two subcenters and a dispensary with 10 beds in the area covered by this project. The doctors and nurses, when available, were concerned only with curative services which chiefly favoured the leaders. They often charged the poor for services despite drawing a nonpracticing allowance. Family planning was the only program that was implemented with any regularity in order to reach the stipulated government targets; the coercive measures employed were generally resented by the population, who associated the Primary Health Care services solely with population control.

6. The services of the not too distant district hospital were of limited use because of lack of adequate transport and the cost of travel.

Despite this dismal picture, there were some hopeful signs that provided a silver lining to an otherwise depressing scene. First, though illiterate and oppressed, the people showed remarkable practical ability and intelligence in making the best use of the meager resources available to them. Second, the prevalent diseases were chiefly of a communicable nature, their diagnosis required elementary medical knowledge and skills, and appropriate medical technology was readily available. Besides being remarkably simple, the technology was also cheap and highly effective as well as safe, both for prevention and cure.

[1] A Primary Health Centre (PHC) is the basic unit of the government for primary health care as well as for the National Disease Control programs. The present PHC caters to about 30,000 population and has two doctors, two multipurpose paramedical workers, and one Health Guide (HG) for every 1,000 population.

We realized that instead of employing the usual anatomical and pathological classification, if the diseases were graded according to the knowledge, skills, and technology required for their diagnosis, prevention, and treatment, it provided a very practical and an entirely new approach to their management. Broadly speaking, the problems fell under the following four categories:

Group I. Minor illness and minor injuries that have traditionally been looked after adequately by the people themselves with local folk remedies.

Group II. Diseases that are responsible for a great deal of morbidity but do not endanger life, e.g., scabies, worms, minor gastric upsets, and simple diarrhea.

Group III. The major killing and maiming diseases of the developing world such as tuberculosis, tetanus, dehydration due to severe diarrhea, dysentery, measles, acute respiratory infections, poliomyelitis, and leprosy.

Group IV. Conditions such as cancer, heart disease, stroke, major trauma, and those requiring surgical assistance.

The problems in any one group, especially if not treated in time, could escalate to the next in a few instances, but as a rule, groups I to III required simple skills for diagnosis or suspicion of the disease, and the majority of diseases could be prevented by simple measures, often by the community's own action. Cheap, simple, safe, and effective treatments were also available for all of these diseases.

In view of this and the fact that there was no hope of delivering the available technology provided by modern medical science under the existing system, we thought it reasonable to explore whether the villagers themselves could be taught the simple medical skills and how to make use of the equally simple available tools to look after their own health problems to the extent possible. We also thought it reasonable to teach them how to use the available medical services and demand what was their due.

In the absence of any precedent, the evolution of the Mandwa project was through a series of trials and errors. This experiment in self-help was explained to the local village leaders (*sarpancha*) who were presuaded to help select a woman from each village for training. Experience reveals that motivation should be the single most important criterion in selection of such part-time health workers and that every village can identify a few such individuals. Since most were semiliterate, training was conducted in an informal manner in the form of weekly discussion groups in the villages themselves.

The training was of an entirely practical nature and under conditions in which the health workers would eventually work. Hardly any teaching aids were employed. The village well, the pregnant woman, and the people who were ill in the village provided adequate material for practical demonstration. The germ theory was taught using the magnifying glass and simple school microscope to examine water from the local well, smears from lepromatous patients, and sputum of those suffering from tuberculosis. The major problem was finding teachers among the professionals who could convert complex theoretical knowledge into simple and practical knowhow, and above all, could overcome their cultural barriers and learn to differentiate between intelligence and education and to respect the highly practical approach of simple village folk as

opposed to their own impractical theoretical education. It was also difficult for the urbanized doctor to adjust to the slower pace of the village.

Despite the payment of a salary equivalent to and even higher than that of the doctor of the government Primary Health Centre, it was virtually impossible to attract a suitable candidate. Most doctors did not believe that a village woman could possibly acquire knowledge on health when it takes two to five years to train a paramedic or a doctor. At best it was considered dangerous practice, and at worse an attempt at institutionalizing quackery. The arduous task of spending most of the day on a motor-cycle visiting villages rather than running a traditional static outpatient service, combined with absence of payment from the patient, was a further disincentive. The only doctor who was prepared to work continuously was a young ayurvedic physician, the son of a local fisherman. Though poor in medical skills, he was acceptable to the people for he belonged to their community.

Finding suitable nurses and even Auxiliary Nurse Midwives (ANMs) posed a similar problem with a high turnover.

The staff of the project consisted of a doctor trained in ayurvedic medicine, an administrator trained in social science with three helpers (to maintain accounts and records and to undertake statistical analysis and the purchase and distribution of medicines to the subcenters), five ANMs, and 27 Village Health Workers (VHWs). Except for the senior administrator, all were local personnel. A small health center was established with 10 beds (used chiefly for maternity cases and for tubectomy operations). The cost of such a service (not accounting for the research inputs) was approximately Rs.6/- (rupees) per capita per annum in 1980 compared to the all-India average of Rs.30/- (4). Of this sum, the cost of medicines could be recouped from the patients.

RESULTS OF THE MANDWA EXPERIMENT

Let us now examine what semiliterate women could achieve in their community with such simple instructions and a very elementary referral and support system without an associated program of economic development or inputs into nutrition, watersupply, sanitation, and improvement of environment. It took about three years to establish the project and for the VHWs to gain the necessary confidence. The effective period of the project was from 1977 to mid-1983 which was followed by a period of turmoil until its closure in January 1984. It was interesting to note that with increasing experience, many of the VHWs surpassed the ANMs in their effective role in the village and they replaced all the ANMs at the subcenters during the last three years of the project. The VHWs also undertook the giving of injections for immunization as well as streptomycin to patients suffering from tuberculosis.

A preliminary survey of the area was undertaken by the Tata Institute of Social Sciences, which revealed that the health and economic situation of this area was no different from that of the country as a whole and hence the national statistics have been used as the baseline. Table 3 shows some of the figures for Mandwa compared to the national figures.

It should be noted that all activities were carried out through individual VHWs on a routine daily or weekly basis, including immunization of children and pregnant

Table 3

Achievements of Mandwa

	Mandwa project 1982	National figures 1982
Birth rate (per 1000)	15	33.3[a]
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Triple antigen	92	25[b]
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mothers, family planning operations, and detection of leprosy. No camp or mass approach was used.

Immunization. The high rate of immunization was achieved only after ANMs were replaced by the VHWs, for this assured regularity and undivided responsibility. This, with improved hygiene at delivery, resulted in the absence of even a single death from tetanus (the second largest cause of death in India) during the entire period of the project.

Leprosy. The number of cases detected by the full-time government leprosy technicians in 12 years prior to the project was 63. The number of cases at the end of the project was 161 and the detection rate of the VHWs was similar to that of the two-year-trained leprosy technician. Moreover, all the cases detected by VHWs were at the early stages of the disease, and with the much improved regularity of treatment there was not a single new case that developed deformity. Since the VHWs visited leprosy and tuberculosis patients in their homes, there was a virtual abolition of stigma and the old deformed patients were reaccepted by their family and community.

Tuberculosis. The rate of early detection was high, and since the patients were given their streptomycin injection at home, the regularity of treatment was ensured, especially because the importance of treatment in preventing family transmission of the disease was explained. Preventive measures such as disposal of sputum were also ensured. It must be stated that the role of the VHWs was to detect suspected new cases and to carry out the treatment as recommended by the doctor after confirmation of diagnosis.

Gastroenteritis. Deaths from dehydration were virtually eliminated by oral rehydration therapy using home-made salt and sugar solutions. More important, preventive action such as cleaning and chlorination of wells and boiling of water prevented the spread to epidemic proportions.

Malaria. Blood smears of fever cases were taken by the VHWs, followed by chloroquine administration. Definitive treatment was provided for positive smear cases and the local community often undertook the spraying of insecticide.

The question naturally arises as to why such a cheap and effective people-based health service, which is in keeping with the recommendations of the country's own Bhore (1) and the ICMR/ICSSR (3) Committees as well as with the National Health Policy (5), fails to get implemented on a nation-wide scale. The answer to this has also been indicated by the Mandwa project.

At an early stage of the experiment, the then Director of Medical Services of the State requested that the project take over the functions of a Primary Health Unit[2] (PHU). The staff sanctioned for a PHU was placed at the disposal of the project administration. This was done with the hope that this experiment would provide a prototype for the development of a similar service on a state-wide basis. Unfortunately, both the district medical personnel as well as the paramedical staff considered this a threat to their comfortable existence, for the community was now made aware of their presence as well as their duties. Not only did they refuse to perform their alloted duties but they took every opportunity to undermine the working of the project. Yet they had no hesitation in claiming credit for the tasks performed by the VHWs, such as detection of cases of malaria, tuberculosis, and leprosy, pre- and postnatal care, immunization of children and pregnant women, and above all, motivation for family planning.

The nine nonallopathic private doctors in the area posed less of a problem, although one doctor who operated a private nursing home prevented the appointment of a VHW from his area. Patients, especially those who could afford it, continued to patronize these doctors for injections, for these were not provided by our service, except for immunizations and tuberculosis. Most of these injections given by other doctors consisted of unnecessary and often dangerous antibiotics such as chloromycetin, analgesics, and vitamin B complex, even for diseases such as the common cold. Interestingly, injections of penicillin or streptomycin or for immunization were seldom employed.

The local leaders, who welcomed us initially, lost interest when they realized that the project was not going to provide a hospital with doctors, nurses, X-ray and pathology facilities, and an ambulance, which in actual fact was their priority. Our repeated pleas to them to form a health committee for the area received little response. The effectiveness of the VHWs varied from village to village. Besides their

[2]It is a "mini" Primary Health Centre with one doctor and other staff set up in areas that do not have easy access to the Primary Health Centre services catering to 30,000 population. The Primary Health Unit (PHU) was a subunit of the old PHC which looked after about 100,000 population.

own ability and motivation, an important factor was the extent of support they received from their village leaders.

Several of the leaders resented the fact that the project succeeded in reaching the poor in their villages while bypassing them, thus arousing fear of an alternative power structure and an attitude of self-reliance developing among the poor. The health professionals were quick to seize this opportunity to drive a further wedge between the project staff and the local leadership.

Despite the fact that the poor and even some of the leaders accepted the project services, the local power structure dominated by the richer and more powerful leaders joined hands with the government health personnel in open hostility and demanded that the project leave the area, handing its assets to them. Their object was achieved after threats and a show of open violence to the project staff.

The question arises as to why the beneficiaries, namely the poor, who formed the majority of the population did not actively oppose this threat. The answer lies in their abject poverty and dependency on the local power structure for their survival. Health is not a priority in their daily life.

Summary

The findings from the Mandwa experiment may be summarized as follows:

1. Modern medical science and technology have provided us with the knowledge as well as the tools for the prevention and treatment of the vast majority of the diseases that affect the people of the developing world.

2. This knowledge and technology is remarkably effective though simple, cheap, and safe.

3. Semiliterate and even illiterate village women have the capacity to absorb this knowledge and use the technology if this is made available to them in a simple and acceptable manner.

4. The role of the professionals is to impart such knowledge, encourage self-help, and provide graded supportive services for problems requiring greater skills and/or facilities. It is not their role to appropriate functions that the people themselves can undertake.

5. Health at this level, at which almost 80 percent of all problems can be tackled by the people themselves, requires low technology but high cultural affinity with the people.

6. The local village women are therefore more suitable for tackling these problems than more highly trained professionals.

7. The average professional fails to discriminate between education and intelligence. He or she looks down upon the illiterate as being unintelligent.

8. The interest of the professional often does not coincide with the interest of the people; hence the appropriation of peoples' health by a process of secrecy and mystification.

9. Health professionals generally perceive a well trained VHW as a hindrance or threat rather than a help. This is because the VHWs often demonstrate results superior to those of the professionals, demystify health, and reduce peoples' dependency. This results in loss of practice in the private sector, creates surveillance, and hence brings accountability in a normally unaccountable public sector.

10. Semiliterate village women have demonstrated that in five years they could almost reach many of the targets set for 2000 A.D.—this without any inputs in nutrition, water supply, sanitation, and improvement in environment. They achieved this despite limited supportive services, and opposition from the private as well as public health sector and latterly from their local politicians. Table 3 gives some of their achievements, and all this at the cost of Rs.6/- per capita per annum.

CONCLUSIONS

Mandwa and similar projects merely demonstrate that the ICSSR/ICMR report's recommendations for health at the village level, where the majority of the people live and where the problems lie and should be solved, is not merely fanciful hypothesis.

Why is it then that the experiences of Mandwa and similar projects have remained isolated and have had little impact on the health service of the country as a whole? To the casual observer this is particularly difficult to comprehend when the national policy continues to harp on "Health for All" through primary health care and community participation. Surely it is not lack of finances because these projects are highly cost effective, nor is it due to lack of manpower. Even though part-time VHWs, now known as Health Guides, have been appointed by the government in the majority of our half-million villages with the same objectives and a similar complement of supporting staff and services as at Mandwa, it has had little impact on the general health of our people.

The answer to these questions has also been provided by Mandwa. The extent of opposition to even such a small project from both the health and the local political structures demonstrates the emptiness of slogans such as "Health for All" or "Rural Development." It reveals the true intentions of the power structure and its vested interest in maintaining the status quo, in which a few individuals can dominate the rest of the community. In a democracy, all programs and activities are carried out in the name of the people and especially of the underprivileged. The fact that almost all benefits of development gravitate to the elite reveals the extent of the dichotomy between preaching and practice, and this applies equally to the field of health in both the public and private sector. While there is dissention within the health system and between it and the bureaucracy and politicians, these forces will close ranks if the existing system is threatened by any external agency that may disturb the balance between them and the silent majority on whose presence they thrive.

Only thus can be explained why, almost four decades after Independence, half the population remains below the poverty line, 100 out of every 1000 children die within the first year of diseases such as gasteroenteritis, and diseases for which we have effective measures of prevention and control continue to take their unrelenting toll. Even here, aggregate statistics hide the true reality because improvement in the upper two or three deciles conceals the infinitely higher mortality and morbidity figures in the lowest two or three. Despite a school in every village, about 60 percent of the population and 75 percent of women remain illiterate, when the nexus between female literacy and health is clearly demonstrated by the statistics of Bihar and Uttar Pradesh—IMR > 250—versus those of Kerala—IMR < 50.

It is unfortunate that even the well intentioned members of the medical profession see health as a medical rather than a social, cultural, economic, and political problem. Even with the best of intentions, most of the voluntary agencies with their purely humane approach often help to create an even greater dependency among those whom they serve.

Mandwa can either be seen as a failure of a community health project or as an experiment that demonstrates how knowledge can help people to overcome their fears and encourage self-reliance. Whether this knowledge and technology can be spread through an organized movement or in a nonformal manner or a combination of both remains to be seen. Whether the impact will be only in health or will also, by demystifying the most mystified subject, create the awareness to overcome the sense of abject helplessness and start a process of questioning of the existing order—this also remains to be seen.

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Original Article on Health Policy and Underdevelopment

THE MANDWA PROJECT: AN EXPERIMENT IN COMMUNITY PARTICIPATION

Noshir H. Antia

The project at Mandwa was designed to study the problems of health in rural India and the delivery of health care by the existing public and private health systems. The results demonstrate the important role of socioeconomic and political factors not only in vital areas such as nutrition, water supply, sanitation, and housing, but also in the delivery of health services. The private sector showed a predominantly curative and monetary orientation, while the public sector demonstrated a lack of accountability to the people it was designed to serve. Under these conditions, an attempt was made to test the possibility of training local women in self-help with a minimal supportive service. The results reveal that adequate knowledge and technology exist for most of the prevalent problems of health and illness in developing countries, and that semiliterate villagers have the capacity to use these effectively if they are provided in a simple manner. This experiment also demonstrates the opposition from local vested interests to any change of the status quo, even in the relatively noncontroversial field of health.

INTRODUCTION

In 1947, a newly emergent independent India resolved that the benefits of development, inclusive of health, henceforth would reach all our people and not be restricted to a select few. In their enthusiasm for rapid advancement and modernization during the prevalent postwar euphoria of science and technology, it was not unnatural that our leaders, many of whom had received their education in the Western tradition, opted for the ad hoc adoption of the Western model for the country's development. To them, modern science and technology provided the necessary means to leap from the bullock cart to the jet age.

Unfortunately, unlike Gandhi, distanced from the masses the leaders failed to appreciate the socioeconomic and above all the cultural problems that this would involve. If any shortcuts were to be tried, the regimented discipline and hardships of a closed society would have to be borne by the leaders as well as by the people. Instead, while adopting the planned approach of the socialist countries, they sought to achieve their goals through a "mixed economy" with ample room for the free play of market forces. This "free" or what may be more aptly termed "free for all" approach has resulted in a patchwork type of development that has chiefly benefited the upper two deciles while 50 percent of the population continues to remain below the poverty line.

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Table 1

Health status: India and China[a]

	India		China	
	1960	1983	1960	1983
Per capita GNP (US$, 1981)	–	260	–	300
Life expectancy at birth (years)	43	55	41	67
Infant mortality rate (per 1000 live births)	165	110[b]	165	39[b]
Child mortality rate (per 1000 population aged 1–4 years)	26	11	26	2
Crude birth rate (per 1000 population)	44	34	39	19
Crude death rate (per 1000 population)	22	13	24	7
Adult literacy rate (percent, 1980)[c]	28	36	43	69

[a]Source (except as noted below): World Development Report 1985, World Bank.
[b]From UNICEF, State of the World's Children 1982–83.
[c]From World Development Report 1983, World Bank.

This is the result of a lack of accountability and remarkably poor performance by the public sector and a highly exploitative private sector devoid of the trusteeship concept of Gandhi. The performance of the health sector can only be appreciated in the context of the overall political economy of the country. Unfortunately, the medical profession working in splendid isolation has failed to perceive health in its wider perspective and hence been unable to diagnose what ails the people as well as itself.

India has always had a rich tradition of its own indigenous systems of medicine which has been a part of the health culture of its people. But it is the allopathic system that has dominated the health scene since independence. This was partly because it was a legacy of the British Raj and as such had been adopted by the local elite, and also because of its inherent superiority in the relief of acute illness, the treatment of communicable disease, and the use of surgery.

In 1947, India had 15 allopathic medical colleges and 47,500 doctors trained in the Western system of medicine. It was also fortunate in having in the Bhore Committee's report (1) a document of unrivaled clarity which analyzed in great detail the problems of delivery of health services to the common person in a country with a large and predominantly rural population and with limited financial resources. The report contains the original concept of primary health care, of which we hear so much today, with a clear advocacy of a decentralized service based within the local community and involving the people in their own health care.

Considering all the facts, it is not surprising that the founding fathers of our nation placed the responsibility for the planning as well as the operation of our health services entirely on the shoulders of the allopathic medical profession.

Four decades later, we realize that though there has been considerable improvement in the health status of our people as measured by the increase in life span and fall in

Table 2

Comparison of Punjab and Kerala[a]

	India	Punjab	Kerala	Target for 2000 A.D.
Birth rate (per 1000)	33.9	30.3	26.0	21.0
Death rate (per 1000)	12.5	9.4	6.9	9.0
Infant mortality (per 1000, 1980)	114	89	40	<60
Per capita income at current prices (Rs.)	1758	3164	1447	
Female literacy (percent)	24.7	34.1	64.5	

[a]Source: Government of India. *Health Statistics of India.* Ministry of Health and Family Welfare, New Delhi, 1984.

infant mortality (IMR) and crude death rates, statistics have also shown (Table 1) that our achievements have fallen far short of our expectation. This is especially true when we compare India with China, a country that gained independence in about the same period and has similar and probably much greater problems to overcome.

Even in our own country, the differences between the poorest state of Kerala (before the Gulf boom) and the richest state of Punjab are remarkable, as shown in Table 2. Even though Kerala received the same health services as the other states of India, the health of its population has already reached the targets set for the rest of the country for the year 2000 AD.

It is evident from the above figures that the health of the people does not merely depend on the income level of the people or medical services; the Punjab per capita income is 2.4 times that of Kerala. John Ratcliffe (2) has attributed the success of Kerala on the health front to mass education and political will. Education, especially of women, is probably the most important factor in improving the health of the family and community. The causes for the inadequacies of the health services have been examined in detail in the 1980 joint report of the Indian Council of Medical Research (ICMR) and the Indian Council of Social Science Research (ICSSR) (3). These causes have also been remarkably well summarized in the government's own statement of its National Health Policy of 1983:

> The demographic and health picture of the country still constitutes a cause for serious and urgent concern. 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. . . . 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 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 of 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 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 the implementation and management of the various health and related programmes.

It is evident that the failure to deliver health care, especially to the rural poor who form the majority of the population, is the result of a lack of professional and political will to look after the underprivileged and share the benefits of development; this is no different from the other fields. Despite protestations to the contrary, the chief beneficiaries of such a system are those who are supposed to deliver the goods. Welfare, including health care, has become another large and profitable business.

Two decades in the public as well as the private sector were more than adequate to convince the author that the medical profession had neither the desire nor the training and capability to deliver health care to our people. Even the sophisticated urban services, which were chiefly monopolized by the elite, left much to be desired, for in the absence of a generalized scientific culture and with an archaic administrative infrastructure they generally ended up as poor imitations of their Western role model and often only a caricature. Even worse, I was convinced that those of us educated in urban medical colleges were totally unaware of the actual problems of health and disease of the common person in our own country, even in the urban slums let alone the villages. What we saw and learned in big hospitals was only the tip of the ice-berg, as represented by the few "interesting" cases of advanced pathology that reached us, often in extremis. The emphasis of medical training was almost entirely on cure and not prevention.

PLANNING OF THE MANDWA PROJECT

Being an observer as well as a part of this scene, I made a decision in the early 1970s to try to understand the actual problems of the health of our people and, if feasible, to explore new avenues whereby the benefits of modern medical science could reach the common person. Since 80 percent of the population of the country is rural, a community comprised of 30,000 population distributed in 30 villages across the harbor of Bombay was chosen for the study, now popularly known as the Mandwa project. Though only 15 kilometers by sea from the great metropolis with all its sophisticated medical services, Mandwa represented a typical undeveloped rural community along the coastal belt of Western India with hardly any worthwhile medical services.

The first two years were spent in trying to understand the problems of health and disease of the people by meeting, observing, and discussing these problems with the people and their leaders in the villages. Also, we observed the functioning of the

Primary Health Centre,[1] which was located 40 kilometers away, and of the District Hospital with 250 beds, which was at a distance of only 20 kilometers. The findings of this exploratory phase can be summed up as follows:

1. The village is as much a stratified community as is the city. The interface between the village and the external world is a few "leaders" who exert financial as well as political control and are the self-appointed trustees of the silent majority, which is virtually unapproachable without going through this local power structure.

2. Health, and especially the preventive aspects, is of little significance to the vast majority whose main preoccupation is to provide the next family meal. Even illness and pain are not adequate reasons to seek medical aid unless they interfere with earning the daily bread. Early detection of disease and regularity of treatment, let alone prevention, were a luxury the villagers could ill afford. What they sought was quick temporary relief, which was provided by the doctor in the form of an injection of a broad spectrum antibiotic and analgesic, a bottle of tonic, and injection of vitamin B complex to which they were now hooked.

3. The commonest problem was malnutrition, which together with the lack of water supply and hygiene and the tensions of survival took an extraordinarily heavy toll on the health of the population. Yet the extensive load of chronic ill health was considered only as the norm.

4. Despite their poverty, villagers incurred considerable expenditure in emergencies such as obstructed labor, accidents, or terminal stages of dehydration, often by resorting to the moneylender.

5. The Government Primary Health Care service was virtually nonexistent despite the two subcenters and a dispensary with 10 beds in the area covered by this project. The doctors and nurses, when available, were concerned only with curative services which chiefly favoured the leaders. They often charged the poor for services despite drawing a nonpracticing allowance. Family planning was the only program that was implemented with any regularity in order to reach the stipulated government targets; the coercive measures employed were generally resented by the population, who associated the Primary Health Care services solely with population control.

6. The services of the not too distant district hospital were of limited use because of lack of adequate transport and the cost of travel.

Despite this dismal picture, there were some hopeful signs that provided a silver lining to an otherwise depressing scene. First, though illiterate and oppressed, the people showed remarkable practical ability and intelligence in making the best use of the meager resources available to them. Second, the prevalent diseases were chiefly of a communicable nature, their diagnosis required elementary medical knowledge and skills, and appropriate medical technology was readily available. Besides being remarkably simple, the technology was also cheap and highly effective as well as safe, both for prevention and cure.

[1] A Primary Health Centre (PHC) is the basic unit of the government for primary health care as well as for the National Disease Control programs. The present PHC caters to about 30,000 population and has two doctors, two multipurpose paramedical workers, and one Health Guide (HG) for every 1,000 population.

We realized that instead of employing the usual anatomical and pathological classification, if the diseases were graded according to the knowledge, skills, and technology required for their diagnosis, prevention, and treatment, it provided a very practical and an entirely new approach to their management. Broadly speaking, the problems fell under the following four categories:

Group I. Minor illness and minor injuries that have traditionally been looked after adequately by the people themselves with local folk remedies.

Group II. Diseases that are responsible for a great deal of morbidity but do not endanger life, e.g., scabies, worms, minor gastric upsets, and simple diarrhea.

Group III. The major killing and maiming diseases of the developing world such as tuberculosis, tetanus, dehydration due to severe diarrhea, dysentery, measles, acute respiratory infections, poliomyelitis, and leprosy.

Group IV. Conditions such as cancer, heart disease, stroke, major trauma, and those requiring surgical assistance.

The problems in any one group, especially if not treated in time, could escalate to the next in a few instances, but as a rule, groups I to III required simple skills for diagnosis or suspicion of the disease, and the majority of diseases could be prevented by simple measures, often by the community's own action. Cheap, simple, safe, and effective treatments were also available for all of these diseases.

In view of this and the fact that there was no hope of delivering the available technology provided by modern medical science under the existing system, we thought it reasonable to explore whether the villagers themselves could be taught the simple medical skills and how to make use of the equally simple available tools to look after their own health problems to the extent possible. We also thought it reasonable to teach them how to use the available medical services and demand what was their due.

In the absence of any precedent, the evolution of the Mandwa project was through a series of trials and errors. This experiment in self-help was explained to the local village leaders (*sarpancha*) who were presuaded to help select a woman from each village for training. Experience reveals that motivation should be the single most important criterion in selection of such part-time health workers and that every village can identify a few such individuals. Since most were semiliterate, training was conducted in an informal manner in the form of weekly discussion groups in the villages themselves.

The training was of an entirely practical nature and under conditions in which the health workers would eventually work. Hardly any teaching aids were employed. The village well, the pregnant woman, and the people who were ill in the village provided adequate material for practical demonstration. The germ theory was taught using the magnifying glass and simple school microscope to examine water from the local well, smears from lepromatous patients, and sputum of those suffering from tuberculosis. The major problem was finding teachers among the professionals who could convert complex theoretical knowledge into simple and practical knowhow, and above all, could overcome their cultural barriers and learn to differentiate between intelligence and education and to respect the highly practical approach of simple village folk as

opposed to their own impractical theoretical education. It was also difficult for the urbanized doctor to adjust to the slower pace of the village.

Despite the payment of a salary equivalent to and even higher than that of the doctor of the government Primary Health Centre, it was virtually impossible to attract a suitable candidate. Most doctors did not believe that a village woman could possibly acquire knowledge on health when it takes two to five years to train a paramedic or a doctor. At best it was considered dangerous practice, and at worse an attempt at institutionalizing quackery. The arduous task of spending most of the day on a motor-cycle visiting villages rather than running a traditional static outpatient service, combined with absence of payment from the patient, was a further disincentive. The only doctor who was prepared to work continuously was a young ayurvedic physician, the son of a local fisherman. Though poor in medical skills, he was acceptable to the people for he belonged to their community.

Finding suitable nurses and even Auxiliary Nurse Midwives (ANMs) posed a similar problem with a high turnover.

The staff of the project consisted of a doctor trained in ayurvedic medicine, an administrator trained in social science with three helpers (to maintain accounts and records and to undertake statistical analysis and the purchase and distribution of medicines to the subcenters), five ANMs, and 27 Village Health Workers (VHWs). Except for the senior administrator, all were local personnel. A small health center was established with 10 beds (used chiefly for maternity cases and for tubectomy operations). The cost of such a service (not accounting for the research inputs) was approximately Rs.6/- (rupees) per capita per annum in 1980 compared to the all-India average of Rs.30/- (4). Of this sum, the cost of medicines could be recouped from the patients.

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Immunization. The high rate of immunization was achieved only after ANMs were replaced by the VHWs, for this assured regularity and undivided responsibility. This, with improved hygiene at delivery, resulted in the absence of even a single death from tetanus (the second largest cause of death in India) during the entire period of the project.

Leprosy. The number of cases detected by the full-time government leprosy technicians in 12 years prior to the project was 63. The number of cases at the end of the project was 161 and the detection rate of the VHWs was similar to that of the two-year-trained leprosy technician. Moreover, all the cases detected by VHWs were at the early stages of the disease, and with the much improved regularity of treatment there was not a single new case that developed deformity. Since the VHWs visited leprosy and tuberculosis patients in their homes, there was a virtual abolition of stigma and the old deformed patients were reaccepted by their family and community.

Tuberculosis. The rate of early detection was high, and since the patients were given their streptomycin injection at home, the regularity of treatment was ensured, especially because the importance of treatment in preventing family transmission of the disease was explained. Preventive measures such as disposal of sputum were also ensured. It must be stated that the role of the VHWs was to detect suspected new cases and to carry out the treatment as recommended by the doctor after confirmation of diagnosis.

Gastroenteritis. Deaths from dehydration were virtually eliminated by oral rehydration therapy using home-made salt and sugar solutions. More important, preventive action such as cleaning and chlorination of wells and boiling of water prevented the spread to epidemic proportions.

Malaria. Blood smears of fever cases were taken by the VHWs, followed by chloroquine administration. Definitive treatment was provided for positive smear cases and the local community often undertook the spraying of insecticide.

The question naturally arises as to why such a cheap and effective people-based health service, which is in keeping with the recommendations of the country's own Bhore (1) and the ICMR/ICSSR (3) Committees as well as with the National Health Policy (5), fails to get implemented on a nation-wide scale. The answer to this has also been indicated by the Mandwa project.

At an early stage of the experiment, the then Director of Medical Services of the State requested that the project take over the functions of a Primary Health Unit[2] (PHU). The staff sanctioned for a PHU was placed at the disposal of the project administration. This was done with the hope that this experiment would provide a prototype for the development of a similar service on a state-wide basis. Unfortunately, both the district medical personnel as well as the paramedical staff considered this a threat to their comfortable existence, for the community was now made aware of their presence as well as their duties. Not only did they refuse to perform their alloted duties but they took every opportunity to undermine the working of the project. Yet they had no hesitation in claiming credit for the tasks performed by the VHWs, such as detection of cases of malaria, tuberculosis, and leprosy, pre- and postnatal care, immunization of children and pregnant women, and above all, motivation for family planning.

The nine nonallopathic private doctors in the area posed less of a problem, although one doctor who operated a private nursing home prevented the appointment of a VHW from his area. Patients, especially those who could afford it, continued to patronize these doctors for injections, for these were not provided by our service, except for immunizations and tuberculosis. Most of these injections given by other doctors consisted of unnecessary and often dangerous antibiotics such as chloromycetin, analgesics, and vitamin B complex, even for diseases such as the common cold. Interestingly, injections of penicillin or streptomycin or for immunization were seldom employed.

The local leaders, who welcomed us initially, lost interest when they realized that the project was not going to provide a hospital with doctors, nurses, X-ray and pathology facilities, and an ambulance, which in actual fact was their priority. Our repeated pleas to them to form a health committee for the area received little response. The effectiveness of the VHWs varied from village to village. Besides their

[2]It is a "mini" Primary Health Centre with one doctor and other staff set up in areas that do not have easy access to the Primary Health Centre services catering to 30,000 population. The Primary Health Unit (PHU) was a subunit of the old PHC which looked after about 100,000 population.

own ability and motivation, an important factor was the extent of support they received from their village leaders.

Several of the leaders resented the fact that the project succeeded in reaching the poor in their villages while bypassing them, thus arousing fear of an alternative power structure and an attitude of self-reliance developing among the poor. The health professionals were quick to seize this opportunity to drive a further wedge between the project staff and the local leadership.

Despite the fact that the poor and even some of the leaders accepted the project services, the local power structure dominated by the richer and more powerful leaders joined hands with the government health personnel in open hostility and demanded that the project leave the area, handing its assets to them. Their object was achieved after threats and a show of open violence to the project staff.

The question arises as to why the beneficiaries, namely the poor, who formed the majority of the population did not actively oppose this threat. The answer lies in their abject poverty and dependency on the local power structure for their survival. Health is not a priority in their daily life.

Summary

The findings from the Mandwa experiment may be summarized as follows:

1. Modern medical science and technology have provided us with the knowledge as well as the tools for the prevention and treatment of the vast majority of the diseases that affect the people of the developing world.

2. This knowledge and technology is remarkably effective though simple, cheap, and safe.

3. Semiliterate and even illiterate village women have the capacity to absorb this knowledge and use the technology if this is made available to them in a simple and acceptable manner.

4. The role of the professionals is to impart such knowledge, encourage self-help, and provide graded supportive services for problems requiring greater skills and/or facilities. It is not their role to appropriate functions that the people themselves can undertake.

5. Health at this level, at which almost 80 percent of all problems can be tackled by the people themselves, requires low technology but high cultural affinity with the people.

6. The local village women are therefore more suitable for tackling these problems than more highly trained professionals.

7. The average professional fails to discriminate between education and intelligence. He or she looks down upon the illiterate as being unintelligent.

8. The interest of the professional often does not coincide with the interest of the people; hence the appropriation of peoples' health by a process of secrecy and mystification.

9. Health professionals generally perceive a well trained VHW as a hindrance or threat rather than a help. This is because the VHWs often demonstrate results superior to those of the professionals, demystify health, and reduce peoples' dependency. This results in loss of practice in the private sector, creates surveillance, and hence brings accountability in a normally unaccountable public sector.

10. Semiliterate village women have demonstrated that in five years they could almost reach many of the targets set for 2000 A.D.—this without any inputs in nutrition, water supply, sanitation, and improvement in environment. They achieved this despite limited supportive services, and opposition from the private as well as public health sector and latterly from their local politicians. Table 3 gives some of their achievements, and all this at the cost of Rs.6/- per capita per annum.

CONCLUSIONS

Mandwa and similar projects merely demonstrate that the ICSSR/ICMR report's recommendations for health at the village level, where the majority of the people live and where the problems lie and should be solved, is not merely fanciful hypothesis.

Why is it then that the experiences of Mandwa and similar projects have remained isolated and have had little impact on the health service of the country as a whole? To the casual observer this is particularly difficult to comprehend when the national policy continues to harp on "Health for All" through primary health care and community participation. Surely it is not lack of finances because these projects are highly cost effective, nor is it due to lack of manpower. Even though part-time VHWs, now known as Health Guides, have been appointed by the government in the majority of our half-million villages with the same objectives and a similar complement of supporting staff and services as at Mandwa, it has had little impact on the general health of our people.

The answer to these questions has also been provided by Mandwa. The extent of opposition to even such a small project from both the health and the local political structures demonstrates the emptiness of slogans such as "Health for All" or "Rural Development." It reveals the true intentions of the power structure and its vested interest in maintaining the status quo, in which a few individuals can dominate the rest of the community. In a democracy, all programs and activities are carried out in the name of the people and especially of the underprivileged. The fact that almost all benefits of development gravitate to the elite reveals the extent of the dichotomy between preaching and practice, and this applies equally to the field of health in both the public and private sector. While there is dissention within the health system and between it and the bureaucracy and politicians, these forces will close ranks if the existing system is threatened by any external agency that may disturb the balance between them and the silent majority on whose presence they thrive.

Only thus can be explained why, almost four decades after Independence, half the population remains below the poverty line, 100 out of every 1000 children die within the first year of diseases such as gasteroenteritis, and diseases for which we have effective measures of prevention and control continue to take their unrelenting toll. Even here, aggregate statistics hide the true reality because improvement in the upper two or three deciles conceals the infinitely higher mortality and morbidity figures in the lowest two or three. Despite a school in every village, about 60 percent of the population and 75 percent of women remain illiterate, when the nexus between female literacy and health is clearly demonstrated by the statistics of Bihar and Uttar Pradesh—IMR > 250—versus those of Kerala—IMR < 50.

It is unfortunate that even the well intentioned members of the medical profession see health as a medical rather than a social, cultural, economic, and political problem. Even with the best of intentions, most of the voluntary agencies with their purely humane approach often help to create an even greater dependency among those whom they serve.

Mandwa can either be seen as a failure of a community health project or as an experiment that demonstrates how knowledge can help people to overcome their fears and encourage self-reliance. Whether this knowledge and technology can be spread through an organized movement or in a nonformal manner or a combination of both remains to be seen. Whether the impact will be only in health or will also, by demystifying the most mystified subject, create the awareness to overcome the sense of abject helplessness and start a process of questioning of the existing order—this also remains to be seen.

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Dubious Package Deal

Health Care in Eighth Plan

Ritu Priya

While the basic orientation of the Eighth Plan approach paper towards decentralisation and employment generation can prove to be a major step for the improvement of health status, there is little recognition of how developments in other sectors have an impact on health. In making health care a component of a social service package there is every danger of it being neglected.

THE approach paper to the Eighth Five-Year Plan prepared by the Planning Commission after the National Front government took over starts by stating that the health delivery systems in rural areas are 'inadequate and defective'. Five lines of action have been suggested to correct the defects.

(1) To make the health delivery system "part of a package programme in which other social services such as education and women's programmes are also brought in".
(2) Special support to national programmes such as for control of leprosy, malaria and 'kala-azar'.
(3) Decentralise planning of details and implementation of programmes to state and local levels keeping some areas such as manpower training, research and health information collection with the central government.
(4) The medical education system must be 'structurally modified'.
(5) The health care system needs to be enriched by using simple inexpensive methods and remedies derived from traditional systems.

The overall direction indicated by the first point and supported by the second one is highly problematic and is the one issue I will focus on in the first part of this report. The second part shall deal with some concrete steps which can initiate a process of change in direction and orientation of the health care delivery system and its personnel.

I

Planning special programmes for discrete interventions and then 'integrating' them into packages is how the health services have developed over the last 40 years. Practice of the concept of integrated preventive, promotive and curative services in this manner has been one of the major causes for failure of the health care system. The packaging of health care with other social services is only a further extension of the same logic. Carrying on this direction of 'integrated' services for health is hardly likely to improve the health care system.

While it is essential to have an integral notion of prevention and care for sound health care the concept of integration is being used superficially. The question I am trying to raise is also not of preventive vs curative services. Nor is it of two separate cadres for preventive and curative work. The question is of the side-lining of curative care in the name of preventive measures on the one hand and the side-lining of basic inputs for health status in the name of special preventive measures on the other. The point is only that both must be given their rightful place—(i) Curative care in the health care system and (ii) promotion of health and prevention of ill-health in national developmental activity. Let me explain myself in some detail.

Thus understanding of the health care system arises out of observations and research in various parts of rural north India and among Delhi's urban poor. The arguments are based on two grounds—(1) the present condition of the health care system, 40 years after planned services have been introduced into it based on this integrated approach, and (2) perceptions of the majority sections of our citizens about health and health care.

Health workers of the public rural health care system are, in addition to being insufficient in number and therefore having large populations to cover, loaded with innumerable tasks, emphasis being on those largely 'preventive' in nature. As one of their minor tasks they provide medical treatment 'also'. What has this meant at ground level?

People want a doctor's medical care when they are ill. What do they do? Most often go to a 'private practitioner' in the area whom they often *know* is not really qualified but will at least give them some injection and some tablets to relieve them of their ailment. They have nowhere else to go. The earlier folk remedies which enabled them to deal with at least the everyday ailments have largely been delegitimised and wiped out of practice and memory. The 'doctor' and his medicine have been glorified out of proportion and have become almost the only first resort.

The public health care system, while it has helped generate this demand, does not really provide medical care. It is supposed to be providing integrated preventive, promotive and curative services. Is it though? The whole rural primary health care system is geared towards family planning work. All personnel, specially those directly in public contact at village level—the Village Health Worker (VHW), the Multi-Purpose Worker (male, i e, the MPW) and the Auxiliary Nurse-Midwife (ANM)—are all busy meeting family planning targets. Immunisation targets have also got added on to the family welfare programme in the name of 'child survival' and therefore have become important. Thirdly, the malaria surveillance and treatment work continues to some extent. No other work worth its name is being done by the rural health services.

These are the only activities the supervisors check—the middle rung supervisors or the PHC doctor or the district medical officer—either during supervision visits or at monthly meetings. No one bothers about how many tuberculosis cases have been detected, how many are being treated or whether anti-tubercular medicines are being adequately supplied. Treatment given in minor ailments, an officially assigned task of the local level workers, is never given a thought to. No one checks the level of knowledge of the workers, their prescribing practices, etc.

On the other hand a major section of the VHWs, ANMs and MPWs are providing full medical care as 'doctor sahebs'. As their official duty they do family planning and immunisation work. As their private practice they give curative care. Along with the minimal training in medical care officially given them, they pick up bits and pieces of information and start practising it.

These government health personnel are partly meeting the demand for medical care unofficially and without adequate training. The rest of the demand is met to some extent by other 'informally trained' persons and by those trained in other systems of medicine (specially those with a BAMS degree), all three in the category of what are called 'quacks'.

Only a very insignificant section of the population comes to the subcentre or primary health centre for medical treatment. The government health services are generally not perceived as institutions for 'care' but as something antagonistic, something meant to impose family planning, etc, on people, not to cater to their needs.

The prescription practices of these 'quacks' are probably causing all kinds of unknown havoc in the bodies of the urban poor and rural populations. E g, excessive use without reason of steroids is a well known hazard caused by 'quacks'. Of course the misuse of medicines is picked up from the malpractice of trained 'doctors'. However as the largest body of personnel providing medical care to the deprived sections the impact of the quacks' wrong practices is more direct.

This is the state in terms of treatment of illness, i e, the curative care. Coming to the preventive and promotive aspect—the direct inputs are nutrition, water, sanitation, etc, employment, women's status and education are also acknowledged determinants of

health status. These are all basically 'non-health' inputs for health. But the jargon of integrated services has been carried to the extent of including all these in 'health programmes' or in 'social services'. Employment, water supply and sanitation all become 'social services'.

Until recently it was the family planning, the immunisation and the malaria programmes which hijacked the health services. The latest trend in the health sector currently being pushed by WHO, UNICEF, the voluntary agencies, etc, is to include all sectors affecting health of a population in health programmes.

Health services mainly for the poorer sections are now to look after not only medical care, detection of cases and their treatment, etc, but also involve themselves with these other 'social services'. The Eighth Plan approach paper is echoing this approach when it talks of the health delivery system as part of a package along with other 'social services'.

Of course these inputs are vital for health. But giving them the garb of a health programme or including them in a package of social services is not an effective way of providing for these needs; rather, only an effective way of seeming to provide for them. In the process long-term measures are avoided and only *ad hoc* solutions tried out.

For instance—provision of water as part of integrated health programmes means, say, putting in hand-pumps. This is done and it is taken for granted that safe water has been provided for. But this is really simplifying the issue of water supply. It has actually to be tackled as an overall problem of water management. For example, in Delhi, the real issue is how to provide the city's entire population with adequate and 'safe' water, not that this jhuggi-jhonpri cluster or that one of even these 50 clusters have got hand-pumps. Because the rest of the 600 will have nothing by way of an assured, sustained water supply. Even in those clusters which do get hand-pumps, their numbers are generally inadequate to meet the total needs of the residents. In Delhi a mix of sources must be tapped for water. Suitable sources and appropriate systems need to be identified area-wise, installed accordingly not only for the slum areas but for all sections of Delhi. This the health service or the Urban Basic Services Programme (a UNICEF-sponsored integrated programme being run by the Delhi administration besides being adopted by other town and city civic administrations) cannot do. And because the hand-pumps have been provided the pressure on the Municipal Corporation or the Delhi Development Authority to do something for overall water management is eased. Then, with the lack of safe water exacerbating health problems such as diarrhoea, cholera and polio the health system 'has to' provide more preventive services in the form of preventive medical technology—immunisation and promotion of ORS packets. In this way the preventive-promotive jargon has come to serve the purpose of by-passing sustainable long-term solutions with medical technological solutions. One cannot be a replacement for the other.

What is needed is to give a significant place to health in the planning of sectors other than the health services. All development activity—from employment generation strategies to agricultural policy; land and water management and animal husbandry to promotion of the food processing industry; development of human settlements and housing—must be planned taking into account their impact on health of the people. Uptil now even our drug policy has been determined by the dictates of the industry alone and not by the health needs of our people. This is not a factor considered even while formulating policies even in areas with most direct impact, e g, the agricultural policy does not keep the link between agriculture, food and nutrition in sight (even in this approach paper).

To cite an example, with the pushing of high-yielding wheat and rice in the last few decades, the production of coarse grain, pulses and oilseeds lost out. Until a couple of decades ago coarse grains and pulses/black gram plus milk products were the basic diet of large parts of the rural population, in north and central India at least. Today it is reduced to 'rotis' of wheat with salt or chillies or a little vegetable. Small-scale animal husbandry has declined and the little milk available is sold to the towns so that intake of milk products has declined among many sections of the rural population. The nutritional quality of people's diet has deteriorated with these changes. And then, instead of dealing with these, we have to develop new 'low-cost nutritional supplements' and devise special programmes.

What in fact does this jargon of integrated preventive-promotive-curative services achieve? On the one hand it is not allowing us to work on long-term, sustainable measures for provision of basic needs; allowing them to be postponed, a waste in both financial and human terms. On the other hand innovative thinking and creativity in the field of health is today being concentrated on how to deliver this integrated 'package' to the 'community' (besides, of course, on high technology super-specialist research). There is no space for innovation and creativity in applying medical knowledge appropriately, or in establishing efficient medical management of common clinical problems according to our needs and conditions. The lack of such medical care is being acutely felt by the common person—rural and urban, rich and poor.

II

Coming back to the question of improving the health services themselves—shouldn't the first task be to gear the public health services to meet the demand for curative care? This will provide better quality medical care and also help in the acceptance of preventive measures more easily. The following are some suggestions for what is possible with the existing infrastructure and personnel: Instead of continuing with the distorted emphasis on family planning the health services should provide good, efficient and safe contraceptive services on demand. The demand for contraception exists specially among women; even poor women of both rural and urban areas. However the aggressive pushing of family planning by government personnel and the experience with various contraceptive methods as provided by the government service discourages the use of family planning services. In addition to the non-health inputs talked about in the approach paper (raising women's status, income levels, etc) provision of contraceptive services with dignity and in the safest manner possible (not 300 to 1000 sterilisations done in one camp in a day; not haphazard insertion of Cu-T but insertion with all aseptic precautions so that chances of PID and other complications are minimised, etc) coupled with improved efficiency of the medical care system including the treatment of children's ailments, will go a long way in encouraging birth control. The undue effort and emphasis on family planning is unnecessary. Instead health personnel can concentrate on providing basic medical care which includes treatment in illness, immunisation, contraceptive services, etc.

The Village Health Worker Scheme needs to be re-established with modifications so that (a) the VHWs have better clinical skills and a better understanding of preventive health aspects, (b) the VHWs actually acquire the role of a people's representative for the health sector rather than as the lowest rung in the hierarchy for implementation of government programmes. With the overall thrust of the approach paper towards decentralisation, revitalising of the panchayati raj institutions, etc, one area must be the autonomy of the VHWs from the health services. His/her accountability must be to the people rather than to the public health services. (c) The VHW must have some credible role, having a legitimate standing on health-related matters with the local authorities and in panchayat bodies for the villagers to begin taking them seriously.

To improve the situation of medical treatment we should start with the ground reality. To begin with the role of the MPW and ANM as providers of medical care should be officially recognised so that they are then given adequate training, their activity supervised and their clinical knowledge and skills constantly checked and upgraded. Improving the quality of medical care and knowledge supplied by the ANM/MPW to the community should in the long run have the effect of upgrading quality of care provided by other so-called 'quacks' as well.

It can be argued that 'training' will not really help in improving the quality of medical care. What about the poor quality of care provided by our trained doctors? It is a valid argument for poor practice is not

only because of lack of knowledge but because of the contrary pulls of commercial gain and rational practice. Tackling the latter problem needs a change in the socio-political climate and is a matter of vision and will of the social and political leadership. However any change in practice cannot be expected in the absence of correct information. We could make a beginning by giving relevant practical knowledge and skills to local level workers.

In order to equip the MPW/ANM adequately through short-term training, innovative modules for management of common medical problems need to be worked out. These would be useful not only for those with lesser medical knowledge but for doctors as well. Medical colleges should be involved in working out these modules and operational research done to test effectiveness of various approaches to medical management under 'field' conditions. Involvement in such efforts would re-orient some medical college doctors as well, making them deal creatively with field conditions and its challenges rather than find excitement in copying foreign research; they will deal with everyday ailments rather than exotic diseases and syndromes.

This suggestion must not be read to mean that the role of ANMs/MPWs should be only curative and a separate cadre is necessary for preventive work. A redefining of their role is needed so that they are actually able to integrate both preventive and curative services.

The primary health care system must be backed up by a good referral system from subcentre to PHC to district hospital to medical college, etc. Improving efficiency of hospitals must be a priority. Privatisation of this so-called 'tertiary sector' in answer to the problem of inefficiency in the public system is a lure which must be resisted. In the present social situation we cannot stop them but at least no government support should be given to this sector. The corporate sector is a purely commercial venture—Apollo Hospitals could be Oberoi Hotels—and should be treated as such. They should not be given any subsidies on land, no subsidies on import of equipment, etc. They cannot provide the poor man a solution to his problem of medical care. On the other hand they will blur the perception of need for improving the public hospital system.

The approach paper also talks of a strong case both on grounds of revenue and equity, for the better-offs to pay for health services utilised by them in the public sector. This does not seem like a sound proposition because the mechanism for differential payment will not work. Or, if a workable mechanism is evolved then the health care provided will not remain equitable; those who pay will get better services. Making the better-offs pay in the form of taxes and the health service remain free for all seems to be a more equitable system which, at least theoretically, provides services according to need and not according to the ability to pay.

The adoption of a drug policy along the lines recommended by the Hathi Committee would also go a long way in changing the scene of curative care.

There is an urgent need to take concrete steps for revitalising traditional health practices so that at least everyday ailments can be effectively dealt with at the home and community level itself. Approaches for this have been worked out very concretely and in great detail, e g, by the Lok Swasthya Parampara Samvardhan Samiti. These must be seriously examined and given a significant place in the health policy.

The approach paper emphasises the importance of traditional systems in reorienting the health system. However it talks only of "enriching the health system by using simple inexpensive methods and remedies of the traditional systems". This line only promotes the Zandus and Daburs, not self-reliant decentralised medical care. The real need is not to just incorporate some remedies from the 'traditional' into the 'modern' system but to revitalise those systems themselves and allow them the space to give society of their best.

A change in the attitude of health professionals is of course essential. "The health care system in the country cannot be made effective unless the medical education system is *structurally modified*" rightly says the approach paper. However it gives no clue as to how this is to be done. We've had attempts in the pat (the Bhore Committee recommendations, the ROME programme) but with little success. How will the effort be different this time?

The approach of the Sokhey Committee (the sub-committee on Health of the National Congress Planning Committee, 1946) with regard to health humanpower development was radically different from that of the Bhore Committee. However, it has never received any serious consideration. It started humanpower development from the base of the pyramid and moved gradually upwards. If the Sokhey Committee approach can be implemented even in part and suitably modified according to the present situation, it can lead to a process of 'structural changes' in the health care system. For instance one step could be to encourage the MPW/ANMs to upgrade their skills and after a certain number of years in service, the best among them could be taken up for training as doctors. A certain percentage of seats could be reserved for them in admission to medical colleges. There they should be treated as 'senior' students not as 'lesser' students as can possibly happen. Their socio-economic background, their maturity and their work experience in the field could slowly change the character of the medical graduate, of the training and of the doctor produced at the end. But this kind of 'structural change' needs a lot of political will behind it for it to be implemented.

The attitude of the doctor to be produced is basically a function of the overall health system and the socio-political conditions and prevailing dominant values. From the mechanism of recruitment for training, to the way training is given, to the final work for which they are to be produced, all influence the quality and attitudes of the medical student. The medical student already has a set of values and aspirations when he/she comes to medical college. Only very effective training and education can change these to any significant extent. It is only when larger societal values are positive that the doctors too will have positive attitudes.

Similarly, they will take the preventive aspects of health care more seriously and attempt to integrate them with their clinical practice when 'health' is overtly part of larger societal concerns. Emphasising 'health' as a goal in national development policy and planning will help create a general environment in which health becomes a major concern. This is an area for the Planning Commission. But more than that it is a political question. The Planning Commission can raise issues, prepare plans accordingly and start a debate on them. But for implementation, how far is the present government ready to go?

The Planning Commission approach paper makes a promising beginning with a very positive shift from only economic planning to social goals as well. The basic orientation towards decentralisation and employment generation can prove to be a major step for improvement of health status and for promoting family planning. However, even in this approach paper, improvement in health services is not seen *per se* as a factor for improving the life of our people. Its need is felt on two grounds only—of increasing productivity of the labour force and of promoting family planning. This is disappointing.

HP.V.11

INDEPENDENT COMMISSION ON HEALTH IN INDIA

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Background and Scope

In spite of the Parliament adopting the National Health Policy in 1983 the health situation in the country today is a cause for deep concern.

There is considerable consternation in the minds of health and development experts as well as NGOs and other organizations involved in the promotion of health care at the grass roots level. The present day "EPIDEMIC OF EPIDEMICS" is a reflection of the extreme deterioration of health services resulting in the failure to provide effective preventive and curative measures. The recent episodes of Plague and Malaria and the defunct health care delivery system in half of the country causing immeasurable hardships to millions of people in the country have ominous portents. The Voluntary Health Association of India (VHAI), which links over 3500 grass-root level health and development non-government organisations across the country, along with its co-travellers, associates and friends, felt the need to facilitate the setting up of an INDEPENDENT COMMISSION ON HEALTH IN INDIA, which would have an in-depth look into the maladies affecting the health care system. Based on its assessment of the ground realities at the micro and macro levels, the Commission will come up with pragmatic, people-oriented solutions for decisive action. It is hoped that this will form a foundation for future health planning of the nation.

The report of the Commission will be completed by January 1996, well in time before the process of the 9th Five Year Plan begins. Copies of this report will be presented to the President of India, the Prime Minister, Union Health Minister, Chief Ministers and Health Ministers of all States, Administrators of Union Territories and Members of the Parliament.

The Independent Commission will do a comprehensive study using scientific socio-economic data covering the entire nation. The major areas of concern which the Independent Commission intents to thoroughly understand and analyse will be:

1. Vulnerable regions and people : The Commission will be involved in a meaningful exercise that will use the available data, both quantitative and qualitative, to identify vulnerable and deprived regions and people in terms of health and development. Visits to selected regions, interactions with people and functionaries at various levels including local and Panchayat bodies by members of the Commission will supplement the analytical work.

2. Epidemic of Epidemics : Vector-borne diseases such as Malaria and Kala-Azar; Water-borne diseases such as Cholera and Gastroenteritis; and other diseases such as STDs/AIDS and Tuberculosis would be looked into in great detail besides the existing National Health Programmes. The aim of this exercise is to determine the reasons why these diseases are still prevalent and what the gaps are that need to be filled in the public health system in the country.

3. Public Health Institutions : The Commission will specifically be looking at All India Institute of Public Health & Hygiene (AIIPH), National Institute of Communicable Diseases (NICD), Indian Council for Medical Research (ICMR), National Institute of Health & Family Welfare (NIHFW) and other such premier Institutions in terms of their functional relevance today with regard to their mandate. The aim is to discern whether their programmes and activities are tuned to the health needs of the people and current realities. This would also help identify progressive public health initiatives in different states of India which have the potential to improve the health status of the people.

4. Family Planning Impasse : In this area the Commission will investigate how we are dealing with the population problem. Though India was the first country in the world to initiate Family Planning programme 40 years ago, the impact has been far from impressive. The Commission will closely look into the relationship between population and the state of health and development in the country.

Mr. Alok Mukhopadhyay, Executive Director of Voluntary Health Association of India will be the **Convenor** and **Dr. Almas Ali**, the **Member-Secretary** of this un-affiliated Commission.

The other renowned experts on the Commission will be:

Mr. R. Srinivasan, Dr. Balu Shankaran, Dr. Harcharan Singh, Prof. Ashish Bose, Dr. D. Banerji, Dr. Raj Arole, Dr. Shanti Ghosh, Dr. N.S. Deodhar, Dr. Darshan Shankar, Dr. H. Sudarshan, and Dr. Bhaskar Ray Chaudhri.

HEALTH IS NOT EVERYTHING BUT EVERYTHING IS NOTHING WITHOUT HEALTH

Members of the Independent Commission on Health in India

Mr. Alok Mukhopadhyay (Convenor): Executive Director, Voluntary Health Association of India. Former Country Director OXFAM. He has made a significant contribution towards promoting voluntary action in the South Asian Region.

Mr. R. Srinivasan: Former Secretary, Ministry of Health and Family Welfare, Government of India and former Chairman of the Board, World Health Organization, Geneva.

Dr. Balu Shankaran: Famous Orthopedic Surgeon and former Director General, Health Services, Government of India and Consultant to the World Health Organization.

Dr. Harcharan Singh: Former Health Advisor, Planning Commission, Government of India and Consultant to World Health Organization in Nepal. Presently Consultant to various national and international health projects.

Prof. Ashish Bose: Honorary Professor at the Institute of Economic Growth and formerly Jawaharlal Nehru Fellow. Former member of National Commission on Urbanization and Advisory Council monitoring the 20 point programme.

Dr. D. Banerjee: Professor (Emeritus), Centre for Social Medicine and Community Health, Jawaharlal Nehru University. Eminent Public Health Scientist and author of numerous well-known books. Known for his life-time contribution to Social medicine, particularly in the field of Tuberculosis and Family Planning.

Dr. Raj Arole: Magsasay award winner, known for his outstanding contribution to rural health through the Comprehensive Rural Health Project, Jamkhed in Maharashtra.

Dr. Shanti Ghosh: Eminent Pediatrician and former Professor of Paediatrics at Safdarjung Hospital, Delhi. Advisor and Consultant to World Health Organization and other international agencies.

Dr. N.S. Deodhar: Former Director, All India of Public Health and Hygiene, Calcutta and Addl. Director General, Health Services, Government of India. Currently Consultant to various national and international health projects.

Dr. Darshan Shankar: Director of the Academy of Development Sciences at Karjat and is one of the founders of Lok Swasthya Parampara Samvardhan Samiti and Foundation for Revitalization of Local Health Traditions. Known for his contributions for the revitalization of traditional health systems of India.

Dr.H.Sudarshan: Vice-President, Voluntary Health Association of India and recipient of the 'Right Livelihood Award' for his outstanding work in the tribal regions of Karnataka.

Prof. Bhaskar Ray Chaudhry: Noted Neuro Surgeon; former President, Indian Medical Association and former Vice-Chancellor, Calcutta University.

Dr. Almas Ali (Member Secretary): Has been involved for almost two decades in social research on health issues, particularly those issues pertaining to the tribals and weaker sections of society. Associated with a number of developmental projects and organisations throughout the country.

Associates

Community Health Cell, Bangalore

Centre for Enquiry into Health and Allied Themes, Bombay

Self-Employed Women's Association, Ahmedabad

Medico Friends Circle, Bombay

Center For Development Studies, Trivandrum

Foundation for the Revitalisation of Local Health Traditions, Bangalore

Vivekananda Gramin Kalyan Kendra, Mysore

Gramin Vikas Vigyan Samiti, Jodhpur

Lok Jagriti Kendra, Bihar

Jagruti, Orissa

VHAI (Delhi and North East Offfices)

State VHAs: Uttar Pradesh, Himachal Pradesh, Tripura, Assam, Orissa, Bihar, Madhya Pradesh, Delhi, Karnataka and Other State VHAs.

Dr. S. P. Tare
Dr. N. K. Sinha
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Dr. Srinivas Murthy
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Dr. Sanjay Ghose
Dr. Bharat Jhunjhunwala
Mr. Thomas Mathai
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Mr. N. M. Mathew
Dr. Ali Baquer
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Ms. Christina de Sa
Mr. Indu Prakash Singh
Ms. Nilina Mitra
Ms. Bhavna Banati
Ms. Chandra Kannipiram
Dr. Sanjay Kapur
Dr. P. N. Sehgal
Ms. Asheena Khalak-Dina
and many others

EDUCATION POLICY FOR HEALTH SCIENCES

A statement of shared concern and evolving collectivity

COMMUNITY HEALTH TRAINERS DIALOGUE
OCTOBER 1991

Preamble

We, the participants of the Community Health Trainers Dialogue representing Community Health and Development trainers, networks and coordinating agencies and faculty members of medical colleges in the voluntary health sector

- *having reflected on the key components of the National Health Policy, the reports of the various committees including the National Education Policy for Health Sciences as found in the Bajaj Report (1989) ;*
- *having considered the need for change in Education for Health in view of our goals and in the context of health and community development; health and culture; human power development; training strategies; education of trainers and the approaches to adopt as also the mechanisms of implementation ;*

have arrived at the following conclusions at the meeting held on October 3-5, 1991 at Bangalore.

NEED FOR CHANGE

The socio-economic, political and cultural situation in our country has resulted in the declining health of the majority of our people who are poor and marginalised, especially the women and children among them.

Various factors including the -

- increasing commercialisation of the health care system, with the tendency to transfer governmental responsibility to privatised, profit-oriented sector ;
- increasing use of inappropriate capital intensive sophisticated technology and high cost services ;

- limited, available resources for health care ;
- the disregard of priorities ;
- the use of English to the exclusion of local languages as medium of training and instruction, with a consequent shortage of competent health workers ;
- lopsided health human power development policy in production, distribution and utilisation in the health sector, not linked to need ;
- the destructive impact of modernisation on culture and health;
- the orientation of health care more in terms of disease than of health ;
- the dominant influence of Western and consumerist practices and values in health care ;
- and the lack of a holistic approach ;

indicate an urgent need for change in our policy for education for health.

GOALS

Considering the goal of Health for All the policy for Education for Health must

- see health as a constituent part of human development and as an integral instrument of building a just and equitable society;
- aim at building up and sustaining a health system that
  * is people oriented, helping the people to cope with their problems in health;
  * is available and accessible preferentially to the poorest sector;
  * strives to enable and empower them to participate in their own health care by sharing in decision making, control, financing and evaluation with regard to their choice of health system;
  * is in consonance with the culture and traditional practices, when these are constructive and beneficial;
  * uses the resources better, with appropriate technology which serves the people.

HEALTH AND COMMUNITY DEVELOPMENT

The increasing recognition of the interaction between health and community development should be reflected in proportionately adequate budgetary allocation for health. Given the resource crunch, the priority needs of the majority of our people must be focussed on.

While we see a gradual shift already taking place from hospital and dispensary to the community, we need to go still further in our progress from curative to promotive and community health, through awareness building and participation in decision making by the members of the community.

All health and development workers together with the people must work as a team.

In this sharing process, care must be taken not to put too much of a load on the primary community level workers.

HEALTH SYSTEMS AND PRACTICES

There is a plurality of health systems and practices in our country, many of which have their roots in our ancient past. These systems are to be recognised for their specific strengths and limitations, and to be nurtured as a valuable and effective heritage. A greater and more sustained effort must be made to study and understand these systems and their specific relation to the various needs of the people.

There is also a complexity of health service systems in operation viz. governmental, private and voluntary. These systems must be decentralised to the extent possible with greater accountability to the people.

HEALTH HUMANPOWER DEVELOPMENT

The present context of education and training needs to be reviewed. What is useful should be retained and what is inappropriate should be removed. The contents of all levels should also include the study of ethics and values, behavioural and social sciences, management, economics of health and ecology.

There is need for the creation of a body of knowledge and skills that are locally relevant and for the building of proper attitude.

The capacity of people to cope with, and the responsibility they take for their health is to be recognised.

Health Personnel

Different grades of workers are needed at different levels of health care and they must include

a. the group of people at the community level, including the voluntary, quasi-governmental, governmental health workers, the teachers and others; and

b. the doctors, nurses, dental surgeons, allied health professionals technicians and others of similar category.

There is need for an optimum mix of the different categories, both quantitative and qualitative, with priority for the health workers at the community level.

Health teams

The training should be such as to enable the members to work as a team for the health of the people.

Continuing Education

Continuing education should enable even the most remotely situated worker to benefit from it. This may be achieved by distance and other methods of learning.

The focus must mainly be on social goals, in addition to needed knowledge, skills and attitudes.

TRAINING STRATEGIES

Education for health should be community-oriented and people-based so that the health professional/worker is able to equip and enable the people to cope with their health problems.

Competence based learning

The health personnel at different levels should be trained with appropriate skills attitudes and knowledge to function effectively in the area of work, encouraging competence based learning.

Opportunities should be provided for learning outside the training institution or organisation in the health care delivery system at various levels. One way of achieving this objectives will be through the greater use of electives in the community with government and voluntary health and development projects.

Value orientation

The training programmes at all levels should lay emphasis on values and ethics including conduct and relationships at the personal level and right to health and distributive justice at the social level.

Health and Culture

All training programmes should take into consideration the way of life of the people and their practices, learn from it and build on it. Both trainers and trainees must approach this area with an attitude of learning.

Governmental and non-governmental programmes

It is the primary responsibility of the government to provide health care services, while the voluntary (NGO) sector also has its increasing role. To achieve the optimum mix, with respect to numbers, types and qualities of health workers and effective training programmes, all efforts should be made to have interaction between governmental and non-governmental sectors, learning from and supportive of each others' efforts.

Systems of Health Care and Medicine

All training programmes must take into consideration peoples' health culture.

Whatever be the focus of the system of health care and medicine, in a training programme, there is need for generating awareness of the plurality of health systems and traditions in the country and encourage a healthy respect for all systems.

Evaluation

All training programmes should be evaluated for their effectiveness to achieve their goals, including their cost effectiveness. The process of evaluation should encourage evaluation by the trainees and the people themselves.

Training of trainers

There is need for improving training of trainers for community based, people-oriented health care. The trainers should be role models for the trainees. For all formal courses, the trainers should devote their full-time for the training.

Methodologies of training

Different methodologies of learning and training, appropriate to the situation should be used. To the extent possible, all training should be more experimental.

Innovative Programmes

To meet the requirements of Health for All innovative training programmes should be encouraged and supported, whether in the governmental or voluntary sectors. National institutes set up to function as torch bearers of innovation should be accountable to the people in this role.

Networking of individuals/institutions involved in promoting relevant innovations in training should be encouraged and strengthened.

This statement of shared concern and an evolving collectivity amongst us is also the beginning of a process of working together towards the evolution of such an educational policy in health sciences responsive to the needs of the large majority of our people - the poor and marginalised. We also resolve that building on our own individual/project/programme/institutional experiences we shall work together, lobbying for these changes and new directions in training of health humanpower in the country.

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AGENDA ITEM No. 1

DRAFT HEALTH POLICY

1999

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NEW DELHI

DRAFT HEALTH POLICY

CONTENTS

DRAFT HEALTH POLICY

1. INTRODUCTION

1.1 Health is one of the core elements that determines human development and progress. To live a long and healthy life is among the most critical options that human development offers to people. Health is an indicator of well-being that has direct implications not only for quality of life but also indirect implications for productivity and economic gain. It is for this reason that every country has considered the promotion of good health among its people a cherished goal.

1.2 While on the one hand the country has the capability to perform the most sophisticated medical procedures, morbidities requiring simple, low cost interventions have daunted health planners. Experience in some other countries has shown that even without a significant increase in per capita income, it is possible to raise the health status by pursuing appropriate policies.

1.3 Liberalisation of the economy and reduction in trade barriers have widened the possibilities for investment in health. While the private sector has been able to take advantage of these developments, the public health system has to grapple with increasing pressure from growing numbers and high expectations. Against this background the Health Policy has to aim to create not only structures that ensure basic health needs but also to see that there are a range of alternatives available to ensure that limited resources are targeted effectively.

1.4 The National Health Policy 1983, reflected the Nation's commitment to provide universal access to primary health care services. It stressed the need to link health services with health related activities such as nutrition, drinking water and sanitation. The active involvement of voluntary organisations in the health sector was sought to be encouraged. The regular supply of essential drugs and vaccines, delivery of good quality health and family planning services and establishment of training and medical research facilities were accorded priority. After a period of consolidation of the infrastructure, India embarked on several disease control programmes for AIDS, Leprosy, TB, Blindness and Malaria and also began availing of external assistance through the World Bank and bilateral agencies. The experience in implementing these projects and relying largely on the infrastructure established earlier has been varied.

1.5 The impact of the Health Policy can be viewed with some satisfaction.

1.6 The crude birth rate (CBR) has declined from 33.7 in 1983 to 27.2 in 1997 which amounts to an annual decline of 0.43 per year. The infant mortality rate has come down from a level of 105 in 1983 to 71 in 1997. The crude death rate has declined from 11.9 in 1983 to 8.9 in 1997. Life expectancy at birth for men has gone up from 55.6 years in 1981-86 to 62.8 in 1996; for women from 56.4 in 1981-86 to 64.2 in 1996. The total fertility rate (TFR) has declined from 4.5 in 1983 to 3.5 in 1995 (desired level of TFR is 2.1 in 2010).

1.7 The success on the Immunization front has been another notable achievement. 96% coverage has been achieved in respect of BCG. The level of Measles immunization which was only 4% in 1985-86 has increased to 83% in 1997-98. The DPT coverage which was 41% in 1985-86 has gone upto 90% in 1997-98 and TT for pregnant women from 40% in 1985-86 to 80% in 1997-98. The most outstanding achievement which has been acknowledged world wide has been the pulse polio programme through which zero incidence is expected to be achieved in 2000. A wide network of primary health centres and sub-centres has been established throughout the country. The incidence of leprosy was brought down from 57 to 5 per 10,000, with eradication achieved in three States. The rest of the country is set to meet eradication status in the next three years. The transmission of guineaworm infestation has been successfully interrupted in endemic villages and certification has been sought from WHO's International Commission confirming eradication of

the disease. The programme for control of Cataract blindness has made an effective dent on the prevalence and incidence of senile cataract which was a huge problem in the country.

1.8 While the broad contours of the National Health Policy (NHP) still hold good, with the passage of time new concerns have emerged requiring more focussed attention. Reemergence of diseases like plague, dengue or malaria, once thought to have been eradicated, and new diseases like Hepatitis and AIDS have necessitated refixing of priorities and formulation of new approaches. Despite substantial investments in the area of food production, water supply and sanitation, morbidity and mortality continue to be exacerbated by nutritional deficiencies, contaminated water, ill planned urbanisation and environmental pollution. At the same time increase in life expectancy and changes in life style have contributed towards the growing incidence of non-communicable diseases like cancer, diabetes, cardio-vascular ailments, generating a massive demand for institutional care.

1.9 Added to this, the persistent gaps in man-power and infrastructure in rural areas and the sub-optimal functioning of referral services have affected different parts of the country. Although there are a large number of hospitals and beds both in the government, voluntary and private sector, some of them lack appropriate manpower, diagnostic and therapeutic services and drugs. Inter-state differences have widened at places with the states with the lowest health indices also having the weakest infrastructure. The emerging burden of disease caused by environmental and societal problems have accentuated the burder responsibility so far targeted mainly to combatting communicable diseases. Although there have been several technological advances, many of these have been denied to most of the population due to lack of resources, awareness among the people as also ignorance about services that they can rightfully claim.

1.10 The 73rd and 74th Constitutional Amendment Acts of 1992, have provided significant opportunities and a framework for the active involvement of Panchayats and Nagar Palikas in all development programmes including Public Health and Sanitation. A process of decentralization and devolution of authority is now necessary to ensure that the district health authorities and block/panchayat level functionaries work in close coordination. It will be necessary to develop models to show how panchayati raj institutions can be made responsible for rural health care institutions like sub-centres and primary health centres and develop and sustain them further with the active and informed participation of the people. Decentralization is required not only to fulfil the Constitutional provisions but to make the primary health care services more efficient and responsive to the needs of the local community. Referral systems and linkages between primary, secondary and tertiary levels of health care institutions will need to be streamlined through incentives extended to entitled patients to receive fast track attention at each level of facility.

1.11 Most daunting will be the task of narrowing inter-state disparities and differentials in health indices acrc the country. Reducing such disparities among States, within regions, districts and sub-districts will need flexibility in the planning process so that the policy design and strategies keep area requirements in view. Success will lie in the ability to restructure the existing system to make it cost effective, participatory and result oriented, to counter resistance and manage change. The role of media, the judiciary and civil society, as a whole, will greatly determine the route that this process would follow. Most critical will be the adequate provisioning of funds and appropriate policies that will help achieve health goals despite the constraints of poverty and illiteracy.

2. HEALTH CARE INFRASTRUCTURE

Rural Health Services

2.1 It will be necessary to ensure that the existing sub-centres and primary health centres are fully operational and those that are having a poor clientele due to locational disadvantage closed down. The gaps at the community health centre level will need to be filled by re-structuring the existing block level PHCs, Taluk

and Sub-divisional hospitals by utilizing the funds earmarked under the Basic Minimum Services package. The current approach of allocating more funds to construct buildings for primary health centres and sub-centres, and expanding the requirements of health workers, will need to be supplemented with a system that improves access to health for the unreached sections of the population. This would include making adequate provision for essential equipment, drugs and consumables relative to the level of facility, addressing the problem of absenteeism of staff, poor maintenance and inefficiency caused by poor supervision. This calls for a restructuring of the primary health care system with adequate autonomy, funds and authority to discharge essential medical and public health functions.

Organizational Structure of the Health Services

2.2 The integration of vertical programmes including family planning, reproductive and child health and disease control into a viable synthesis will be promoted so that the infrastructure can be used to optimal advantage. The process of integration will be addressed from the Ministry of Health & Family Welfare at the Centre through the States with a view to enhancing the output and cost-effectiveness of programmes. At the village level, the duties and functions of all health staff implementing the health programmes would be made available to Panchayats and villagers, to enable them to demand services and draw attention to the gaps which exist at each facility. Encouragement would be given to handing over the management and administrative control of the primary health centres to Zilla Parishads where they exist and of the sub-centres to the panchayats.

2.3 The adoption of a decentralised recruitment policy for filling vacancies of doctors in rural areas and the introduction of an element of limited compulsory rural service appears to be warranted by the current trend of doctors seeking to work only in urban and peri-urban settings. The local recruitment of doctors, if necessary on a part-time basis, will be permitted. The possibility of sub-centres, PHCs and district hospitals being run in an autonomous fashion with the involvement of industrial establishments, cooperatives, religious and charitable institutions will be explored. Local practitioners will be permitted to pay rent and practice in the PHCs after OPD hours. In order to encourage in-service doctors to function in rural areas, a percentage of the post-graduate seats would need to be reserved for in-service medical officers and the eligibility condition for joining post-graduate courses for in-service doctors linked with completion of rural postings. In the States where there is a serious and continuous shortage of doctors in rural institutions, the possibility of posting upgraded paramedics will be given serious consideration. This strategy has improved health outcomes in other countries and can be tried selectively depending on situational requirements.

2.4 The need for establishing a senior focal point at the district level for health, family welfare and women and child development schemes has been recognized. The States would be encouraged to set up a district based hierarchy for overseeing the implementation of national programmes and public health functions.

2.5 Health, physiology and hygiene would be introduced as compulsory subjects at the primary, secondary and high school levels with students being used actively to disseminate messages on preventive measures and health promotion. This offers immense possibilities for information dissemination, which undertaken in a coherent and coordinated manner, could bring about changes in behaviour patterns and help inculcate a health seeking attitude.

Urban Health

2.6 Unlike the rural health services, there have not been any structured efforts to provide primary, secondary and tertiary care services in geographically delineated areas in the urban sector. As a result, either insubstantial utilisation of urban health centres has taken place or there has been a overcrowding at the secondary and tertiary care hospitals. As a direct result of urbanization, there has been a spread of urban slums which have inadequate access to basic health facilities. The possibility of mobilizing resources from

industrial enterprises, private health care institutions and voluntary organizations would be explored and given a fair trial. The essential services would need to include medical and surgical services including eye and ENT care; obstetric care and new-born care and child health; counselling for reproductive health and contraception; dental services; emergency and trauma care; and prevention and control of communicable and non-communicable diseases. Wherever feasible, instead of setting up new infrastructure, efforts would be made to build partnerships with the private and voluntary sectors to provide basic services. This would be particularly necessary in the case of urban slums which have become a cause for overwhelming concern where the people for lack of timely primary health care eventually become a burden on the city hospitals.

3. ENVIRONMENTAL HEALTH AND SANITATION

3.1 Environmental factors (in particular, drinking water and sanitation) play a crucial role in influencing morbidity and mortality, apart from nutrition and the income level of the people.

3.2 The need to advocate the improvement of drainage, sullage and solid waste management would be made a direct responsibility of the health sector so that health hazards like large scale soil and water pollution are drawn attention to which has been among the primary factors attributable for the high prevalence of soil-related and water-borne diseases in rural areas and the spread of infection in urban and peri-urban areas.

3.3 Although the availability of drinking water has increased substantially and the norms for defining the distance to a safe drinking water source have been revised, people continue to obtain water from unsafe water sources. Water Quality Surveillance would be given emphasis to prevent the risk of ground water contamination and to alert the community about the consequence of drinking unsafe water.

3.4 The population at large would be given practical knowledge about personal hygiene, health hazards and the method of promoting and maintaining good health in all aspects. The traditional pillars of health care - regular habits, health education, yoga, dietary practices, food safety, civic values, home treatment for minor ailments and injuries etc. would be reinforced.

3.5 The notification and early reporting of designated communicable, occupational and other diseases will be made mandatory and suppression of data made punishable.

Health Risk Assessments and Public Health Institutions

3.6 Given the accelerated pace of industrialisation, environmental hazards would need to be addressed at th planning stage itself. Before the construction of new factories, railway lines, power plants, dams, mines or stone quarries is taken up, a health impact assessment study would be mandated to be carried out and the funds for addressing the emerging health risks provided for during the formulation of the project to cover the implementation and maintenance phases. There is an immediate need to substantially strengthen the existing public health institutions and regional and State laboratories. Essential public health functions which address preventive health care, immunization, establishing a rapid public health response system will receive priority. The capacity to undertake laboratory analysis at the district level, the availability of reagents and the ability to network early warning signals will be developed and will receive the status of essential public health functions.

3.7 The epidemiological and entomological capacity at the district level would be strengthened by covering the whole country through a disease surveillance programme aimed at proper networking of public health institutions, laboratories and trained health personnel so that a syndromic approach to disease outbreaks can be adopted. Without the involvement of the private sector, the basis for epidemiological intelligence and surveillance may remain undependable and unrepresentative. The best practices available globally would

be accessed and a model suitable for Indian conditions introduced in order to build a reliable epidemiological base to plan public health initiatives.

Hospital Waste Management

3.8 All hospitals in the country whether in the Government or Private Sector are now required by law to initiate an appropriate hospital waste management system. Each hospital would have an infection Control and Waste Management Committee to devise policies and segregation of waste and infection control. The provision of incinerators/appropriate method of waste disposal to be installed in hospitals having more than 50 beds would be monitored. The establishment of common incineration facilities would be encouraged. The enforcement of the law would be undertaken by involving the public in overseeing compliance and reporting shortcomings.

Nutrition

3.9 Food and nutrition security for the vulnerable section of the society would be viewed not only as issues concerning the science of nutrition but would be related to the right to work, the right to health, the right to education and the right to information, all of which are dependent on a healthy state of mind and body. Within the overall ambit of the National Nutrition Policy, priority has to be assigned to the equitable distribution of food to all including women and girl. Pregnant women and nursing mothers constitute one of the most important target groups particularly as investment in their health and nutrition directly affects the birth weight of new born children and their development. The need to start complementary feeding at six months and for tackling malnourishment in the under 5 age group are two more interventions which need to be augmented where critical gaps continue to persist.

3.10 The lack of iron and iodine intake also need to be given reinformed attention. Micronutrient malnutrition is not confined to India but is accepted as a global problem. Investment in assessing the magnitude of iron, Vit-A and iodine deficiency with sustained intervention strategies to improve dietary intake of micronutrients will be provided for within sectoral allocations.

3.11 People's own responsibility for their health at the level of the individual and the family would be given appropriate focus. Imparting health nutrition education in terms of knowledge as well as practice will be given a major thrust to help people overcome the aggressive marketing of consumer goods and services often injurious to health.

4. COMMUNICABLE DISEASES

4.1 The health status of a people is determined among other things by the availability of safe drinking water, sanitary disposal of human waste and other wastes, adequate nutrition, literacy levels, educational attainment and the status of women. Health outcomes are mostly the result of activities and policies that fall outside the health sector: agricultural output and food production, poverty alleviation programmes in the area of rural employment, education and social welfare, housing, water supply and sanitation etc. Health outcomes are also dependent upon non programmatic initiatives such as governance and the capacity of the regulatory systems to enforce the rule of law related to food adulteration, maintenance of prescribed standards in the manufacture and sale of drugs. An integrated and multisectoral approach is essential for implementing health programmes which would have a direct impact on the disease profile.

Tuberculosis

4.2 Tuberculosis remains one of India's most serious health problems and has been identified as one of the hot-spots for multi-drug resistance. It is estimated that there are 5,00,000 deaths per year from tuberculosis

in the country - more than 1,000 every day, 1 every minute. The Revised National Tuberculosis Control Programme (RNTCP) is being expanded in a phased manner across the country. In the next 10 years, the challenge for prevention and control of tuberculosis will be to implement RNTCP throughout the country while ensuring high quality of service delivery. For this to happen, the capability of undertaking quality diagnosis will be upgraded through the provision of essential equipment. Increased access to quality microscopy services, uninterrupted drug supply, directly observed treatment at a place convenient to the patient, and the introduction of new reporting system will be implemented countrywide. In addition, HIV-associated tuberculosis is likely to increase in the coming years and could greatly increase the burden of tuberculosis in the country. Therefore, new strategies will be introduced to reduce the burden of HIV-associated tuberculosis.

Leprosy

4.3 With a significant decline in the number of leprosy patients due to effective cure with multi-drug therapy, it is expected that leprosy will be eliminated in most of the States/UTs by end of year 2000 : the remaining States may take up to year 2005. The present strategy of detecting hidden cases and treating them with MDT will continue. Efforts would be made for proper integration of leprosy services with general health care particularly for ulcer care and attention to the problems of disabilities. The need for socio-economic rehabilitation of leprosy cured persons having disability beyond grade II will be given priority.

AIDS Control Policy (In Summary)

4.4 The problem of AIDS is a public health challenge and will continue to be treated as a matter of great urgency calling for commitment, effective implementation of the programme, provision of accurate information and education to make people aware of the need to protect themselves from HIV infection. The State will introduce a helpful and supportive social environment so that people who suspect themselves to be infected can come forward for voluntary testing and for seeking help so that they can live peacefully with other members of the society. Special efforts would be made to remove fear psychosis from the minds of people and prevent discrimination and stigmatisation. While a separate AIDS Control Policy is under formulation the notable elements would include:

* Development of a strong ownership of the HIV/AIDS Prevention and Control Programme by the Centre and State Governments.

* Strong advocacy and social mobilisation from the top most level in government to ensure the spread of the message throughout the country with full cooperation of NGOs and Community Based Organisations.

* Promotion of low cost care to people living with HIV and AIDS without any discrimination and stigmatization. This would include encouraging systematic attempts to create homes for people with AIDS who may no longer be able to live with their families.

* Promotion of management of Sexually Transmitted Diseases (STDs) through a syndromic approach.

* Expansion of targeted intervention strategies for high risk groups of the population.

* Reduction in transmission of HIV d by transfusion of blood and blood products by mobilisation of efforts to increase voluntary bloo on and screening of blood.

* Strengthening the effectiveness of ogramme through technical, managerial and financial support.

* Expansion of STI/HIV/AIDS sentinel surveillance and operational research programmes.

* Inter-sectoral and cross-sectoral collaboration with the public, private, corporate sectors to involve citizens in responding to the problem of HIV/AIDS.

* A sizeable research effort would be launched to develop drugs, vaccines and testing kits in a time bound manner.

Draft National Blood Policy (In Summary)

4.5 The recent Supreme Court judgement on Revamping of Blood Transfusion Services has brought into focus the urgent need for streamlining and managing the blood transfusion services in the country. The mandatory licensing of Blood Banks, the elimination of the professional donor system and the revision of Drugs and Cosmetics Rules to prescribe standard practices have already been introduced. Government's commitment to make adequate and safe blood and blood products available will be reinforced. A separate National Blood Policy which has been formulated would set out the guidelines and directions for better management of blood transfusion services, giving meaningful encouragement to blood donation, expansion of blood separation and component facilities, phased indigenisation of blood bank equipment and testing kits and emphasis on biosafety measures as they relate to safe blood. Screening of blood would also include HCV alongwith the existing four diseases already being screened.

Malaria

4.6 The ongoing programme with 100 percent Central assistance in the seven North-Eastern States and the tribal districts of the country where the prevalence of P.falciparum malaria is high, will be continued. The enhanced malaria control programme will also be implemented in all districts, cities and towns having a rising slide-positivity rate and in areas where there have been focal outbreaks of malaria in previous years. The main components would include early diagnosis and prompt treatment through strengthening of active and passive surveillance; laboratory diagnosis; selective vector control by integrating various sector control approaches; promotion of personal protection methods; prediction, early detection and effective response to malaria outbreaks; and intensified information, education and communication campaigns. The involvement of the community in the prevention and control of malaria will be given the strongest emhasis with the aim of eliminating mosquito breeding through people's participation.

Filariasis

4.7 During the Ninth Plan, the strategy for filariasis control would include single dose DEC mass therapy to be introduced in a phased manner to eventually become a National Programme. Vector control measures, detection and treatment of microfilaria carriers, and treatment of acute and chronic filariasis would continue.

Dengue

4.8 For the containment of dengue, efforts will be made to establish an organised system of surveillance and monitoring; strengthening facilities for early diagnosis and prompt treatment; and intensification of IEC efforts to ensure that all households implement peri-domestic measures to reduce the breeding of Aedes. The adoption and enforcement of urban bye-laws will be pursued so that those responsible for creating breeding grounds for mosquitoes are made accountable for the same. A Dengue Control Programme would be introduced to cover the high risk areas of the country.

5. CONTROL AND PREVENTION OF NON-COMMUNICABLE DISEASES AND EMPHASIS ON OCCUPATIONAL HEALTH

5.1 Life-style related diseases are at times a concomitant outcome of increase in life expectancy as well as industrialization, urbanization and increase in earning capacity. Cardiovascular diseases, cancers, diabetes are becoming major contributors to the burden of disease.The thrust would be on early prevention through organized health education campaigns aimed at informing the population including children and young adults of the dangers of rich diets in saturated fat, salt and excess calories, absence of physical activity and addiction to tobacco and alcohol. The magnitude of the major non-communicable diseases would be assessed through standardised surveys. National and State systems would be set up for vital registration. Targeted primary prevention strategies would be developed. Keeping in mind the demographic transition cost-effective interventions for both diagnosis and primary treatment of non-communicable diseases at the primary health centres and rural hospitals will be introduced in a phased manner. A major research effort would be mounted aimed at creating cost-effective models suitable for rural conditions.

5.2 The health infrastructure would be involved in monitoring the provision of occupational health care by generating data on occupational diseases and making the employers responsible for prevention and treatment. The tertiary and district hospitals would be expected to maintain cause of injury statistics to highlight the extent of morbidity caused by occupational diseases.

5.3 A comprehensive legislation on reducing the use of tobacco products would be introduced with all tobacco products having to carry a bold direct warning of a prescribed direction easily intelligible to even illiterate people. The advertisement of tobacco products would be banned and the sale of such products to minors made a punishable offence. Tobacco education would be included in the curricula of schools and medical colleges.

Control of Blindness and Restoration of Vision

5.4 The camp approach for cataract surgery would be phased out and voluntary organisations encouraged to use the health infrastructure, both for management and follow-up. The training of surgeons conducting IOL implant surgery would be standardized with an emphasis on sight restoring operations.

5.5 National norms would be developed for the diagnosis and management of glaucoma at the PHC level.

National Cancer Control Programme (NCD)

5.6 The incidence of Cancer is growing which poses a costly public health problem due to increasing life expectancy and changing life styles. There are about 2.5 million cases of cancer in the country at a given point of time and approximately 0.8 million new cases are registered each year. The National Cancer Control Programme would be strengthened through primary prevention, secondary prevention and treatment of cancer patients. The strategy under the programme would include health education, early detection, strengthening of existing institutions and adoption of anti-tobacco measures to reduce tobacco consumption. With the growing incidence of cancer, special efforts would be made to garner resources for providing cancer drugs which are extremely expensive and outside the reach of a vast majority of the population.

Special problems of Persons with Disabilities

5.7 In the new - Persons with Disabilities (Equal Opportunities, Protection or Rights and Full Participation) Act, 1995, the seven categories of disability include blindness, low vision, leprosy that has been cured, but where

there is a loss of sensation or deformity causing social and physical embarrassment, hearing impairment, locomotor disability, mental retardation and mental illness.

5.8 With the introduction of the Prevention of Disabilities Act, 1995, centres for Rehabilitation will need to be set up at the District Hospitals. The existing health infrastructure would be strengthened to incorporate provisions for the prevention of disabilities and rehabilitation of the victims. Each State and Union Territory would ensure that PHC doctors and para-medical personnel receive training and are given orientation in the medical aspects of rehabilitation. Strategies would need to be devised to overcome the myths, misconceptions and prejudices surrounding disabilities and deformities which have been a hinderance in undertaking meaningful efforts to rehabilitate the disabled and make them productive members of the community. The recommendations of the Medical Council of India to start Physical Medicine and Rehabilitation Departments in every medical college would be implemented.

5.9 In all poverty alleviation programmes, priority would be given to actively involve persons with disabilities. District hospitals would be strengthened to cater to the medical rehabilitation aspects. PHC doctors would be sensitized to provide early and special treatment to patients with disabilities. Health and safety measures would be promoted at the work place, home, public places and public transport.

6. DRUG POLICY AND PRESCRIPTION PRACTICE

6.1 Within the overall framework of the Drug Policy 1994, a National Drug Authority will be established to oversee inter-state commerce and undertake central registration of drugs.

6.2 The Proceedings of the Drugs Technical Advisory Board and its decision to withdraw hazardous drugs and those of questionable therapeutic value will be published in relevant publications for the benefit of the consumer. The Central Drug Control Organization would be strengthened and new Central Laboratories to cater to Regional needs established.

6.3 The capacity to undertake drug testing would be augmented by providing additional equipment and manpower and undertaking appropriate renovation and modernization of the laboratories. The enforcement staff at Central and State levels would be strengthened and their capabilities enhanced through specialized training.

6.4 Drug package labelling will compulsorily have to carry proper drug information and consumer warnings. Pharmacists will be under instructions to warn consumers about side effects of drugs. The concept of Over The Counter drugs and prescription drugs will be defined and administered through the licensing authorities.

6.5 The essential drug list which has already been declared for different levels of health facility will be adopted countrywide so that there is uniformity in approach. Surveillance on patterns of drug misuse and on monitoring of adverse drug reactions would be undertaken and reports thereof discussed at the Drug Technical Advisory Board and published for consumer information.

6.6 The indigenous production of testing kits for Hepatitis 'C' and HIV/AIDS will be encouraged.

Vaccines

6.7 The country is self-sufficient in production of all the vaccine required for National Immunization Programme except Oral Polio and BCG Vaccines. The Polio concentrates are imported blended, bottled and supplied to the States. 60% requirement of BCG Vaccine is fulfilled by the indigenous production and the rest (40%) is imported. The efforts would be continued to attain complete self-reliance in the production of vaccines.

6.8 The vaccine producing Institutes in the Public Sector would be assisted to renovate and modernize their production capacities so that they can continue to contribute in maintaining standards and containing the prices of essential vaccines intended for the universal immunization programme. Whenever possible, they would be corporatized through joint ventures to make them function cost-effectively.

6.9 The traditional neural vaccine used in the treatment of Rabies is very painful and at times capable of producing neuroparalytic disorders. The indigenous production of a more safe and receptive tissue culture vaccine will be encouraged and the traditional neural vaccine phased out.

6.10 Considering the threat of Yellow Fever in the Asian Region, the production of Yellow Fever vaccine restarted in the country will be augmented as a precautionary measure with the surplus made available for export.

7. PREVENTION OF FOOD ADULTERATION

7.1 Food safety would be placed high on the National agenda. A National Food Council would be established. Steps would be taken for augmenting the infrastructure for the Prevention of Food Adulteration Programme both at the Central and State level. This would include establishment of new Cent Food Laboratories, training of staff, establishment of Import Quality Control Units at the Ports and augmentation of the Central and State food laboratories to enable them to perform sensitive tests as well as quantitative analysis of hazardous substances. The establishment of District Food Inspection Units would be given priority.

7.2 The quality of street foods would be given attention particularly in and around places of congregation like schools, colleges, market places and shopping centres. Registered Consumer Organisations/NGOs will be actively involved in the programmes on Food Safety and Quality Control.

7.3 A strong consumer movement would be created through the media and the importance of Food Safety and Quality Control would be explained particularly to students and NSS volunteers to propagate a sense of awareness about health hazards.

7.4 Designated courts would be established to see that the trial of food adulteration officers is efficacious and swift.

8. TRAUMA AND EMERGENCY SERVICES

8.1 The right of the citizen as determined by the Supreme Court to access emergency care in any hospital and to receive the first line of critical care would be publicized. Communication and wireless links would be established in all hospitals running a 24 hour emergency so that diagnostic facilities and specialized treatment can be accessed, networked and shared for the benefit of the citizen.

8.2 A system of providing quick administration of quality first aid, and speedy lifting of accident victims to the nearest hospital for complete trauma management would be introduced, in the first place, to cater to high risk spots on National Highways in conjunction with the Highway Authority of India and Telecommunication authorities.

8.3 Policies and schemes to compensate private tertiary hospitals which volunteer to treat accident victims in the wake of large scale disasters would be introduced to reduce the unmanageable load cast on public hospitals during such emergencies.

9. INTERSECTORAL COORDINATION

9.1 Intersectoral co-ordination between relevant departments would be strengthened so that the preventive, promotive aspect of health care are integrated and propagated through the existing extension arms of the government machinery. A close partnership between voluntary organisations, private practitioners and local government infrastructure networks would also be developed so that the spread of health education messages becomes a universal responsibility.

10. HEALTH CARE FOR SPECIAL GROUPS

Health of Women

10.1 Girls start working earlier than boys, work longer and harder throughout their lives. The energy consumption in mere survival tasks of - fetching fuel, water, fodder; care of animals; washing; cleaning which are exclusively women's responsibility results in a negative nutritional balance and calorie deficit. The programmes on AIDS, STD and Family Planning would be integrated so that women can have access to all the inputs through a single source at the primary health level. The large number of abortions and abortion deaths reflect the increase in the number of inflicted, unwanted pregnancies which women have to bear. These contribute substantially to maternal mortality. The non-availability of trained attendants for deliveries would be corrected in a time bound manner by laying down targets for yearly achievement.

10.2 Changes in medical and nursing curriculum would be introduced to incorporate women's health concerns.

10.3 A separate Population Policy would be announced. Hitherto, public policy has been restricted to the reproductive health of women. There is need to broaden the framework and provide women access to other services. This can be possible only when health care delivery is fully integrated. Health will also need to be centred within the broader context of empowerment of women and interrelated to the overall plans and strategies of the other related departments working for gender equity.

Health Care of Children

10.4 The largest mortality amongst infants and children takes place under five years of age mainly on account of low birth weight, respiratory diseases, diarrhoea, malnutrition, measles, the outcome of improper antenatal, natal and post-natal care and premature birth.

10.5 Children are also engaged in stressful conditions in agriculture, hazardous industries, domestic jobs, etc. The health of children has to be safeguarded through special health check-ups which will be organized in conjunction with other activities aimed at checking child labour and uplifting the quality of life of children. Reporting of causes of injury in the case of accidents involving children will be made mandatory so that corrective action can be taken including the use of penal provisions where called for

10.6 The enforcement of the Child Marriage Restraints Act which will help in reducing the number of teenage pregnancies will be given nationwide priority so that society at large is involved in preventing the illegal marriage of girls before the age of 18.

10.7 Special attention would be given to the nutritional status of adolescent girls and pregnant women through the Reproductive Child Health Project and the health services strengthened so that children get proper protection and timely treatment against the common diseases of childhood.

10.8 Universal immunisation of children against vaccine preventable diseases, elimination of polio and near elimination of Tetanus and Measles would continue to be a priority.

Elderly persons

10.9 The concept of geriatric care would be introduced into hospital services at all levels, both in urban and rural areas. Special efforts would be made to address the health component of the policy on aging - particularly introducing the promotion of health giving life styles and freedom from psychosocial problems as an essential component of care for the elderly.

Mental Health

10.10 Mental illness having been included as one of the disabilities eligible for certain benefits under the provisions on the Disability Act, 1995. Schemes would be instituted for the rehabilitation of the mentally ill and their acceptance within the community. Nervous disorders constitute the highest burden of disease and they affect women predominantly. Anti-depressant drugs would be stocked at public sector health centres and hospitals at the sub-divisional level and measures taken to address the social stigma attached to mental illness.

10.11 The improvement of mental hospitals and Departments of Psychiatry in general and teaching hospitals in terms of adequate staff and services will be given priority attention. Regular and adequate supply of medicines required for treatment of the mentally ill will be ensured at the district hospitals and health centres.

10.12 The pilot community mental health programme under implementation for the primary health care level would be expanded.

10.13 Existing mental hospitals would be selected to be upgraded as Regional centres for community mental health and for standing as examples of best practice for surrounding areas.

10.14 Departments of Psychiatry would be created in all the medical colleges and the mental health training of graduate medical students given fresh orientation. Mental health care would be integrated with primary health care and the doctors, staff and community trained to recognize early signs of mental problems so that besides treatment and follow-up of mentally ill persons are integrated with the community through different welfare schemes.

10.15 The Central and State Mental Health Authorities would play an effective role in enforcing the existing legislations and measures would be introduced to see that every mental hospital, its wards and inmates are inspected by groups of public spirited individuals who would periodically report the state of affairs to the visitors and authorities set up under the Act.

Dental Health

10.16 Oral health would be made an integral part of the general health policy and separate Directorates established to pursue the public health aspects of proper dental care. Dental colleges would be asked to set aside quality time to build student knowledge on preventive and community dentistry. The dental check up of children would be introduced by providing linkages with dental surgeons both in the public and private sector who would be paid for services rendered on the basis of case finding.

11. SYSTEMS SUPPORT FOR HEALTH SERVICES

Voluntary Sector in Health Care

11.1 While voluntary agencies and NGOs have been used extensively in implementing health sector programmes and this would be continued and expanded, a forum to elicit their views and to deal with generic operational

problems would be established so that the interaction is meaningful and continuous and there is a formal body to take note of the need for mid-term correctives. Voluntary agencies and Community Based Organisations would continue to be used for the effective implementation of National Programmes as well as to spread health education and act as a watch dog over the provision of health services within the public and private sectors.

Health Finance

11.2 The share of public health in the expenditures of the state governments would be increased annually and the focus would be on consolidating and improving the existing health structure and system rather than spending on expansion of infrastructure. Facility wise list of procedures alongwith a check list of equipment, drugs and consumables would be available at every district hospital, community centre and primary health centre for public information. Maintenance of facilities will be separately provided for in the State and district budgets.

11.3 There is need to have the upper crusts of the society pay for the services. User fees or private insurance are some of the means available for such sharing of costs. Limits will also be introduced and imposed on free treatment facilities in Government hospitals so that citizens pay for expensive procedures and only those who are clearly unable to pay get free or subsidised treatment. Guidelines and norms for deciding paying capacity will be evolved limited to other economic indicators.

11.4 The need to maintain national health accounts to monitor health expenditures will be given concrete shape. Expenditure would be reviewed activity-wise to oversee the actual returns on investment so as to introduce timely corrective action.

11.5 Research and experiments would be undertaken to create financially sustainable models of free health care for the poor in rural and urban areas.

Relevant Technology

Health Management Information Systems

11.6 Priority would be accorded to the establishment of Health Management Information Systems which are able to identify the gaps so that resources can be assigned meaningfully. The benefits of computer technology have so far percolated into medical colleges, research and training institutions. Small projects for data collection at the district level, E-mail communication through the satellite and modern techniques have been introduced on a pilot scale but their universal application is still many years away. The collection of information in a continuous fashion to enable correctives being introduced in a timely manner will therefore need to be achieved through the use of modern systems of data processing. While this will improve the efficiency and effectiveness of the health care system, it will also facilitate better policy planning.

11.7 Efforts will be made for the development and testing of appropriate inexpensive technologies for measuring weight and height to facilitate early detection of under nutrition in adults and children; in the PHCs, self-recording instruments for measuring arterial blood pressure for use by ANMs/male multi-purpose workers and hand-held electronic data entry machines for ANM/MMPW will also be introduced in a phased manner.

11.8 Attempts will have to be made to create a district data base on health manpower belonging to various categories including ISM&H practitioners working for government, voluntary and private sectors so that they can be used effectively in promoting health care through proper orientation and training.

12. PRIVATE HEALTH SECTOR

12.1 At the outset, the need to encourage the private sector and give them an enabling environment to develo multispeciality hospitals and diagnostic centres of quality is recognized. Their potential for providing hig class medical care, conserving previous foreign exchange which would be spent in having to sen complicated cases abroad for treatment as well as their capacity for attracting foreign clientele in search advanced medical care is recognized. None-the-less, the other side of the coin represented by the existen of poor quality, unregulated nursing homes and clinics is also a reality.

Regulatory measures for Private Nursing Homes and Hospitals

12.2 Laws would be enacted to provide for registration of only those private hospitals which have minimu facilities for different forms of treatment. Monitoring mechanisms would be developed to ensure that th facilities and services created in private and voluntary sector hospitals are available and maintained at th desired level. Private Hospitals in non-conforming areas which are posing health hazards would b recommended for being moved to conforming areas.

12.3 Medical care in the private sector has so far worked in isolation without being accountable to any regulatio or even self-regulatory mechanisms. Juxtaposed with some of the finest examples of world class me c care instances of callousness, negligence and poor quality care continue to be reported. Although public institutions are beset with similar complaints, the existence of internal supervisory systems, media attentio and parliamentary vigilance, have to some extent protected the rights of the public. In the absence of suc a mechanism in the private medical sector there is a strong case for external regulation, particularly whe the public is paying for the services.

12.4 The States will encourage the establishment of accreditation mechanisms to give a star rating to each leve of facility and this information will be made available through Directories on medical facilities for public consumption. The gap that exists in the absence of a standard-setting agency will sought to be filled through the Bureau of Standards, the Medical and Nursing Councils and the Consumer Forum working together to evolve standards for nursing homes and hospitals without unnecessarily pushing costs up through expensive procedures which are of limited medical value.

12.5 A Council for Medical Care Standards will be established which can function as an independent regulatory body for the country and all new establishments will be required to fulfil the standards prescribed by the Council, before getting clearance from the appropriate accreditation authority. Existing facilities will be given limited period to attain such standards. The Council will grant recognition to accreditation Councils at State and district level which will have powers to levy charges for registration and renewal. A Charter mark scheme will be suggested for being adopted voluntarily by the hospitals for the benefit and guidance of the consumer.

12.6 The State and local bodies would introduce incentives and disincentives to make for the dispersal of medical practitioners concentrating their practice in urban areas. They would declare a policy on establishment of the newer medical and diagnostic centres, nursing homes and clinics would address the concern of spatial equity. The Medical, Nursing and Dental Councils will be enjoined to play a more effective role in checking the ethical aspects of private practice including over pricing and profiteering at the cost of the ignorant consumers.

12.7 While implementing the existing Acts and laws, an entirely new range of comprehensive regulations will be introduced to prescribe minimum requirements of qualified staff, conditions for carrying out specialized interventions and procedures within a set of established procedures for quality assurance. The maintenance of medical records of patients will be made mandatory the absence of which has prevented conclusive action being taken under the Consumer Protection Act.

12.8 The subject of quackery would be tackled by making registration of all medical practitioners under the relevant State laws mandatory. Non-registered practitioners would not have a right to practice medicine and the judgement of the Supreme Court in respect of medical practice would be enforced.

Social responsibility of Industry

12.9 The corporate sector will be expected to respond to the challenges in the area of primary health care, as part of community development efforts in rural and urban areas. The sector would be expected to sponsor information and education programmes on health issues, using modern professional skills of advertising and public relations, using various media as a part of this social responsibility. A legislation which would seek this mandatory service would be introduced and the funds spent on health promotion included in the annual report of each company engaging more than 100 workers.s

13. MEDICAL EDUCATION

Policy Objectives

13.1 Maintenance of high standards of medical education will continue to be the primary policy objective within the overall ambit of the National Health Policy. In addition, the endeavour shall be to bridge the gap between availability and demand for medical manpower in rural areas and to ensure that the quality of medical education is socially relevant.

Assessment of availability and need of medical manpower

13.2 For making an assessment of the availability of medical manpower and future needs of the country it shall be prescribed by law that all medical personnel (including dental and para-medical) shall get their registration with the appropriate technical Council once every five years. Provision shall also be made for registration of additional qualifications/super-specialisations in order to create a data base on manpower in various specialities.

13.3 The existing medical and dental institutions shall be geographically mapped and areas of the country found deficient in such infrastructure will be given preference for establishing new facilities. Establishment of new medical and dental colleges within the same area will be discouraged ad sustained availability of qualified medical teachers made a criteria for determining the establishment of more medical and dental colleges.

Increasing availability of medical manpower in rural areas

13.4 The recruitment of medical personnel will be decentralised and powers vested in the local bodies for making such recruitments. Skills of para-medical personnel will be upgraded to enable them to provide basic medicines even in the absence of a medical personnel.

Restructuring of the Professional Councils

13.5 The Councils will be restructured in order to enable them to be responsive to changing social requirements. All States/UTs shall have Councils to represent the Medical, Dental, Nursing and Para-medical professions that are comprised of elected representatives of the concerned professional community. Efforts to weed out unqualified medical practitioners shall be renewed. The Professional Councils would be strengthened to make them effective in maintaining standards and encouraged to become self sufficient by raising resources through re-registration of doctors.

13.6 While the position of the Councils as autonomous elected professional bodies will be maintained, the need for them to interact with representatives of those sections of society who need health care the most would be recognized. A forum for exchange of ideas will be set up where a more realistic rendering of what the country needs can be deliberated upon with representatives from the social sciences, voluntary agencies, consumer groups as well as professionals from National level training and research centres.

13.7 The Indian Nursing Council and State Nursing Councils would be made more effective through technical and monetary support to enable them to regulate the standard of nurse's training and education keeping in mind developments in other parts of the world which place reliance on trained nurses in the absence of doctors.

Manpower Planning for Dentists and Para-Professionals

13.8 There is an acute shortage of dental graduates and post graduates.The growth of dental profession and services has largely been patterned along treatment provided in highly developed countries. The need for preparing a cadre of dentists capable of addressing the needs of rural areas particularly of school children and the elderly will be recognised by introducing special programmes through the Dental Council.

13.9 Yet another area of imbalance is in the production of para-medics particularly nursing personnel. The nurse population ratio in India has been unsatisfactory. With the advancement of medical sciences and technology, nurses are required to work effectively in different speciality areas and therefore, speciality training need to be imparted in keeping with the growing needs. The qualitative and quantitative expansion of nursing services will be given renewed attention.

13.10 There is at present no authentic information regarding the present stock of registered para-medical professional as a number of them are either not functioning or have gone abroad. The establishment of Councils for left-out categories of para-professionals and declaration of a manpower production and exodus policy for key personnel will be given a direction.

Human Resource Development

13.11 There shall be a separate body for determination of the pay structure, terms and conditions of the services of medical teachers. Special incentives shall be given for specialisation in subjects in which there is a shortage of teachers.

13.12 Institutes of excellence set up under Acts of Parliament like All India Institute of Medical Sciences, New Delhi and Post Graduate Institute of Medical Education and Research, Chandigarh would continue to be governed according to relevant Statutes

13.13 Continuing medical education will be further encouraged and the renewal of Registration shall eventually be linked to attending a prescribed number of CME programme. Special programmes shall be introduced to improve the skills of para-medical staff to enable them to provide a basic first line of medical care even in the absence of a medical practitioner.

Fees and Resource Mobilisation

13.14 There shall be a similar fee structure for all medical institutions in the private sector including universities and deemed universities. The penalty for charging capitation fees will be further enhanced and violations of the MCI Act shall invite further disqualifications under the Act.

14. HEALTH INSURANCE

14.1 When Health Insurance is thrown open for private and foreign investment, there will be a growing need to regulate the sector to ensure that who need medical cover the most are not left out of the system. While health insurance would largely be catering to the organised sector and those who have paying capacity, none-the-less, regulatory mechanisms would be introduced to ensure that the interests of the consumer are protected. A joint forum to formulate Health Insurance Regulation relevant to the country's needs will be established alongwith the Insurance Regulatory Authority.

14.2 The possibility of adopting various forms of health insurance to be supported by the State to cover indigent groups and the aged would be examined. The benefit of providing such cover particularly in rural areas instead of establishing new medical centres would be considered.

15. MEDICAL INDUSTRY

15.1 The country has built a vast capacity for manufacturing bio-medical equipment and medical devices. There is at present no single agency capable of laying down standards for medical instruments, equipment and devices. This systems militates against the consumers' interest in terms of quality control. It also provides no forum for understanding the dimension of such production and the criticality of the products in order to judge whether exemptions ought to be given for specific equipment, devices and consumables which are of life saving nature. This also applies to the whole range of drugs and vaccines manufactured in the country. The National Drug Authority would be responsible for seeking applications for duty reduction and which would assess the impact the equipment or device has on life-saving treatment so that recommendations could be made on the individual merits of the proposals received keeping in mind principles which would be laid down. Medical devices would be brought under the purview of the Drugs and Cosmetics Act for standard setting.

16. MEDICAL RESEARCH

16.1 The health of the people of India is in a stage of transition. As the country moves from an under-developed nation to a developing one it is grappling with a triple burden of diseases which beset both the developing as well as the developed countries. India still faces the burden of nutritional disorders, over population and lack of maternal and child health care, large number of communicable diseases, and the emergent non-communicable or life-style related diseases. Newer, forgotten, and re-emerging infections especially due to the drug resistant strains of microbes are a cause of serious concern. Spiralling costs and rising demands are putting health systems under strain. Millions are spent on health care annually, yet millions receive inadequate unsatisfactory services. The basic objective of medical research and the ultimate test of its utility would involve the translation 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 frontline health workers, in the remotest corners of the country.

16.2 There is a need to quantify the impact on health of economic policies and performance, the contribution of investments made in health in improving the productivity of the poor.

16.3 Special attention would be paid to socially deprived and economically disadvantaged sections of the society to understand their social, health and nutritional problems and making available a health care system that is acceptable to them.

16.4 An atmosphere conducive for research interaction is essential for holistic development. Biomedical resea is fast becoming cost and expertise intensive with new developments taking place each day. comprehensive research agenda would be formulated and put into action by pooling the available natio resources. Promotion of international collaboration for capacity building of the infrastructure would encouraged to create the requisite competencies for the future. A larger funding for R&D based project proposals as opposed to the present practice of routinely providing lumpsum grants to instituti will be introduced. This will ensure that in the long term projects are related to capacity to deli results.

16.5 For research inputs to feed into planning for health, it is crucial to strengthen the research laborato in the country to undertake research using tools of modern biology. The overall effort would aim at balanced development of basic clinical and problem-oriented research.

17. PRIORITIES FOR HEALTH PROMOTION IN THE 21ST CENTURY

17.1 Both the public and private sectors would be made responsible for the promotion of good health by pursu policies and practices that:-

- lay emphasis on the certainty of health to complete well being.
- avoid harming the health of other individuals.
- protect the environment and ensure sustainable use of resources.
- restrict production and trade in inherently harmful goods and substances such as tobacco armaments, as well as unhealthy marketing practices.
- safeguard both the citizen in the marketplace and the individual in the workplace.
- include equity-focused health impact assessments as an integral part of policy development.

18. POLICY ON INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY

18.1 India has a rich centuries old heritage of traditional, medical and health sciences. The philosophy Ayurveda and other systems like Siddha and Yoga are testimony to ancient tradition on which scientific he care was extended to the people. The ancient medical systems have a holistic approach taking into accou all aspects of human health and disease. However, with the intermingling of cultures, these syste relegated not only to a secondary status but they were also suppressed. Yet it is to the credit of the syst that they have survived and have continued to be practised widely in the country.

18.2 Immediately after Independence starting with the First Five Year Plan, these systems of medicine recei a broad policy support and moderate resources. As a result, a broad infrastructural frame work has b created for the development and promotion of these systems.

18.3 At present, the country has more than 6 lakh practitioners of the Indian Systems of Medicine Homoeopathy and around 300 educational institutions producing about 13000 graduates every year. Th are 21000 dispensaries and 6500 hospitals of Indian Systems of Medicines and Homeopathy. There are about 9000 pharmacies manufacturing drugs of ISM&H. Unfortunately, the services of these systems under-utilised at present.

18.4 The earlier National Health Policy acknowledge the high local acceptance and the respect enjoyed by Indian Systems of Medicine and Homoeopathy in the country. The policy expressed the need to init

19. SHORT AND MEDIUM TERM GOALS UNDER THE HEALTH POLICY 1999

19.1 The overall guiding principles for future policy will be to ensure equity in health and not deny acce health care for want of the ability to pay.

19.2 The goals to be achieved in the short and medium term are :-

- eradication of leprosy, polio, yaws, filariasis and guineaworm infestation and sustaining the achieve through proper prevention and detection programmes;
- reduction in infant mortality to less than 30 per thousand live births.
- universal immunisation, reduction by half of low birth weight babies and doubling of the numb institutional deliveries;
- reduction in maternal mortality to less than 100 per one hundred thousand live births.
- Reduction in annual malarial parasitic index per 1000 cases to 1.5 in 2010 and to 1 in 2015.
- Cure rate of TB to go up from the present 50% to 85% in 2015.
- Prevalence of Cataract Blindness to be reduced from 1.4% to 0.80% by 2015.
- establishment of facilities for early diagnosis and treatment of cancer, CVD and hypertension a District level and at the Community Health Centre level in a phased manner.
- capacity development for treatment of mental health and disability at all district headquarters.
- establishment of a broad based disease surveillance and a computerised health information netwo the district level.
- formulation of a special policy framework for the rational development of human resources and integration of Indian Systems of Medicine in the overall delivery of health services.

HP 1.14

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001

Tel. 310694, 322064

HP

NATIONAL HEALTH POLICY

The approach of our ancient medical system was of a holistic nature, which took into account all the aspects of human health and disease. Nevertheless, due to the influence of the west, it has been reduced to curative, an urban-biased, top-down and an elite-oriented approach. This improvements have to be made to combate BLINDNESS, MALARIA, DIARRHOEAL DISEASES, LEPROSY, TB etc.

In order that our health service are to be effective, there arises the need for transfer of knowledge, simple skills and technologies to health voluntaries who are selected by the communities. Moreover, primary health care must be provided with special emphasis on preventive, promotive and rehabilitative aspects together with other systems of indigenous medicines, such as AURVEDIC, UNANI, SIDHA, HOMEOPATHY, YOGA, NATUROPATHY, etc. Hence the large stock of such health manpower could be utilised for promoting an effective health care services in India.

Besides these aspects, attention to be paid in the other aspects such as a well developed distribution of low cast food, of acceptable quality, available to every person especially to the rural poor, prevention of food adulteration and maintenance of the quality of the drugs, safe drinking water, proper environmental sanitation, immunization programme, a well planned matternal and child health services to reduce morbidity, disabilities and mortalities so as to promote better health.

Production of life saving drugs under their generic names especially for the treatment of TB and leprosy are to be within the reach of the rural poor who suffer mostly from these diseases. The use of low cast and no cast indigenous and herbal medicines are to be encouraged.

Nevertheless, when we critically analyse this statement, we see that very little efforts have been made in the promotion of low cast drugs for example, nearly 40 to 60 million people suffer from endemic GOITRE through its prevention is so cheap by using iodized salt which is not available to the people in need. In the same way, more time and money are spent to produce expensive drugs than the production of Vitamin A, the deffiency of which lead to blindness as 30,000 million children suffer from

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this today. But at the same time, out of the total production of Rs. 1000 million (in 1976) 25% was taken away by Vitamins and tonics while 20% by anti-biotics. Hence, it is not enough to see that drugs are produced by Indians and in abundence, but it is even more important to see what drugs are produced and for whom? e.g. the diseases of poverty such as TB and Leprosy get scant attention and thus DAPSON for Leprosy and INH for TB are constantly in short supply.

Hence all health and human development must ultimately constitute an integral component of the overall socio-economic development process in the country. It is thus of vital importa e to ensure effective co-ordination between health and other developmental activities in order to build healthy communities.

Reference: 1. Statement on National Health Policy (1982)
2. Seminar on the National Health Policy - a report.

COMMUNITY HEALTH DEPARTMENT, CHAI

The Catholic Hospital Association of India

C. B. C. I. Centre, Goldakkhana, New Delhi - 110001

Tel. 310694, 322064

NATIONAL HEALTH POLICY AND THE SEVENTH FIVE YEAR PLAN

[Following are a few suggestions submitted by the Catholic Hospital Association of India to the Director General of Health Services, New Delhi, within the over all ambit of National Health Policy Document for being considered for incorporation in the ensuing Seventh Five Year Plan, in response to a request made by the Director General in his letter dated 25th February 1984 addressed to the Catholic Hospital Association of India. This was prepared in consultation with other National and Church related organisations based in Delhi.]

At the very outset we welcome the new National Health Policy of the Government for its commitment to the rural and under privilaged sections of the society and making an effort to reach out to the masses through a decentralised pattern of health care delivery system through PHCs and sub-centres with active participation of the people and voluntary organisations. In a country like ours, governmental efforts alone can not cater to the needs of the people particularly in remote rural areas, especially in the field of health. We also felt satisfied that the roles of voluntary agencies are recognised by the government in this health policy.

The discussion centred around the following points:

i. Role of voluntary agencies and their relation to the government at various levels.

ii. Community participation in health care.

iii. Nutrition and Environment factors.

iv. Low cost drugs/Low cost health care.

v. Reorganisation of health care education system.

vi. Population stabilisation.

We felt that, inspite of good policy decisions by the government from time to time and its desire to improve the lot of the poor, the programmes do not reach the target groups. We identified the following few factors, there could be many more, responsible for this situation.

1. Lack of community participation in the government programmes.

2. Lack of proper attitudes and value orientations of the health care personnel and thereby lack of commitment to people.

3. Failure from the part of the government at various levels in implementing policies.

4. Meagre budget allocation to the health sector and particularly to the rural health programmes, for purchase and supply of essential drugs and providing other minimum facilities.

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We have the following to suggest for resolving the above:

1. The Voluntary agencies can play an important role to organise educational programmes for the poor in matters relating to health to make them conscious of what it means to be healthy and when to approach health care institutions. They also can create an awareness in the people about their rights and responsibilities. In such programmes necessary financial assistance should be given to the voluntary agencies, by the government.
2. Since voluntary agencies are better equipped in terms of commitment etc. they should be encouraged.
3. The government health care personnel should be made aware of their accountability and commitment to people whom they are commissioned to serve, and necessary steps should be taken to ensure this.
4. Since PHCs, as it function today, are not viewed as people's institution, to monitor and evaluate the effective functioning of the PHCs, committees should be set up at the PHC level, consisting of formal and informal leaders of the area with due representation from the people and from the voluntary agencies. This would ensure more active participation of the people in health care. However this should be preceeded by awareness building programmes. Voluntary agencies can play a big role in this.

   Similar committees should be set up at the district, State and national level to perform same functions at the respective levels. The committees should be involved in the planning, implementation and evaluation levels in all the schemes.

5. Organise motivation training programmes for doctors and other health care personnel for giving the right orientation and proper motivation to work in the rural areas. Here also the cooperation of the volunatry agencies could be sought.
6. Efficiently run community health projects in the voluntary sector could be identified and considered for recognising as resource centres for planning, training, evaluation etc. of programmes for the government. The rich experiences from the part of the voluntary agencies in working with people should be made full use in this regards.
7. Community Health Workers should be selected by and from the community itself.
8. Community Health Workers trained by the voluntary agencies should be employed by the government programmes.

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9. Similarly the government should assist the voluntary agencies of good standing giving financial support for the payment of health workers etc.

For promotion of nutrition, better sanitation and healthy environment, the following points were highlighted.

1. Nutrition, safe drinking water, healthy sanitary facilities and healthy environment are basic to any health programme as they are also the basic rights of everyone. However, these come under different departments of the government, which itself stands on the way of an effective health programme. Hence the existing inter-sectoral cooperation should be enhanced to effectively implement the provisions of these facilities.
2. Locally available low cost nutrients should be promoted.
3. Materials used at present for nutrition education very often do not correspond the local situation. Hence efforts should be made to develop adequate teaching materials based on the real situations of the rural and urban poor. This can vary from place to place and provision should be made for necessary adaptation.
4. An increasing trend is found in the consumption of baby food. The poor also are misled by propoganda. Advertisement and mass media have a vital role in promoting this unhealthy trend. We strongly propose that something urgently needs to be done both in regulating the production and mass media support of baby foods. Legislative measures should be expedited to deal with the offenders.
5. Along with the feeding programmes, health education programmes also should be included. The feeding programmes, thus should not be an end in itself, but rather a means to an end.
6. While identifying the low purchasing power of the poorer sections of the population, it is equally important and binding on the part of the government to spell out clear, concrete and organised efforts to increase their purchasing power. This is of crucial importance to enable the masses to earn good quality food and purchase nutrients. The effective implementation of minimum wages could be one among such organised efforts.
7. The number of fair price shops in the country should be increased particularly in rural areas to ensure better availability of essential commodities.

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Regarding the re-organisation of health care education system we have the following to suggest:

1. The existing health care education system should be reorganised to give it community orientation and relevance to the real needs of the people, engulfed by poverty and mal-nutrition. Hence the reorganised system should include:
   a. topics relating to the awareness of community needs and analysis of the society.
   b. management of community health programmes.
   c. field programmes with training in teaching people and in relating with people. During the training period the medical students and doctors could be asked to work with voluntary agencies involved in rural community health programmes.
   d. orienting doctors to prescribe drugs under generic names.

2. An entirely new cadre of medical personnel to be trained suitable particularly for rural areas. Competent voluntary agencies should be invited to design and conduct such courses and such should be recognised by the government.

3. The carriculum for nurses' training will also have to be reorganised to train right type of health care people. The government would do well if it would collaborate with voluntary agencies in this field.

4. While formulating the new medical education policy, voluntary agencies involved in health related activities, such as Medico Friend Circle, Voluntary Health Association of India, Catholic Hospital Association of India etc. should be consulted.

5. Efforts should be made to promote other systems of medicines, especially indigeneous ones, by organising short term courses by them recognised by the government. Here again the voluntary agencies could play a big role.

Two general suggestions regarding the drug policy:

1. Government health care institutions should promote and treat with essential drugs with generic names. Correspondingly discourage the use of brand name drugs.

2. Due publicity be given to essential drugs, by the government.

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Regarding population stabilization, concept of small family should be promoted not by force but by persuation, education, motivation and by voluntary acceptance thereby Methods used in this regard should also be in keeping with human dignity and the cultural background of our people. Natural Methods of Family Planning should be given due importance and recognition. Expertise available in this field, in the international, national and local level should be made use of for this purpose. However, care should be taken to give correct and scientific knowledge in this regard. The Natural Family Planning Association of India through its President c/o Indian Social Institute, Lodi Road, New Delhi 110 003; the FIAMC Bio-Medical Ethics Centre through its Executive Director, c/o St. Pius College, Goregaon East, Bombay-400063 and the Catholic Hospital Association of India through its Executive Director, CBCI Centre, Goldakkhana, New Delh-110001, could be contacted for this purpose.

It is common knowledge that there is a close corelation between nutrition and high literacy rate on the one hand and low fertility rate on the other. The Government would do well if more emphasis could be given to education of women and providing better nutrition, particularly for women, and less emphasis on the so called terminal methods of family planning with not so successful result. This should be kept in mind when allocating funds to various programmes.

In conclusion we wish to re-affirm that the reason for the ill-health of the poor is attributable not to the lack of government policies or programmes but to the problems connected with proper implementation. We once again place on record the courageous step the government has taken in bringing out this wonderful national health policy and requests the government and all concerned to have the same courage to get it implemented. In all these, there should be a genuine collaboration in the spirit of true partnership between the government and bonafide voluntary agencies keeping the good of the people at large as the prime concern. What is to be avoided by all means is a "holier than thou" attitude both from the part of the voluntary agencies and the government.

New Delhi
17.4.1984

FR. JOHN VATTAMATTOM SVD
Executive Director, CHAI

HP 1.15

MP

The following proposal was submitted to the Government of India and approved by the Ministry of Health and Family - Welfare on March 25, 1987.

WORKSHOPS ON THE NATIONAL HEALTH POLICY AND "HEALTH FOR ALL" AWARENESS SEMINARS

INTRODUCTION:

The Alma Ata Declaration affirms that health is a fundamental human right; that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors. In addition to the health sectors, the Declaration adds, Primary Health care constitutes the first element of continuing health care process and therefore requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control a primary health care, making fullest use of local, national and available resources, and to this end develops through appropriate education the ability of communities to participate.

The Bhore Committee 1946 report provided a revolutionary and well reasoned blueprint for the reorganisation of health services. Curative and preventive services were to be integrated. Deep thinking and wider action on the more basic issues of reorganising role definitions within the health team, with special attention to new relationships between doctors and auxiliaries should have been done long ago. The Bhore Committee report had urged the development of a wholly new orientation. Progressively, there has been considerable advance in providing the structure of the system, but there are major gaps and the system has never developed smooth functioning inter-relationships.

In recognition of the crucial need to initiate an active and constructive dialogue among all groups for continuing identification of progress or lack of progress in this regard and seeking participatory measures to accelerate progress, the Voluntary Health Association of India proposes to conduct state level residential workshops on the National Health - Policy and Health for All awareness seminars at Block levels.

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Voluntary Health Association of India (VHAI) is a federation of State Voluntary Health Associations, through whom it has linkages with more than 3000 institutions and organisations. Besides, VHAI has extensive reach to Government training institutions, universities and other centre of education which subscribe to VHAI publications.

VHAI has a place in the recent evolution of health development and health strategy in the country considering its unique innovative attempts to promote Health Care Administration Education and a well-defined residency course in community health for fresh medicos, a Health Equipment maintenance course for fresh recruits from technical institutes providing to the small rural health centres a mobile team of young experts to repair delicate machines and instruments on site at low cost. The Nurse Anaesthesia Course recognised by the Indian Nursing Council is a unique initiative in this country. VHAI's Diploma Course in Community Health Management is also the first of its kind. The correspondence courses in community health and the community health team training initiated by VHAI have contributed in a very significant way to furthering primary health care.

VHAI publications covering a wide spectrum of health specific and related issues are indispensable in voluntary and Government training programmes.

Besides the above, the Voluntary Health Association of India has played a key role in transferring the vision of the Alma-Ata goal throughout the country since the year 1983. The National seminar on the Health Policy in 1983 was followed up by seminars in 11 states for fostering an understanding and appreciation of the text of the policy and the role and responsibility of those involved in Primary Health Care in the voluntary sector.

A large number of health personnel from Primary Health Centres, sub-centres and the Government Secretariat in different states received their first copy of the National - Health Policy from VHAI, which were available in Hindi, Bengali, Tamil and English. Since adequate number of copies were not available with the Government, VHAI printed

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30,000 copies which were soon exhausted. The enthusiasm generated among them led VHAI to formulate a scheme to hold state level residential workshops in the 16 states where the Voluntary Health Association of India has affiliated units; specially to bring government functionaries together with their counterparts in the voluntary health centres and other organisations. In this context, two workshops in Bihar and Kerala in 1986 were held and the third one in this series is proposed to be held from 2-4 April, 1987, in Lucknow. VHAI's experience with the two earlier workshops held in Bihar and Kerala have initiated a process of sharing, learning, planning and doing together that which is indispensable for raising the health consciousness and evolving a new pattern of health care which will meet in a more adequate way the needs of the people; and providing a reasonable basis of mutually strengthening linkages between all levels of the health care system. It has paved the way for voluntary groups to forge horizontal and vertical links with the government system at all levels. Monitoring and evaluation of the workshop, together with the follow up action proposals will be drawn up within a time frame, with the collaboration of respective participants.

In view of the fact that the National Health Policy is based on the Alma Ata Declaration, which promises health for all and further that the World Health Assembly, 1985 resolution initiated by the Government of India and accepted by all settles categorically the imperative to promote a relationship of partnership between the government and voluntary organisations, VHAI as a major NGO, with its state units and the vast network of organisational and associated members, makes the proposal as follows :-

1. That the Voluntary Health Association of India will hold 3-day state level residential workshops on the above pattern with - <u>Objectives</u>

(a) improving the efficacy of existing health services at all levels, especially support services to Primary Health Care;

(b) enhancing role perceptions of every member of the health teams at all levels;

(c) enhancing community perception of their role in health development.

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At the end of the workshop, the participants

a) should be aware of the specific health targets in their area and the resources available to them;

b) should be aware of their role as leaders of their teams and the expectations from the leader both to motivate, educate, guide and support team members to fulfil their role in strengthening primary health care;

c) should be aware of the initiatives necessary to forge intersectoral linkages to translate policies into actions;

d) should be able effectively to facilitate 1-day "Health for All" awareness seminars at Block and village levels involving grass-root community organisations like Mahila-Mandals, Yuva Mandals, young farmers clubs, village - leaders etc.

PARTICIPANTS:

Participants will be drawn from District Health Centres of the government and the voluntary sectors. The list of government participants will be given by the respective District Health Officers. State VHAs will elect the voluntary participants. In states where VHAs do not exist, suitable steps will be taken by VHAI to identify those to be involved.

RESOURCE PERSONS:

Resource persons will be selected with great care. The criterion will be the dedication and attainment of the individual in activity significant to rural health development, urban slums and work with vulnerable groups. The resource team will be balanced with 1:3 from the government and the voluntary organisations. While majority of the Resource Persons will be region specific, a few extra - ordinary leaders, who have distinguished themselves and have international esteem will be invited to contribute their vision and enrich the workshop.

The panel of these esteemed health leaders is made up of Baba Amte, Drs. Matelle and Rajnikant Arole, Dr.N.H.Antia, Dr. C.Gopalan, Dr. Banu Coyaji, Drs. Rani and Abhay Bang,

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Dr. Anil Desai, Smt. Elaben Bhatt, Dr. V. Hande, Dr. Ragini Prem, Dr. Samir Chaudhuri, Dr. Debabar Banerji, Ms. Indu Kapoor, Ms. Mirai Chatterji and others who have integrated in their own work the most meaningful and significant aspects of health.

METHODOLOGY:

Several methods may be adopted to suit the socio-cultural affinities of different state. However, the following are common :-

Panel discussion sessions, Group work, Plenary sessions, Role plays, Study of displays and exhibitions, and Report writing sessions, to be followed by a field visit where possible.

Being residential workshops, sessions may extend beyond formal timing schedule leading to meaningful group dynamics.

Group leaders and rapporteurs are selected by participants. Group leaders conduct the session while Resource Person is available for reference only.

Education kits will be provided to all the participants and resource persons. The kit will comprise of the following :

- The text of the Policy in the regional language
- A map of the state with district boundaries
- An organogram highlighting the specific areas to be taken up at state workshop
- Visual charts indicating health education methodologies
- Printed Case studies of programmes emerging from exemplary inter-sectoral coordination and health team relationships in other parts of the country.
- Appropriate books and booklets serving as reference material available from VHAI and government agencies.

SUPPLEMENTARY ADDITIONS:

- Follow up source books indicating allocation of manpower, financial and technical resources available at the level of Districts, Blocks and villages from the government and voluntary organisations in respect of health and development activity.

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WORKSHOP CONTENT:

I. The core chapters from the National Health Policy on (a) Primary Health Care and Problems requiring urgent attention, (b) Health Education and (c) Indigenous systems of medicine will be taken up for reference with the aid of an organogram. The region specific Resource Team would draw up the framework for initiating discussions at panel discussion sessions based on feedback from advance questionnaires delivered to participants.

II. The "Health for All" Strategy adopted by the Central Health Council.

BUDGET:

State level residential workshops on the pattern enumerated above will be held in Andhra Pradesh, Gujarat, Delhi, Karnataka, Himachal Pradesh, Haryana, Jammu & Kashmir, Madhya Pradesh, Maharashtra, North East Region (Assam, Arunachal, Manipur, Meghalaya, Mizoram, Nagaland and Tripura), Orissa, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal.

A consolidated budget based on respective sizes of states and on the basis of two representatives per district for participation totalling a sum of Rs.10,78,745/- is attached - See Annexure "A". Detailed statement for UP State - see Annexure "B". Exhibition, Training module and kit - see Annexure "C".

ONE-DAY "HEALTH FOR ALL" AWARENESS SEMINARS:

The thrust of the Alma Ata Declaration goal is "that the Government should enhance the capacity and determination of the people to solve their own problems". The natural corollary to this thrust would be the holding of "Health for All" awareness seminar at Block and Village levels. In recent years, alternative strategies to reach health have been tried through government infrastructure and through modest and significant initiatives of health professionals and health workers. However, much more is to be done as the HFA strategy calls for dramatic changes. In fact, a social revolution in health development is needed.

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"Health for All" implies the removal of the obstacles to health - that is to say, the elimination of malnutrition, ignorance, contaminated drinking water and unhygienic housing - quite as much as it means the solutions of problems such as lack of doctors, hospital beds, drugs and vaccines.

Given the magnitude of these tasks, strong political will and the mobilisation of public support is essential for launching the necessary Health for All action. VHAI proposes to hold 1-day Health for All awareness seminars in 5000 blocks of this country in collaboration with all the active socio-cultural and development groups engaged at the macro and micro levels. The modalities of organising these seminars will be worked out with each one of them separately.

These seminars will have clear objectives :-

a) to change the mentality of people to take a comprehensive view of health, in which their total will-being is at stake.
b) to make clear that the drive towards the goal of Health for all by the year 2000 can only be inspired and fuelled by concerted inter-sectoral action of all people in agriculture education, culture, industry, food and nutrition and information,
c) to make clear that in order to effect a national change in resource allocation, national and local leaders can promote policy-making mechanism to progressively correct the imbalance in maldistribution of resources,
d) to make visible the health risks inherent in the use of certain technolgies leading to deterioration of health and nutritional status,
e) to understand that two-way interaction between Health and Family Planning is a means to improve maternal and child health,
f) to understand that there is effect of child health and survival on family planning motivations and that this understanding needs to be strengthened.

PARTICIPANTS:

1. The participants in these 1-day "Health for All" seminars will be organisers and members of groups at the village level, responsible leaders from the Block and District Panchayats.

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These may be non-health groups involved in socio-economic, cutural or religious activities like young farmers clubs, mahila mandals, traun mandals, school teachers, panchayat and panchayat committee members, members of agricultural and land cooperatives, societies/village banking institutions.

2. All village health workers
(There will be separate seminars for homogenous groups to make necessary impact).

PROGRAMME: (will be divided into a morning session - general and afternoon sessions- subjects)

The seminars will be action-oriented. Resource persons will be drawn from different states to expose their practical experiences in primary health care. (see attached Resource-Persons list.)

Knowledge of resources available at the village, taluk and District levels to fulfil the targets of PHC at individual and community level will be brought home to them.

The role expectations from doctors and the role expectations from teams of auxiliaries to reach large populations will be discussed in group meetings and at plenaries.

The role of village health workers and the supportive mechanism for them at the community and referral level will be discussed.

Social and Scientific inputs to work out the dynamics of changing mass need of all - to standardise the motivational approaches that will convince families to practice planned parenthood will be attempted.

The role of administration leaders in realising the goals of HFA will be discussed.

An afternoon session will be devoted to two or more of the following topics: since 1-day health awareness programmes may draw large participation, these will be taken up in groups and summaries shared at the plenaries :

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1) Sources of water and simple water purification methods to achieve Health for All (HFA)
2) Promotion of village sanitation and personal hygiene to promote HFA
3) Use of foods for health and prevention and cure of diseases to achieve HFA
4) Use and economy of solar and biomass energy to promote HFA
5) The cause effects and approaches to speedy treatment of communicable diseases to ensure HFA
6) Symptoms and home treatment of common diseases
7) Using low cost and rational medicines to ensure HFA
8) Application of Herbal and Home remedies to aid HFA
9) Role of practionners of traditional medicines to reach the goal of HFA

Who will conduct 1-day "Health for All" Awareness Seminars ?

(RESOURCE PERSONS)

1. Since these seminars are to be organised at the village and taluk levels, a panel of experienced local personnel identified by VHAI and State VHAs in consultation with the active local groups and the health department will form the core Resource pool.

2. Committed and exceptional individuals, who have shown the way in neighbouring districts and blocks, even from other states.

   The role of these individuals in generating a powerful impulse towards a resurgence and faith in community and family care about health cannot be minimised.

3. Members of the health team attached to Primary and Subsidiary Health Centres.

4. Local government leaders and members of Parliament of the area, who have distinguished themselves by concern for their constituencies.

(See Budget annexure D)

ANNEXURE A

CONSOLIDATED STATEMENT OF EXPECTED EXPENSES ON NATIONAL HEALTH POLICY WORKSHOPS IN STATES

STATES/UNION TERRITORIES	NO. OF DISTRICTS	AMOUNT RUPEES
Andhra Pradesh	23	64,400.00
Gujarat	19	61,560.00
Haryana	12	55,400.00
Himachal Pradesh	12	55,400.00
Jammu & Kashmir	14	57,160.00
Karnataka	19	61,560.00
Kerala	12	55,400.00
Madhya Pradesh	45	84,440.00
Maharashtra	26	67,720.00
Orissa	19	56,280.00
Punjab	12	55,400.00
Rajasthan	26	67,720.00
Tamil Nadu	16	58,920.00
Uttar Pradesh	57	95,000.00
West Bengal	16	58,920.00
North East Region	37	61,025.00
Total No.Districts	365	Total Amount: Rs.10,78,745.00

* Follow-up

For follow-up action towards Travel and Documentation, a supplementary budget will be prepared in consultation with participants in due course.

ANNEXURE B

STATE LEVEL WORKSHOP ON NATIONAL HEALTH POLICY IN U.P.

Estimate of Expenses on 3-day residential workshop for District Health personnel from Government and Voluntary sectors from 57 U.P. Districts.

The budget estimates given under the various heads of accounts are adjustable within the overall amount for the project.

		Rs.
1)	T.A. for 114 participants @ Rs.200/-	Rs. 22,800.00
2)	D.A. for 114 outside participants @ Rs.75/- per day for 3 days	Rs. 25,650.00
3)	D.A. for 8 local participants @ Rs. 20/- per day for 3 days	Rs. 480.00
4)	D.A. for 8 outstation experts @ Rs.150/- per day for 3 days	Rs. 3,600.00
5)	T.A. for 8 outstation experts @ Rs.200/- each	Rs. 1,600.00
6)	D.A. for 8 local experts @ Rs.50/- per day for 3 days	Rs. 1,200.00
7)	Secretarial assistance @ Rs.2000/- p.m. for 1 month	Rs. 2,000.00
8)	Stationery and postage etc.	Rs.15,000.00
9)	Tea/Coffee for 130 persons twice daily @ Rs.5/- per person for three days	Rs. 1,950.00
10)	Compilation and printing of a Report on the Workshop	Rs.10,000.00
11)	Follow-up expenses on travels, etc. for 1987	Rs.10,720.00
	GRAND TOTAL:	Rs.95,000.00

ANNEXURE C

STATE LEVEL WORKSHOP ON THE NATIONAL HEALTH POLICY

		Rs.
1.	500 sets of portable exhibits in regional languages on Primary Health Care, Symptoms and prevention of communicable diseases. Sanitation and Personal Hygiene, Water Management, Mother and Child Health, Nutrition, Family Planning, Disability Prevention, Environment, Agricultural - Technology, low cost housing, Sulabh - souchalayas, smokeless chulhas, bio-gas, appropriate technology.	Rs.5,00,000.00
2.	500 sets of charts on organisational, managerial and financial resources of Primary Health Care	Rs.1,00,000.00
3.	1000 Education Kits (for participants and Resource persons)	Rs.1,00,000.00
4.	Expenses for preparatory work for the workshop	Rs.1,50,000.00
5.	Contingencies	Rs. 50,000.00
	TOTAL	Rs.9,00,000.00

* A set will be available to all 365 Districts to be covered by State level Workshops.

NOTE:

A set will also be presented to all Districts in Bihar, and Kerala, where VHAI has already held State level workshops in 1986.

ANNEXURE D

BUDGET FOR VILLAGE/TALUK LEVEL 1-DAY 'HEALTH FOR ALL' AWARENESS SEMINARS

Expenses for One Seminar - Projected attendence 100 persons

	Rs.
Conveyance for 50% of the participants coming from an average distance of 8 kms @ Rs.5/- per person x 50	Rs. 250.00
Educational Kit to be distributed to 100 persons @ Rs.50/- per kit	Rs.5,000.00
Cost of Lungar for 100 participants and 10 organisers = 110 persons x Rs.15/- eqch person	Rs.1,650.00
Travelling expenses of the personnel conducting seminar 2 x Rs.200/- each	Rs. 400.00
Boarding & lodging expenses of the personnel conducting seminar 2 x Rs.100/- each	Rs. 200.00
Miscelleneous expenses	Rs. 500.00
TOTAL	Rs.8,000.00

8000 x 5000 Blocks	Rs.40000,000.00
VHAI's overhead expenses for coordinating the programme through State VHAs and other Volags at 12½%.....	5000,000.00
GRAND TOTAL:	Rs.4,50,00,000.00

TRUE COPY

No.M.11014/10/87-IH
GOVERNMENT OF INDIA
Ministry of Health & Family Welfare
....

New Delhi, dt. the 10th March, 1987.

To

The WHO Representative,
WHO, Nirman Bhavan,
New Delhi.

Subject:- WHO Assistance for organising Workshop on National Health Policy & Health for All by the year 2000.

I am directed to convey the approval of Government of India for the organising of State Level Workshops on National Health Policy and "Health for All" Awareness Seminars in all the States by the Voluntary Health Association of India and to forward the proposal of VHAI, for funding by WHO. The entire expenditure as indicated by the VHAI in their project proposals may be incurred from the WHO country programme IND MPN-002 under which such activities have been provided for. A copy of the proposal from VHAI is enclosed.

Yours faithfully,

(Dr. K.S. GANESHAN)
Under Secretary to the Government of India

copy to

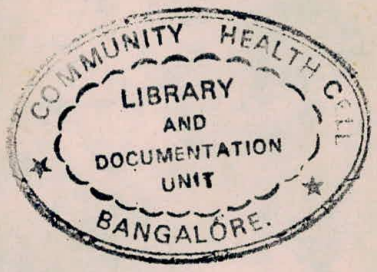
Voluntary Health Association of India, New Delhi,
40 Institutional Area (Near Kutab Hotel)
South of I.I.T., New Delhi 110016.

Sd/-
(Dr. K.S. GANESHAN)
Under Secretary to the Government of India.

Copy to

A.D-G-(IH)

POSITION PAPER ON NATIONAL HEALTH POLICY



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POSITION PAPER ON NATIONAL HEALTH POLICY

The National Health Policy as planned may remain only a policy document unless all of us make a commitment to it, and try to implement it at all levels. Each of us must carefully analyse the health problems, keeping in mind the country's capacity to deal with them. The goals and priorities will be fixed accordingly. Strategies to achieve them need to be based on social justice and equity, intrasectoral linkage and self-reliance as far as possible.

The ill-conceived and inadequate health services currently provided to the vast majority of the population has created a feeling of social injustice and given many voluntary organisations the impetus to act as natural leaders of their communities. They have the responsibility to lead movements for the change. For this they need to identify the strategies to develop their full leadership potential. They should look beyond the traditional system of health care and develop a deeper understanding of the philosophy of primary health care and a commitment to achieve health for all by 2000 A.D.

1. PROVISION OF HEALTH SERVICES TO ALL

For those who live in remote areas and belong to the lower income groups, health care can be provided only through a system which creates a broad base of functionaries and provides health care to the maximum number of people. The training of new community health workers at the village level has only duplicated the existing system and has not proved very helpful in the long run. Wherever the traditional health functionaries have been involved, the infrastructure has become stronger. The health care system may continue to be lopsided, unless efforts are made to improve the training and supervision of CHW's and Dais.

2. REFERRAL SYSTEM AND PRIMARY HEALTH CARE : A STRATEGY

The bottlenecks that exist between the village and a health sub-centre are again a matter of concern. The health assistant is no better equipped with the skills and will to deal with certain health problems than a CHW. So unless there is a way to reach Primary Health Centres very little can be done at these levels.

Another important point is that the referral system does not allow for any planned way to go from one to another. There is no geographical or political boundary which one cannot cross. Unless the screening is done at all levels, the political and the social linkage is established between a specialist hospital to a Primary Health Centre of the block, from there to the village sub-centre and back from village to the specialist hospital; the congestion, duplication and the parallel system will continue to exist. The suggested change of effective links between primary health centres and medical colleges and hospitals in order to harness and provide specialised skills is no doubt progressive thinking for re-orientation of medical education and better health service, but its implementation has been held up due to many administrative difficulties. As a result, neither are the Block Administrators taking responsibility for the better functioning of these Primary Health Centres nor have the medical college hospitals established a proper linkage with them. Very few specialists from these hospitals like to go out to the Primary Health Centres. In fact the person who goes there is only a junior or senior resident working in those specialised units. Most of the time they treat these trips as holiday excursions. There is no continuity of ties nor any feedback from such hospitals to the Primary Health Centre doctor.

3. INFORMATION SUPPORT

To estalish a proper information support, there must be a well-defined referral system. General practitioners, indigenous practitioners and all others who are involved in any way with the health care system should become a part of the information support. The Epidemiological Cell in each State may not be essential but it should have a computerised system for collecting and processing information from different units. Without information, support evaluation and monitoring of any programme is not possible.

4. RE-ORIENTATION OF HEALTH PERSONNEL

To equip health personnel with appropriate and scientific techniques we must provide a system of continuous education. Inservice training programmes are essential to develop the skill to do the job better. Certain managerial skills which are never imparted to medical professionals in their undergraduate courses must become a part of the orientation training programmes. All courses could be so planned that NGO/Govt. officials attend the courses together and can interact with each other.

The voluntary organisations have a greater sense of dedication and commitment to social causes and are more open to change. This gives them an enormous advantage in the field. They provide care at all levels in all kinds of settings to the poorer section. They frequently act as links between the individuals, community and the rest of the health care system.

5. INTERSECTORAL COORDINATION

That various sectors have influence on health is well understood, but intra or intersectoral coordination remains most of the time only in the minds of people or as words on paper. Actual coordination at various levels is possible only if the planning of the two sectors are done at one place, and from bottom to top. The possibility of removing the bottlenecks is maximised if two sectors, well connected like water and sanitation, nutrition and education, are planned together. Again, regarding the educational status of woman and her acceptance of family planning, both must be worked out together, and receive the same importance. The administrative blocks also need attention. There is a need to define the job responsibility of various people at different levels, as well as a policy of delegation of authority at each level. If decision making is confined to the planners' level, the implementing functionaries find it very difficult to carry out their day-to-day duties.

6. ALTERNATIVE SYSTEMS OF MEDICINE

There is a need for integrating the training programmes of different personnel in different systems. The policy has recommended the use of indigenous systems of medicine like Ayurveda, Unani, Sidha and Homeopathy. It also emphasises introducing Yoga and Naturopathy into the overall Health Care Programme. But when it comes to putting this into practice, none of the Primary Health Centres or the dispensaries is equipped to give advice on any of the traditional systems of medicine.

Traditional systems of medicine have always had a place in our culture. They are both less expensive than modern medicine and more easily accessible to the majority of our population. To allow them to stagnate will only increase existing inequalities in the health care system. Therefore, ways of integrating the modern with traditional system of medicine must be thought of.

7. REGIONAL IMBALANCES OF THE HEALTH CARE SYSTEM

It is of vital importance to correct the regional imbalances that exist in health care systems today. The policy cannot be successfully implemented unless sustained political, social and administrative support is obtained from everyone concerned. Here the local communities play a very important role and it is our duty to make them aware of the facilities they are entitled to, so that they demand the care they need. The concept of preventive and promotive services is still lacking all through.

8. MEDICAL EDUCATION

We need not go into the details of formal medical education as we all know that it is not tailored to meet the requirements of the type of medical practitioners who work

in Primary Health Centres. If more clear and effective strategies could be specified, the wasted resources could be harnessed. The re-orientation of medical education has been talked about for the last several years but very little has been done to make education community-oriented and problem-based. Most of a medical graduate's time is spent in hospitals. The type of knowledge and skills that he/she acquires are the ones from the hospital itself, when almost 80% of the ailments are preventable and can be cured by simple remedies. But these cases never reach the hospital for their attention.

The National Health Policy is aimed at taking services to the doorstep of the people ensuring fuller participation of the community and improvement in the quality of their life. It is intended to restructure the health care services on the preventive, promotive and rehabilitative aspect rather than on cure only. Therefore to provide trained personnel with the right attitude and outlook is more important for proper functioning of the services talked of in the policy document.

9. MEDICAL RESEARCH

It is the opinion of various experts that today there is a lot of money being wasted on basic research which could be well shared by the developed world. The technical know-how can be easily obtained from them.

Special research on health care system, problem based medical education and need-based para-medical education at various levels, require a lot more attention than is being given in this country. In my opinion "behaviour problem" of the recipients of health services should form the priority for the research grant in India. There is also a need for a constant feedback on the new findings and advances in medical research and their application to health services. The dissemination of this information to the proper levels both upward and downward are equally important. Unless we keep informing our workers at the grassroots level of what is happening at the central level, the implementation of the programmes become difficult.

10. THE TARGETS

The National Health Policy paper gives the targets to be achieved according to the time frame. These targets are not comprehensive nor have they been worked out on any realistic terms. The exercise only tells what future achievements can be expected provided the base is known. No doubt it is better to work on some frame, to measure the milestone and progress being made but the baseline information is of crucial importance.

The target sets are based on certain information that was available at one point of time: perhaps as far as 1975 or 1976. Unless the relevant data is available from different states it is of no use setting up targets to reduce the incidence. A few studies

carried out by big institutions like the All India Institute of Medical Sciences or PGI Chandigarh tell us very little about the overall health status of our country. Lack of vigilance in reporting and collecting of information will hinder us from reaching our targets.

11. ROLE OF NGO's

The role of voluntary agencies has been very well spelt out by the Alma Ata Declaration. It includes:

1. Identification of the needs and problems of the people.
2. Development and innovative programmes for Primary Health Care, in the context of comprehensive human development.
3. Promotion of full participation by individuals and communities in the planning, implementation and control of these programmes.
4. Training of health workers, supervisors, administrators, planners and various agricultural and development workers, along with training schemes, build on the skills of traditional healers and midwives.
5. Creation of new and effective methods of health education.
6. Recognition of the essential role of women in health promotion and in the full range of community development concerns.
7. Contribution to the search for greater social justice.
8. Development of locally appropriate health technologies and use of resources.

Most of the voluntary organisations are working for both health and development. The standards of health cannot be improved unless there is an improvement in the general quality of life. The NGO's are more willing to go to the most difficult areas where nothing exists as far as the health system is concerned. Still they find it difficult to be recognised and get little or no help from the government system. It is time we all realised that to achieve health for all by 2000 AD, the involvement of the voluntary sector is essential.

THE DILEMMA—NATIONAL HEALTH PROGRAMME

Most of the time the doctor faces a very big dilemma in his day-to-day functioning. He is unable to find what to do and how to get started with diverse programmes like TB, Leprosy, Prevention of Blindness, Malaria control, Family Planning, Immunization, School Health, Nutrition and MCH, as well as to keep evaluating the programmes from time to time. Only if the planning process, information system, resources, supervision, coordination and training is adequate can the

doctor use his energy as a team leader to build up the team, organise the community, keep proper records, monitor the programmes and do a follow up review, as well as initiate certain changes in the programme when the need arises.

The bring about any change is a very complex task. The people who are striving to reach the goal of health for all must have a clear understanding of the National Health Policy, the critical issue required for its implementation and the broad principles involved in it.

In these three days let us together work out an action plan for our own areas keeping all the elements of the National Health Policy in mind and evolve our own strategies to reach the goal of health for all by 2000 AD.

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DECENTRALISATION OF HEALTH CARE:

HOW DOES HEALTH POLICY 'FIT'?

-- Meera Chatterjee, Ph.D.

Paper prepared for the Workshop on
"Towards a Decentralised Health Care:
A Fresh Look at the National Health Policy"
at the National Institute of Advanced Studies,
Bangalore, 20-23 September 1990.

I. The National Health Policy's View of Decentralisation

Rationale. The Statement of National Health Policy provides its own raison d'etre as the need to establish "an integrated, comprehensive approach towards the future development of medical education, research and health services." Not only are 'integration' and 'comprehensiveness' intended to be departures from the past, but each of the three major components (education, research and services) has to break from the patterns established over three - now four - decades. The policy statement avers that "the hospital-based disease and cure-oriented approach" which has "provided benefits to the upper crusts of society" has to give way to "comprehensive primary health care services to the entire population," including "preventive, promotive, public health and rehabilitative aspects of health care."

The statement goes on to diagnose the problems caused by the "existing approach." It "tended to enhance dependency and weaken the community's capacity to cope with its problems." Existing patterns of education and training of medical and health personnel resulted in the "development of a cultural gap between the people and the personnel providing care." Health programmes "failed to involve individuals and families in establishing a self-reliant community." The planning process has been oblivious of the need to involve "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."

Aims. Thus, the policy aims to move toward:

- --universal, comprehensive primary health care, which is culturally acceptable;
- --people's involvement in planning, implementing and managing health care;
- --community self-reliance in health matters;
- --integration of health and human development with socio-economic development.

Structure and Functions. The basis of universal health care is intended to be a "well-dispersed network" of services as it is believed that the

majority of health functions can be effectively handled at the community level - by the people themselves with the organised support of volunteers and paramedics. Health volunteers are to be selected by, to enjoy the confidence of, and be accountable to their communities. However, their actions are to be part of definitive action plans prepared at higher levels (see below) which are based on simple and inexpensive interventions.

The policy states:

> "The success of the decentralised primary health 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."

and further that:

> "The decentralisation of services would require the establishment of a well-worked out referral system to provide adequate expertise at the various levels of the organisational set-up nearest to the community...(and to) ensure the optimal utlisation of expertise at the higher levels of the hierarchical structure..."

Specialist services are to be provided as near to beneficiaries as possible. In order to provide the integrated package of services addressed to the entire range of poor health conditions, a nation-wide chain of sanitary-cum-epidemiological stations is proposed to be established. These stations, based at Primary Health Centres, would have suitably trained staff to identify, plan and provide services. In addition, the District Health Organisation is to have a well-organised epidemiological unit to coordinate and superintend the functioning of the field stations. In urban areas, municipal and local authorities would be equipped to perform similar functions. A health information system is to be established, and monitoring conducted with respect to indicators and targets which have been set by the policy. It is in these connections that the integrated approach to medical education, research and health services is germane. Further, the policy states that these approaches should be implemented and extended through community participation and contributions.

Foci. Certain other intentions of the policy are also closely related to, if not subsumed in, a decentralised approach. These are:

-- its focus on vulnerable groups, particularly the call for MCH services to be provided "at the doorstep," to involve traditional birth attendants, etc.

-- its concern with correction of rural/urban and regional imbalances, eg. in speciality centres; the location of curative centres is to be in keeping with population densities, topography, transport connections, etc.

-- the priority it ascribes to service provision for tribal, hill and backward areas and endemic-disease affected populations.

Resources. The policy further stipulates that health care should be provided "at a cost which the people can afford." Besides community manpower, it also advocates maximal utilisation of available resources - eg. the use of local building materials and local mechanisms for repair, maintenance, etc. of equipment; the upgrading of existing facilities rather than establishment of new ones. Private medical practitioners, including indigenous practitioners are to be integrated into the overall health effort, and their availability is to determine the phasing out of private practice by government doctors. Non-governmental organisations are also to be encouraged through provision of technical support and financial assistance by the government to enlarge their services and increase their numbers. Their investment in curative centres is sought. While government investment in speciality and super-speciality services is also expected to continue, the policy proposes that "the majority of government speciality centres can provide adequate care to those entitled to free care, the affluent sectors being looked after by paying clinics." It is also advocated that health insurance schemes be devised to mobilise additional resources to ensure that the community "shares the cost of services, in keeping with its paying capacity."

Intersectoral Action. Finally, the integration of several other health-related activities which are also discussed by the policy is a function of decentralisation, such as:

--nutrition - specifically, improving the purchasing power of the poor, generating productive employment through employment guarantee schemes combined with a "nutrition and health cover;" supplementary feeding programmes; and nutrition education; and

-- water supply and sanitation (which are also expected to involve communities).

For these, intersectoral coordinating committees are advocated at the state, district and block levels, while at the community level they are expected to form part of an "integrated programme of rural development."

Clearly, the National Health Policy views decentralisation as a key to its rationale and aims, to its vision of the structure and functioning of the health system, to its foci, to its approaches to resource generation and utilisation, and to the intersectoral actions it advocates. The question before us, then, is not "What changes are required in the health policy to bring it in consonance with the philosophy of decentralisation and to increase people's participation?" (as expressed in the tentative Workshop Programme). Rather, we must ask: "Is the Policy's view of decentralisation consonant with current approaches to decentralisation in the country?" and "How can the implementation of decentralised health care proceed in the context of the current health and politico-bureaucratic systems?" Thus, the remainder of this paper will examine the 'fit' between three pieces of the "decentralisation of health care" puzzle - health policy, the health system,

and current models of decentralisation.

II. Representation for Universal Access

The policy's main thrust is "universal access" to health care. While decentralisation is purported to bring this about, we must examine whether this has yet occurred, or is occurring in India. If so, how has it been done; and if not, what have been the impediments to it, and what is the potential?

Clearly, none of the states which have had decentralised governments over a substantial period of time - Gujarat, Maharashtra, and West Bengal - nor Karnataka, whose experiment though newer is bolder and has the benefit of earlier experience, have achieved "universal access." Is it just a matter of time? Probably not. Rather, there are fundamental problems which must be tackled if "decentralisation" is to bring about universal access to health care. Alternatively, we may need to admit that the problems are so fundamental that universalisation is impossible to achieve through decentralisation, and all we can hope for is somewhat better distribution of health care, or, simply, better health care as has been achieved to some extent in Maharashtra. (We should note, however, that Tamil Nadu has fared even better than Maharashtra without decentralisation, and neither Gujarat nor West Bengal have improved health beyond what might be expected in their socio-economic - rather than politico-bureaucratic - contexts).

The first problem is inherent in the nature of the institutions that embody "democratic decentralisation" - they are unrepresentative. Universal access means skewing health care availability in favour of previously neglected groups, catering to their specific health needs and overcoming their particular constraints. But these groups (eg. the poor, women and children) are under-represented in Panchayati Raj bodies and lack the power to influence reorientation and redistribution. (In the case of women and children, social norms also reduce attention to them, though more effective women's participation in local government could conceivably overcome this to some extent.) Can a redressal of current imbalances be effected by the oligarchies who dominate panchayats, zilla parishads, etc.? They could, indeed, make decisions in favour of the excluded groups either if they are imbued with an especially philanthrophic spirit, of if they perceive such decisions to be in self-interest. Unfortunately, philanthrophy can hardly be a "model;" and the process of enhancing "enlightened self-interest" and creating a vision of health care as a common good has yet to begin. Rather, the current reality is that health care is viewed as a zero-sum game - more for the poor means less for the rich - because of severe shortages of health resources. Thus, the first need, if decentralisation is to fit with health policy, is expanded meaningful representation on PRIs of "neglected groups." This must be accompanied by a 'process of enlightenment' of the traditional elites, and also by increases in resources (discussed below). In the absence of any of these desirable changes, universal access and equitable distribution are unlikely to be achieved.

III. Resource Generation and Allocation

From where should these resources come? The health policy talks of generating them locally, and panchayati raj, too, once spoke of the same, but neither effort has approached this possibility (the latter with concern for the health sector) with the seriousness it deserves. The current system of resource generation by panchayats and zilla parishads is inadequate to the task. Only a few percent of the taxes and fees collected by them are retained, while most are funnelled upward to the state government. Their income from other sources (enterprises, investments and public contributions) is minimal. Even urban municipalities have had troublesome experiences - their tax base is also small and inelastic. Where efforts have been made, contributions directly for health purposes have been virtually negligible. Ultimately, both rural and urban bodies have depended on state government assistance by way of assigned revenues and grants. Although these are devolved to lower levels on the basis of equity considerations (population, backwardness, needy groups, etc.), the system is 'inefficient' as the costs of collection and devolution are high. Ultimately, there is never enough finance to meet the considerable expenditures entailed by the multitude of functions and duties of local bodies, among which health service provision is relatively low priority.

Thus, the second problem impeding effective decentralisation for health is the current system of financing health care. It is excessively centralised and completely normative, leaving little room for local decision-making regarding allocation. Ultimately, most of the finances for health care have come either from the state governments or the Centre, in the form of block grants tied to specific programmes, schemes or expenditure norms. Thus, neither are resources generated locally, nor are they allocated (or 'allocable') in accordance with local needs. This is as true in the four "model" states as it is elsewhere. An additional stumbling block is that, even where local decision-making is exercised over block grants, say by the zilla parishads, decisions may not be made in favour of health because of the competing claims of roads, schools, etc. which are given higher priority.

Problem One confounds Problem Two in the following ways. Firstly, inadequate attention to the needs and constraints of the poor, women and children, etc. results in the scarce health resources being spent on hospital care rather than primary health activities, in complete negation of health policy. Secondly, although the needs of these groups are critical, their capacity to contribute to resource generation is limited. Thus, Problems One and Two already call for a complex remedy: local bodies must generate resources from wealthier sources, but spend them on the neglected groups. How can this be ensured? Invoking "higher authorities" would seem to be quite contrary to the spirit of decentralisation, but the activities of local bodies can perhaps be brought in line with policy imperatives by also shifting the weight of state and Central government expenditures in favour of primary health care so that both "carrots and sticks" operate down the line.

Therefore, it would seem that if decentralisation is to meaningfully

bring about universal access to health care, specific revenues must be generated for health which can be used locally, allocated in accordance with local needs and numbers by democratic decision-making processes. Villages must gain access to resources for health care. Given Constitutional and 'traditional' treatment of tax revenues, resource generation should perhaps take the form of a Human Resource Development Fund, based on fixed contributions from families and institutions according to status and income, and utilised specifically for health and education, although water supply, sanitation and other social services are conceivably also candidates. A bold step may be to vest the management of this fund with women's organisations, such as broad-based mahila mandals. The HRD Fund should be additional to the grants received from the state government, which invariably are earmarked, have to be spent on specific schemes or according to specific norms, and in any case are insufficient. In short, the implementation of health policy and of decentralisation are probably not likely to progress very far until people begin to fund services for themselves, as the state and Central governments are already only funding what they can and want to.

Alternatively (or additionally?) a fee-for-service approach can be utilised, graduated according to paying capacity. In effect, unless local bodies can generate enough resources to provide the entire gamut of health services from primary to tertiary, they will need to concentrate on low-cost health care. In conditions of scarcity, government health services could be "reserved" for the poor, even though there is widespread feeling, based on trends in the private sector, that the poor (who are extremely dependent on good health for survival) are willing to pay for health services if these are good quality. Under any circumstances, improving the quality of services is a definite requirement if health care is to be effective and universal. Certain public health services will continue to need complete underwriting by the state (eg. malaria spraying, surveillance and case detection, etc.) It is these that could remain under "central" fiscal control, effecting a division of responsibility between local bodies and the Central and state governments. There is also no getting away from central control of medical education, research, the drug industry, health legislation, and so on.

IV. Health Planning and Service Provision

The current top-down mode of health planning and resource provision is, in fact, the major impediment to decentralised health care. The essence of decentralisation is planning according to local needs, allocating resources in keeping with these needs, and local management of services so that, with appropriate monitoring, changes can be made within short time-frames to enhance effectiveness. Currently, while planning and resource allocation involve iterative processes between the administrative secretariats and technical directorates at the higher levels of the health system, health service management at the district level and below is almost entirely the responsibility of medical personnel. While District Collectors have some powers to oversee the District Health Organisation, the "technical" nature of health services by and large preserves their independence. Even in the panchayati raj states, secretarial power has not devolved to the district

level in the health system, so that there is considerable 'misfit' between the politico-bureaucratic structure and the "technical" (implementing) health system.

This misfit is often expressed in terms of conflict. "The people" or their leaders are considered to be "ignorant" of health care by the medical hierarchy. Doctors resent the "interference" of politicians, bureaucrats or other lay people. Leaders are accused of misusing their powers, of needing "guidelines." Health workers are unclear which of their "two masters" (the doctor or the politician/bureaucrat) is to be given greater obeisance. Reporting horizontally is perceived to conflict with reporting vertically. Under decentralisation, "technical" supervision of health workers will continue to rest with their more qualified superiors, while administrative control will be exercised by panchayats. It is a moot point whether these parallel, separate and disjointed systems can be made one, though this would seem to be a major pre-requisite for effective decentralisation.

Furthermore, despite the effusive rhetoric of the National Health Policy, there is little evidence to date of decentralisation within the health system. In fact, if one examines health care trends since the NHP was adopted in 1983, one must conclude that the health system has gone in the other direction - toward greater central control and direction. There has been an increasing tendency over time for high priority health issues to be dealt with through "national programmes," planned and funded (50 to 100 per cent) by the Central Government. More and more of the basic health infrastructure in the states has been established under Central Plan schemes, notably the Family Welfare Programme. While the states have had some autonomy in decisions about rural health services under the Minimum Needs Programme, this has been reflected more in their inadequate health expenditures and the slow pace of implementation, than in the development of independent initiatives. There is even less devolution of creative responsibility from the state to the district level. Despite the size of the district health infrastructure, and the large and motley populations for which they are responsible, district health organisations mostly implement plans handed down to them from above. Although health plans are to be formulated at the district level, and district health officials have drawing and disbursing powers, the essence of decentralisation - working out local approaches to local problems is seldom practised. There will be increasing need for this if universalisation of health care is to come about. Both the Centre and the states will need to be more flexible in permitting local aproaches and responses to local developments, rather than enforcing standardised packages and procedures.

The health policy itself does not go far enough on the issue of health planning. This responsibility is vested primarily in the epidemiological field stations at block and district levels, although community involvement is suggested. Under decentralisation, the health organisation must play the role of information-giver and educator of people's organisations which can then plan in accordance with need and demand. This relationship is quite the opposite of the prevailing situation in which the people are subservient to health institutions for their health care needs rather than supervising them!

It is argued (not without justification) that health needs are largely the same everywhere, that we know what they are, and that in the context of severe resource constraints, it is more efficient to simply divide the pie and distribute it in accordance with norms. It is significant that while primary health care calls for a form of decentralisation which involves "bottom-up planning" and horizontal integration, decentralisation in India is more akin to top-down devolution of responsibility where vertical links are strongly maintained, rather than horizontal harmonisation established. Plans are simply handed down from Centre to states to districts to blocks and to villages, in which manpower, materials and money are allocated on a population basis. Even the relatively simple matter of indenting for drugs according to local needs does not function in a decentralised mode because the bulk of drug budgets is expended on the standard drugs which are centrally-procured and distributed. The remainder of the budget which is subject to district-level decision making is usually used to procure more expensive non-essential drugs, because these are what are demanded by those who influence the DHO's decisions! While this normative approach to health manpower and service provision and to budgetting ensures that resources are spread equally across populations by the Centre and the states, it is quite antithetical to-decentralisation.

Another manifestation of the "centralist tendency" of the health system is the "Technology Mission approach." This approach not only imposed an additional structure at the top of the health pyramid from which decisions emanated, but also favoured centralisation through the adoption of technological approaches whose diffusion depended on central control and management. The techno-bureaucratic approach which has been adopted for universal immunisation is more in keeping with "selective PHC" than with holistic primary health care, which is the essence of the health policy. Besides being considered more feasible, in contrast with primary health care which is considered "idealistic" because of the actions required beyond the health system in the spheres of social justice, etc., selective PHC is deemed efficient and effective. In the case of immunisation, it is also considered equitable because high coverage is an implicit condition for effectiveness. However, with other interventions such as oral rehydration and vitamin A prophylaxis, achieving the equity objective is less certain. These interventions depend more on household knowledge, decision-making processes or actions, which in turn are influenced by social and economic characteristics (such as education, income). With diminished coverage and effectiveness, equity will also diminish. Few existing health technologies lend themselves to wide distribution and local application which is independent of underlying socio-economic conditions. In general, the technological approach does not "involve" people - they are merely recipients (targets) of a service, centrally planned. Nor does it adress underlying conditions such as unsanitary environments or practices which expose people to disease. While some technology-based health interventions such as immunisation may reduce specific morbidities and mortality, few others have this capacity. Such approaches do little to invert the top-heavy health pyramid or even broaden its base.

Indeed, programme management within the health system is similarly top-down as targets set by the Central or state governments have been the driving

force. While the use of targets in family planning is notorious, the approach covers several other national programmes - immunisation, malaria, etc. Concerned with meeting targets (though the actual numbers may have no relevance at the local level) the district and block level health organisations have little scope for utilising health manpower and materials to address local problems. Only during epidemics does this machinery appear to gear itself up for "fire-fighting" which entails rapid appraisal, on-the-spot decision-making and emergency shifts in the deployment of resources.

The exigencies of resource constraints, people's participation and provision of primary health care at the doorstep would seem to dictate that the disreputed community health workers' (Health Guides') scheme must be revived. We have learned enough lessons over the past two decades to encourage PRIs to reintroduce this scheme so that its earlier pitfalls are avoided and it is implemented in a meaningful way. The National Health Policy, decentralisation and health system all converge on this modality of implementing health care which still has the potential for equity and effectiveness. Further, there is little doubt that for effective decentralisation another key requirement will be strong links between primary and secondary and tertiary health services through a working referral system.

It should be noted that the trends in the health system which were discussed above also do not fit either with the policy thrust or with the approach to decentralisation that is intended to tackle the underlying conditions of disease. The health sector in India has done little to further intersectoral action, even in the closely related areas of nutrition, and water supply and sanitation. It is especially critical to mesh health planning with education planning as the synergism between these sectors is increasingly recognised. (The HRD Fund proposed above would go some way toward linking these services.)

V. A Caveat to Decentralisation?

Besides equitable distribution at the micro-level (which we have discussed above), universal access also implies equitable distribution of health resources across regions, rural and urban areas, etc. The health policy is especially concerned about rectifying regional imbalances, and with special attention to "tribal, hill and backward areas." Because of the "macro" nature of these areas, such corrections will require the attention of the Centre and of state governments, perhaps more than of district-level government. Can decentralisation accomodate this "affirmative action" approach? Or, as in the case of micro-level units such as villages, will those who already have get more? The divergence between "need" and "demand" (or effective demand) is therefore a serious constraint to the implementation of health policy within the context of decentralisation. The poor (whether person or state) need, while the rich demand, and the latter largely control the processes of resource allocation nationally as well as the panchayati raj institutions locally. In effect, perhaps equity - across regions, social groups, age groups, and gender - can only be ensured from 'outside' and 'upstairs.'

In this context, the lack of equality in the resource mobilisation capabilities of the states and districts is also critical. Experience has shown that better off areas can raise more finances and therefore implement better quality care (For example, in Gujarat, Baroda and Khera districts have usually raised more family planning incentive money by tapping industry). This will exacerbate already large differentials in quantities and quality of health services.

VI. Summing Up

Both the National Health Policy and the philosophy of decentralisation have equity at the core of their being, and so are in essence 'on the same wavelength.' However, several critical problems have been identified that stand in the way of their being implemented meaningfully. Firstly, panchayati raj institutions have not overcome the problems of social heterogeneity in the villages and the control of PRIs by better-off elites reduces their potential for implementing health care for the poor. Secondly, the inadequate resource base of PRIs makes it difficult to implement locally relevant health care, particularly as grants received from the Centre and state governments are tied to preset norms and expenditure patterns. Decentralisation is meaningless without local resource generation. Third, PRIs must have the capacity to plan according to local needs and demand, and to raise and allocate resources in keeping with their plans. Need-based/demand-oriented planning is quite different from the norm-based methods now in use which are based on limited resource availabilities and equal sharing principles. Fourth, the combination of oligarchical control and limited resources results in the traditional skewedness of health spending - on sophisticated medical care for the few rather than on basic primary health care for all. Fifth, if the resource base of local bodies is to be increased in a meaningful way, attention must be paid to implementing systems which provide good quality health care to the poor despite their lower paying capacity. Sixth, the implementation of health policy, ie. of primary health care, requires the health system to change in keeping with the philosophy of decentralisation. In particular, the relationship between the technical and politico-bureaucratic cadres needs to be clearly defined so that planning and management controls are exercised in accordance with democratic principles and professional interests are subordinated to people's concerns. Seventh, health plans, in terms of the activities to be undertaken by service providers and the resources allocated to them, must emanate from below and, hence, the "national programme," "technological" and "target-based" approaches which currently dictate programme management from above must give way to locally decided and suited strategies.

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Review article

Reforming the health sector in developing countries: the central role of policy analysis

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Policy analysis is an established discipline in the industrialized world, yet its application to developing countries has been limited. The health sector in particular appears to have been neglected. This is surprising because there is a well recognized crisis in health systems, and prescriptions abound of *what* health policy reforms countries should introduce. However, little attention has been paid to *how* countries should carry out reforms, much less *who* is likely to favour or resist such policies.

This paper argues that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and sub-national levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed. Focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. The paper is organized in 4 sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what other disciplines have written that help to develop a framework of analysis. And the final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

Introduction

Policy analysis is an established research and academic discipline in the industrialized world, but its application to developing countries has been limited, and the health sector in particular appears to have been neglected.

This is all the more surprising because of the growing crisis in health systems. The initial optimism of the Primary Health Care (PHC) revolution of the late 1970s has been challenged by a number of trends: escalating costs but lower public health budgets because of economic recession; the emergence of AIDS; the increase in the number of large-scale and complex disasters; the prevalence of chronic diseases side by side with persisting communicable diseases; worsening inequities in access to services; demoralized health staff; emerging drug resistance to some diseases. In the face of severe economic constraints and shifts towards neo-liberal values, many countries have introduced structural adjustment programmes which have led to cuts in public health services, introduction of, or increased, charges for health care, and liberalization of the health sector to promote private sector development. The effects of such economic reform programmes have been harsh. Zimbabweans dubbed their Economic Structural Adjustment Programme (ESAP) the Extreme Suffering of the African People (Woodroffe 1993). Gains in health status achieved up to the 1970s are being eroded, and evidence is growing of the negative effects of health reforms on health status, especially on the vulnerable (Kanji and Jazdowska 1993; Messkoub 1992; Pinstrup-Anderson 1993).[1]

This crisis in health is well recognized and prescriptions of *what* countries should do abound (for example in the World Bank's *World Development Report 1993: Investing in Health*). However, there is very little attention to *how* countries should carry out reforms, much less *who* is likely to favour or resist such policies. Just as the primary health care approach foundered by concentrating on content (the introduction of voluntary community health worker programmes) rather than process (how communities would be encouraged to support such workers), so recent health reforms are likely to fail because it is expected that policies will be implemented as planned without taking into consideration factors that affect implementation.

This paper argues that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and sub-national levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed (Figure 1). Focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. As Reich (1994a) has argued, policy reform is a profoundly political process, affecting the origins, formulation and implementation of policy. Policy-makers, whether politicians or bureaucrats, are acutely aware that reforms are often unpopular and can cause significant social instability. They may be reluctant to push through reforms, even when part of loan agreements. The World Bank admits that only 55% of conditions in structural adjustment loan agreements have been fully implemented when the final tranche of funds is released (Clapp 1994; 307).

New paradigms of thinking urgently need to be applied to the health sector, to understand the factors influencing the effectiveness of policy change. This approach has already been advocated for the fields of development and economic policy, by scholars questioning conventional and received wisdom about the role of the state (Mackintosh 1992), and the role of external donors (White 1990). Manor (1991; 6) has argued the need for 'thick description' rather than 'parsimonious models'. We argue that the same challenge exists for health, because the context within which health policy is formulated and implemented has changed. From a policy domain characterized primarily by consensus, health policy is increasingly subject to conflict and uncertainty, and this change calls for alternative ways of thinking about policy. We argue that

- policy analysis offers a more comprehensive framework for thinking about health reform than approaches which concentrate on the technical features of the content of reform;
- literature from political economy and other disciplines offers insights to the way policy analysis could be applied in the health sector;
- by using a simple analytical model (Figure 1) which incorporates the concepts of context, process, and actors as well as content, policy-makers and researchers will be able to understand better the process of health policy reform, and to plan for more effective implementation. The model

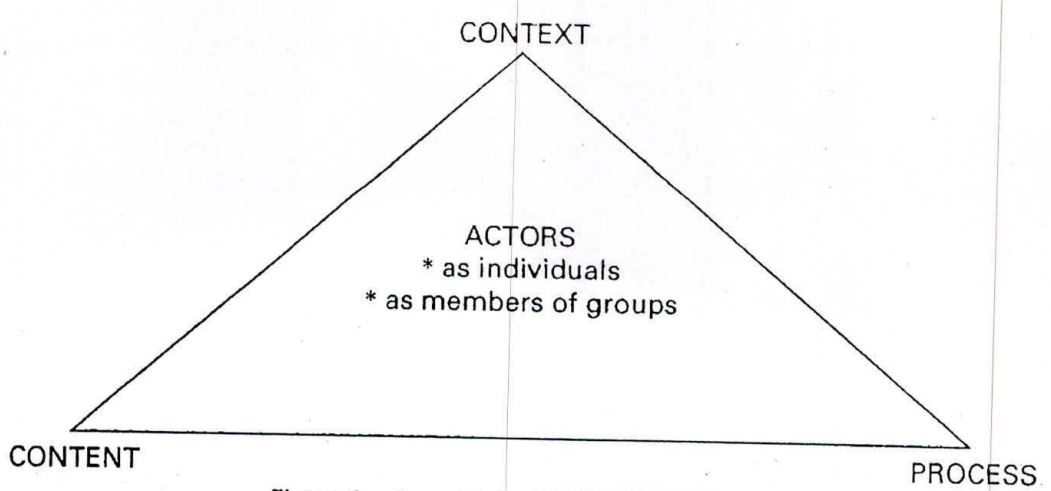

Figure 1. A model for health policy analysis

can thus be used both retrospectively and prospectively.

This is a highly simplified model of an extremely complex set of interrelationships, and gives the impression that each can be considered separately. In reality actors are influenced (as individuals and as members of interest groups or professional associations) by the context within which they live and work, at both the macro-government level and the micro-institutional level. Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture.[2] The process of policy-making (how issues get on to the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions. In other words, we argue that the traditional focus on the content of policy neglects the other dimensions of process, actors and context which can make the difference between effective and ineffective policy choice and implementation.

This paper is organized in 4 sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what other disciplines have written that help to develop a framework of analysis. And the final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

The shift from consensus to conflict in health policy

A changing development context

The scope and scale of political and economic change in the late 1980s and 1990s has been dramatic, and has led to significant political and economic policy reforms which have also influenced sectors such as health.

In the 1950s and 1960s state directed development was part of the intellectual environment of the time (Sen 1983). It was justified through economic analysis that identified market mechanisms as being inadequate in developing countries (Chowdhury and Kirkpatrick 1994; 1), legitimizing governments' role in intervening to correct market imperfections through public sector investment. It also fitted well with the interests of political rulers allowing them to establish or consolidate loyalty through extending state enterprises or bureaucracies. And in this period international aid expanded to support the state.

The return to classical economic theory - the neo-liberalism of the 1980s - was a reaction partly to positive economic growth and development in Asia (where many governments had promoted neo-liberal policies); partly to the growth of what came to be seen as over-extended and weak public sectors in some developing countries; and partly to the recognition that government preferences expressed through policies did not unambiguously promote the interests of their populations. Indebtedness, instability and, above all, inefficiency were perceived as failures in economic policy.

From the 1980s many actors played a part in expressing dissatisfaction with the state. From many different disciplines and positions writers complained of the 'self-deceiving state' (Chambers 1992) or 'the unequal state' (Bayart 1993). In central and eastern Europe people took to the streets to overturn the state in 1989. And the international financial institutions, such as the World Bank and IMF, became impatient with what were perceived to be authoritarian developing country governments. Given their central role in debt rescheduling and new loan agreements, these agencies were able to introduce significant conditions in the form of structural adjustment programmes which demanded political reforms (e.g. retraction of the civil service, introduction of multi-party elections) as well as economic reforms (e.g. trade liberalization, removal of subsidies). Economic adjustment programmes affected the health sector through cuts in budgets, promotion of the private sector, and the introduction of user charges for health services.

The tendency of those advocating policy reforms was to perceive them as technical: international experts negotiated reform programmes with national policy-makers. Although many agreed

that some reform was necessary (despite fierce debates about scope, timing and conditions), the focus on the content of reform neglected important factors such as varying political cultures and institutions, the influence of ideologies or schools of thought, and historical traditions.[3]

From the late 1980s economists and political scientists argued that complex economic reforms which had immediate and major distributional (and often drastic) effects on populations, and where benefits were long term (and major doubts existed on the extent of benefit), could not be treated as technical policies that would be automatically implemented. National policy-makers and scholars increasingly criticized technocratic approaches. Lindenberg (1989; 359) quotes an anonymous policy-maker saying

> 'Often these people who come here from international organizations to preach the gospel of stabilization and structural adjustment know as much about the political and economic consequences of what they are proposing as the medicine men who used to prescribe leeches to correct imbalances in the four humours of their patients.'

Herbst (1990) argued that structural adjustment programmes that demanded major curtailment of public enterprises in Africa did not recognize that such enterprises had been an important source of reward and patronage to African leaders for decades. Reducing their activities threatened important constituencies and could lead to weak implementation or make the state much less flexible in dealing with crises. In similar vein, Haggard and Webb (1993) observed that structural adjustment programmes were undermined by their tendency to ignore the institutional characteristics of the political system, the internal and external economy, and the design of reform programmes.

A changing health context

The changing political economy had repercussions for health policy and facilitated the idea of reforming the health sector. During the period when the state played a strong central development role, health policy had been decided largely on consensual grounds, partly because it was controlled by a medical elite. During this period health policies were largely uncontroversial, received broad (if passive) support from the population, and appeared as 'low politics'[4] issues on the political agenda. They were almost entirely concerned with the *content* of policy (e.g. how to improve access and coverage, how to increase efficiency in the use of hospital beds), and reforms were largely limited to organizational questions regarding health systems (e.g. the relationship between different levels of health service - tertiary, secondary and primary).

In the 1980s, however, as neo-liberal ideas began to dominate, health policies moved into a policy arena in which previously accepted values were challenged (e.g. by calls for 'cost sharing' and the promotion of private health care provic). A context in which market values dom ate leaves little room for morality, values and feelings, and may undermine and destroy previously accepted, socially constructed concepts of public purpose, public morality and public accountability (Wuyts et al. 1992). Debates about health policy were increasingly characterized by conflict, making them, relative to previous decades, 'high politics' agenda items. This conflict inevitably generated considerable uncertainty around appropriate policy choice.

How did the change from consensus to conflict occur? The period of consensus was largely derived from a relatively restricted policy field dominated by medicine. From the 1940s to the mid 1970s health policy was fuelled by tremendous confidence in medical sci e. Sulphonamides, penicillin and broad spectrum antibiotics provided the tools to challenge disease. The synthesis of DDT and its application to control malaria, vaccines against infectious diseases, the advent of the oral contraceptive, all strengthened professional monopoly and lay beliefs that medicine had the answers: health policy-makers had merely to decide how to manage and organize health services to make them accessible, available, acceptable and affordable.

The domination of health policy by medical professionals was repeated in international circles. From the 1950s international and bilateral agencies became more involved in health, and established their credibility by conquering yaws, eradicating smallpox and (more controversially) helping to control malaria. They provided

technical expertise and funds for various programmes in health, including family planning.

However, by the late 1960s the medical paradigm was increasingly challenged from both within and outside the profession. Past policy which had emphasized disease treatment in centres of excellence was questioned by historians, epidemiologists and economists, who showed that much illness was poverty related (Abel-Smith and Leiserson 1978), that drugs which had appeared to be 'magic bullets' had many unintended consequences (Illich 1975), and that teaching hospitals served a small proportion of the population but swallowed large proportions of the health budget (King 1966). Social scientists increasingly encroached on the policy domain of medical professionals, raising questions about the effects of culture on health behaviour and the elative costs of different health care activities among other things.

The launching of the primary health care approach in 1978 reflected the thinking of these different groups, and expanded the health policy arena to include many other groups than medical professionals. The loss of professional monopoly opened the way for conflict in policy debates. This was manifest in global level debates about comprehensive versus selective care (Rifkin and Walt 1988), in the battle to get an international code on breastmilk substitutes and over establishing an essential drugs programme (Walt 1993).

However, even though the notion of 'political ill' introduced in the Alma Ata policy document on Primary Health Care acknowledged the role of politics and conflict in health policy, it was never conceptually developed (with a few recent exceptions such as Reich 1994b; Whitehead 1990), and had little effect on donor-supported health policies implemented in many low income countries. These continued to be largely technical, vertically-organized programmes such as immunization against 6 childhood infectious diseases and control of diarrhoeal disease. Even national primary health care policies were often interpreted narrowly and expediently as vertical programmes within ministries of health (Decosas 1990), or as synonomous with community health worker programmes or expansion of rural health infrastructures (Walt 1990).

Neo-liberal policies introduced new tensions into the health policy domain. In the industrialized world there was increasing emphasis on cost containment and efficiency improvement, leading to concepts of the internal market and separation between providers and purchasers, and a controversial emphasis on the virtues of competition. Managers and economists increasingly intervened in areas previously controlled by professionals. In the developing world donors and financial institutions laid down neo-liberal conditions for debt servicing and loan agreements: these included a reduced role for the public sector, the introduction, or raising, of fees for consultations, drugs and admission to hospital, and reductions in the regulation of the private sector.

The shift from consensus to conflict in health policy served to heighten awareness about the failure of past policies. For example, by the late 1980s many aid agencies were admitting that years of experience in primary health care had shown that technical solutions, while often necessary, were not sufficient to sustain policy outcomes, especially in poorer countries. While infant mortality rates had decreased and coverage of immunization had increased in many countries, those gains came at the same time as growing social inequalities, poor quality of care, and worsening living conditions. It had become clear that the effectiveness of programmes was influenced by values and culture (both national and international), accountability, morale, and communication, among other things, but that such factors had been neglected in the belief that better techniques or technologies could by themselves tackle the causes of ill-health (Cutts 1994; Nabarro and Chinnock 1988; Heggenhougen and Clements 1987).

Looking for new policy solutions, donors promoted decentralization policies to remove control from central, distant state authorities; service delivery through non-government organizations which were perceived to be closer to local communities and which might instil a greater sense of democracy; and 'good governance' which included reform within smaller bureaucracies (performance related pay, greater flexi-

bility in recruitment and dismissal) and greater accountability.

In so doing, however, two issues were raised. One related to sovereignty, accountability and unequal power relations. Put baldly, national governments wanted loans or grants from international organizations, but received them only if they agreed to impose economic reforms. For some this reflected conditionality without responsibility (Cliff 1993). However, international agencies were themselves accountable to their own constituencies, and have been affected in some countries by scepticism expressed about the role of aid and the value of technical assistance and cooperation (Bauer 1981; Hancock 1989). Also international agencies are themselves actors of great variation; multilateral, bilateral and non-government organizations are fuelled by different goals and values. Bollini and Reich (1994), for example, differentiate between 'internationally minded' and 'nationally minded' agencies.

The other issue related to a lack of understanding of the policy process: there were huge gaps in knowledge about how bureaucracies worked or how policy-makers responded to pressure. While concerns with 'good government' demanded understanding about bureaucratic culture and decision-making processes, this knowledge was fragmented and partial. It was unclear how far implementation of reforms would be influenced by domestic policy processes given the lack of information about institutional development and how organizational and administrative systems worked. For example, while there was force behind the arguments for greater effectiveness and efficiency, there was little understanding about how this would occur in a contracting rather than an expanding economy. As Cumper (1993) argued, health planning had always been based on assumed growth, and the knowledge and techniques for originating and implementing change in contracting health systems was missing. Introducing competition, whether through internal markets, as in the UK, or through non-governmental organizations in developing countries, raised major questions about the conditions for success for which there were no answers (Broomberg 1994).

In this policy environment ideological certainty expressed through policy documents such as the *World Development Report 1993: Investing in Health* appears a great deal more robust than it is (Reich 1994a). And because of this there is a nascent acceptance that new analytic approaches are needed which offer a better understanding and more complete explanation of the policy environment. We argue that our framework for policy analysis offers such an approach.

What is policy analysis?

Policy analysis draws on concepts from a number of disciplines: economics, political science, sociology, public administration ıd history, and emerged as a subdiscipline in the ıate 1960s, mainly in the United States. It is variously defined by different scholars, comes in many guises, and offers a confusing heterogeneity of different theories ranging from highly prescriptive to descriptive (Heclo 1972).

Most policy analysis focuses on the policy process. Dror (1993; 4), for example, defines policy analysis as 'approaches, methods, methodologies and techniques for improving discrete policy decisions'. Similarly, Paul et al. (1989; 1) define policy analysis as 'the task of analyzing and evaluating public policy options in the context of given goals for choice by policymakers or other relevant actors'. The implication in these definitions of policy analysis is that policy-makers are concerned largely with the content of policy re intendedly rational, and need to have particular skills to make proper choices among well-defined policy alternatives in the furtherance of complex but compatible goals.

These approaches are similar to those characterized by the incrementalist or rational schools of policy-making. The classical proponent of the first approach is Lindblom (1959), who is concerned with analyzing what happens in organizations or what happened in a particular decision. His is a descriptive approach which argues in favour of incrementalism and acknowledges a process of bargaining between different interest groups in the process of policy-making. The rational approach is more abstract, and deals with values and how policy-making *should* be undertaken. It offers a prescriptive and 'ideal model' of how policy-making ought to be undertaken, providing a way of improving the

effectiveness of policy-making by explicitly identifying values and goals before making policy choices and selecting the best policy options based on comprehensive information about the costs and consequences of each (Simon 1957).

These approaches centre their analysis on policy-making, although Lindblom emphasizes the role of actors as partisans in the policy process. Our approach to policy analysis goes further because, while it is concerned with the processes of policy-making, it is also centrally concerned with the behaviour of actors in formulating and implementing policy *and* the context within which policies are promulgated (Figure 1). It offers a much broader framework for thinking about health policy. In adopting this model we argue that policy is not simply about prescription or description, and nor does it develop in a social vacuum; it is the outcome of complex social, political and economic interactions.

Our model of policy analysis is thus nearer to political economy approaches, which also draw on the concepts of several disciplines but have been dominated by economics and politics. Recent political economy theorizing has been driven largely by a concern to explain the processes related to formulation and implementation of structural adjustment programmes in low income countries. The richest analyses have been provided by development theorists, economists and political scientists. What have these approaches to offer health policy analysis?

What can be learned from other disciplines?

Economics has made a major contribution to health policy over the past two decades. From the late 1960s policy-makers increasingly turned to economists for analysis of health care costs and health service financing options. Within a decade growing numbers of health economists were to be found in academic institutions, international organizations, ministries of health; they dominated health services research and health policy discussions. Economics plays an important part in appraising options in policy-making, helping policy-makers to make choices on the basis of efficiency and equity. Partly because of its central concern with the allocation of scarce resources and partly because it deals with measurable effects, economics has increasingly been seen to offer valuable techniques for policy-making (Sharpe 1977).

However, while few would deny the usefulness of economics as one of the tools for policy choice, like any discipline, it has its limitations. Green (1990; 274) has argued for example, that there is a danger that economists may be seen as 'neutral technocrats, harbingers of rationality and conveyors of objectivity', although they are, as any other actors, fuelled by particular values which may or may not be articulated (or even recognized) explicitly. Fuchs (1993) gives three examples that illustrate the limitations of economics in health policy. The first is that economics is a general method or way of thinking, but does not necessarily offer solutions for health policy-makers because of the peculiarities of the health care market. For example, in most industries where there is excess capacity prices fall sharply and some firms are forced out of business. But in the health care markets of the USA there are excess supplies of hospital beds, high technology and certain surgical and medical specialists, while charges and fees remain high.

Fuch's second example is in the social and political domain: while economics helps to understand how health care costs are higher in the USA than in Canada or Germany, economics does not explain 'Canada's superior political capacity to enact and administer universal health insurance' or the greater willingness of Germans to obey centrally established rules for health expenditure. And finally, Fuchs's third limit relates to the importance of values in health policy. Conflicts over values are particularly stark in the health policy arena: for example, should advanced medical technologies be made available to all, in spite of cost, or should funds be spent on public health and the prevention of disease? Economics cannot provide guidance on which value system to favour in policy-making.

Economists themselves have increasingly recognized the need to enrich their focus and methods of enquiry with conceptual tools from other disciplines, and it is to policy and political analysis they have turned (Healey and Robinson 1992; Meier 1993).

> 'Economists are trained in the study of the operation of economic forces within political, social and moral constraints. This approach has to be supplemented (and in some cases replaced) by the study of the operation and manipulation of political, social and psychological forces within economic limits. More fundamentally, the distinction between economic and noneconomic variables may not be tenable if the aim is to understand society.' (Streeten 1993; 1286)

Development theorists have similarly re-appraised old relationships between economic growth and development, highlighting the need for different modes of analysis (Manor 1991; Chambers 1992).

Thus economists have joined with political scientists, sociologists and anthropologists to provide a better understanding of the *political environment* within which policies are decided and executed. Much of the impetus for this resurrection of the tenets of political economy was stimulated by the introduction of economic reforms through structural adjustment programmes. Initial debates revolved around the benefits and disbenefits of economic adjustment, and were concerned with timing, scale, and debates about short and long term effectiveness (Cornia et al. 1987; Mosley et al. 1991; Parfitt 1993; Stewart 1991). In other words, they were concerned with the content of structural adjustment programmes.

By the end of the 1980s, however, a number of writers were pointing to the poverty of this approach. Elliott (1988) argued that the prescriptions of structural adjustment programmes in Africa assumed that reforms would be accepted and implemented through a process of policy dialogue and that this was naive. Policy reformers did not sufficiently consider the political culture of African countries and it was the political culture that would ensure that reforms failed. Nelson (1990) and Haggard and Kaufman (1992) also argued that economic analyses world-wide had neglected the political dimensions, and without an understanding of the process of policy (and, for example, the risks political leaders were being asked to take), policy failure was likely. An analysis of economic development experience in Africa demonstrated that the continent's comparatively poor performance could have been predicted had analysis taken more account of political science concepts of the state, personal rule, history and social structure (ODI 1992).

The argument that politics and economics could not be separated in analyzing economic policy reform was captured in Lindenberg's description of 'two-legged' governments:

> 'One leg is economic, consisting of all the national economic strategies designed to improve the well being of the population. The other leg is political, because economic strategies rarely endure unless they are also politically feasible. Problems with either leg can cause a government to stumble. Poorly conceived economic strategy can result in undue national hardship. Popular reaction to ill conceived policies is sometimes strong enough to bring governments down. Similarly, politically expedient policies can keep rulers in power in the short term at the expense of national bankruptcy, increased human misery and eventual public outrage.' (1989; 359)

The implication of the thinking of all these scholars was that had policy reformers perceived governments as two-legged when they introduced structural adjustment policies, the much criticized prescriptive manner of introducing and enforcing reforms might have been avoided, and implementation tailored more to the needs of individual countries.

Many writing in the political economy field take a dynamic approach to policy analysis, believing that if policy analysis *precedes* policy choice, the chances of more effective implementation are greater. 'Policy analysis matters because it helps us to act effectively' (Wuyts 1992; 285). This position is arrived at through the development of explanatory frameworks of relationships between state and society, political actors such as governments, foreign donors and interest groups, which draw on historical, cultural and sociological concepts to add depth to explanation. While all start with the premise that political factors are a feature of all policy analysis, they offer a wide variety of approaches and frameworks. Some however, focus more on

the *macro-political context* of policy-making, and others on the *actors* involved in policy-making, although inevitably there is a great deal of overlap.

Focusing on context

Many policy analysts are concerned to make explicit the macro, contextual factors that influence policy. Their central concern is with the state and its role in economic policy reform. However they write from different perspectives.

One of the dominant questions has been about the rightful role of the state. This debate underlies all policy analysis, viewing the state *either* as having a central role in policy-making, *or* as having an increasingly marginal role. Mackintosh (1992) reviews the political and theoretical critiques of the state. The 'public interest' view of the state, which underpinned early development theory, was challenged by two critiques: the Marxist critics who saw the state as ruled by class and power relations (suggesting the state was not a disinterested institution promoting the public interest, but one exercising power in favour of dominant classes); and the 'private interest' (or public choice) theorists, who argued that the state was made up of self-interested bureaucrats and politicians who, in their search for power, would be forced to respond to majority views. This view of the state provided the rationale for reductions in the role of government and increased competition between state structures.

Mackintosh's clear analysis shows that whilst Marxist and 'private interest' analyses have some similarities, they cannot necessarily be reconciled with the 'public interest' view of the state. 'Reform of the state on a market model conflicts with reform which seeks to strengthen the state as a vehicle of social solidarity' (Mackintosh 1992; 89). Others have also criticized the 'private interest' or public choice theorists. Toye (1993; 135-6), for example, accuses them of displaying a 'profoundly cynical view of the state in developing countries', suggesting that 'to attribute individual self-interest as their exclusive motive to politicians in developing countries is to deny their sincerity, their merit and, ultimately, their legitimate right to govern'.

While many policy analysts accept the need for reform of the state, most perceive that the state must continue to have a central role in policy-making. Streeten (1993) emphasizes the role of state intervention in assisting markets to work better, not simply favouring the already powerful groups. Perkins and Roemer (1991) also observe that the state cannot be treated simply as an impediment to the proper functioning of free markets - the real debate is not so much whether the state should be involved but how state intervention should be handled. Klitgaard (1991b) argues that policy analysts need to go beyond the 'state versus market' arguments, challenging them to make both the market and the state work better.

Others have characterized the state as weak or strong, and looked for factors which helped to provide political explanations for patterns of policy. Whitehead (1990), for example, surveys 8 overlapping factors which provide explanations for differences in macroeconomic management of change in developing countries. He suggests that it should be possible to synthesize these 8 factors, identify whether states are strong or weak, and then analyze what this would mean for the speed, flexibility and likely effectiveness of various policy options. The factors Whitehead identifies as important to consider in policy analysis are: historical traditions (colonialism, independence, experience of war); socio-structural determinants (social class, ethnic and religious divisions); the self-interest of politically powerful sectors (the position of ruling elites); entrenched characteristics of the political system (democratic experience); formal properties of the political institutions (regulation of state power, authority and accountability); the influence of particular economic ideologies or schools of thought (neo-liberalism); the logic of particular sequential processes of the 'vicious circle' (growing inflation leads to speculation, high interest rates, hoarding) against the 'virtuous circle' (price stability causes prices to fall, wages to stabilize, confidence to return); and a variety of *ad hoc* or conjunctural considerations (such as accidents of good or bad timing).

Migdal (1988) also attempts to characterize states as weak or strong, but juxtaposes them against 'society', arguing that many low income countries have weak states and strong societies, which explains the partial or failed implementation of many policies. According to this view, the state

this century has had a tenuous hold on society which is why it often falls back on the military. Other institutions - religious, caste, tribe or family - have kept these societies together. Consequently, the capacity of the state to intervene effectively has always been weak. Hinnebusch (1993) has used the notion of strong and weak state and society to explain the politics of economic reform in Egypt, suggesting that the balance of power between state and society affects the policy process. For example, when there is a strong state and a strong society, he suggests there is likely to be a balance of power between the two, and therefore considerable consensus on reform. With a weak state and weak society there is little strength to reform, and unresolved problems increase the state's vulnerability to external forces, so that reform is imposed.

Writers concerned with the context of policy-making do not only focus on the state. Some are concerned with culture, and the extent to which cultural factors pervade the policy environment. Hyden (1983), for example, has argued that cultural factors are an important part of the policy context, influencing political behaviour. His description of an African 'economy of affection' explores traditional obligations at all levels of society, and illustrates how these lead to contradictory expectations of those in all levels of public office (obligations to family versus the promotion of national interest, for example). Liddle (1992; 797) argues that in Indonesian political culture the pervasive notion of *ke-Timuran* or 'Eastern-ness' must be taken into account in considering the policy environment:

> '*Ke-Timuran* has to do with the attitudes necessary to the maintenance of a harmonious society. It contains such ideas as respect for the views of others in general, deference to elders and to authority in particular, a notion that differences of opinion should be expressed privately and nonconfrontationally.'

Focusing on actors

For many writers concerned with policy analysis, the key determinant of policy change is the group of actors involved, and the focus is often on government. Lindenberg (1989), for example, reviews how the governments of Panama, Costa Rica and Guatemala managed support and opposition to their stabilization and structural adjustment policies in the mid-1980s. He concludes his analysis with a set of initial lessons which could help other governments manage the 'winners and losers during the process of economic change', although he points out these are not blueprints given each country's unique history and policy environment. In his analysis of adjustment policies in three African countries Toye (1992) concludes that the World Bank did not sufficiently take into consideration the vested interests of government leaders and rich farmers in the agricultural sector, and as a result, efforts to reform the economy faltered.

Attempting to answer the question 'Who makes economic policy in Africa?', Gulhati (1990) suggests national policy-makers are influenced by four political variables: political trends in the country, and especially the character of the ruler (he divides rulers into 'princes', autocrats, prophets and tyrants); social stratification (class, ethnic and regional loyalties); foreign donors and investors; and the size and quality of the civil service. These variables (some of which overlap with Whitehead's) focus on the actors within each category, and attempt to provide an overview of the political culture of the country. Gulhati goes on to identify points of intervention in the resulting policy environment if reforms are to be successful.

In reviewing Whitehead and Gulhati's papers, Bery (1990) suggests that both frameworks, while not that useful for national policy-makers, offer outsiders, such as donors, a way of assessing the probability of success of a particular reform effort. Perhaps because he is focusing on Africa, and Whitehead's examples are more from Latin America, Gulhati accords donors far greater influence in shaping national decisions; he also shows more concern than Whitehead for the extent to which the civil service affects the execution of policies.

Attention on the civil service is argued to be important because of the strategic roles bureaucrats play in the implementation of reforms. Some have sought to understand the influence of actors by focusing on the relationship between politicians and bureaucrats. Brown (1989), Mukan-

dala (1992) and Panday (1989) for example, argue that in Liberia, Tanzania and Nepal respectively bureaucrats have played a relatively insignificant role in the policy process, largely because of the dominance of politicians (and in Nepal the Royal Palace).[5] In contrast, Koehn (1983) has argued that Nigeria has seen so many changes of mainly military government that civil servants have controlled policy-making through their greater expertise and continuity. Charlton (1991) likewise suggests that in comparison with politicians, civil servants in Botswana played a particularly important role at independence, although the balance of power between politicians and bureaucrats changed over time. Gulhati (1991) observes that the failure to build consensus between officials and politicians on the need for reform in Zambia (and the fact that the reform measures were largely developed outside Zambia by the IMF, World Bank and foreign consultants) was one of the reasons for that country's economic impasse during the 1980s.

A few writers are concerned with societal actors, rather than policy elites within government (Ghai 1992). Tironi and Lagos (1991), for example, argue that structural adjustment policies in Latin America are bringing about profound changes in the social structure of those countries implementing them. They suggest a number of factors (the strength of the government and its administration, the dependence on multilateral financial agencies, the will and capacity of social actors to resist) will determine whether structural adjustment policies are implemented by shock measures or more gradually. They place particular emphasis on the roles of trade unions and the business community, and on marginal social groups as well as political parties and the state, exploring their relative influence on the constellation of factors that influence policy.

In his review of development policy as a process, Wuyts (1992; 283) argues that the public cannot be separated from the state: 'State institutions are influenced by public action, and in turn, provide the means through which this action is sustained or modified.' He argues that public action is not simply an additional factor in analyzing the state's role in the policy process, but is an integral part. Hyden and Karlstrom (1993; 1402) also emphasize the complexity of policy environments and interaction of actors within them:

> 'a narrow focus on the inherent values of specific policy instruments or on the presumed interests of various policy actors at a certain time is not enough. What needs to be added is a longitudinal dimension that helps us understand how various actors interact with each other on specific issues and with what outcomes.'

Liddle (1992) writes from the development (rather than economic) perspective, arguing that theories of the causes of development in the Third World have paid too little attention to policy, and are too concerned with generalization. The tendency to formulate global assessments and prescriptions in development is taken up by Uphoff (1992) who proposes an approach which 'particularizes' and disaggregates. Long and Van der Ploeg (1989) also criticize development theories for espousing rather general, mechanical models of the relationship between policy, implementation and outcomes. They take an actor perspective that starts with individuals and their households rather than with political elites in government, and argue in favour of deconstructing the process of policy implementation, looking more closely at how interventions 'enter the life worlds of the individuals and groups affected and thus come to form part of the resources and constraints of the social strategies they develop' (1989; 228).

To sum up, the papers reviewed above represent a number of publications which have appeared over the past few years which are concerned with the effects of policy. Basic to their argument is the fact that policy outcomes can only be understood within a historical context, and by identifying the different actors who may have influenced policy. However, few scholars look explicitly at the *process* of policy-making, Grindle and Thomas (1991) being the most important exception to this observation. Partly this is because each analyst comes from a different perspective or central concern, ranging from macro-political views of the state and state-societal relations, to micro-political views of how policies affect and are influenced by individuals and households. The literature is therefore diffuse and rich in its diversity and complexity, but lacks consistency and rigor.

Focus on processes

Very few of the papers described above do more than touch on the processes of policy-making: they are more concerned with explaining contextual factors or the behaviour of actors. What Grindle and Thomas (1991) provide is an analytical framework which incorporates processes to help understand how public policy is made, and who influences it. Their approach is mostly derived from economic policy reform, although they give one example of health sector reform in Mali. They focus on actors (policy elites who are largely perceived as key politicians and bureaucrats) and processes of agenda setting, decision making and implementing reform. While principally analytic, they try to map out a process and identify critical factors that affect the policy outcomes of reform initiatives, believing that this approach can help to influence the process of reform as well as to understand it. They compare the policy process in circumstances of crisis as well as routine or 'politics-as-usual', take into consideration the likely responses to particular policies (support and resistance, where it arises, and its relative strengths), the resources needed for implementation, and include judgements about enabling or constraining contexts.

Their analysis focuses on the overlapping boundaries of state and society, and although they somewhat neglect the role of vested interests and interest groups, the framework they offer is unusual because they integrate explicitly context, actors and processes of policy-making.

Health policy analysis

As has been shown, economic reform led to a spate of papers arguing that more attention should be focused on the policy environment. The result has been a valuable outgrowth of approaches, rich in diversity and explanation. However, it has hardly touched the health sector. Although health reform has paralleled economic reform in many developing countries (not to mention the industrialized world), little interest has been shown in the policy environment. In the mid-1980s Abel-Smith, for example, drew attention to the world economic crisis and its repercussions on health, demonstrating the drastic effects of recession. Structural adjustment programmes were alluded to (in terms of government cut-backs in the health sector), but the focus was on economics and not politics (Abel-Smith 1986). A few exceptions to this focus stand out. Analysis of health sector reforms in Chad and in Niger explored some of the political and economic factors that explained partial or slow implementation of reforms (Foltz 1994; Foltz and Foltz 1991). Bennett and Tangcharoensathien (1994) analyzed the context and processes of policy change encouraging the growth of private health care in Thailand, drawing on Grindle and Thomas' analytical framework. Dahlgren (1990) and Mwabu (1993) evaluate the process of introducing charges into the Kenyan health sector; Reich explored pharmaceutical policies in a number of countries using a pol al economy perspective (1994a).

These papers suggest that health reform is not easy, is subject to considerable external influences (external to the health sector as well as to the country) and is often resisted. A review of health sector reforms in 4 countries in Africa supported by non-project aid from the US Agency for International Development, concludes that evaluation of a number of experiences suggests that

> 'the completion of health sector reforms is more difficult than that of reform in other sectors.' (Donaldson 1993; 13)

Some of the reasons why the health sector may differ from the economic sector may lie in such factors as the peculiarities of the health care market, the status of health professionals, conflicts over values about coverage, access to high technology, and control over the quality of life.

While there is a lack of policy analysis on health reform in developing countries (as described above), there is a sparse literature which is concerned with actors and their roles in health policy-making, and with political economy approaches to health.

Ugalde (1978) focused on policy-making in the health sector in Colombia and Iran, showing that not only did medical professionals and their values dominate the policy process, but that policy-making was limited to a tight circle of top elites, especially in Iran but also in Colombia. Ugalde suggests that international donors

perpetuated this under-developed system of demand articulation in spite of rhetoric about community participation. The strong position of a small elite of health professionals in influencing health policy was also apparent in Mozambique after independence (Walt and Cliff 1986) and the authors suggest that exogenous factors such as war and structural adjustment agreements (negotiations with the IMF and World Bank began in 1985) combined to change the thrust of health policy.

Many of those writing about health policy in developing countries have been concerned about the extent to which national health policy making has been undermined since the 1980s by dependence on donors. In some countries in Africa between 60–70% of the government health budget is provided from external sources. A few case studies have explored directly how far donors are influencing health policy in particular countries (Okuonzi and Macrae 1994; Cliff 1993; Cliff et al. 1986; Linsenmeyer 1989), and others have looked at donor influence as part of the health policy arena both within less developed countries (Justice 1986) and from inside the agencies (Gerein 1986). Emerging global interdependence is also a major concern in the analysis of the increase in violence and complex, large-scale disasters (Duffield 1994). The impact of political violence on health and health services has been described as a public health issue by Zwi and Ugalde (1991) and its lasting impact on 'post'-conflict societies is illustrated by Macrae, Zwi and Birungi (1994). Duffield (1994) suggests that aid agencies have often depoliticized policy by reducing it to a technical matter of organization or good practice, and argues strongly that policy must be premised on the centrality of indigenous political relations and not imposed from outside.

There are a few political economy approaches to analyzing health policy. One of the earliest historical overviews of how political and economic systems affected the development of health care is Doyal's *Political Economy of Health* (1979). Turshen (1984) used a similar analytical approach to describe how disease experiences changed with colonial history in Tanzania, and how politics has affected public health issues (Turshen 1989). A more recent and useful review on the political economy of health transitions is provided by Reich (1994b), who distinguishes between two approaches: the government intervention school, which sees a place for public sector control over the free market, and the neo-liberal or market forces school, which rejects government intervention and looks to the private sector for advances in health policy. Morgan (1993) also takes a political economy approach in looking at community participation in health in Costa Rica. Stock and Anyinam (1992) conclude that health services have not been greatly influenced by ideology in Africa, but as neo-liberal reforms begin to bite this conclusion may be challenged. Kalumba and Freund (1989) suggest that revelations of social discrepancies within and between regions led to the eclipse of idealism in Zambia in the late 1980s.

The growth of global interdependence has highlighted the role of international and bilateral agencies in health, and their relationships with national policy-making. A critique of WHO's Health for All advocacy by Navarro (1984) explored the relationship between global political rhetoric and power. A number of international relations scholars have examined policy-making in international agencies: Sikkink (1986) looked at the agenda setting role of UNICEF and WHO in relation to the International Code on Breastmilk Substitutes; Taylor (1991) examined several international agencies, one of which was WHO, to explore the consequences of financial pressures in the UN system. One of the issues on changes in financing within WHO raises questions of where power lies within the organization (Walt 1993). Several authors have explored the role of international agencies in the development of pharmaceutical policy (Kanji et al. 1992; Chetley 1990; Reich 1987).

Although many of the above papers use a policy analysis approach, it is often implicit. In contrast, Leichter's comparative framework of 4 health policies in 4 industrialized countries offers a useful and explicit overview for policy analysis, and can be adapted to different situations. He draws on 4 contextual categories of factors which affect the policy process: situational, structural, cultural and environmental, which offer a scheme for analyzing public policy (Leichter 1979; 41).

The dearth of literature that addresses the way in which health policies are made and implemented in the developing world emphasises the need for more detailed and comprehensive health policy analysis.

Building policy analysis into health studies

We have argued that historically much health policy has been simply concerned with the technical features of policy content, rather than with the processes of putting policy into effect. As a result policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved. Policy analysis cannot continue to ignore the *how* of policy reform.

While the policy environment in health was relatively consensual, the technical orientation of health policy raised few objections. However, the current policy environment is more uncertain and more conflictual, and policy debates raise fundamental questions about the values and group interests being furthered by policy change. Given that policy reforms often depend on political compromise and not on rational debate, a particular influence on their impact is the power structure within which they operate. In the health sector there are important and influential policy networks of managers and professionals and, at least in the UK, the hostility and differences between these two groups are legion (Salter 1994). In many low income countries there are large gaps between top and lower level bureaucrats, between nurses and doctors, between policy elites and managers. In such countries power is further complicated because it rests not only on internal relationships, but significantly, on external relationships with advisers, experts, aid donors and financial institutions. Policy analysis cannot continue to ignore the influence of values and group interests – the *who* of policy reform – on policy choice and implementation practices.

Our simple analytical model (Figure 1) emphasizes the critical role of these actors in the policy process, influencing the values inherent in policy and the specific policies chosen through that process, and influenced by the policy context (historical, political, economic and socio-cultural). Decisions over policy content are not simply technical, but reflect what is politically feasible at the time of policy choice. Seeing policy as a dynamic process is also key to this analysis: the policy environment is continuously shifting, transforming relations between groups and between institutions. Indeed Warwick (1979) refers to 'transactional analysis' rather than policy analysis to stress the complexity of social, economic and political interactions which include value systems.

In promoting this view of policy analysis we are aware of the arguments that are marshalled against policy analysis: that all policy is decided for political reasons, and is therefore unique to time and place; that because it is so complex, the social sciences cannot offer sufficiently specific tools to be precise about outcomes; that access to information is difficult and can be delicate; that it may become quickly outdated especially in unstable political situations; that policy analysis is based on Western concepts, which are not applicable in less developed countries. The conclusion from such points is that there is little point in doing policy analysis, apart from intrinsic understanding, because it is never generalizable and cannot lead to change.

We strongly disagree with these arguments. Indeed, one of the reasons for policy analysis is precisely to influence policy outcomes. As Grindle and Thomas (1991; 141) put it

> 'We have proposed that decision makers and policy managers can analyze their environment, in the context of a political economy framework, to see if the conditions and capacity exist for successfully implementing a reform.'

Reich (1993) has developed a method of political mapping to assist in the analysis of policy environments. As a tool, political mapping can be used for both research (retrospective analysis) and for planning (prospective analysis). For example, it offers several different ways for investigating which actors might be affected by a particular policy, and assessing their relative strengths and weaknesses. If such an exercise is undertaken before a policy is put into effect, it should be possible to assess which groups are likely to be resistant and to plan strategies to overcome opposition.

Others have similarly used policy analysis in helping national policy-makers think through the implications of particular health policies (Gilson 1993). Klitgaard describes his attempts to build analytical capacity among government officials in Equatorial Guinea (1991a) and in Bolivia (1991b).

We emphasize the critical importance of sensitivity and caution in this approach to policy analysis, recognizing the potential influence of the analyst's own values and perspectives over the analysis and even the decisions made. We also accept that policies are formulated and implemented within specific historical contexts, and outcomes are dependent on time and place. However, this does *not* mean that nothing can be done to change policy. We suggest that the current crisis in health demands rigorous and comprehensive analysis of the policy process and its influence on policy effectiveness, as input into future policy making.

Endnotes

[1] Long-term evidence for the negative effects on health of economic reforms is still difficult to interpret however, and open to dispute (World Bank 1994).

[2] Leichter (1979) refers to these as situational, structural, cultural and environmental factors.

[3] It must be acknowledged that policy-makers in international organizations are aware of their own limitations in national settings, and are not insensitive to intervening, or being seen to be intervening, in issues of sovereignty and domestic politics. Offering technical advice and assistance on the other hand, is perceived as legitimate.

[4] The terms 'high' and 'low' politics are borrowed from the international relations literature, and compare major, contentious policy issues (often crisis engendered), with routine, politics-as-usual policies (Walt 1994; 42).

[5] It is relevant to note here that one of the criticisms of policy analysis is that it is subject to continuing change: these three countries have been subject to major political changes since these papers were published, rendering these particular conclusions useful largely in historical terms.

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POLICY AND EVALUATION PERSPECTIVES ON TRADITIONAL HEALTH PRACTITIONERS IN NATIONAL HEALTH CARE SYSTEMS*

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Abstract—After much resistance by physicians and health planners to traditional practitioners, international policy has recently shifted to support their inclusion in modern-sector health care programs. Governments in several dozen countries now utilize midwives in official health and family planning programs but, with only a few exceptions, continue to resist incorporating traditional healers into the national health care system. Bureaucratic and sociological reasons for this are discussed and recommendations are made for more balanced evaluation of the traditional practitioner components that have been developed in national and other health care systems.

The late 1970s were a major turning point in the long history of the uncomfortable if not antagonistic relationship between 'modern' and 'traditional' healing systems. Rather than being a disparaged subject in most medical circles, the possibility of utilizing traditional, or indigenous, practitioners in 'modern' Western-type health care systems has now received the official stamp of WHO approval and become part of the formal policy of that organization as well as of many national governments and international donor agencies alike. A survey of national health systems established throughout the less developed nations of Africa, Asia, and Latin America reveals, however, that little progress has been made in actually utilizing indigenous health practitioners, especially healers, in these national systems. It appears in fact that in the entire developing world there are only one or two countries in which traditional healers have actually been incorporated, as traditional healers, in the national health care system.

If the policy is there, why then is it so little implemented and how should outcomes be evaluated when it is? These are questions this essay seeks to answer. Part of the answer to the first question lies in the way policies giving formal approval to utilizing indigenous practitioners were formulated and adopted in the first place—with qualification. Part of it lies equally in the general, generic difficulties that all developing country governments are experiencing in extending public health care services into the rural areas. The answer to the second question, that regarding evaluation, relates closely to these difficulties. The present essay focuses not on the now familiar reasons for the long-standing reluctance or refusal of Western-oriented medical professionals to accept and work with indigenous practitioners—reasons having to do with sociocultural distance, professional bias, and so on—for these are already well documented [1]. Rather, we focus here on some of the major but less often discussed structural reasons why national health systems have done so little in utilizing indigenous practitioners even when policies have been adopted that would seem to pave the way.

INTERNATIONAL POLICY: 'WHERE APPROPRIATE'

In 1977, the Thirtieth World Health Assembly of the World Health Organization passed a resolution promoting development of training and research in traditional systems of medicine. In the following year, 1978, the International Conference on Primary Health Care held in Alma-Ata under WHO and UNICEF sponsorship passed additional resolutions supporting the utilization of indigenous practitioners in government-sponsored health care systems. Shortly thereafter other international 'donor' organizations also adopted similar policies stating that it is now acceptable for their grants and loans to be used to finance health programs utilizing traditional practitioners.

Policies of international agencies concerned with health are important in two major ways. Those of the World Health Organization in particular, even though not directly enforceable on a country-by-country basis, are preeminently significant in that individual member nations commit themselves to them in principle through the approval given them by those nations' delegates. Policies of various other donor organizations (such as United Nations agencies, the World Bank, and bilateral donors such as the U.S. Agency for International Development) are likewise important in that they provide a great portion of the financial resources that presently permit developing country governments to extend national health services into rural towns and villages. Thus together the policies of WHO and the other donor organizations are of great consequence in giving both sanction and

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financial means to national governments for the development and expansion of health systems—systems that could draw upon the services of traditional practitioners. Absence of supportive international policy in any given sensitive or controversial area does not mean that a country will not move ahead on its own, as did China, but for most countries the existence of supportive international policy is a major facilitator in moving ahead. The significant point here, however, is that while supportive international policy facilitates adoption of a particular strategy, in this case utilization of traditional practitioners, it by no means automatically assures it will happen.

Looking more closely at the above-mentioned policy resolutions, we see that they are cautious and qualified. The 1977 WHO resolution, for example, after lengthy debate in and out of committee, was finally formulated as follows (emphasis added):

> The Thirtieth World Health Assembly ...
>
> 1. *Records with appreciation the efforts of WHO to initiate studies* on the use of traditional systems of medicine in conjunction with modern medicine;
>
> 2. *Urges interested governments* to give adequate importance to the utilization of their traditional systems of medicine *with appropriate regulations, as suited* to their national health systems;
>
> 3. *Requests the [WHO] Director-General to assist* Member States in organizing educational and research activities and to award fellowships for training in research techniques for studies of health care systems and for investigating the technological procedures related to traditional indigenous systems of medicine; and
>
> 4. Further *requests the Director-General and the Regional Directors to give high priority* to technical cooperation for these activities *and to consider* appropriate financing of these activities [2].

The 1978 "Declaration of Alma-Ata", while similarly conferring international sanction and a high-level go-ahead on the previously contended subject, was also similarly cautious in stating (emphasis again added):

> Primary health care: ...
>
> 7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners *as needed*, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community ....

and, under discussion of "technical and operational aspects",

> ... High priority should be given to the development of adequate manpower in health and related sectors, suitably trained for and attuned to primary health care, including traditional workers and traditional birth attendants, *where appropriate* ....

and finally, under discussion of community health workers,

> *Traditional medical practitioners* and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well *worth while exploring the possibilities of engaging them* in primary health care and of training them accordingly [3].

Finally, the health policy paper of a major bilateral funder of developing country health programs also gave cautious sanction to the idea but likewise implied reservation in its endorsement, stating:

> ... Traditional practitioners are already widely utilized in their communities and may provide effective care in many circumstances. Specific types of *traditional practitioners* who *may be encouraged* to participate in primary health care programs include midwives ("traditional birth attendants"), herbalists, and religious and secular leaders and counselors who already provide information and assistance on fertility regulation and maternal and child health. *Traditional medicines also deserve further study* as a readily available and inexpensive resource for combatting certain prevalent health problems [4].

In all the above policy statements, and in related documents of the respective agencies, two facts are noteworthy. First, they all are concensus documents, arrived at after considerable debate and difference of opinion; thus the choice of gentle wording and use of qualifiers such as 'where appropriate' and 'as needed' was necessary in order to bring divergent minds into agreement while leaving wide latitude for interpretation. Second, these documents generally say more, and do so more positively, about indigenous midwives ('traditional birth attendants') than about indigenous healers. The policies say it is permissible, and perhaps even recommended, to utilize indigenous midwives and healers, but they leave it up to others to determine when the time is appropriate. In reality, then, as these policies are implemented (i.e. as representatives of these agencies sit down among themselves, or with health planners in the developing countries, and reach decisions as to what particular activities their funds will be used to finance) indigenous practitioners, and especially indigenous healers, are often simply forgotten unless the developing country personnel themselves decide that the time and place are appropriate. Relative to their active promotion of other health improvement strategies, international agencies do not take particularly active initiative in facilitating or even encouraging the utilization of traditional practitioners. Where they do, the initiative far more often concerns indigenous midwives than indigenous healers.

Policies of the international agencies thus leave the developing country health planners with essentially the same set of policy options that they had before with regard to utilizing traditional practitioners. A typology of six such policy options can be easily identified:

(a) Illegalization or otherwise severe restriction of traditional practitioners (an option that, in countries where adopted, has nowhere yet proven possible to fully implement).

(b) Ignoring traditional practitioners, at least officially.

(c) Nonformal recognition of and occasional cooperation with traditional practitioners.

(d) Formal recognition of traditional practitioners and their various institutions.

(e) Recruitment and training practitioners for incorporation or utilization in a modern-sector primary health care program. (This is actually two policy options—one being the 'upgrading' strategy in which traditional practitioners are given training to improve the way they carry out their traditional repertoire of tasks and the second being the strategy in which traditional practitioners are recruited to a newly instituted cadre of community, or village, health workers and then trained in a new repertoire of tasks.)

(f) Licensing or registration of traditional practitioners, which may or may not be combined with (d) or (e) above (licensing, like illegalization, also being difficult if not impossible to implement throughout rural districts).

(g) Actual integration of traditional and modern systems with referral and similar cooperation proceeding in both directions (also extremely difficult to implement) [5].

IMPLEMENTATION: CRUCIAL DISTINCTIONS IN 'UTILIZATION'

To understand what has and has not been accomplished by way of actual efforts to 'incorporate' or 'utilize' indigenous practitioners in national health care programs, three crucial distinctions must be made concerning the type of practitioner and the type of traditional–modern relationship. These are: (1) between government policies of actual incorporation vs simple coexistence; (2) between traditional midwives and traditional healers; and (3) between pilot projects and national programs.

Regarding the first of these distinctions, where governments have officially accepted the existence and institutions of traditional practitioners, most are still more likely to let the traditional practitioners simply coexist in a pluralism of health systems rather than to incorporate the traditional practitioners as paid workers in the national (official) health care system. A case in point is India where the national government permits Ayurvedic, Yunani, and other traditional practitioners to pursue flourishing practices and in 1972 even announced a plan in which they would become core workers in a nationwide rural health care system. The plan was abandoned shortly thereafter, however, following the replacement of the health minister under whom the plan was formulated. Instead the Indian government has subsequently created, as the mainstay of its national primary health care system, a new cadre of health care providers called 'community health workers', most of whom had little if any prior health care experience and very few of whom had ever been traditional practitioners [6]. A similar sequence of events has occurred in numerous other countries.

As for the second distinction, projects and programs that have incorporated indigenous midwives ('traditional birth attendants') are far more numerous than those incorporating traditional healers (at perhaps a ratio of at least 20 to 1, although nowhere is this definitively quantified). A major reason for this is the fact that traditional midwives, while performing a wide range of diverse functions, are concerned primarily with the technical processes of childbirth where their interventions are not particularly alien to modern-sector medical professionals—even though the latter may express dismay over the lack of sterile procedure and sanitary environment characterizing a traditional midwife's practice. Traditional healers, in contrast, have a practice frequently premised on supernatural and other belief systems that are distinctly alien to and not easily comprehended by modern-sector practitioners.

Traditional midwives have been given formal training ('upgrading') and utilized as service providers in projects in at least forty-four countries: the Asian countries of Afghanistan, Bangladesh, India, Indonesia, Malaysia, Nepal, Pakistan, the Philippines, and Thailand; Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay and Peru in Latin America; Cameroon, Central African Republic, Chad, Ethiopia, Ghana, Kenya, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Tanzania, Upper Volta, and Zambia in Africa; and, in the Near East, Egypt, Iran, Syria, and Yemen [7]. While there has been much discussion by governments and funding agencies of possibilities for incorporating traditional healers as service providers in modern-sector projects and programs, instances of this actually occurring are significantly fewer. Although literature describing the actual attempts is also much less abundant, the list of countries in which such projects and programs have been undertaken appears to include: Bangladesh, China, India, Nepal, the Philippines, and Sri Lanka in Asia; Bolivia, Brazil, and Haiti in Latin America; and Botswana, Ghana, Kenya, Liberia, Niger, Nigeria, and Zimbabwe in Africa (with governments in the Near East being quite staunchly resistant to efforts to support or encourage indigenous healers). This list totals sixteen countries in contrast to the forty-four in which projects have incorporated traditional midwives [8].

It is also worth noting in this context that most of the projects and programs utilizing traditional healers have tended to single out herbalists and related specialists (e.g. compounders) rather than religious, shamanistic, or other spiritual healers. Again this is in large part because the procedures and substances of the herbal-type practitioners are relatively less alien, and alienating, to modern-sector professionals than are those of the religious-type practitioner [9]. A clear illustration of this principle is provided by China where the vigorous promotion of traditional medicine by the Maoist government meant that it supported and encouraged herbalists and research and development of herbal medicine but has sought persistently to eliminate the large numbers of spiritists and diviners that flourished before 1949. A minority of China's 'barefoot doctors' were originally herbalists, and all barefoot doctors have been encouraged to use herbal as well as 'Western' medicines, but few if any spiritists or diviners have ever become barefoot doctors [10].

A result of the greater number of efforts to utilize traditional midwives is that protocols and standards for their training, performance, and supervision are far more numerous and well-developed than for traditional healers, thus making it easier to initiate ad-

ditional programs involving traditional midwives. Dozens if not hundreds of protocols and standards for traditional midwives have been developed, refined, and exchanged by and among a large number of national governments, charitable and other non-governmental organizations, and various WHO offices [11]. In contrast, projects and protocols for traditional healers probably number only a few dozen at most and tend to involve significantly smaller numbers of practitioners. The Primary Health Training for Indigenous Healers Program in Ghana's Techiman District provides an unusual example of a project centering specifically on traditional healers [12]. In other projects involving traditional healers the latter tend to be only a minor element of the project. For example, the CIMDER project in Colombia, which has emphasized the use of traditional midwives and healers had, as of 1979, incorporated seven folk healers (*curanderos*) but depended for the bulk of its activities on fifteen vaccinators, thirty-four health promoters, twelve sanitary inspectors, and eleven multipurpose workers in addition to the usual range of nurses and physicians [13].

This brings us to the final distinction noted above, namely that between pilot projects and national programs. Here is is important to recognize that most attempts to involve traditional practitioners in modern-sector health-care activities have occurred in relatively small pilot or other localized projects in which the traditional practitioners involved have often numbered no more than a dozen or so (for example, the CIMDER project noted above). This is true for both midwife and healer efforts, but especially for healers. According to one recent synopsis, of the forty-four countries listed above in which pilot or other small-scale projects have trained and utilized traditional midwives, only seventeen countries have, at some time during the past two decades, incorporated traditional midwives into the national health care system or family planning program. These are: Afghanistan, Bangladesh, India, Indonesia, Malaysia, Pakistan, and the Philippines in Asia; Colombia, Costa Rica, Dominican Republic, Ecuador, Haiti, Honduras, Mexico, and Nicaragua in Latin America; and Liberia and Sierra Leone in Africa [14]. Of the sixteen countries noted above in which pilot or other small-scale projects have incorporated traditional healers, it appears that only in two, Zimbabwe and possibly Nigeria, are traditional healers being utilized, in their traditional healing roles, as service providers in the national health-care system. Elsewhere, notably in China and Bangladesh, traditional healers have also been recruited into the national health care system but only as members of a newly-created corps of village health workers (i.e. 'barefoot doctors' or 'village medics' respectively) rather than as traditional healers *per se* [15].

It should also be noted that a large proportion of the pilot projects are sponsored by non-governmental organizations (both local and foreign) and that they are implemented in a typically 'hands-on' manner made possible by a relatively favorable ratio of health-care workers to the population served. National programs, in contrast, are the products of national governments and are thus typically implemented in a top-down bureaucratic manner which together with a relatively unfavorable ratio of health-care workers to the population served, makes the more intensive and more effective hands-on approach the exception rather than the rule. Frequently, even in countries where such pilot projects have been relatively successful, national programs have not adopted the indigenous practitioner model established by the pilot project. A case in point is provided by Thailand where nearly three hundred traditional birth attendants were trained to deliver services as part of the government-sponsored Lampang Health Development Project, which was implemented from 1974 to 1981 as a single-province demonstration project with expectations of nation-wide replication [16]. Although the traditional birth attendant component of the Lampang project was regarded as fairly successful, when the Thai government expanded its primary health care efforts to a twenty-province program in 1978 the new strategy as implemented did not include any traditional practitioners, even though early planning documents indicated that this was to happen [17].

REASONS FOR LACK OF GREATER PROGRESS EVEN IN POSITIVE NATIONAL POLICY CONTEXT

Excluding from consideration countries whose policies make illegal or otherwise severely restrict traditional practitioners, why have countries that have adopted policies favorable to traditional medicine made so little progress—relative to the hopes and promise that advocates have set out—in utilizing traditional practitioners in their national health care systems? A number of related observations from the fields of policy analysis and valuation help clarify this question. These observations are not necessarily new, and may even seem extremely obvious, to medical and development anthropologists familiar with the work of anthropologists such as George Foster [18]. But in general discussions of the effectiveness of traditional practitioners—discussions in which physicians, health planners, and other non-social scientists dominate—the linkage is not often made between the narrower issues concerning traditional practitioners alone and the much broader bureaucratic, professional, and policy issues constraining, or at least concerning, entire programs. If is for this reason, and in view of the great amount of energy that many anthropologists and others still continue to invest in promoting the utilization of indigenous practitioners in modern-sector programs, while overlooking the obstacles to doing so, that the following observations are presented [19].

1. *Even national policy is not always implemented nor always binding*

It is a well-known fact among policy analysts that policy performance usually falls short of policy promise—that the goals and targets of the formulators of policy become diluted, deferred, and even ebb away as implementors take over [20]. Any national policy may well go ignored unless a particular individual, interest group, or regulatory body of sufficiently high administrative authority and capability actively pushes to have the policy implemented and enforced. Thus a policy calling for involvement of traditional practitioners may be adopted on paper in a capital city but unless persons with conviction and clout are in and, importantly, remain in a position to see the policy through the actual changes in budget, salary, personnel, and time allocations at the central and regional levels, little will change out in the rural communities where the majority of the population lives. Often in developing countries rapid and successive shifts of regimes and consequent ministerial reshufflings preclude such follow-through despite an original intent (as was illustrated by the abandonment noted above of India's 1972 traditional practitioner plan folloing the change of health ministers).

2. *Paucity of evaluative findings regarding effectiveness of traditional practitioners*

There now exists a fairly voluminous literature that describes indigenous health practitioners in various parts of the world and advocates their incorporation into modern health care programs. Still, there has been little systematic evaluation—either qualitative or quantitative—of their performance. Neither have there been many evaluations of (a) the efficacy of the various practices of indigenous practitioners nor of (b) the efficacy of utilizing indigenous practitioners in modern-sector programs. This lack of evaluative evidence serves as fuel for the arguments of health planners and providers who do not want to work with indigenous practitioners and hinders those who would like to do so in making a case for doing so or in knowing exactly how best to proceed [21].

3. *Poor performance of national primary health care programs*

At the same time, there now exists a substantial body of evaluations that have been carried out on national primary health care programs, and these point to two general conclusions that are important to bear in mind with regard to traditional practitioner evaluation. First is that the performance of national health care programs in demonstrably improving the health of rural populations has generally been poor. Second is the fact that little conclusive evidence exists that proves or establishes the efficacy of other categories of rural health care providers in reducing the morbidity and mortality of rural populations. The sorry truth is that it simply cannot be shown—in the majority if not all cases of national programs—that health status has improved and, in fact, in some instances the incidence of infectious diseases has been found to be on the increase. In Nepal, for example, the incidence of malaria actually became greater in districts where the new national Integrated Community Health Program was first implemented—this in contrast to neighboring districts which experienced no such increase [22].

It is not intended here to condemn national health care programs or to imply that the rural or primary health care approach is a failure, as some harsher critics insist is the case [23]. Rather what is intended is to highlight the need to distinguish among different levels of evaluative criteria according to which progress is measured. On the one hand, ultimate indicators of program success are reduced levels of morbidity, mortality, and fer[illegible] this is where progress is especially difficult to achieve, given the complex constraints that impinge on rural health program effectiveness, and perhaps equally if not more difficult to measure even if achieved. On the other hand progress in terms of intermediate indicators—such as improved access to and improved quality of health services provided—is easier to achieve and measure. Yet, even here the record is not good [24].

4. *Success of traditional practitioner component is dependent on effectiveness of overall program*

The status—and success or lack thereof—of the national program overall directly influences the status and success of the component thereof seeking to utilize traditional practitioners. By way of example, we can take health personnel at the district level who are responsible for the follow-up, support, and supervision of village-level health workers—be they traditional practitioners or others; if these personnel are dissatisfied over their pay and are without adequate time or transportation to carry out assigned supervisory responsibilities, then the performance of traditional practitioners as part of the general system automatically suffers.

5. *Unanticipated high recurrent costs of national health care systems*

The past couple of years have seen rapidly mounting awareness that developing country governments cannot afford the national primary health care programs that they have set forth in their various five-year and other development plans. In part the inflation caused by the post-1974 oil crisis has been devastating (e.g. a cost increase in Nepal's national health care system of about 30% beyond normal, budgeted-for inflation). In part the problem is also due to the fact that assumptions made in the planning stage were unrealistic to begin with, and have proven themselves so since (for instance, that village health workers will be content to continue working as unpaid volunteers or that district-physicians would be willing to take on new supervisory responsibilities without commensurate increases in pay). With some exceptions, the most notable being China, most national health systems in the poorer countries of Africa, Asia, and Latin America are financed to a great extent by foreign donors with the consequence that those countries' governments would not be able to sustain the programs if left on their own [25]. Recent evaluations highlight the seriousness of this problem in United States-supported health programs in Senegal and the Philippines, for example, but the problem is widespread [26]. In an environment of such great financial constraints it is not surprising that program components other than traditional practitioners become higher priority in the allocation of scarce resources.

6. *Priorities of key decision-makers and implementors take precedence over improving rural health*

Underlying the first observation above is the fact that the political and personal priorities of key decision-makers and program implementors (all up and down the line but especially, perhaps, at the top) take precedence over more general goals of improving the lives—including the health—of poor, largely illiterate

people living out in the rural hinterland [27]. Among such political priorities are the following.

The desire of a regime to extend its influence and authority into the countryside. Not only do national governments seek to develop support from the rural areas of their countries by the actual provision of health and other services through rural "outreach" or extension programs. Many regimes moreover, and newly established ones in particular, actually use such outreach programs as a form of political clientelism. That is, they also seek to develop and consolidate rural support bases by handing out jobs and related fringe benefits (such as vehicles, buildings, and overseas training) not just, or even primarily, on the basis of technical qualifications but to persons judged most likely to render political support. This is true not so much perhaps at the village level where personnel are most frequently recruited as volunteer workers but at the rural township level and above where health-worker positions are more often salaried and frequently have civil service status, thus providing a fair assurance of relative long-term security as well as, in many instances, a base from which to earn additional income. An example of this sort of political clientelism is provided by Bangladesh's corps of maternal and child health workers, a large proportion of whom are daughters of rural political elites and show little interest either in public service in general or in working to improve the health of their less fortunate neighbors in particular. If such poorly motivated personnel are then asked to collaborate with traditional healers, the traditional healer component of the larger program is automatically off to a bad start.

'Turf' considerations—the desire of central-level bureaucrats to retain or enlarge their spheres of control over staff and budgets. Certainly not unique to developing countries, control over bureaucratic 'turf' is a goal held by a good many program managers at all levels and one which, like that just mentioned, is frequently at odds with increasing the effectiveness of a public program, health or otherwise. Thus, say, a 'division chief' in charge of training (including that for traditional practitioners) may be aspiring to expand his sphere of influence by having the program's research function combined with training and his own position then elevated to 'department director' for research and training. If his energies are being spent in this direction then he is clearly less likely to direct adequate attention to ascertaining that his subordinates in charge of traditional practitioner and other community-level training are doing an effective job.

Political priorities of international funding agencies. Priorities of international donor agencies contributing a major portion of the costs for a developing country's national health system may also be at odds with getting the system to perform effectively, or more effectively. In Pakistan, for example, a national seven-year basic health services program being supported by the United States government was abruptly cut back to a three-year program when in 1979 the U.S. government decided to cut off economic assistance to Pakistan because of U.S. official displeasure over Pakistan's move to build nuclear reactors. When, following the Soviet invasion of Afghanistan and the fall of the pro-American regime in Iran, the U.S. government again began contemplating restoring economic aid to Pakistan, discussions likewise began about resuming support to the national basic health services scheme that had earlier been set back when U.S. strategic priorities overrode developmental priorities. Clearly such disturbances in a health system's development guarantee poor progress for a scheme to utilize traditional practitioners in that system.

Overriding personal priorities related to personal and family situations. Frequently persons in charge of implementing health programs at the district and subdistrict levels where the program attempts to link up with traditional practitioners are physicians or administrators who are considerably more eager to advance their own careers or their families' socioeconomic positions than engage in the public service work with which they are charged. In virtually every developing country, government physicians are regularly busy if not preoccupied with a private practice and frequently striving to be transferred back to the capital; other civil service administrators are often pulling hard too at various efforts to augment their modest salaries in order to be able to afford to send their children to a university in the capital or furnish their home with modern conveniences. Thus, in the face of competing demands for limited time, the great majority of such individuals are not likely to spend their evenings worrying about how to improve collaboration with traditional practitioners nor even to devote a great amount of on-the-job time, relatively speaking, to this complicated task.

7. Culture gap from modern to traditional sector too great for officials to bridge easily

Primary health care, regardless of how the particular system is set up, is very difficult. Implementation requires organizing a large body of many different categories of workers to perform a complex range of new tasks generally without adequate forethought as to why those persons should be willing to take on the extra work, in many if not most cases without corresponding remuneration for the additional tasks to be performed. Given the enormous challenge of trying to implement a national primary health care scheme, let alone achieve 'health for all by the year 2000', it has generally proven more difficult and thus more time-consuming, at least in the short run, for modern-sector personnel to work with traditional practitioners—especially healers—than to work with villagers of the sort that have usually been selected in most countries as community or primary health workers. Characteristically, the latter have been young people without a great deal of schooling—say, perhaps, only six to ten years—yet this schooling has typically grounded them in modern-sector ideas and their relative youth and lack of prior health care experience made them quite open to the material put forth in training programs of national primary health care systems. Traditional practitioners, in contrast, are typically mature adults with set ideas, ideas developed through and put into real-life everyday practice in a way that makes the traditional practitioners less likely to accept training material, or other instructions, unless they they are clearly linked to the realities of the people and environment that make up their world. This is true not just for training but perhaps to all aspects of performan pected by the national primary health care

program attempting to 'utilize' traditional practitioners.

QUESTIONS FOR THE EVALUATION OF PROGRAM COMPONENTS UTILIZING TRADITIONAL HEALTH PRACTITIONERS

The performance of traditional health practitioners who have been brought into a modern-sector health care system, or project, must not be evaluated in a vacuum. Evaluators must look at not just the performance of the traditional practitioners but also ask whether the system or project, and especially its traditional–modern interaction points, was properly conceived and implemented to give the utilization attempt a fair chance. Where performance of traditional practitioners has been judged poor by program administrators and evaluators, this is frequently attributed to reasons having solely to do with the traditional practitioners—for example, illiteracy, superstitiousness, being untrainable, failing to report in on schedule, not following instructions given during training, continuing to use unclean procedures, unwillingness to cooperate, and so on. While these may be characteristics of poorer than anticipated performance, they should not be accepted as the sole or even most important reasons for that substandard performance. Rather, underlying explanations should be sought in the structure of the health care system that has been attempting to utilize the traditional practitioners. That is, their performance should be viewed as an *outcome* and then the 'inputs' and related components leading to that outcome also examined. It is suggested, therefore, that each evaluation of the traditional practitioner component of a national health care system seek to answer the following key questions [28].

1. Performance of the traditional practitioners

What improvements in the health of the rural population served has occurred or is occurring as a result of bringing traditional practitioners into the formal health care system? If it is too soon to see clear changes, what evidence exists that such improvements are likely to occur in the near future? [29]

2. Reasons for effective performance, or lack thereof

Under this rubric are seven key questions to answer (each needing further specification of indicators as to what constitutes 'best', 'most appropriate', 'most likely', and so on). These are the following. **(a)** *Program design.* Is the strategy for utilizing traditional practitioners the best that could be employed given existing local and national constraints (e.g. cultural, economic, and infrastructural)? **(b)** *Recruitment.* Are the selection criteria according to which traditional practitioners have been recruited those most appropriate for bringing in traditional practitioners most likely to perform effectively? **(c)** *Training.* Are the training curricula and materials as practical as possible and tailored to the local culture and conditions? **(d)** *Responsibilities.* Are the expectations of tasks to be performed by the traditional practitioners appropriate given prevailing health problems and realistic given local culture and conditions? **(e)** *Supplies.* Are the equipment and drugs that the traditional practitioners are ex to use and dispense consistently available to them in appropriate quantities? **(f)** *Support and supervision.* Do the personnel designated as supervisors for the traditional practitioners have adequate time, transportation, and other means to provide frequent, supportive assistance (in contrast to supervision that is infrequent, undependable, and authoritative)? **(g)** *Status and relationships to rest of system.* Have as many steps been taken as possible to legitimize the status of the traditional practitioners and to facilitate cooperation with other health professionals in such a way as to maximize chances of improving the health of the population at large?

3. Effectiveness relative to other community-level health workers

How more or less effective are the traditional practitioners than other categories of health workers in actually bringing about health improvements at the community level? Here it is necessary to look carefully also at the performance of both established medical system practitioners (i.e. physicians, nurses, and midwives) as well as newly recruited categories of workers (i.e. community or primary health care workers, volunteer or otherwise). What clear evidence exists that these latter categories of personnel will prove more cost-effective during the next decade or so in improving the health of the general populace, especially of that great majority of it who live in the rural areas? [30] Finally, how should this knowledge be used to improve the overall performance of the health care system?

RECOMMENDATIONS FOR SOCIAL SCIENTISTS

Time is long past for social scientists to move beyond describing, extolling the virtues of traditional health practitioners, and advocating their inclusion in modern health care systems. The above observations taken together suggest four recommendations to which those of us who are social scientists concerned with community-level health in Africa, Asia, and Latin America should pay greater attention in our future work. First, we must seek more consistently to involve traditional practitioners at the earliest possible planning stages in all research and service projects with which we ourselves are engaged. Second, there is need for us to turn more attention to the area of motivational analysis. It is increasingly clear that health planners in capital cities make many unrealistic assumptions about what village and other rural people do and can be motivated to do. Here anthropological and other sociological studies can provide information of great use in designing programs more linked to reality and thus more likely to succeed. Third, there is likewise great need for social scientists working at the village level to devote more attention to questions related to the economics of health care. Here also national-level planners have been making many overoptimistic and similarly inaccurate assumptions about community health financing—health-related expenditure patterns and the willingness of villagers to engage in health work for little or no remuneration; here also is an opportunity for social scientists to make important contributions to improving the knowledge base on which multimillion-dollar health programs are built. Fourth and finally, it is

important that we, in our writing, put forth clear recommendations and conclusions that health planners can draw upon in improving program design and implementation. Many social scientists among us may respond to this by protesting that their data do not permit them to be so bold. To this we must urge that social scientists be bold and press forth with recommendations as far as it is possible based not just on their data but also on their related sociological insights and then, rather than stopping at that point, continue by offering hypotheses that their observations suggest. This will serve not only health planners and program implementors but will also have the merit of simultaneously serving the social scientist's own discipline by contributing ultimately to the building up of a greater theoretical body of knowledge. In so doing we will thereby contribute not only to knowledge about traditional practitioners but also to the larger body of theory and practice related to improving the health of the hundreds of millions of rural people for whom today traditional health practitioners are still the primary health care workers.

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8. This list includes the following project and program efforts (some of which, however, may not have progressed much beyond the planning stage): Bangladesh's Palli Chikitsak ('Village Medic') program, China's use of herbalists as part of the 'barefoot doctor' corps, Nepal's Shanta Bhawan Hospital's Community Health Program's use of traditional village compounders, the Philippine Barangay Health Aide Project's use of herbalists and spiritual healers, the use in Sri Lanka of Ayurvedic physicians for family planning, the PRHETIH program in Ghana, Nigeria's passage of a law in 1980 to integrate herbalists and spirit mediums into the national health service, and Zimbabwe's incorporation of traditional healers (*ngangas*) into its national health service. It is difficult to arrive at a definitive listing since often what is reported as 'utilization of traditional practitioners' in an overview article or document (e.g. Traditional and Modern Medical Systems Special Issue in *Soc. Sci. Med.* **15A**, 1981, or American Public Health Association. *Tracking Report on AID-Sponsored Primary Health Care Projects*. Washington DC, 1980) turns out to mean either traditional midwives or, rather than use of traditional healers as service providers, simply a conference or meetings in which traditional healers have participated. For example, Kathmandu's Shanta Bhawan Hospital succeeded in bringing local shamans (*jhankris*) together with doctors and health department officials for an innovative seminar but did not actually use them as service providers (*Community Health Services 1975 Report*, p. 9. Shanta Bhawan Hospital, Kathmandu, Nepal). Likewise the Kotobabi polyclinic project in Ghana, which has also been singled out for working with traditional healers, includes them on subdistrict health education committees but does not incorporate them for health care delivery (American Public Health Association. Kotobabi Polyclinic, Ghana. Project Capsule Series, Washington, DC, 1979). Where errors or oversights in bringing together and interpreting the relevant literature have crept into this essay, the author would appreciate having it brought to her attention.
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POLICIES TOWARDS INDIGENOUS HEALERS IN INDEPENDENT INDIA

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Abstract—Policies towards indigenous healers in independent India show considerable continuities with policies followed in the British period, varying according to the sex of the healer. Traditional birth attendants (*dais*) have been offered short periods of training by the State since 1902, whereas until recently male healers (*vaids* and *hakims*, and later homoeopaths) have been treated with official hostility. Current plans include the training of religious and ritual healers in psychiatric services as well as the employment of indigenous healers in new community health schemes. These changes are assessed in the context of a political economy of health services.

INTRODUCTION

Many discussions of the potential role of indigenous healers in health systems ignore the historical dimension, apparently assuming that the proposals are novel and practicable. No-one should make this mistake in India, where there is the work of Leslie and Brass to draw attention to shifts in policy from 1820 onwards [1]. In this paper I want to elaborate on a small part of this topic by looking at official policy with respect to indigenous healers in the context of theories about the dynamics of relationships between indigenous and cosmopolitan medicine.

There are, in essence, three views of these relationships in India. The first is the **naive scientistic** that the process is one in which the indigenous systems are steadily giving ground to the onward march of science, with only the areas where Western medicine is ineffective remaining for the indigenous practitioners. This was the dominant view of the British doctors in India; it remains common, though many Indian doctors express guarded sympathy and support for the relevance of indigenous medicine. The second view is the agnostic anthropological, best expressed in Leslie's phrase describing Asian medical systems as 'coexisting normative institutions', in which cultural processes of change are not simply unidirectional (with indigenous medicine being affected by cosmopolitan medicine but not vice versa) but multidirectional, with no predictions of necessary future patterns [2]. The third view is the political structuralist one, in which the superiority of Western medicine follows not from its scientific advances but because it is more closely linked to the class interests of the political leadership in the country [3]. I shall explore some of the strengths and weaknesses of these positions by taking a closer look at policies towards indigenous medicine in India, tracing the links between the British period and post-1947 policies, with particular focus on policy proposals made (and to a lesser extent implemented) since 1971.

Two caveats should be entered here. Firstly, there may be no clear relationship between official discussions of indigenous healers and the situation 'on the ground'. In particular, the official mind tends to see the systems of indigenous medicine as discrete and discontinuous, whereas Leslie's model of healers occupying positions which shade into one another seems more plausible [4]. Secondly, there is a great deal of regional variation, not only pre-1947 when the Native States could follow policies radically different from those of British India, but also since Independence, when health policies have been constitutionally the sphere of the States.

THE BRITISH PERIOD

It is customary to see 1835 as a major turning point in British attitudes to Indian culture. This was the year of Macauley's *Minute* on educational policy, where he argued that European culture should provide the curriculum of schools and colleges. This strengthened the opposition to schemes which attempted a mixing of European and Indian cultures, or were designed to restore Indian culture to its presumed glory. In medical education it meant that the Calcutta 'Native Medical Institution', founded in 1822, would no longer teach aspects of *Ayurveda* (the Hindu medical scriptures, especially those of *Susruta* and *Caraka*) nor of *Unani* (the medical doctrines derived from Greek medicine and more closely linked to Muslim culture). While this move had obvious significance, it did not mean a total ban on such teaching, nor on co-operative relationships between the British Raj and indigenous practitioners as a class. As Hume has demonstrated, for example, in Punjab the Provincial Government employed *hakims* (*Unani* practitioners) in the 1860s and 1870s, usually as vaccinators and health extension workers, and the University of the Punjab offered courses in *Ayurveda* and *Unani* medicine until 1907 [5].

One reason for the tolerance displayed by the State is that its own services, and practitioners trained in its medical schools and colleges, had a minimal impact before the end of the nineteenth century. The first four medical colleges (Bombay, Madras and Lahore following Calcutta by the 1850's) produced too few graduates to make much impact on the setting of practice for most indigenous healers, and were mostly employed in the growing State bureaucracy—in the

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THE INTERFACE OF DUAL SYSTEMS OF HEALTH CARE IN THE DEVELOPING WORLD: TOWARD HEALTH POLICY INITIATIVES IN AFRICA*

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Abstract—Basically, there are two systems of health care in the developing world: one is traditional and prescientific; the other modern, scientific and Western in derivation. The two exist side by side, yet remain functionally unrelated in any intentional sense; with the traditional, ethnic system being disregarded by the government-supported modern system, although it is the dominant mode of health care for over three quarters of the population of the developing world. The structure of this dualism with particular reference to Africa should be more widely recognized and used in national health care planning.

Neither traditional nor modern medicine is adequately meeting health care needs; therefore we must ask if, together, they can be articulated so as to produce a synergistic outcome that will maximize the use of scarce financial resources? It is suggested that the modern system can be consciously articulated downwards so as to increase the potential for integration with traditional medicine at the village level through referral systems and training programs while traditional medicine can be supported by the modern system with the use of village health aides, traditional birth attendants, traditional psychiatric aides, village drug stocks, herbal medicine research and referral systems. The dualistic and dichotomized health care systems are ripe for change. Many governments do themselves a grave disservice by officially ignoring traditional medicine and not considering its partial or fuller incorporation in health care planning.

INTRODUCTION

Basically there are two systems of health care in the developing world: one is traditional, pre-scientific and ethnic; the other modern, scientific and Western in derivation [1]. The systems are different in terms of availability and quality of care, technology, and social adaptability; yet ideally both aim to serve the same population in need. At the interface between the two systems some fusion occurs. Techniques and medications of modern practice are increasingly filtering through to local healers who are not trained in modern medicine; and where feasible most ill persons attempt to obtain the most effective therapies from both systems, often concurrently or serially for the same illness episode. The two systems exist side by side, yet remain functionally unrelated in any intentional sense. Paradoxically the government-supported modern system, which tends to be synonymous with a monopolistic medical "establishment" and a doctor-dependent, hospital-based, curative health care model, does not, with few exceptions, officially recognize, cooperate with, or adjust to the traditional ethnic systems. This stance is unrealistic because the ethnic therapeutic systems, based on a variety of healing strategies, are collectively the dominant mode of health care [2]. Furthermore, government health ministries greatly diminish their opportunities and responsibility for understanding and influencing the health status of the communities they are supposed to serve by ignoring the many positive qualities and social utility of traditional forms of health care [1]. Traditional healers are, of course, well-aware of the official disregard they are accorded. Many are also receptive to the idea of collaboration with the modern

* Portions of this paper are based upon a field project on urban and rural ethnomedicine conducted in Kenya by Dr Good in 1977–78 with the support of a grant from the National Science Foundation, Washington, D.C. Field observations in traditional medicine were made by the Drs Katz in visits to Kenya in the summers of 1974 and 1977. The paper as conjointly developed here utilizes and expands upon a discussion paper originally prepared by Dr Hunter for an international symposium on rural health care hosted by the Dartmouth Medical School, July 24–27, 1978.

system, but lack prestige and influence in the higher circles of political decision-making.

Although the Western-inspired medical delivery system has been almost universally adopted at the national level, as designed it is inefficient; dependent on expensively trained personnel; often grossly overtaxed by the level of expectations and demands placed upon it; and generally of limited relevance to the conditions and goals of developing countries [3]. It renders insufficient care even in central urban areas, and virtually no care at all in extensive rural areas [4]. Even where modern health services are physically present, social and cultural factors may mean they are not preferred for many illnesses [5–7]. Between the parallel but poorly connected traditional and modern systems there exists a serious lack of even the most elemental care for a large proportion of the population of the developing world. This pattern is expected to persist into the 21st century, regardless of incremental expansion of modern health personnel and facilities. The shortfall is gravely compounded by radical social and economic upheavals, a shrinking supply of traditional practitioners in some *rural* areas [8, 9] and by the contemporary population explosion which is without historical precedent. The purpose of this essay is to expose the structure of this dualism in the developing world, with particular reference to Africa; to argue for its fuller recognition; and to suggest that political commitment to humanistic health care reform could effect a much better use of scarce resources for the common good.

TRADITIONAL MEDICINE

There is an obvious risk in making sweeping generalizations about so large, complex and ill-defined an area as the "developing world", and also about so richly diverse a realm as "traditional medicine". Each generalization will produce controversial and particularistic exceptions. Nevertheless, the attempt to formulate broad statements has conceptual merit and utility in development planning. Hence, the remarks which follow are offered at a generic or universal level to promote discussion in support of health policy formulation.

Although confirmatory data sources are meager, available evidence suggests that the great bulk of rural health care in the developing world, perhaps 75–90%, depending on the locale, is provided by the traditional system [10, 11]. This is certainly true of rural areas where often the modern medical services scarcely penetrate. In Ethiopia it has been estimated that more than 85% of the population lacks access to modern health care [4]. Despite three generations of Western-style medicine in Kenya, traditional medical practitioners treat a large share of individual health problems in most areas of the country [8, 9, 12]. One recent study in Kenya concludes that overall only 15% of African women deliver under modern medical supervision [13], a level confirmed in a local rural investigation in 1978 which predicted that 87% of expected rural births occur at home without such supervision [8]. In India, only 10–20% of rural people utilize government health services [14]. The importance of traditional medical resources can also be inferred from Morley's analysis of the users of modern health services in the "average" developing country. Only 5–10% use all available services quite effectively; 30–60% make some use; and 20–40% make practically no use of these services [7]. On a global scale, it is suggested conservatively that usership of traditional medical care systems probably exceeds scientific medicine by a factor of at least 2 to 1 [2].

A traditional or ethnomedical care system (other labels include "folk" and "customary") is conceptualized as the whole approach of an ethnic community to disease and illness, organized spatially and changing over time. It includes medical taxonomy, folk knowledge, guidelines, traditions and values, health behavior rules and patterns, supportive social institutions, and identified personnel and structures for delivery of preventive and restorative therapy [15].

Characteristics of traditional medicine range among societies, cultures, environments and agricultural systems. Practices of the Bolivian altiplano will differ from those of the Guatemalan highlands and, in turn, will be distinct from those of the forest zones of Africa or Indonesia. Ancient, codified medical systems of the Arabic and Moslem realms (Unani-Tibbi), the Tibetan system (Amchi), India (Ayurvedic, Yoga, and Siddha), and classical China have sophistication, elaborate protocols, recognized viability, and contemporary acceptance. They form a special case—important in their own right—and in some instances are experiencing rejuvenation and renewed prestige alongside modern medicine. On the other hand are the more localized, "indigenous" systems of traditional healing characteristic of what were essentially nonliterate peoples of tropical Africa and Asia, and the Americas. There are thus "great", or formalized, traditions and "little", non-formalized traditions of healing [16]. Essentially, however, our discussion focuses on purely indigenous traditional medicine, or to the "little" tradition, although these are often found interacting in syncretistic forms, as in the Islamic diaspora. Adequate rendering of the "little" tradition or folk medicine concept requires separate and detailed treatment. In this paper we emphasize that indigenous traditional medicine is widely diffused, mostly nonhierarchical, less systematized, and more often than not devoid of written record. Specialized knowledge is transmitted through oral tradition and apprenticeship. Consequently, there are considerable local variations in practice among places and practitioners. We also refer to the common meanings recently summarized by Press [6]. Thus folk or indigenous traditional medicine is, broadly, (1) any health system at variance with a codified, formal, and literate medical tradition such as Western, scientific, or Ayurvedic; (2) any system of health practice which departs from the official health practice of the community; and (3) a system featuring a substantial degree of shared knowledge between users and practitioners.

In all respects, traditional health care reflects the socioreligious structures of indigenous societies from which it emerges, together with the values, behaviors, and practices developed over the millenia. We accept a description of *African traditional medicine* as "the totality of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and

observation handed down from generation to generation, verbally or in writing" [10].

The original African concept of disease causation incorporates beliefs in natural or God-given illness; belief in supernatural forces, including witchcraft, sorcery, ghosts, spirit disturbance, and breaching a taboo or breaking kinship rules or religious obligations. Conflicts and tension in social relations are a basic principle underpinning group-specific interpretations of the causes of sickness and misfortune. These contexts have both *horizontal* (relatives, neighbors, coworkers) and *vertical* expressions (e.g. with ancestral generations which can in turn affect an individual's relationship with living kin) [17]. This causal framework arises from a basically unitarian view of nature which encompasses the physical world and a sociological environment which expresses continuity between the living and the dead, together with the metaphysical forces of the universe. A person's body, mind and spirit are conceived of as a whole, and at a given time the state of one is reflected in the others [18]. Hence the etiology and symptomology of disease is rarely, if ever, characterized as an isolated phenomenon—merely the consequence of a malfunctioning organ or a lesion therein, whether spontaneous or instigated by some physical cause [19]. Instead, disease is seen as "a rupture of life's harmony" [10]. It is necessary not only to diagnose the illness, but to determine and correct the factors which cause it to afflict a specific individual. The traditional healing process often takes on the character of a psychosocial drama—with the goal of restoring the patient to a therapeutic community [19]. In Swahili, the ideal of health is *uzima*, or wholeness;

> "... man is never alone as an individual but always part of a whole, a part of his kin, his clan, lineage, family past and present which again through an elaborate symbolic framework related the human race with the nature around and with the whole universe. Health is to retain that *uzima*, wholeness, and to be part of it in such a way that the balance is not disturbed. Man's wholeness was essentially preserved when he remained as an integrated part of the whole and lived in harmony ... If there were problems between groups of people or individuals with varying interests in the group, it resulted in shaken health. The symptoms of it were stomach trouble or aching body, loss of mental health, an accidental injury, house burning, loss of crops, death of a child, or whatever was considered an occurrence upsetting the balance, spoiling *uzima*" [20].

The *traditional healer* in Africa is recognized by his own community as competent to provide health services by using plant, animal and mineral substances as well as other methods based on the social, cultural and religious background. He also utilizes the prevailing knowledge, attitudes and beliefs in the community about physical, mental and social well-being, and the causes of disease and disability [21].

Specialist practitioners, both male and female, have evolved in African traditional medicine. They include diviners and seers; herbalists who employ wide armamentaria of plant medicines pharmacologically active against infections and parasitic diseases, and others which are of ritual and magical importance [8, 22–24]; spiritualists, cultists, faith healers, priests and priestesses, and other religious specialists who both cure and prevent with prayerful prescriptions and techniques such as offerings, confession and fasting [25, 26]. Many healers function as psychotherapists or traditional psychiatrists [27–31], treating neuroses and anxieties, psychoses, depression [32, 33] and other conditions (some of which, of course, may be organically based). A prominent contemporary example would be the Zebolic rite in Zaire. The Zebola healers mainly see female patients who are suffering from psychological disorders which reflect maladaptation to urban life, and treat them in a genuine village-centered therapeutic community where family members are engaged in the healing process [34]. This concept of the family as the "extended patient", aptly described by Appiah-Kubi [35], stands in contrast to the isolation of the patient from his family often imposed by the modern medical system.

There are also traditional surgeons and bonesetters of acknowledged skill [36–39], specialists in female reproductive disorders, and male and female birth attendants [40, 41]. It would be exceptional for a traditional healer to claim expertise in all of these branches, the general limit being two or three specialties [8, 10].

All health care begins with a perception of illness, either by the patient or his associates, and reactions to symptomologies are culturally influenced [42, 43]. Therapy commences with self-awareness and, depending on the problem, self-treatment with household remedies and consultations within an intimate circle of kin and friends. In traditional health care systems, household elders will assist and senior villagers with recognized skills will be turned to. Healers of wider repute may be consulted if the case warrants it, and means permit. Reputations of some traditional healers extend for hundreds of miles and reflect regional, national and even international demand [44]. Some respond to requests for long-distance, personal visits, and a minority provide mobile services at selected locations on a periodic cycle. Clientele may be drawn from a broad cross-section of ethnic and socioeconomic groups, and from both rural and urban settings. In rural areas, particularly, most traditional healers are part of the local culture and share the same language, culture and beliefs as their patients. However, throughout Africa it is not at all uncommon to consult a specialist from another ethnic group [8, 42]. What appears to be of greatest importance relative to social acceptance and therapeutic effectiveness is cultural empathy and value consonance between patient and healer [5].

Diagnosis in traditional medicine is based on one or more of several procedures, including *observation* of the patient's attitudes, gestures, ability to perform basic tasks as a test of logical reasoning (in cases of mental disorder), and close relations; *divination* and possession, which may lead beyond diagnosis to prognosis and prescribed treatment [39, 45]; *case history*, which may be intensive and cover a patient's family and social milieu; *clinical examination*, including palpation (e.g. to assess pulse rate and body temperature, and to detect splenomegaly, depressed fontanelle, and pitting edema) and physical inspection; and *biological diagnosis*, through examination of blood, urine, stools and discharges.

One should avoid any temptation to romanticize and exaggerate the accomplishments of African tradi-

tional medicine, despite its unquestioned clinical and social value. There is by no means uniform knowledge or utilization of even the generic therapeutic methods. For example, although psychotherapy, occult practices and phytotherapy are probably well-developed in most healing systems south of the Sahara, surgery and orthopedics are practiced but not universally. Difficulties of diagnosis in certain chronic and emergency conditions due to ignorance; lack of rigorous dosology and drug selection; and, from an external viewpoint, the perplexing intangible means and ends of particular forms of psychosomatic therapy, and the perpetuation of belief in witchcraft and sorcery, may justifiably be seen as negative features [10]. To these we might also add a caveat concerning the growing commercialism of many traditional healers (a trait widely shared with modern health professionals in private practice). These factors should not, however, obscure the evidence that, on balance, traditional medicine (1) has been and continues, potentially, to be a very valuable human resource system; and (2) if restructured as part of a carefully planned strategy of self-reliant community development, could contribute appreciably towards meeting national primary health care requirements in this century.

Whereas scientific medical practitioners might readily demonstrate the inappropriateness of specific traditional medical practices, the same has already been shown for some "modern" therapeutic regimens [46]. Modern medicine has its fads; practices deemed good today may be found worthless or even harmful tomorrow. The reality of iatrogenic mistakes should be accepted as the consequence of lack of present knowledge and the inadequacy of the art of medicine rather than carelessness or deviation from accepted practice. The thalidomide episode and the recently recognized effects on the children of women to whom diethyl stilbesterol (DES) was administered during pregnancy are only two examples.

Traditional African medicine exhibits a diverse complement of therapeutic procedures which reflects ingenuity, trial and error experimentation, and the gradual accumulation of empirical wisdom over time. Techniques which have their equivalents in modern medicine include, for example, oral, cutaneous, rectal and respiratory administration of plant preparations; hydrotherapy, treatment by radiant heat, counter-irritation, massage and psychiatric testing.

Midwives quite obviously perform a crucial health care function in all societies in the region. They provide prenatal care, some applying skills such as ability to rotate the fetus; assistance during labor, delivery and after birth; and often continuing care for newborns and young children. Although abilities vary individually, many traditional midwives are relied upon to perform the roles of gynecologist, obstetrician, herbalist, dietician and pediatrician [8, 10].

The recent surge of scientific interest in African pharmacopoeias highlights an important dimension of traditional healing—the historical importance of which cannot be overestimated [47]. Research aimed at discovering the pharmacodynamic properties and therapeutic potential of widely used traditional plant medicines is now a common activity in African universities and certain government-aided agencies in West [48] and East Africa, often in cooperation with foreign research centers. In Kenya, for example, researchers have been focusing on plants such as *Maytenus buchananii*, which yields a compound of low toxicity known as maytansire. Initial human trials by the National Cancer Institute in Washington, D.C. have yielded evidence of its positive activity in reducing tumor volume in childhood leukemia and ovarian and lymph node cancers [49]. Extracts from this and related plants have reportedly been used in Kenya for traditional treatment of venereal disease, rheumatic pains and swellings, gastrointestinal disorders, and internal body injuries. Other medicinal plant compounds in Kenya have known or potential uses as antimicrobials, cardiac glucosides, hypotensives, and drugs which relieve inflammation, spasms, and asthma [21, 50].

Continuing "discoveries" confirming the active pharmacological properties of traditional herbs should not be ignored [51–53]. The classical example of malaria and quinine bark in South America is reinforced by the relatively recent introduction of *Rauwolfia*, long used in Africa and India, into the Western pharmacopia [54, 55].

In 1975 researchers in Ghana were informed of a small seed which villagers in the Kwahu district ingest to protect themselves against an annual dry-season epidemic of abscesses. This epidemic was, in fact, "an infection with the ... parasitic disease dracunculiasis, and the seed in question is a preventive against that disease" [10]. Wangwe has identified plants which are used by the Abasamia of Kenya to improve lactation and prevent neonatal tetanus [56]. Some plants are basically repellent to insects, and others are believed to offer protection against poisoning and contagious diseases such as chickenpox and smallpox [10]. Ethnobotanical (and vernacular) names of plants with reputed medicinal and ritual healing value typically number in the hundreds for a given ethnic group [8, 55, 57].

A point of clarification is in order concerning the function of African pharmacopia. In contrast to the Western tradition in which "medicine" and "pharmacy" have remained largely distinct, African therapies show a close association of the two elements. Many non-African commentators, in particular, identify traditional medicine, explicitly or implicitly, with a narrow, stereotyped set of practices relating to the collection, preparation, and administration of "herbal remedies", or pharmacopoeias. There is a strong tendency to define healing in terms of herbal "cures" or "remedies" for specific diseases. This restrictive concept overlooks the fact that, as in modern medicine, the majority of illnesses dealt with by traditional healers are self-limiting and have a very substantial psychological component. Herbal treatment and individual or group psychotherapy are typically combined, although the latter methods may be employed without recourse to herbs. A common effect is that the patient's symptoms and feeling are improved without necessarily changing his pathological condition. In essence, as the striking results of the "placebo experiments" in the United States and Europe suggest, those who respond favorably to placebos are apparently "predisposed to accept and react to socially defined symbols of healing" [58, 59]. The use of herbal medicines is thus inseparable from the *art* of

man healing, including healer–patient interdependence and the paraphernalia which enhance the mystery of curing agents.

Moreover, many "medicinal" plants are believed to possess, or acquire, magical powers (as in the case of plants transformed into *ng'ondu* among the Kamba in Kenya). Such plants are not conceived of as effective in themselves. Rather, healer and patient alike see them at one level as carriers of, or as the material framework for, the intangible supernatural force that will produce beneficient results [8, 10, 21, 60]. Above all, the healer's most important function is to restore social order, for traditional "medicine is bound up with the concept of magical power or influence and its possible effects are not limited to what we would regard primarily as pharmacological cures" [26].

In the more remote areas, traditional health care may be the only source of help available. Patients will have little or no chance of access to modern medical services. Their use of traditional care will vary with the gravity of the case; the nature of the illness, the type of specialist customarily sought (e.g. diviner), and the acculturation of the client; the proximity of a preferred or reputable specialist, and transportation. There are frictions of travel time and travel cost, as might be expected; but surprising distances are traversed for health care, especially on foot, regardless of the expense, time, and effort involved if people believe the result will be favorable. In cases where modern medicine is also accessible to part of the rural population, individual decision-making tends to be pragmatic—influenced by previous experience, concept of etiology, perceived chronicity, and expectations of a cure. In rural Kilungu in Kenya, for example, it is unlikely that the local Kamba women would seek treatment for infertility, edema attributed to witchcraft, or *mutambuko* (pain in limb joints) at one of the two government Health Centres, or at the fee-charging mission hospital. On the other hand, observation of many of these women who are mothers reveals they have a strong (but by no means exclusive) preference for modern curative medicine, where and when it is accessible, for their "under-five" children suffering with fever, acute respiratory infections, and diarrheal diseases [8]. Research has shown that this selective acceptance of modern medicine is, at best, only vaguely related to mothers' cognitive orientation to modern conceptions of etiology, mode of spread, prevention and treatment of diseases [61].

Economic costs of traditional medicine in rural areas are relatively well-adapted to local resources, although this too is changing rapidly in many areas. Traditional healers typically may not directly charge on a fee-for-service basis, and money transactions may be entirely absent. Many practitioners accept payment in kind, often only after the outcome of the treatment is known. Levels of indebtedness may be decided by the client. A particular token down payment is usual and customary. Settlement may be postponed through mutual agreement until the following agricultural season, and can take the form of a gift of a chicken or goat, foodstuffs, or some assistance in the form of farm labor. The amount of payment varies with the severity of illness and the time required for successful therapy. Children are assessed less than adults, and free treatment is common for relatives, close friends, and in some destitute cases.

In many rural areas, reliance on traditional healers and midwives is undoubtedly strengthened by the scarcity and low accessibility of modern medical services. The shortage of these services and the desire for "quick modern cures" also drives increasing numbers of the African rural population towards untrained, self-styled and unscrupulous "bush doctors". These illegal practitioners, who unfortunately are sometimes misidentified as *bona fide* traditional healers, administer injections of preparations such as liquid chloroquine and dispense prescription-type drugs purchased through black market channels—often with tragic results for entire families [62]. Their urban counterparts are the notorious "bus-stop dispensers" and "doctor boys", or "backstreet doctors", whose lucrative job is to hustle antibiotic capsules, abortifacients and other illicitly-obtained drugs to anxious clients in crowded city streets, bus depots, and markets [63, 64]. Whereas these "fringe" practitioners are a factor of great concern in the overall pattern of health care, we wish to keep them separate from our purpose in this paper.

In Africa's towns and cities the greater availability of modern medical care is met by an increased level of sickness and community demand for both modern and traditional medicine. In short, complementarity and elasticity of demand for health services are both in effect. Western-style clinics and hospitals of the modern system are intensively patronized foci of urban health care; but a most interesting phenomenon is patients' widespread use of both systems interchangeably, consecutively, or even concurrently for the same ailment. Moreover, these behavior patterns occur despite the paradox of the very high cost of much traditional medical treatment vs fee-free government services [8]. Patient flow and reverse flow between the parallel systems is a much understudied and highly complex process about which more information and sound theory are needed. It is, of course, a form of integrative behavior, akin to syncretic religious belief.

Recent research in several large African cities, including Nairobi, Kenya [8]; Dar es Salaam, Tanzania [65]; Ibadan, Nigeria [26]; Lusaka, Zambia [66]; Kinshasha, Zaire [67], and Kampala, Uganda [68] indicate that urban centers are viable and vigorous arenas of traditional medicine. In Nairobi, this phenomenon would obtain even if the City Council were able to provide numerous additional modern dispensaries distributed uniformly across the city. People universally prefer to have options, and Kenyans are no exception. In self-help urban "villages" such as Nairobi's Mathare Valley [69], the spacing between traditional healers (Swahili = *waganga*) is typically less than 70 metres. In this extremely congested, low-income environment, sheltered living space is estimated at less than two square meters per person. Consequently, few *waganga* have the luxury of, or even see a need for, making rational locational decisions which relate to the placement of their competitor's "clinics". Many are migrants from rural areas of marginal agricultural potential. They are strongly attracted to the city by a perceived opportunity to realize substantial economic gain from

practicing traditional healing for profit. Income potential becomes a function of charisma, prior reputation, and entrepreneurial ability [8]. These Mathare *waganga*, and the hundreds of others elsewhere in Nairobi, play an extremely significant role in the life of the city. As described by Andrew Hake,

> "It is not just that they are an economic factor, handling considerable sums of money between them. Far more important, they provide a crucial element in the 'spiritual', psychological, emotional, psychic inner life of most of the city's population. They are at once feared and ridiculed, sought out and avoided, paid and cheated, being both healers and sources of anxiety, links with the past, powerful influences on the present and seers of the future" [69].

Urban traditional healers tend to be generalists who serve a heterogeneous ethnic clientele drawn from all classes. Many if not most of the illnesses they treat are symptomatic of societies undergoing rapid urbanization, commercialization, and social change. (In Senegal, for example, it has been observed that "the peasant consults the marabout or the healer less frequently than does the city dweller, always attracted to the supernatural as a result of the break with his original environment" [70].) Their clients' problems are very commonly attributed to, or suggest the need for protection against, witchcraft and sorcery. These theories of causation are linked to a wide variety of conditions which are eventually accompanied by frank somatic or behavioral symptoms. Typical examples include psychogenic sterility, chronic general malaise, abdominal disorders, edemas, and many disturbances which reflect individual coping, adaptation or acculturation difficulties such as inability to secure employment, sex or marital partners; strained or broken kin relations; alcoholism; and job failure. Mental disturbances, ranging from mild, temporary neurosis to chronic psychotic forms of behavior, often head the list of illnesses traditional healers perceive themselves as "best qualified to treat". In addition to witchcraft and sorcery, disturbed spirits, the curse, excessive anxiety and drug abuse are believed to be common causative factors [8].

Modern medicine is not presently organized to handle the rapidly growing caseload of mental and sociopathic disorders, which approach communicable diseases in their importance. In contrast, the town-based traditional healer is generally rural-born, and is capable of offering clientele who are recent migrants a familiar conceptual and behavioral point of reference in matters of health, sickness, and survival in the urban milieu. Many of the same labels for illness, ideas of causation, ritual paraphernalia and curative methods are already known to such clients, even though the symbolism may be recast away from particularistic-ethnic content towards a more universal symbolic framework acceptable to a variety of ethnic groups [17]. This common ground, and the experience, compassion and advice a traditional healer will often share, can serve to reduce stress and facilitate adjustment to town life. What the urban healer frequently lacks is the support of a residential kin or cult group to participate in the therapy process. Hence, diagnosis and treatment of town-dwellers' health problems reflect approaches which are credible and possible in urban conditions. This usually means avoidance of diagnoses which require extensive rituals [8, 17].

Traditional medicine is an omnipresent reality of life for both rural and urban folk—an indigenous resource system still serving the majority of Africa and the remainder of the Third World. Yet, despite its preponderant importance, it is incredibly overlooked and discounted by development planning agencies. Interest, where it exists, is generally limited to the preparation of national inventories of medicinal plants, and to sporadic, uncoordinated attempts to conduct phytochemical, pharmacotechnical, pharmacodynamic and clinical studies with a view to the establishment of pharmaceutical industries. However, few African governments officially recognize traditional healers, and fewer still make any attempt to incorporate their services into a national health plan [71, 72]. This ambivalence and *de jure* nonrecognition, which the modern medical establishment rationalizes through its own cult of science and professionalism, cannot diminish the immense *de facto* contribution made by traditional health care. Traditional medicine reflects a marshalling of resources for self-help by peasant and infraurban communities. It expresses the strength of African cultures to meet human needs. Given that health care *in toto*, both traditional and modern, is extremely inadequate for the overwhelming majority of African populations, the critical question arises: Should post-colonial governments continue their *laissez-faire* stance towards traditional medicine, concentrating all resources on the class- and residentially-segregated modern health care sector, even where the latter fails to reach the great majority of the population [19, 73]?

MODERN MEDICINE

The modern health care system, based on Western science and technology, is surprisingly new in most of the Third World. In Africa its introduction largely dates from the late 19th century. It is alien there, coinciding with colonial invasions, the rise of capitalism, the penetration of European educational values, and often with Christianization [74, 75, 76, 77]. At first all doctors were foreigners, endowed with "magical" powers of the new ruling classes. Missionary doctors and colonial medical officers pioneered Western medicine, often with spectacular success. The introduction of antibiotics in the mid-20th century further augmented their contributions. Immunization campaigns, and non-medical developments such as improved water supplies, brought about a dramatic fall in death rates.

Yet, in recent decades, once-euphoric expectations for the orthodox model of modern medical care in Africa have subsided in the face of growing awareness of its many limitations. Medical schools are a case in point. Although they have increased considerably in Africa (as well as in Asia and Latin America) since independence, there is much criticism of the overall value of their producing larger numbers of *conventionally* trained doctors. Several interrelated arguments form the case against maintenance of the status quo in medical education [2, 3].

1. Economic costs of training "sufficient" doctors to "international standard" in African countries are pro-

hibitive and relatively wasteful—at least 15 to 20 times the cost of preparing one medical/clinical assistant [78].

2. Many doctors do not practice in their own countries after qualifying. Reasons include lack of acceptable pathways to professional development and rewards (e.g. specialty certification and income base) and political instability, both of which stimulate a "brain drain" producing "reverse foreign aid." Alternatively, these highly qualified professionals may abandon medicine for a career at home in politics, government or business.

3. Highly trained medical specialists are needed in every developing country. However, the fundamental need is for health personnel whose qualifications and lifestyle (especially willingness to work in rural areas) are oriented toward provision of *primary* health care and the treatment and prevention of common diseases.

> A recent study of health services conducted for USAID's Technical Assistance Program to the Government of Kenya found that (p. 75)
>
> "the training of physicians prepares them to render services in hospital settings, and to treat diseases (complex and relatively less common) which are largely irrelevant to the needs of a rural population and, equally important, irrelevant to the equipment available and to the training of paraphysician support staff" [73].

Ironically, the same study (pp. 80–81) also notes that in terms of the tasks they perform onsite, clinical officers who work in hospitals and rural health centers "appear, with three years of training, to be overtrained" and underutilized relative to their skills and the major categories of disease they routinely confront.

4. A related factor is the attitude of the elite in many developing countries—in favor of transposed, expensive Western-style medical standards. Their political influence and conservatism help to insure that these standards are reflected in national health plans, even though only a small minority will realize the benefits. Such attitudes and values also ensure that medical schools are designed more as national prestige symbols than as progressive instruments for reforming medical education in the interests of improved health care for the majority.

Other criticisms leveled at the modern medical care model emphasize that it is crisis-oriented, particularly when financially restricted; treats symptomologies; is technology-dependent and resource consuming; and allocates few resources and attaches little prestige to less immediately productive preventive programs, even though recognizing their importance [79]. Morley emphasizes that in developing countries "three-quarters of the deaths are caused by conditions that can be prevented at low cost, but three-quarters of the medical budget is spent on curative services" [81]. Moreover, because health care systems have generally undergone little structural change since independence, the health care experience for rural Africans in many countries is largely the same as it was during colonial rule [9]. In some cases, outstanding colonial programs such as the *Ecole Africaine de Medecine* in Senegal, which produced over 800 "sub-professional" *medicins africains* between 1918 and 1951, have been dropped in favor of a "proper" medical faculty [3]. Significant new efforts include the varied, innovative, community-centered approaches to preventive and curative care promoted by the Institute of Child Health of the University of Lagos, Nigeria [80].

The litany of disillusionment nevertheless continues, and most criticisms are indeed valid. However, for good reasons, the demand for modern health care is insatiable. Thus, perhaps the biggest criticism is that there is not enough of it! For example, in quantitative terms only Congo, Swaziland and Zambia have enough doctors to provide a crude ratio of 1:10,000 people. This relationship is by no means stable, however, since a large percentage of doctors are expatriates. In Kenya, only 600 of 1800 doctors are Kenyan citizens. The estimated doctor-to-population ratios are 1:987 and 1:70,000 for urban and rural areas, respectively. Moreover, 70% of all doctors are in private practice in Kenya's towns, whereas 10% of all physicians serve rural areas [73]. Nigeria, with 80 million people and less than 3000 doctors, has a ratio of approximately 1:25,000. Since most of these doctors live and work in the larger cities, the bulk of the population is served at a ratio of 1:50,000 to 1:100,000. Rwanda's ratio is 1:625 for Kigali, the capital, and 1:90,500 for the rest of the country [3, 82]. As orthodox indices of health manpower these doctor–population ratios effectively represent nearly zero availability of modern health care for most of the population.

Of course, statistics relating to doctors alone do not accurately represent the quantity of health services available to people in developing countries. However, even when doctors, nurses, medical assistants and midwives are considered as a single resource pool there is still wide disparity, regionally within developing countries, and in comparison with the industrial nations. Thus Burundi has approximately 8.3 health workers, Mali 26.7 and Canada 749.5, per 100,000 population [83]. Added to this are the problems of imbalanced, top-heavy staffing which results in too few auxiliaries to support the health services. In some African countries this takes the form of an "inverted pyramid", where the small number of doctors actually exceeds the number of auxiliary staff. This problem is exacerbated where the auxiliaries are not permitted to work except under a doctor's direct supervision [82]. Hence, the key issue is what *kind* of care can and should be made available: "If you ask people what they want, most will tell you they want hospitals and doctors. But what they really mean is that they want to be kept well" [84]. Must African health ministries postpone better health care for the overwhelming majority of the population until enough doctors are trained and hospitals built? Tanzania's national experiment with medical auxiliaries offers one potentially significant alternative [85].

This absolute, quantitative lack of modern health care, or at best the widespread insufficiency of its services, is exacerbated by the population explosion. Most countries in Africa are doubling their population size every 20–30 years; birth rates are in the order of 40–50 per 1,000; and youth dependency ratios are high with 40–50% of the population younger than 15 years of age. Importantly, there is a flood of migrants to urban areas. Cities are doubling

in size every 6–15 years, yet there is little economic basis for such growth apart from the informal self-help and client–patron arrangements which characterize the transitional urban economy [69, 86]. This expansion of the jobless and underemployed, most of whom are physically accommodated in spontaneous or "uncontrolled" settlements [69, 87], produces a great strain on the urban health care system. At the same time, the rural areas, which are still the home of 80% or more of the population, are largely neglected. District and regional hospitals are few and far between, and they are understaffed; satellite clinics, health posts and mobile services are scarce; and nursing staff, other paramedicals, and medications may be in short supply or nonexistent.

Rising political consciousness is an important urban phenomenon and, among other considerations, it demands that governments provide *urban* health services even at the expense of the rural hinterlands. Thus, inequitable government investments, lifestyle aspirations, and also social and economic inducements—including opportunities for doctors to maintain lucrative private practices while employed on government service, or to receive "non-practice" allowances in lieu of such activity [88]—produce concentrations of doctors in the cities. The by-product is spatial-segregation of medical facilities, not unlike the pattern of racial segregation during the colonial era [19]. A recent study in Kenya concludes that 80% of the national health budget is consumed by residents of Nairobi, Mombasa, and Kisumu—the three largest cities [73]. Geographically, a map of doctor location at the national scale in most developing countries is virtually a map of urban centers. Yet urban and rural areas are part of the same interconnected economic system, and unmet health needs are a universal national problem that bears both on human welfare and economic growth.

Connected with the problem of underserved populations is the need to keep new modern facilities, such as teaching-research hospitals, at a manageable scale, financially and physically. Some hospital systems are believed to be growing too big, too quickly, creating an intolerable national burden with ballooning overhead costs to be absorbed by the health budget; and ultimately contributing to the defeat of the goal of adequate health services for all citizens [73].

It is apparent that a constellation of forces bear on the issues of health care in Africa and the remainder of the Thirld World. They include the population explosion, social upheaval, cultural change, technological impact, changing economic and occupational relationships, new dependencies and consumer expectations, politization and, in some countries, an emergent proletariat. These forces, together with new levels of awareness, as well as an increased intensity of information flow, bring compounding urgency. It seems extremely improbable that modern medicine, given its typically monopolistic structuring in Africa [3], can unilaterally provide the necessary solutions.

Neither traditional nor modern medicine is adequately meeting health care needs. Separately or together, both fall short. There are parallel but separate and inadequate systems; and national resources are scarce. What steps, therefore, could be considered to remedy the situation—given that the goal is always improved total care, including prevention?

PROMOTING COOPERATION

The interface of the two systems may not be the best area to begin. Dying patients transferred into or out of the modern hospital do nothing to enhance confidence on either side. Doctors are frustrated by the delayed commencement of appropriate treatment, and patients and patients' families, in turn, come to know the hospital as a place in which one dies. On the other hand, hospitals as institutions are generally not organized to care for the mental health and physical care of terminally ill patients. One consequence is that an in-patient may be bluntly given his prognosis by the hospital doctors, discharged, and then delivered by an anxious family (unwilling to accept the death decree) into the hands of a traditional healer, whose responsibility it now becomes to treat a patient suffering from both a grave organic illness *and* severe psychological insult resulting from the hospital's dispensation of the case [8].

Obviously, the net effect of cooperation and collaboration between the traditional and modern systems, in terms of patient behavior and health levels, cannot be determined in advance of concerted, well-planned efforts to test the concept in practice. If the two systems were to be consciously articulated together, we believe there would surely be a synergistic outcome with positive health value—even though this could be interpreted from certain quarters as having the effect of "delaying" acculturation to modern medicine [89]. Both systems might be gradually modified so as to be more closely interrelated. Increasingly, there are calls for collaboration. Authors such as Nchinda [90] and Conco [91] make strong supporting statements but give few specific recommendations for achieving a rapport. A few tentative steps in this direction have already been taken. The Nigerian experimental use of traditional healers in psychiatry is well-known [92], although details of procedures and results have never been adequately reported. African countries including Ghana, Nigeria and Sudan, and Asian states such as Indonesia, Malaysia, Thailand, Philippines and Pakistan recognize, train and use the services of traditional birth attendants [93]. In Liberia (and Kenya), traditional practitioners refer patients to the hospital if they believe they are unable to help. Conversely, Liberian "bone doctors" are encouraged to use the hospital's X-ray facilities before and after setting fractures [94]. Such examples are localized and limited in scope, and essentially represent individual adjustments to present reality rather than national policy.

In 1978 the World Health Organization issued a call for the "promotion and development of traditional medicine". The report stresses the need for scientific planning; indicates possible obstacles to success, such as fear of the iatrogenic effects of traditional medicine and resistance by "intransigent advocates of one or another system"; and outlines areas of needed research. Recognizing that traditional medicine will, of necessity if not also by desire, remain the major source of health care for much of the world for some time to come, W.H.O. recommends national implementation of an integration policy wherever feasible [95].

Initially in each country there is a need for several pilot projects, backed by strong public support and planning inputs from the national and local health administrations. These experiments would give greatest emphasis to rural areas, but should also include urban health care environments in which traditional medicine is expanding today. Human resources and opportunities for trial programs are certainly not lacking. For example, data obtained systematically during in-depth interviews of 66 traditional healers in part of Nairobi, Kenya show that the great majority already practice referrals and report substantial interest in cooperating with modern medical practitioners [95].

Ultimately, the decision to move toward cooperation and integration will require extensive and significant reforms in the definition and organization of health care, regardless of the scale of change sought. Personnel and working relationships which characterize the medical "skills pyramid" will be augmented and reordered, and local communities will be expected to assume greater responsibility for the kind of health care they receive. The appropriateness and extent of specific reforms will vary from one country to another, with due allowance for local conditions. In all respects, however, the mustering of political will and commitment by national governments, health ministries and organized medicine is clearly the crucial first step in promoting cooperative approaches to health care. However, inaction and tokenism are effectively decisions not to change the *status quo*. Is there a paradigm for cooperation and integration? Specifically what changes might be called for?

Probably the best approach would be to start with the consumers: that is, the peasants and the urban poor. This approach would commence with individuals, families and, most importantly, *communities* of villagers, their perceptions, world views and health needs. With a real, rather than a token, focus on the peasant, with "peasantocentrism" as the starting point, planning for health care would work upwards and not down. Conceptually, due weight would be given to the sick farmer, ailing woman, or wasting child, rather than to the needs of a seemingly remote providers' bureaucracy. As Martin puts it, "programs are still developed too much within high level 'planning cells' and Ministry offices, by people whose ... community awareness can sometimes be questioned" [95].

Any alternate approach, such as the one we are recommending, will obviously have to intermesh closely with the already existing government health care structure. To advocate incorporation of traditional healers into the system does not mean to suggest training fewer medical assistants, although it should necessitate changes in their training, as will be discussed below. It is, however, based upon a conscious effort to involve each community in the process of solving its own health problems, more effectively; and on the premise that it is socially and psychologically beneficial, as well as economically sensible, if individuals who supply primary health care come from and are an integral part of the local community. This approach, the attempt to develop from the bottom upward, has been recommended before [96] and implemented with varying success in Tanzania's Ujamaa villages, the "health promotors" of Guatemala, and China [97]. The involvement of already practicing traditional healers into the overall, integrated health planning would add a new dimension, for they are a potential source of insight into a large number of "culture specific" illnesses, a reservoir of information about herbal medicines, and experienced with a variety of psychiatric techniques [33].

Careful *pre-planning* of locations of pilot projects, comprehensive objectives and a range of potentially workable health care delivery models should be the essential first step toward intentional strengthening of linkages between the traditional and modern health services. Although each country will have to modify the suggestions to conform to local conditions, representatives of all types of health personnel intended for participation in the projects, indigenous social scientists, and health ministry planners and officials should be integrated at all stages of planning and review. Pilot programs should be created with a view to nationwide replicability. Research on traditional medical systems has recently been conducted in several countries in the region, including Ghana, Nigeria, Zaire, Kenya [8], Botswana [98], and Zambia [66, 99]. Contacts and, presumably, good rapport with traditional practitioners have already been established there in specific locales. These sites would seem to suggest, for the countries concerned, excellent locations for the initial pilot programs to promote and assess the cooperative potential of traditional and modern medicine.

A cross-section of traditional practitioners selected by their own communities, respected community leaders, and others knowledgeable about traditional medicine, health needs and disease patterns in the specific localities concerned should be part of the pre-planning process. For innovations in the delivery of health care to be adopted, it will be crucial to generate "grass-roots" support and identification with the experiment; and, ultimately, shared community responsibility. Indeed, faithful integration of community development principles in all phases of planning will be crucial to the success of each phase of the undertaking. In effect, this clearly suggests that the basic *spatial units* in which the new arrangements for primary health care and cross-referral occur would be defined by *community social boundaries*. These are boundaries within which individuals, including herbalists, midwives and diviners, and groups, interact and reciprocate with each other on a more or less daily basis. Community patterning varies considerably across Africa in terms of socio-spatial organization and scale. Consequently, the community boundaries used to delimit primary health service areas may coincide with nucleated or dispersed village and hamlets, herding units, marketing areas, or other localized, interdependent household or functional groupings in which people have substantial face-to-face contact and reciprocity relationships. This approach departs from the idea once proposed by W.H.O. that basic, conventional health services "may serve a population of 20,000–25,000 through a group of small health posts whose number would be determined by the size of the area, and its geographical boundaries". In fact,

as Singer and Araneta insist, this latter approach is often quite opposite to the concept of social boundaries so central to the definition of a community [100].

Ideally, the communities in our proposed model would be linked to the regional government dispensary or health center for referrals and special services, would establish a local supervisory health committee, and would receive regular, frequent visits by the health center team at locations accessible to several villages, such as markets, schools or trading centers. The additional on-the-job training which traditional healers would receive to enhance their usefulness in the community health team would also be provided for other members of the team. This is based on the principle reportedly pioneered by the University Centre for Health Sciences in Yaounde, Cameroon, that "those who will work together should develop their professional relationship (and interdependence) from the start" [90, 101].

In regard to necessary policy changes, with consequences for planning activity, there is a range of possible specific actions focused on traditional health care which may be experimentally tested, reviewed, and evaluated. Such actions would include the following:

1. Establish procedures and criteria which will permit, in an atmosphere of mutual trust and respect, systematic evaluation of the basic knowledge of various kinds of traditional specialists, and their diagnostic skills relative to the medical assistants, nurses, and midwives currently responsible for providing government health services in the local area. The latter experiment would necessarily require separate diagnoses of the same patient-subjects. The preparation, dosology, and efficacy of traditional herbal preparations could also be included in this phase of the program. A major problem all participants must be prepared to face immediately—once a decision to experiment with the cooperative approach is taken—is how to reconcile the different value systems inherent in the traditional and modern approaches to illness.

2. Identify and train one or more traditional healers (e.g. herbalists) as *health aides* for each village, hamlet, or mobile pastoral community. These aides should normally be residents of the communities they serve—not strangers and not salaried bureaucrats. They should be selected by the community and responsible to the community they serve. Some workshop-type instruction in hygiene, sanitation, first-aid procedure, asepsis, and health education could be provided in the nearest government or private dispensary or health center. Traditional healers in the program would be trained to give simple treatments at the point of first—and perhaps only—contact; assist in local immunization campaigns; and to refer patients to dispensaries or rotating satellite clinics held in a central place for a cluster of communities. They could be fairly recompensed by their communities, although government remuneration should not be discounted as an incentive. (This point of entry to primary care complement's current policies of the W.H.O. which are designed to encourage community participation and self-help through the establishment of "village health workers" and village health councils [102].) Since many healers would be illiterate, they might be relatively more stable and less likely to move away after learning new skills. Literate assistants might also be recruited from among underemployed secondary school leavers to maintain simple records and vital statistics.

3. Identify and train traditional birth attendants (TBA's) with a goal of perhaps providing at least one person with basic scientific midwifery skills per community. Each TBA who completes the program could be encouraged to take on responsibility for a younger apprentice. Training should be simple and emphasize skills such as the recognition and prompt referral of high risk cases and complications, particularly hemorrhage, toxemia and infection; asepsis and proper cord care to avoid tetanus infections at delivery; and family planning. These and other approaches to TBA's are currently being developed and evaluated by the Danfa Project in a rural area containing 60,000 people north of Accra, in Ghana [103].

4. Identify and use selected traditional healers (medico-religious specialists) as *psychiatric aides* in the community, linked with appropriate, unobtrusive external health care support. Psychiatrists in Africa [30, 92], among the Navaho in America [104], and elsewhere are finding that traditional healers are respected and heeded, and that they can play an important role in rehabilitating and re-integrating chronic patients [105]. It would be valuable to have such specialists attached as clinical associates and be located near each health center and hospital. However, psychiatric aides should be physically separate from health units so as not to interfere with (a) the healer's engagement of the value process; and (b) "expectancy" (psychiatry) or "placebo" effects (medicine) on the outcome of therapy [106]. The rationale for this experimenting with psychiatric aides is based on the global experience of modern health specialists. According to Dr T. A. Lambo of Nigeria, Deputy Director of the World Health Organization, 70–80% of patients who come to doctors' offices and clinics "are not suffering from any discernible organic disorder" [107]. Indeed, in view of the escalating demand for psychiatric services in affluent Western societies, and the recent findings of field research in Tanzania [5, 7], Kenya [8] and elsewhere, there is little justification for assuming that African populations will not continue to require culturally-relevant assistance in matters of psychological health.

5. Supply small stocks of drugs to communities, perhaps on a "cost-plus" revolving credit basis. These would be made available to health aides and TBA's who have been taught and have demonstrated competency in their proper use. Tablets, injections, syrups, ointments and other materials could be strictly limited to the principal illnesses; for example, malaria, infant gastrointestinal disorders, scabies, and trachoma. In hyperendemic disease regions, the list of medications could be modified so as to treat particular regional hazards such as malaria, schistosomiasis, and onchocerciasis. The benefits to nomadic groups and to small villages which may be completely isolated from otherwise available health centers by seasonal weather are obvious, and should offer a major incentive for cooperation by the entire community.

novative approaches to supplying essential drugs is critical need in view of the chronic shortages and on total unavailability of drugs in rural health facilis due to high product costs, inequitable distribution the direction of hospital-based curative services, or management and misappropriation [108]. The *pharmacy* concept, a decentralized system which as reportedly been successfully introduced in Camerun, would appear to have excellent potential and presents a model which other countries might profitly emulate [109].

6. A flexible, rudimentary referral system could be couraged using the community as the basic cell for imary care. Village health aides, midwives and hers would need established channels for sending t refractory and complicated cases, without fear of dicule or denigration. Presently there are no intenional or formalized linkages between traditional alers, doctors and other modern health personnel; owever, as we noted earlier in this paper, given the pportunity, people do resort to both systems. Planned implementation of cross-system referrals and terdependency would reduce the often acephalous olation characteristic of much traditional health re, especially in rural areas. Existing spontaneous atient flows would be guided, improved and, possibly, optimized. Traditional medicine would thus be linked to a larger national system and to technically higher levels of health care.

The foregoing proposals to not radically disrupt or threaten the traditional health care system. The primary orientation towards indigenous values is not changed in fostering reforms that promote increased self-reliance. It is not proposed that traditional medicine should be regulated, but the question may be addressed: Should traditional healers be trained, certified, and licensed to practice? Most considerations seem strongly to disfavor control, although in the minority of ethnic and community settings where traditional healers do cooperate with one another, it might be advantageous to encourage them to form or further develop professional associations [8, 98], and a carefully constructed code of ethics [21]. However, regulatory management by government would be alien to the fabric of traditional medicine. Barriers to free access to traditional medicine would be deeply resented, both by the clients and the healers. Implementation of a control scheme would be impossible, wasteful of resources, and undesirable. In fact, regulation should be avoided so as not to drive practitioners underground [110].

It would be much better to use incentives to recruit and train traditional healers and health aides, and to give them a competitive advantage over nonparticipating healers. Those not encouraged by such inducements would be free to practice at will; and their presence would give the peasant an alternative, which competition would be of some marginal value.

Policy options which focus more directly on the modern health care sector must also be considered. Among those to be evaluated are:

1. Substantially increasing the number of part-time health workers (in addition to selected traditional healers) in line with principles recently outlined by Morley [81]. Here, also, would be an opportunity to absorb some of the surplus of unemployed secondary school graduates and leavers whose literacy skills could be of great value in their communities.

2. Substantially increasing the numbers of health professionals (auxiliaries) at intermediate and lower levels and, at the same time, giving them increased responsibilities for medical care. They should be assigned to work in their own communities, or at least among their own ethnic group. Their training and subsequent service should include interaction with traditional healers. This recommendation would effect a broader delegation of duties, thereby giving more support to doctors, and also diminish the topheaviness of the modern medical care hierarchy [111–113].

3. Increasing the in-country training of doctors. Their orientation would thus be attuned to the realities of local cultural norms, and to scarce technological resources. This proposal would call for the establishment of new medical schools, even in very small countries; and it would also require reforms in medical education curricula, appropriate to specific local needs, most especially with regard to the use of limited resources. Regional medical training programs would be an extension of this idea—whereby a group of medical schools of adjacent or nearby countries would pool their postgraduate medical training programmes. Home-trained doctors would be better adapted than foreign-trained, more concerned about priorities of community health care, less frustrated with the lack of technological support, less likely to be exportable and, hence, to be lost in the "brain drain".

4. Consonant with broadening the base of the pyramid of health care providers would be the need to carefully integrate referral systems at each level of care. Apart from members of the family, a patient's first contact for health care would be with a village health aide. Referrals would then proceed, if required, up the hierarchy, at perhaps five levels from: (1) village health aide/birth attendant, to (2) health agent or community nurse's aide, to (3) nurse, medical assistant, or clinical officer, to (4) general medical doctor, and to (5) specialist medical doctor. The referral tiers would also be spatially organized through linked catchment areas, based at the lowest level on community social boundaries. This would tend to minimize aggregate patient travel and also identify the more remote communities to be visited on regular rotation by a health team from the regional health center. Risks of mis-diagnosis and delayed referral would have to be evaluated in benefit–cost terms, against the risk of no diagnosis at all. Treatment responsibilities at lower levels would need to be categorically defined in terms of access to listed drugs, and so on.

Inter-meshing with traditional healers would be possible at the primary community level (village or hamlet); and some healers might also be employed at the regional health center. New categories of resident village-level health aides might be developed. The health agent who travels around an area by motorized bicycle treating domestic animals could also be trained to de-worm human subjects and give other treatments. The idea is not revolutionary: it can be turned around to recommend that health aides who

treat humans should also be trained to treat animals, since human health and animal health are closely interwoven in the peasant world. Traditional herbalists often treat domestic livestock as well as humans [23].

Unstated but implicit in discussing health care, so far, is the role of major public health programs in preventive medicine. It is known that the capping of wells or the introduction of piped water supplies can reduce infant and child mortality quicker than any free access to modern drugs; that large-scale control programs for selected diseases such as smallpox, trypanosomiasis, or onchocerciasis will transcend local-level health-care organization. However, the involvement of efficient local level health care management is indispensible to the success of capital intensive "large-scale health schemes. Individual, village-level preventive medicine is absolutely critical, for example, in areas of infant weaning, nutrition, or schistosomiasis prevention. Thus, for our present purposes no differentiations are drawn between public and preventive medicine, large-scale or small-scale.

The dualistic and dichotomized health care systems of the developing world seem ripe for modification and mutual adjustment, especially given the dire scarcity of economic resources. The health sector, *per se*, must compete with agriculture, transportation, and other sectors for very limited development funds. The example of China with its "barefoot doctors" has been much overworked, but nevertheless, China does successfully combine traditional and modern medical practices, using local level health aides, both in rural and urban settings, with a spatially integrated referral system. The successes in community health achieved by the Chinese during revolutionary reconstruction have since led to a quest for quality of care and lengthened periods of training in all categories (barefoot doctors now study for 2 years rather than three months) [114]. How much of their experience is transferable across cultures and polities is an open question. The Tanzanian experiment, with its decentralized health services, may also be viewed in this light. Cuba's polyclinics are primarily addressed to urban and semiurban populations. Wherever one looks there are health care delivery modes or models, but caution advises against their simplistic pursuit and adoption.

Culturally adapted local and regional solutions, modifying the *status quo ante*, are recommended. Paramount would be some integration of the traditional and modern systems. This would represent a diffusion downwards of modern care and a diffusion upwards of traditional care. In Africa, scattered attempts at experimenting with ideas in this vein are currently being tried out and a synoptic review is urgently needed to evaluate these and other novel and experimental experiences.

In summary, it is argued that countries of Africa and the developing world in general do themselves a disservice by officially ignoring traditional medicine, by excluding it from the central planning process, and by not considering its partial or fuller incorporation as a public policy option in health care planning.

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