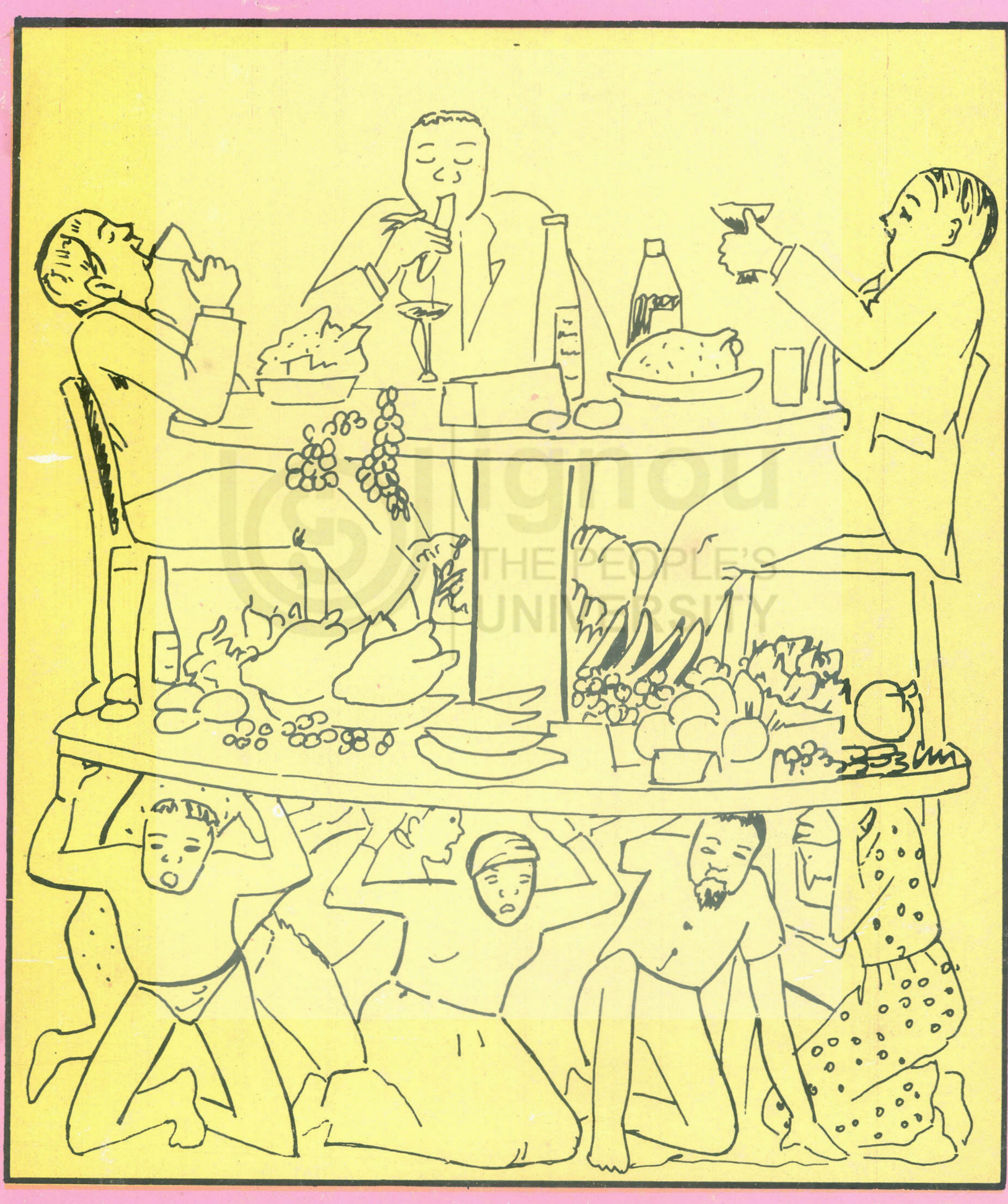
Indira Gandhi National Open University
School of Continuing Education

RD.D. 6
Rural Health Care



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HEALTH CARE : PLANNING AND MANAGEMENT

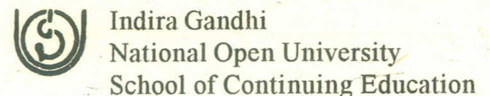
3

“शिक्षा मानव को बन्धनों से मुक्त करती है और आज के युग में तो यह लोकतंत्र की भावना का आधार भी है। जन्म तथा अन्य कारणों से उत्पन्न जाति एवं वर्गगत विषमताओं को दूर करते हुए मनुष्य को इन सबसे ऊपर उठाती है।”

— *इन्दिरा गांधी*

“Education is a liberating force, and in our age it is also a democratising force, cutting across the barriers of caste and class, smoothing out inequalities imposed by birth and other circumstances.”

—Indira Gandhi



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Block

3

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INTRODUCTION TO BLOCK 3

In this modern era application of management science has assumed significant importance. Its application can be found in every sector of development. Health sector is no exception. Though the field of management covers wide spectrum of topics we have chosen three important topics in this block to give you an over all picture of the process and methods of managing rural health programmes. They are planning, management and communication. Accordingly we have titled the first three units of this block as "Planning Rural Health Care Services" (**unit 10**), "Management of Rural Health Care Services" (**unit 11**), and " Communication and Health Education" (**unit 12**) respectively.

The three important factors discussed in unit 10 are the concept and characteristics of planning, process of planning and the importance of planning with the community. The process of planning may be easy to understand, but if we do not know how to involve the community in planning the programme cannot be of people's programme. This we have explained with the help of a successful case study. The process of planning is also explained with an example.

Unit 11 deals with some of the key functions of managing a rural health care programme. The key functions discussed are implementation, designing an information system, monitoring and evaluation. For effective implementation we have considered factors such as coordination of activities, deployment of personnel, allocation of resources and information management. The process of designing an information system is again explained in the context of a community based health care programme. Some of the model tools, given as annexes, used for maintaining an information system may be useful to you. We have laid heavy emphasis on the participation of community in monitoring and evaluating a health care programme. What is more important in monitoring and evaluation is identifying useful indicators. A modest attempt is made in this unit to assist you to identify indicators necessary for monitoring and evaluation.

Building people's awareness is fundamental to their participation. How far some of the effective means and methods of communication and health education can be used to raise the level of awareness of communities is discussed in unit 12. Developing strategies for health education is an important section of this unit, which needs to be read with care and attention as this might help you in designing a health education programme appropriate to your context.

The last unit (**13**) of this block gives you an over view of the experiences of NGOs in health care. The experiences provided in this unit gives us an understanding of the approaches and programme activities followed by different NGOs. While reading this unit please keep in mind that the strategies followed by them might have either changed by now or some of the NGOs mentioned may not exist in the same name as they might have diversified their activities in some other name (spin off). Nevertheless, their experiences have been presented as they were/are some of the most successful models in health care.

We hope the units presented in this block will be of immense interest to you.

Good luck and best wishes to you.

UNIT 10 PLANNING RURAL HEALTH CARE SERVICES

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10.1 Introduction
10.2 Meaning and Characteristics of Planning
10.3 The Process Planning
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10.0 AIMS & OBJECTIVES

Planning is an important factor in addressing rural health problems. The diversity of rural health problems demands that planning for health care services cannot be left to the state alone. Effective planning at various levels, particularly at the community level is required to deal with effectively the growing health crisis in our country. After reading this unit, you will be able to:

- Understand the meaning and process of planning
- Set goals and objectives
- Plan and formulate activities
- Appreciate the need for involving community in planning rural health care services.

10.1 INTRODUCTION

In this unit, we will discuss the need and importance of planning for rural health care services. Planning is one of the important functions of management. The need for planning arises because there is a complex situation in which the health problems occur. We cannot plan if the existing station is not properly analyzed. Only when we analyze the situation we will be able to set goals and objectives and formulate an action plan to deal with the health problems. Planning as a process therefore, involves all these steps. While discussion these steps, you will find that the focus and emphasis is on participative planning. You will appreciate that community based health planning is normally different from institutional based approach to planning. This study programme is helping you to prepare for involvement at the grassroot level. You are therefore, encouraged to pick up the crucial components of planning in relation to rural health. Let us begin this unit by understanding the meaning and characteristics of planning.

10.2 MEANING AND CHARACTERISTICS OF PLANNING

In RD.03, you would have already learnt the meaning of planning. However, in this unit you shall learn more about planning and its characteristics in the context of rural health care.

10.2.1 Meaning

Planning is a universal phenomenon. No activity takes place without some type of planning. Here, we are discussing about systematic planning which means we decide in

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advance what needs to be done in future. Preparing ourselves to take appropriate actions in future to achieve the predetermined goals which we have to set to improve the health of the people. Planning is a means to an end and can achieve it's purpose if properly inter linked with other aspects of management such as implementation, monitoring and evaluation.

> Thus, the concept of planning can be summarized as an important function of management dealing mainly with decision about objectives, activities and resources by systematically considering what, which, where, when, how much and how the health team will perform (Rosemary etel, 1992)

10.2.2 Characteristics

The concept of planning will become more clear if we consider the following:

1. Situational Analysis

Systematic planning is based on the analysis of the existing situation or a problem. The situational analysis also helps us to identify and prioritize the problems to be addressed. Thus, planning is never done on a hypothetical situation, rather it is based on concrete facts and evidences.

2. Planning is a Thinking Process

To plan, you need conceptual skills because planning is an intellectual process. It requires ability to think, to visualize and look ahead into the future, to form opinions, generate ideas and draw a vivid picture of the future. An important aspect of planning is to look into the future and anticipate opportunities and threats, find out what the possible problems would be in future and to find out ways and means of neutralizing such problems.

3. A process of Taking Decisions

Planning is a process of decision making. The quality of decisions depends on the availability of relevant information. In planning, it is essential to have a good health information system so that right decision may be taken for the benefit of community. The decisions are taken at the community level, at the project level, at the block level and so on. In this process, you should try to build up the capacity of the community so that they could take decisions affecting their lives. This can only happen if they are involved from the very beginning of the process of planning the programmes.

- **Planning is a Dynamic Process**

Planning is a dynamic process. When you think of planning a primary health care programme, you are expected to adopt a holistic approach. Which means health is not only dependent on provision of good hospital based services or accessibility of primary health care services. There are many other factors which influence and promote health such as agriculture, environment and healthy social practices. When you take into consideration the above and many other factors, you could clearly see the dynamics in planning. It is, therefore, obvious that health planning cannot be done in isolation but many relevant factors need to be looked into more carefully.

Check Your Progress 1

Note: (i) Space is given below for you answer

(ii) Check your answer with the ones given at the end of this unit

1. Define Planning

....

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2. Match the following

I.	Dynamic Process	Looking into the future
II.	Thinking Process	Information system
III.	Decision Taking Process	Holistic approach

10.3 THE PROCESS OF PLANNING

The process of planning essentially deals with some of the steps to be followed. Though these steps are systematic and sequential they are just the guidelines for effective planning. We shall discuss some of the important steps in the ensuing part of this unit.

10.3.1 Selection of Target Area and Population

Needless to say that when we plan for a rural health care programme, we should be clear about the target community residing in a definite geographical area. While selecting the target community the following factors are to be considered:

1. **Non availability of Health Care Services**

As you know, in India, there are still large rural and tribal areas devoid of the basic health care facilities. Instead of initiating community based health care programmes in such grossly neglected areas, efforts are being duplicated in areas where availability is a non-issue. This is because the factors influencing selection of target community are self-centered rather than community oriented. For example, the NGO chief initiating the health care programme may belong to that area or the donor agency may want to select an area strictly on the basis of its easy proximity to airport or railway station. Though consideration of such factors may be necessary, they may over ride on the most crucial factor i.e., the non-availability of basic health care services. The area where health care services have not yet reached should find favour in the choice of selecting a target area and community.

2. **Inaccessibility of Health Care Services**

India has a large network of providing basic health care services, especially, through Primary Health Centers (PHCs). Though the services provided through such networks are inadequate, they do not reach the people particularly the poor, for whom it is meant. There are many factors affecting the accessibility issue. The most crucial ones are (i) the distance between the health care centres and the community, (ii) denial of services to the poor as they are not able to meet the undesirable demand of the staff at the PHC to pay for the health services and (iii) political influences which favour the rich and the powerful to avail even the minimum health care services available at the PHCs and other public health care delivery networks. Therefore, while selecting a target community in a particular area, utmost care must be taken to choose communities which suffer from denial of basic health care services despite their persistent requests and demands.

10.3.2 Community Diagnosis

Often well conceived and carefully planned health care programmes fail even before they take off because of viewing health problems in isolation from other critical issues largely influencing the lives of the people. Therefore, having identified the potential community, for health care interventions, it is inevitable to analyze the community, particularly its structures and functions. For scientific diagnosis of a community what is of immediate importance is to identify the type of information to be gathered. This is imminent because the choice of information will determine the outcome of our analysis. Following are some of the suggestive information to be collected for community diagnosis.

Table 1. Information to be collected for community diagnosis

Broad Category/Segment	Suggestive list of information
Demography Profile	Population, births, deaths, age groups, sex and education
Livelihood Systems	Household income, occupation, availability of food, facilities for education, health, communication and avenues for rural marketing etc.
Social Structure	Caste system, family composition and migration pattern.
Economic Structure	Ownership and distribution of land and other productive assets, cropping pattern, irrigation system, wage pattern, credit systems, marketing structures and labour system.
Political Structure	Domination of party politics, role of Panchayati Raj Institution, institutional mechanisms for resolving community conflicts, disputes and promoting human rights and gender equality.
Health Profile	Causes and consequences of common diseases, prevalence and distribution of diseases, major causes of deaths, particularly of children and mothers, traditional health care practices, availability and accessibility of health care services etc.

Please note that the type of information to be collected under each major category is not independent of each others and therefore, some of the items may fall under more than one major segment mentioned above.

The result of analyzing the target community with the help of certain information such as mentioned above is the broad understanding of some of the major problems, their causes and the major victims of such problems. This analysis will also help you to see the inter relatedness of the existing problems, for example poverty and diarrhoea. Let us consider this diagram

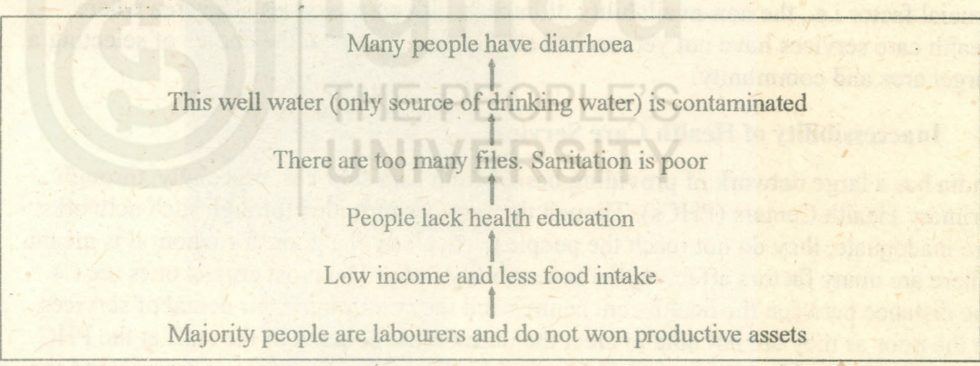

Fig: 1 Interrelationship between poverty and disease

From this diagram, we understand the link between the inability to own productive assets leading to poverty and diarrhoea. Even if the well water is contaminated, if the people have the health education i.e. to boil the water before drinking, they may not suffer so much from diarrhoea. But what if people have health education and not have the money to buy fuel to boil the water? This question explains the link between poverty and diarrhoea. This link we are able to estabilsh only if we do a thorough community diagnosis. While analyzing the community ensure that the analysis is done with full participation of the community.

10.3.3 Identification and Prioritization of Health Problems

From the analysis of the community, we will discover many health problems faced by that community. But we may not be able to deal with all the problems simultaneously. Moreover, when we start a health care programmes in a community, it is better to deal with one programme so that maximum input is given to achieve the desired results. It may be easy to identity many health problems, but it may be used for prioritizing the problem:

Gather some of the important persons of the selected community. Ensure that this includes the village dais, the traditional practitioners and those who have some knowledge about the health problems.

2. Ask them to list all the health problems identified from the community diagnosis. Put them on a board/flip chart paper (if the people gathered there are illiterates draw pictures). For example, let us assume the following are the major health problems in that community:
   - Diarrhoea
   - Malaria
   - Tuberculosis
   - Scabies
   - Leprosy

3. Display and explain the following format drawn on the board/flip chart:

SI. No.	Problem	How Serious?	How wide-Spread?	How Important to community?	How suitable joint community action possible?	Can community pay for minimum services?	Total Score	Rank
1.	Diarrhoea							
2.	Malaria							
3.	Tuberculo sis							
4.	Scabies							
5.	Leprosy							

Score: 3=maximum, 2=medium, 1-minimum

How Serious:
Do these diseases cause death often?
Do these diseases lead to loss of family income, high expenditure on health etc.?
How Widespread:
Do that diseases affect the entire community? How Important to Community?
Do all the people in the community perceive them to be serious problems?
How suitable joint action possible:
Have people already taken some initiative to address these problems?
Can the Community pay for the minimum services:
Will people pay for minimum services? Do they have the capacity to pay?

4. Ask them to give their score (collective). Let up take the following illustrative example.

SI. No.	Problem	How Serious?	How wide-Spread?	How Important to community?	How suitable joint Community Action Possible?	Can community pay for minimum services?	Total Score	Rank
1.	Diarrhoea	3	3	3	2	1	12	II
2.	Malaria	2	3	3	1	1	10	III
3.	Tuberculo sis	3	3	3	3	2	14	I
4.	Scabies	2	2	1	1	2	8	IV
5.	Leprosy	2	1	1	1	1	6	V

Note: You can also ask each individual to give her/his score and finally take only the rank for computation. For example, if there are ten persons present find out which disease is considered as rank I by maximum persons.

10.3.4 Problem Analysis

The next step in project planning is analyzing the identified problem in more detail. While analyzing the problem what is normally attempted is to identify all the critical factors contributing to the problem. These factors can be broadly categorized into three. They are:

- Disease related factors
- Service (health care) related factors
- Socio-cultural, political and economic factors

The following table presents a set of information, for each category of factors, may be used to understand the seriousness of the problem, in our case, tuberculosis.

Table2: Suggestive list of information to be used for analyzing TB as a major health problem:

Sl. No.	Set of Factors	Information to be considered
1.	Disease Related	Causes, early signs, symptoms, response to treatment and causing death and how frequently.
2.	Service Related	Nearest health center, availability of drugs, travel cost, attitude of the staff towards the patients, quality of guidance given by the staff, intensity of supervision, monitoring and follow up, quality of drugs, availability of adequate staff at the health centre and frequency of default.
3.	Socio-cultural and economic factors	Availability of alternative treatment, traditional beliefs, customs and practices, people's perception on causes and consequences of TB, paying capacity for treatment, people's knowledge on the need for treatment, methods of storing drugs at home, nexus between the staff of health centre and the power group in the community.

10.3.5 Goal Setting

A project without a goal is like a ship sailing without knowing its destiny and direction. Therefore, it is very important to set the goal while planning for a rural health care programme.

Goal can be described as a comprehensive statement of the task to be performed in relation to a problem and stated in a manner that can be measured or quantified. In other words goal must be:

S= Specific, M=Measurable, A= Achievable/Agreed upon, R= Realistic, T=Time bound

Let us consider the following goal statement in case of a TB programme:

Reduction of TB cases by 40 percent within a period of 3 years in 15 villages of Chandrapur Block of Ganjam district, Orissa

As you may see, this goal statement is specific, measurable, achievable/agreed upon, realistic and time specific. It is also to be noted that goal is the long term one.

Effective goal setting is crucial for project planning as it develops a common vision that gives members of the health team a sense of direction and ownership.

10.3.6 Setting Objectives

When a goal which is to be achieved over a long term is broken into short-term achievable tasks, it becomes objectives. For example, you want to travel from Delhi to Chennai by train. In this case, your goal is to reach Chennai. While traveling you have to cross many important stations, such as Gwalior, Bhopal, Vishakhapatnam etc. Reaching these stations or milestones are the objectives. Similarly in the case of a TB programme which we have been using as an illustration, the following statements can be considered as objectives.

- Examining every member (or the suspected cases) of all the households in the selected villages for TB in the next six months.
- Linking every positive cases with the near by health centre within the next eight months for treatment with adequate follow up measures.
- Enabling every TB patients (and their family members) to realize the importance of uninterrupted intake of drugs for TB treatment within next six months.
- Ensure food security (at least two meals a day) to all the poor households in the selected villages within next 12 months. (Please note that though achievement of this objective is difficult, yet it is desirable because TB is a poverty disease and poverty is largely linked to the capacity to produce or buy food commodities.,

As you may see these objectives are also specific, measurable, achievable, agreed upon, realistic and time bound. Objectives also tell us that unless they are achieved, the goal cannot be reached. The following statements can be used to understand more clearly the meaning of an objective.

An objective is a specific aim to be achieved in the short range which leads us towards the goal.

OR

"An objective is the intended result of a successful programme or activity"

Setting clear objectives is important primarily for two reasons viz., (i) to draw a definite plan of action and (ii) to evaluate the results with validity. This function of setting objectives leads us to the next step in project planning i.e., activity planning.

10.3.7 Activity Planning

Activities are the means or the inputs to achieve the end results (objectives and goals). Therefore, planning for activities assumes significant importance in project planning. For a clear and precise activity planning, the following steps may be used:

1. Recall and internalize the goals and objectives.
2. Identify the major activities to be implemented.
3. Put the activities in a logical sequence.
4. Estimate time (minimum and maximum) for the accomplishment of each and every activity.

For more details of an activity planning please recall all you have already learnt in Block 3 RDD3.

In case of TB programme we may consider the following activities given in a sequence with a suggestive time frame.

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Table-3. Activity plan for a TB control programme

Sl. No.	Activity	Duration
1. Pre Project Phase	Preparation of project proposal Submission of project proposal and receipt of project sanction letter from the funding agency.	2 months 4 months
2. Project phase	Selection and appointment and training of staff, including community health workers. Purchase of equipments vehicles (if any) and other materials required for the project. Establishing an MOU/gentlemen agreement between the project holder, community and the near by health center. Initial awareness programme for the community on TB (causes) consequences and treatment pattern. Examination of the target population for TB. Linking every +ve cases with the nearby health centre for treatment. Establish programme activities to ensure food security to every poor household.	3 months can be done simultaneously 3 months 1 months 3 months 3 months 1 months 6 months
3. Post Project Phase	Project Evaluation	3 months

Note:

(i) Monitoring is an important activity. Since it is an ongoing activity at regular intervals, it cannot be allotted a separate time duration. This activity will start of the project itself (implementation).

(ii) It is only a hypothetical estimation. Normally, the time duration depends on the area of coverage, number of households in every village, the distance between each village and the number of staff available.

Check Your Progress 2

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. Mention the factors to be considered while selecting a target area/population

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2. List the type of information to be collected for analyzing livelihood systems

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3. Explain goal

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4. Mention the steps involved in activity planning

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10.3.8 Project Designing

Project designing basically deals with the process and structure of implementation, monitoring and evaluation. While planning, it is therefore, useful to design the strategy for project implementation, monitoring and evaluation. Since these are essentially the functions of management we, shall discuss them in detail in the next unit on Management of Rural Health Care Programmes.

10.3.9 Cost Estimation (Budget Preparation)

It can be said that a project without adequate and assured financial support is like a body without a soul or vice versa. At the same time it is also important to know whether the finance required is realistic or not. A realistic picture of a financial requirement will emerge only if we know how to plan the cost of the project.

Normally, the budget estimate is divided into two categories viz. (i) capital cost (non recurring) and (ii) recurring expenses. This capital includes the cost of fixed assets such as land, building, equipments, furnitures and vehicles. The items to be included under recurring expenditures are salary, honorarium, travel allowance, food expenses, hiring charges, printing and stationary, and any other miscellaneous expenses to be incurred towards administration of the project at regular intervals. The following budget estimate is given as an example:

Table 4: Budget Estimate for 3 Years (1991-2001)

Expenditure	Cost & Expected Source (rs.)		Total (Rs)
	Local Contribution	Donor Agency	
A.Capital (Non-recurring)			
1. Land	1,50,000.00	-	1,50,000.00
2. Building	4,00,000.00	-	4,00,000.00
3. Lab. Equipments		40, 000.00	40,000.00
4. Vehicle		4,00,000.00	4,00,000.00
5. Computers(1)		50,000.00	50,000.00
6. Furniture and fittings		30,000.00	30,000.00
Sub Total (A)	5,50,000.00	5,20,000.00	10,70,000.00

Expenditure	Cost & Expected Source (rs.)		Total (Rs)
	Local Contribution	Donor Agency	
B. **Recurring**			
1. Honorarium to Director @ Rs. 5,000 per month (5,000 X 1 X36)		1,80,000.00	1,80,000.00
2. Salary to 1 Project Coordinator @ Rs. 3,000 per month (3,000X36)		1,08,000.00	1,08,000.00

Expenditure	Cost & Expected Source (rs.)		Total (Rs)
	Local Contribution	Donor Agency	
3. Honorarium to 5 Village Health Workers @ Rs. 1,000 per month (1,000X5X36)		1,80,000.00	1,80,000.00
4. Salary to 1 driver @ Rs. 2,000 per month (2,000X1X36)		72,000.00	72,000.00
5. Salary to 1 office assistance @ Rs. 2,000 per month (2,000X1X36)		72,000.00	72,000.00
6. Lab Technician @ Rs. 2,000 [rt ,pmyj (2,000X1X36)		72,000.00	72,000.00
7. TA to Director @ Rs. 2,000 per month (2,000X1X36)		72,000.00	72,000.00
8. TA to Project Coordinator @ Rs. 1,000 per month (1,000X36)		36,000.00	36,000.00
9. TA to Village Health Wrokers @ Rs. 200 per month (200X5X36)		36,000.00	36,000.00
10. Training Programmes per year for health workers @ Rs.8,000 per programme (8,000X4X3)		96,000.00	96,000.00
11. Honorarium to resource persons @ Rs. !0,000 per year(10,000.0X3)		30,000.00	30,000.00
12. Training materials @ Rs. 10,000 per year (10,000X3)		30,000.00	30,000.00
13. Telephone @ Rs. 2,000 per month (2,000X36)		72,000.00	72,000.00
14. Printing/photocopy @ Rs. 2,000 per month (2,000X36)		72,000.00	72,000.00
15. Postage & stationary @ Rs. 2,000 per month (2,000X36)		72,000.00	72,000.00
16. Fuel & maintenance @ Rs. 5,000 per month (5,000 per month (5,000X36)		1,80,000,00	1,80,000.00

Expenditure		Cost & Expected Source (Rs.)		Total (Rs.)
		Local Contribution	Donor Agency	
17	Water, electricity and building maintenance @ Rs. 1,000 per month (1,000X36)	36,000.00		36,000.00
Sub Total (B)		36,000.00	14,16,000.00	14,52,000.00
Total (A+B)		5,50.000.00	19,36,000.00	25,22,000.00
Local Contribution		5,86.000.00		
Grant Requested from Donor Agency		19,36,000.00		

10.3.10 Preparation of Project Proposal

One of the important functions of project planning is preparation of a project proposal. As you know, unless we put the whole plan in the form of a project document, others may not know that we are planning to do. Moreover, in order to seek financial assistance from donor agencies, we need to develop a clear and precise proposal. Preparation of a good project proposal is an important managerial skill which everyone involved in project planning and management ought to possess.

Different organization use different formats/styles for preparing a project proposal. Some donor agencies have their own prescribed formats and they will not entertain the proposal if it does not conform to their format. Therefore, it is useful to check with the funding agency before sending the proposal. However, there are some common elements to be included in any project proposal. We may consider the following guidelines.

Sl. No.	Common Items	Key Features
1.	Title of the Project	Should be short and precise.Should convey the essence of the proposal
2.	Name of the Project Holder	This could either be an individual (head of the organization or a group of individuals (board of Governors, Trustees, etc.
3.	Name of the Legal Holder	Same as above.
4.	Name of the Project Implementing Agency	Name with correct address and other communication information such as telephone, fax, email etc.
5.	Brief Description of the Project Implementation Agency.	This is nothing but the brief profile of the organization. This includes the following: • Name and address, name of contact person, registration number, FCRA number. • Area of operation-villages, block and district. • Vision and Mission. • Organizational structure. • Main activities- past and present • List of Donor Agencies associated with the agency. • Evaluation of any programme. • Resources available-human, material, and financial. • Publication, research, documentation. • Annual auditor's report. • This profile can be given at appendix too.

6.	Profile of the Target Area or the Proposed Area of Operation.	Location-villages, block, district, and state. Geo-physical, condition-physical setting, rainfall, nature of soil, type of natural resources available and the climate and seasonal variations.Demographic profile.Social characteristics-caste, system, education pattern, health status, cultural beliefs, customs and practices, social organizations and institutions, leadership pattern and voting pattern. Economic conditions- ownership and distribution of productive assets, income distribution, food production, distribution and consumption, wage pattern, credit pattern, marketing structures and avenues and recent changes in the structure of economy if any.
7.	Problem Analysis	Mention that the problem identified is a serious threat to the lives of the people if it is not addressed. Also mention which group of the community is affected most and the justification.
8.	Goals and Objectives	See section 10.3.6.
9.	Activities	Mention them in a sequence along with the implementation schedule.
10.	Implementation Strategy	Mention them in a sequence along with the implementation schedule.
11.	Expected Results	Mention the strategy at all levels i.e., from the village, block and district depending on the coverage and indicate the role of different committees and the key persons and design for monitoring.
12.	Evaluation	A brief plan for evaluation indicating who will evaluate and when.
13.	Reporting and Documentation	Reporting at what intervals and to whom. Methods of documentation and publication if any.
14.	Budget	A detailed year wise budget indicating the local contribution and the expected contribution from the donor agency.
15.	Sustainability	Steps to be taken to sustain the project after the project period is over. What is important to mention here is the financial viability and the community ownership of the project.

Activity 1

Prepare a project proposal for starting a community based TB control programme.

10.4 PARTICIPATIVE PLANNING WITH COMMUNITY

In this chapter we want to focus on how the community can be involved in planning a Rural Health Programme. The success of any community-based programme depend on the extent of community involvement. This leads us to a question as to why the community should be involved in planning.

10.4.1 The Advantages

The advantages of involving community in planning are many. However, we shall consider the following:

1. Relevant Planning

Involvement of the community will make the planning relevant to local needs, the environment and working conditions. We always plan keeping in mind a particular context or a community.

2. Building up the community:

If you plan with community you help them to think, analyze, to forecast and look ahead of time and develop strategy for the future. This is another process of empowering the community and preparing them to take charge of their lives. This is also another step leading towards sustainability.

3. Community ownership

The best way to help the community to own the project is through community participation. When they sit to plan a programme with you, they not only get involved mentally but also start getting attached to the particular project/programme at a very personal level.

4. It helps in programme implementation

No programme can be implemented without the help of the community. Most of the programmes fail at the implementation stage as there is no participation of the community. It is most likely that a community will take active part in the implementation of a programme, if it has from the beginning participated in planning and understood its implications and benefits.

10.4.2 How to Involve Community in Planning

1. Forming focus groups.

Depending on what you are going to plan you may form focus groups. If you are going to plan a programme on increasing agriculture production, you may form a group of interested farmers. If you are planning a programme on safe motherhood, you can invite village Dai, elderly women and mothers to form a group to discuss on various related aspects of safe motherhood.

2. Participating in village meetings.

In the village both formal and non formal meetings may take place. Even after obtaining prior permission of the village panchayat, you can participate in their meetings and through them plan certain activities. Generally in the evenings people sit in groups either under a tree or in a community hall or in a temple. Sensitively you may use this opportunity to involve them in an informal manner in planning certain activities.

10.4.3 Bhandardara Experience (a Case Study)

Bhandardara is situated in District Ahmednagar in the State of Maharashtra. It is a tribal area situated in the most interior part which becomes inaccessible during monsoon. Majority of the people are economically very poor and die of many avoidable health problems.

The beginning of a comprehensive rural health and development project in this area is unique and interesting. The village Health Workers of Jamkhed district (comprehansive Rural Health Project, (CRHP) Ahmednager of Maharashtra were introduced to the needs and problems of people who live in Bhandardara area. These village Health Workers visited the place and decided to initiate and start a project to improve health and promote development. Here is a practical demonstration of community initiation and community participation in planning.

a) The VHW's of Jamkhed went to Bhandardara and with the help of project team identified the major problems. They lived in the houses of villages, participated in their life and sat with them at a time convenient to them and looked at the problems from their perspective.

b) After the health problems were identified the community at Bhandardara was involved in planning a strategy to deal with the problems. For example, a number of children were suffering from scabies. With the active participation of the community, through home remedy (using Neem Leave) within few months the community was able to control the scabies.

c) Potential Village Health Workers were selected and supported by their respective communities. The ongoing training of these Village Health Workers was planned by the community itself with the help and guidance of the project staff.

As a result of community involvement in planning and implementation, the programmes launched were very successful. Within three years the following impact of the programme became visible.

a) Community got organized. Many formal and informal active groups of women and men were formed.

b) The scabies, which was very common, was to a great extent eradicated.

c) Villagers selected one Village Health Worker from each village who was trained.

d) Infant and maternal mortality rate come down drastically.

e) Through cooperative/income generation programme financial position of many families improved.

f) After the earthquake in Latur area, many villagers from Bhandardara area extended personal help to the needy by visiting the earthquake affected area.

Check Your Progress 3

Note: (i) Space is given below for you answer.

(ii) Check the answer with the one given at the end of this Unit.

1. What are the advantages of participative planning.

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10.5 LET US SUM UP

In this unit, first we have discussed the meaning and characteristics of planning. Some of the features of planning we have explained are: (I) situational analysis, (ii) planning is a thinking process, (iii) planning is a decision making process and (iv) planning is a dynamic process. The second section of this unit is the process of planning. The process of planning involves ten major steps. All the steps are necessary steps in planning. While it is important to know these steps, it is also useful to know the sequences of these steps. Remember that without setting goals and objectives, we cannot plan for a rural health care programme. Preparing a project proposal is an important skill every person involved in planning and managing a rural health care programme should possess. However, this skill you can acquire only through practice. We have given some of the factors which are to be considered while preparing a project proposal. Using these common factors, you may prepare a model project proposal.

In the last section of this unit, we have explained why participative planning with the community is important. This we have discussed mainly because of the fact that only when the community begins to deal with their health problems they can improve their health status. As we have already mentioned in this section, the key to community participation is organization of women and men groups and enabling them to realize that community health is a process of community experiment and development. The Bhandaradora example is just one example. We hope, persons like you will learn from such examples and initiate similar models in your respective areas.

10.6 KEY WORDS

Livelihood System:	Refers to a set of factors considered to be inevitable for the survival and sustenance of the people.
Focus groups:	Group consists of members who have similar interests. For example, while planning a programme on increasing agricultural production, the focus group for this programme is the farmers and those involved in agricultural production.

10.7 Suggested Readings

Arole, Raj and Mabelle, A (1998), Jankhed: Comprehensive Rural Health Programme.

Chandra, Prasanna, (1988), *Project, Preparation*, Appraisal, Budgeting and Inplemenfation, New Delhi, Tata Mc Graw Hill.

Lankenster, Ted. (1992), *A setting up community Health Programme*: A practical mannual for use in development countries, london, Maemillan.

McMahon, Rosemary, Elizabeth, B and Manrice, P (1992), On Being In charge: A Guide to Mangement in Primary Health Care, Geneva WHO.

10.8 MODEL ANSWERS

Check Your Progress 1

1. Planning can be defined as an important function of management dealing mainly with decisions about objectives, activities and resources by systematically considering what, which, where, when, how much, and how the health team will perform.
2. (i) Dynamic Process - Holistic approval

   (ii) Thinking Process - Looking into the future

   (iii) Decision Taking Process- Information system

Check Your Progress 2

1. (i) Non availability of health care services

   (ii) Inaccessibility of health care services
2. Household income, occupation, availability of food, facilities for education, health, communication and avenues for rural marketing etc.
3. Goal can be described as a comprehensive statement of the task to be perfomred in relation to a problem and stated in a manner that can be measured or quantified. In other worlds goal must be:

   S=Specific

   M=Measurable

   A=Achievable/Agreed upon

   R=Realistic

   T=Time bound
4. The steps involved in activity planning are:

   I. Recall and internalize the goals and objectives

   II. Identify the major activities to tbe implemented

   III. Put the activities in a logical sequence

   IV. Estimate time for the accomplishment of every activity.

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Check Your Progress 3

1. (i) Relevant Planning

   (ii) Building up the community

   (iii) Community ownership

   (iv) Smooth programme implementation

   (v) Formation of focus groups

UNIT 11 MANAGEMENT OF RURAL HEALTH CARE SERVICES

Contents

11.0 Aims and Objectives
11.1 Introduction
11.2 Management: Concepts and Principles
11.3 Implementation of Rural Health Care Programmes
11.4 Health Information System
11.5 Monitoring and Evaluation of Rural Health Care Programmes
11.6 Let Us Sum Up
11.7 Key Words
11.8 Suggested Readings
11.9 Model Answers

11.0 AIMS AND OBJECTIVES

In the previous unit, you have learnt the process of planning a rural health programme. When a well-planned programme is implemented, the health of the community will not improve if it is not managed efficiently. Therefore, management of rural health care programmes assumes importance. After reading this unit, you will be able to:

- Understand the concepts and principles of management
- Take appropriate measures to implement a programme more efficiently
- Identify and maintain an appropriate information system for a rural health care programme
- Monitor and evaluate rural health care programmes

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11.1 INTRODUCTION

The principles of management are increasingly being applied to every sector of development and it can be seen more in the case of health sector. Planning, monitoring and evaluation are some of the important principles of management. While we attempt to learn the importance of applying these principles, we must also remember the fact that their application in health sector is not entirely the prerogative of the planners and the managers alone. What is advocated strongly in this unit is that the people who are the recipients of the health care services are also capable of participating in the process of managing a health care programme. This is important because without people's participation no programme can be implemented effectively to address the health issues confronting the rural communities.

In the previous unit we have already discussed the process and importance of planning a health care programme. In this unit, we are going to address three other important functions of management i.e. implementation, monitoring and evaluation. At the same time we will also learn that these functions can become more effective only if there is a sound information system. What we need to learn more in this unit is the necessary steps to be taken to implement, monitor and evaluate a programme. Let us begin this unit by understanding the concepts and principles of management.

11.2 MANAGEMENT: CONCEPTS AND PRINCIPLES

There is no universally acceptable definition of management, yet we find that management science has universal application in all the sectors of development. However, the need for defining management has not been undermined as every sector has defined this term without losing the common elements of management. In Block 3,

Unit '1 of RDD. 3 you must have already learnt the meaning of management. Yet we are going to give a synoptic view of the same in this unit too. However, it may be useful if you read that unit before you further read this unit.

11.2.1 Concept of Management

The definitions of management are many. While perusing these definitions we find that some of them contain the key elements of management. We shall consider the following one for our understanding on the concept of management.

Management is a creative and dynamic process, which facilitates the members of a team to achieve what is intended to be achieved in a specific duration with optimum utilization of the available resources. As you may see there are five elements in this definition. We shall discuss them one by one.

1. **Dynamic and a facilitating process:** First of all management is a dynamic process which takes place over a period of time. It is creative and flexible because the members of the management team enjoy freedom to think and take appropriate means to achieve the end results. It is dynamic because what is creative today becomes redundant as members invent or discover new and better ways of achieving the goals.
2. **Team:** Management is a process in which people are involved. People are the most valuable resources in an organisation. People do not work in isolation. They work as a team. In a team every member is important, as she/he possess a particular skill which others don't. The team cannot function if one member of a team does not function or cooperate. Management as a process facilitates teamwork and cooperation.
3. **Achieving what is intended to achieve:** Management as a process has gained importance mainly because it enables the members to achieve what they wanted to achieve. This happens because the members of the team set achievable targets and they have evolved appropriate means to achieve them. As a result every member of the team is aware of the target to be achieved and how to achieve them. In this process each one also knows what her/his role is. Thus management as a process enables the members not only to set targets but also to evolve appropriate means to achieve them.
4. **Specific time duration:** Achieving a set target becomes a laudable event only when it is done with in a specific time frame. This is more important in the case of health sector as improving the health status of the suffering population cannot wait for a long time.
5. **Optimum utilization of available resources:** At times we may not have sufficient resources to implement a health care programme and we may be forced to achieve the target with the available resources. Optimum use implies making best use of the available resources. In management process this occupies a distinct position as the efficiency of the project is measured in terms of input-output ratio. Careful and efficient use of resources assumes importance for two reasons. First of all; the resources are scarce and secondly, it helps the organisation to save and use the resources for some other purpose for which either little resource or no resource is available. An efficient project manager will attach high priority to optimum utilization of available resources.

These are some of the common elements you will find in most of the definitions. However, as a creative manager you may add more elements to enrich your knowledge on management. The concept of management will become clearer if we understand some of the key principles of management.

11.2.2 Principles of Management

As in the case of definition of management, there is no commonly agreed view on the principles of management. However, we shall consider the following principles.

1. **Commitment to advancement:** It is easy to set goals and objectives. But, in the absence of commitment on the part of the team members, especially of the leaders, it is difficult to achieve what we wanted to achieve. The call for commitment is

more genuine and justifiable in the field of health as health is concerned with the life and death of people. Unfortunately those who profess management pay less regard for commitment and there is a growing perception among them that commitment is meant for missionaries and not foe managers. This is a wrong perception because there are well qualified and trained medical professionals who have committed their lives for promoting the health and well being of the poor. One such example is Dr. R.S. Arole (and late Dr. (Mrs) Mabelle Arole) who is spearheading a health movement in the rural villages of Maharashtra. We shall learn more about them in the next unit. Commitment is a call to accomplish the purpose for which one is called and if it is coupled with professionalism, achievement will become an enduring hallmark of every health care project.

2. **People are the potential partners:** As professionals managing a health care programme, what perception do we have on the people, particularly the poor. Often, our perception of the people is coloured by qualifications, positions and power. In our strive towards efficiency and achieving better results we tend to forget people and attach importance to managing materials and money. We tend to treat people as dependants and recipients of health care services. We do not consider them as persons who can participate in the process of programme planning and management. This perception has to change. We must also believe that the success of the programme essentially depends on the degree of freedom people have to take decisions which will improve their health status. It calls for respecting their traditional knowledge/wisdom, skills and practices.

3. **Getting things done through people:** This principle is closely related to the previous one. If people are accepted as potential partners they can effectively participate in the process of health development. Their knowledge and skills can be used to achieve the desired objectives. Their existing knowledge and skills can be enhanced to undertake programme activities. Once people begin to participate as equal partners, they will begin to own the programme and they will take necessary steps to initiate further measures till the goal is achieved. People have the capacity and if their capacity is adequately and effectively harnessed the success of the health care programme can be more rewarding.

4. **Team work:** Provision of health care being a complex process it involves multi disciplinary efforts. It calls for a team whose members apply different skills to achieve a common goal. In a team the role and contribution of each member is important. Every health team dealing with the health of the community must recognize the role of community health workers whose role is inevitable for the promotion of health. In team work, the role of team leader is important as he/she is expected to keep the members of the teams as a single and unified unit.

5. **Convergence of efforts:** As Members of a team each member may be actively involved in applying his/her specialised skills. But if it is done by each member without knowing the common or convergent point, the goal of the programme cannot be achieved. For this, it is important that different activities converge at a common point. This is possible only if each member of the team is aware of the common goal and each one knows how his/her role is interrelated. Here, again the role of the team leader in facilitating the process is important.

6. **Efficient use of available resources:** The health team may have resources, though limited. But if they do not know how to use them efficiently, the goal of the health care programme cannot be reached. The types of resources included in a health care programme are (I) manpower (human resources), (ii) materials and (iii) money. Often, we give priority to the use of material and money and we seldom realise the fact that people (staff) are the most potent resources. Efficient use of resources includes: (I) using the resources for the purpose it is meant at a time when it is most needed, (ii) use of resources on priority basis when the resources are scarce, (iii) shared involvement with common purpose and (iv) avoidance of duplication of efforts.

7. **Learning from experiences:** Before initiating a comprehensive health care programme, it is useful to study the past efforts either in the same area or elsewhere as this would help the health team to learn the factors responsible for both the success and failure. This in turn will help the team for formulating appropriate and cost-effective health care plans. Duplication and/or multiplication

of efforts in same area can be avoided. While it is important to learn from other's experiences it is also equally important to learn from one's own experiences and take corrective measures accordingly.

8. **Shared Responsibility:** For achieving the desired goals sharing the responsibility at all levels is important. It does not only mean delegating duties to the staff down the line, rather it means delegation and sharing of power so that the persons responsible at different level of a health care delivery system can take appropriate decisions and actions without delay. Sharing of responsibility also means evolving mutual trust and respect. It also means honouring the decisions taken and owning the responsibility for the consequences.

Check Your Progress 1

Note: (I) Space is given below for your answer.

(ii) Check your answer with the ones given at the end of this unit

1. Mention the key elements of management

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2. People are the potential partners in managing a health care programme. Explain

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11.3 IMPLEMENTATION OF RURAL HEALTH CARE PROGRAMMES

Success of a well-planned programme can be assessed only when it is implemented. It is at the implementation stage every planned programme is put to test. It is at this stage the entire team is put into operation and all the members of the team begin to feel their strengths and limitations both as individuals and as a team (group).

11.3.1 Concept of Implementation

Implementation is a process of executing or putting into practice a planned programme. The process of implementation primarily deals with four functions. They are (i) coordination of activities, (ii) deployment of personnel, (iii) allocation of resources and (iv) maintaining and processing of relevant information. We shall explain each function in detail in the subsequent part of this section.

11.3.2 Functions of Implementation

As we have seen above the process of implementation has four functions. Let us discuss coordination of activities first.

1. **Coordination of activities:** All of us are aware of the fact that implementation is nothing but the execution of the planned activities as activities form the backbone of any programme. In a programme, there are many activities to be implemented but the results of these activities cannot be achieved if they are not coordinated.

Coordination implies that the " the process of bringing the activities of different persons into relation with one another so as to achieve a common goal."

For example, one of the activities of MCH programme is immunisation. In order to carry out this activity on a particular date/ day, you need to check before hand how many children are to be immunised, the quality and availability of vaccines, the availability and preparedness of required staff and the records/ registers to enter the detailed information. While doing this, you are in a position to ensure the implementation of this activity on a date as per the plan. In doing so you are also coordinating the functions of all the staff involved in immunisation.

As result of this check, you are also revising and updating the activity schedule as needed and can communicate the decisions to all concerned.

2. **Deployment of personnel:** No activity can be implemented without deployment of the required personnel. In every plan, the requirement of manpower is mentioned. Deployment means (i) organising work, i.e. deciding who will do what and when and where, (ii) direction of personnel and (iii) supervision of personnel. Let us discuss briefly the meaning of each of the functions of deployment of personnel.

   i) **Organising work:** It means assigning specific tasks to each staff, setting procedures for holding staff meeting periodically to resolve issues of implementation and assisting the staff to perform their assigned tasks through in service training programmes.

   The tools used for facilitating this process are job description, duty roasters and operating procedures.

   ii) **Direction of personnel:** Assigning specific job without authority is meaningless. Everyone involved in the programme must be given some authority to undertake specific tasks as this will avoid duplication of efforts and claiming credit for the task performed by someoneelse and prevent avoidance of performing tasks. It also includes who will report to whom, the duration of control over staff and providing incentives to encourage participation and performance.

   iii) **Supervision of personnel:** Some of the important functions of supervision are (i) applying strictly the agreed work standards (ii) specifying procedures for appraisal of staff members, (iii) training need assessment of the staff and (iv) supporting staff in implementation of their tasks, team building and conflict resolution.

3. **Allocation of Resources:** Needless to state that without resources no programme can be implemented. The resources, apart from human resources include, finance, material and other infrastructures such as building, land etc. Allocation of such resources means ensuring availability, access, control over consumption and use, maintaining quality and inventory and disposal of the unwanted materials.

4. **Information Management:** Information is vital to health care programme. Not only does this help the health team to know the health status of the community, but also to plan for improving the health status. Some of the critical indicators of health, such as IMR, MMR, and rate of disease prevalence can be assessed only if we have proper information system. In the next section of this unit, we shall discuss in detail how to design a health information system.

Check Your Progress 2

Note: (I) Space is given below for your answer.

(ii) Check your answer with the ones given at the end of this unit.

1. Define implementation

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2. What is the difference between "coordination" and " organising work"?

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11.4 HEALTH INFORMATION SYSTEM (HIS): EVOLUTION, MEANING AND DESIGN

Information as a system is said to have emerged in 300 B.C. The clay tablets excavated at Summer in Mesopotamia are found to be having an inventory system with information on receipts made to individuals from a temple grain store. Though we do not have enough evidence to to prove how they used this information system, it can be argued that the evolution of information system began with food grains which is closely related to health. However, collection of information more directly related to health is said to have begun in 1250 B.C.

In Egypt during the period of king Rameses II, the system of recording births and deaths was introduced. The more authentic ways of recording the details of newly born within 30 days was first prevalent in 578-535 B C, in Rome. Similarly in A D 720 compulsory registration of live births, deaths and marriages were introduced in some parts of Japan. (Hand book of Vital Statistics Methods (1995), United Nations, New York).

In 1886 Registration Act for births, deaths and marriages were introduced in India, Burma and Pakistan. In 1965 International classification of diseases was introduced. Since then health information system has taken a revolutionary turn and in the recent past community based health information system has gained significant importance.

Recent developments in this field can be attributed to the declaration of Primary Health Care (PHC) at Alma At in 1978 and the role of Non-Governmental Organizations (NGOs) promoting PHC movement in various communities (rural, tribal, hill and urban) of the world. Since the advent of PHC a broader view on health information system accommodating factors beyond disease and medicine has emerged.

11.4.1 Meaning of Information

In order to understand the meaning of information, we must first understand the term data. Data is a set of isolated facts, figures, statistics, unrelated and uninterpreted. In other words, data is a collection of numbers, letters or symbols that can be processed, maintained or produced by an information system. Data becomes information when it is processed and placed in some context. Therefore, what then is information?

Information is the result of product or processing data. Information is an occurrence or a set of occurrences, which carry messages and when perceived by the recipients via any of the senses, increase their state of knowledge. Before we see an example each for data and information, let us understand some of the main characteristics or attributes of information.

- Based on facts, figures and statistics.
- Has a context.
- Conveys a message.
- Leads to knowledge, action and change.
- Considered an important resource.
- Perceived differently by different people in different situations.

11.4.2 Health Information System: Concepts

There are many definitions used to explain the meaning of health information system. We may perhaps consider the following definitions.

- "A mechanism for the collection. analysis and distribution (dissemination) of health statistical information required to enable health planners to assess priorities, and to assist them in deciding how to meet particular priority needs and finally to enable health administrators to measure their achievement" (WHO/EURO-(1971 Information Health Statistics, Third European conference).

- "A mechanism for the collection, processing, analysis and transmission of information required for organizing and operating health services, and also for research and training". (WHO/EURO, (1993) conference on Health Information System).

- "A health information system in the broadest sense may be defined as an organization that operates in the health care environment. It is composed of:

  (a) hardware, including transmission devices, (b) personnel, such as organizers, planners, designers, managers, programmers, operators and users, (c) software (Operating systems and application programmes), (d) organizational rules influencing human behavior and (e) health care information gained from patients ("WHO, (1984) Health planning and management glossary, SEARO Regional health (Papers, No. 2.).

Though these definitions are accepted by most of the institution based health practitioners, they neither adequately reflect people's participation in developing health information system nor suggest strong actions for change. Therefore, what is needed for us is to evolve an information system for health at the community level with active participation of the people.

11.4.3 Designing a Community Based Health Information System

The process of designing a community based health information system (CBHIS) has the following stages. They are:

- Identifying the areas on which information is needed
- Collection and maintenance of information
- Using the information for action and change

1. **Areas of information**

Identifying the areas of information would largely depend on the various stages at which information is needed. The following table presents the different stages of collecting information at one of the successful community health projects viz: Comprehensive Rural Health Care Project (CRHP).

Table 11.1: Information needed at various stages of a health care programme

Sl. No.	Stage	Participants	Main Activities	Information needed on
	(2)	(3)	(4)	(5)
1.	Pre Planning	CRHP Farmers' Club Mahila Mandal Mobile TeamVHWs	- Selecting villages - Identifying appropriate survey methods - Information gathering - Analysis and interpretation	- Demographic profile of village - Epidemiology of disease - Factors affecting health (disease related) - Socio economic, cultural and political factors. - Existing infrastructure and health care services.

2.	Action Planning	All of the above	- Prioritization of problems - Setting objectives - Evolving programme activities. - Staff selection and fixing targets - Finance mobilization - Schedules for implementation, monitoring and evaluation - Identifying proper reporting mechanism - Identifying other interested organization and networking	- In addition to all the information mentioned above, information regarding finance, profile of other organizations and staff are to be gathered.
3.	Action Implementation	- All of the above	- Carrying out all the activities as per the schedule. - Meeting the targets - Periodical (Monthly) assessment of activities accomplished. - Corrective measures. - Periodical training of VHWs,	- Target coverage. - New problems and issues - Financial statements. - Materials.
4.	Evaluation	- All of the above	- Setting objectives - Identifying indicators - Setting time limit.-Task assignment - Identifying sources and methods - Analysis and interpretation - Recommending suggestions for future action.	- All the objectives and the attendant indicators.
5.	Feed back and planning for the future	-	-	-

2. **Collection and maintenance of information**

While evolving a CBHIS it is important to decide who will collect what information and when. Normally, the main participants must be the health workers representing the community. It is also important to know the methods of collecting information. In the recent past participatory rural appraisal (PRA) or participatory rapid appraisal (PRA) methods are used to collect information. The use of such methods elicits active participation of the community not only in understanding their health problems but also to evolve appropriate action strategies to deal with them. Besides PRA the other commonly used methods are household and sample surveys, routine reporting of cases and deaths recorded at treatment centre, and epidemiological investigations of out breaks and surveillance (passive, active and sentinel).

In community based primary health care programmes, the requisite information is collected and maintained at various levels viz, family, Village Health Workers, community and the health centre (hospital or clinic). The following table gives some of the suggested information maintained at these levels.

Table 11. 2 Levels at which Information is maintained:

Sl. No.	Level *	Information Regarding **
(1)	(2)	(3)
1.	Family	- Growth monitoring and immunization. - Treatment schedule for chronic Illnesses such as T.B. Leprosy etc. - Thrift and savings account.
2.	Village Health Worker	- All of the above - ANC (Pregnant mothers) - Record of leprosy and T.B/patients. - Temporary family planning - Birth record. - Family income - Educational status - Nutritional status of mothers and children.
3.	Community (Farmer's Club, Mahila Mandals, Youth club etc.)	- Consolidated information of all the above kept in the community hall or temple, or church or school or but stand etc.
4.	Health Centre/Hospital/ clinic	- Programme wise or villagewise information on all the above. - Income and expenditure-Assets and their maintenance.-Staff training.

* Varies from project to project and country to country

** Some of the information formats used in CRHP are given in annexes (1-10) as model information system. They include:

1. Socio - economic profile of families: (Annexure 1)
2. Village health worker's daily report: (Annexure 2)
3. Antenatal Care (ANC) and treatment (Annexure 3)
4. Safe delivery and post Natal care(Annexure 4)
5. Villagewise care for eyes(Annexure 5)
6. Total detection of leprosy and T.B. patients (Annexure 6)
7. Villagewise Tuberculosis Detection List (Annexure 7)
8. Villagewise death registration list (Annexure 8)
9. Under five immunisation(Annexure 9)
10. Villagewise and consolidated information on health care services.(Annexure 10)

In order to understand the maintenance and feed back of health information system, we must understand first the flow chain. Since most of us are going to be involved in community based primary health care programmes, let us see how it is done at CRHP which has taken a lead in promoting community based primary health care programmes. The following diagram explains this.

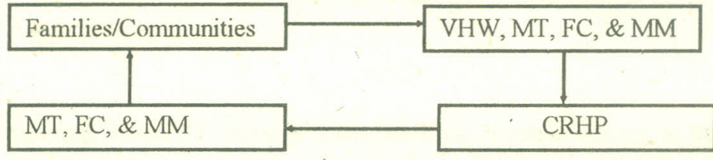

Fig. 1 Flow of health information at CRHP

MT= Mobile Team, FC= Farmers' Club, MM= Mahila Mandal, VHW = Village Health Worker

Similarly, maintenance of health information also depends on the different stages at which health information is gathered. With the increasing application of computer technology, it may be necessary, if possible, to use relevant software packages to store, process, analyse and maintain information. However, in rural and tribal areas, it is difficult to use computer technology due to erratic supply of electricity and other facilities required to maintain computers.

Check Your Progress 3

Note: (I) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. What is the difference between the first and the second definition of health information system?

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....

....

Activity 1

Out of the three given definitions which one would you prefer and why?

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Activity 2

Draw the flow of information system in a rural health care (community based) programme with which you are familiar or associated and explain the role of village health workers.

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11.4.4 Sources of Information

While information can be collected from the primary sources viz the people, the secondary source (information already existing with the other organizations, Farmers' Club etc.) could also be used.The primary health care programmes normally work better at community level, and therefore, it is essential for us to know the sources at the community level. However, it is also important for us to know the sources from which the health information at the national level is collected. The main sources of health information include (i) the census, (ii) registration of vital events, (iii) sample registration system, (iv) notification of infectious diseases, (v) records of hospitals and other institutions (vi) disease surveillance, (vii) health and morbidity surveys and (viii) national sample surveys.

1. **Census**

Human census conducted at regular intervals (in India once in every 10 years) provides population count on a specific date. It provides a lot of information on the population size and demographic profile including age and sex distribution. It also gives the socio-economic and cultural profile of people. Also publishes the directory of villages and towns giving their areas, population and amenities like drinking water and land use.

2. Registration of Vital Events

The vital events registered in most of the countries are births, deaths and marriages. In India, according to birth and death registration act 1873 (became a Central Act in 1969) deaths and births are to be compulsorily registered within 3 days and 7 days respectively. In India the Registration of births and deaths act, 1969 prescribes recording of causes of death in case of each registered death.

3. Sample Registration System (SRS)

In order to obtain more reliable and authentic information the Registrar General India, introduced SRS in 1964-65. The main objective of SRS is to provide reliable estimates of births and death rates at the state and national levels for urban and rural areas separately. It also provides various other measurers of fertility and mortality. The sample units in the rural areas is either a village (if the population is less than 2000, or a segment of village if population is 2000 or above).

A census enumeration block with an average population size of 750. The field investigation under SRS consist of continuous enumeration of births and deaths in a sample of village/urban blocks by a resident part time enumerator, and an independent six monthly retrospective survey by a full time supervisor. Data from these two sources are matched and the disparities/mismatches observed are verified. The enumerator sends monthly report in duplicate to the state headquarters, which are consolidated and sent to office of Registrar General (RG) India. Later, after the half -yearly survey is completed and data corrected, the final data are sent to RG's office.

4. Notification of Infectious Diseases

The central Bureau of Health Intelligence (CBHI) in the Directorate General of Health services, collects regularly data occurrence of principal diseases (about 20 in number) from all states and union territories of India.

5. Routine records at Hospitals and Other Health Institutions

In the absence of reliable and complete community based data on health situation institutional data routinely generated from the records of hospitals and other health institutions become valuable source of data on diseases prevalent in the community, Health seeking behavior of people, range and scope of services available in a community.

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6. Disease Surveillance

Surveillance means "close watch especially on suspected persons". In public health, it is understood in two ways. They are (i) continuous scrutiny of factors determining the occurrence and distribution of disease or other conditions of ill health and (ii) special reporting system which is set up for particularly important health problem. Disease surveillance helps us to:

- Assess priorities based on demonstrated morbidity and mortality.
- Plan control strategies.
- Monitor the progress in control programme towards achievement of disease reduction targets. Evaluate and suggest the need for any programme modifications.
- Assess the impact of the control measures against the diseases.

One of the methods of surveillance is sentinel surveillance. A hospital, health centre, laboratory etc. which attend to a large number of particular types of diseases which are under surveillance are considered as possible sentinel centres. Such institutions are selected and asked to provide the specific information on selected diseases. Normally, the following criteria are used to consider a centre as a sentinel center. The are:

- Large attendance of patients of a particular disease.
- Facilities for reasonably accurate diagnosis of disease.
- Facilities for good recording and reporting

- Non exclusion of certain type of people on the basis of cost of treatment or specialized treatment.
- Easy accessibility to people.
- Willingness to submit regular reports.

The organization of sentinel surveillance is at three levels. They are:

- Collection and forwarding information at the sentinel centre.
- Immediate and appropriate action taken on the received information at district/state level.
- Coordination at the central level.

(Determine the nature of data needed, devising forms, identifying sentinel centres, monitoring, evaluation and analysis of data and making planning and policy decisions).

7. **Health Sample Survey**

These are special and time bound arrangements for collection of data on different aspects of health problems, services and other related issues.

8. **National Sample Survey (NSS)**

NSS is a multi subject, integrated and continuous sample survey launched in 1950 for collection of data on various aspects of national economy required by different agencies of Government. It included house holds surveys on socio-economic areas such as land, agriculture, birth, death, fertility, family planning, morbidity, and housing conditions etc. Each survey extends over a period of a few months or a year and is termed a round. The data collection is carried out by a team of permanent whole time and well trained investigators who use personal interview schedule for obtaining data from the household members.

These are some of the sources from which the health information at the national level is generated and maintained. Though these are meant for national level information system, some of them can also be used at the community level. For instance disease surveillance can be used at the community level to generate more accurate information on certain disease,which need to be controlled within a particular time period.

11.4.5 Uses of Health Information System

Needless to say that the HIS helps us in many ways. The HIS helps us to:

- Assess the progress and achievement in health development
- Evaluate the impact of health services / health programmes on the community
- Identify the factors that are unfavorable for the successful implementation of the programmes.
- Identify the extent of people's participation.
- Assess the extent of requisite international coordination.
- Take corrective measures to achieve the targets within the prescribed time frame.
- Identify the training needs of the VHWs and others.
- Plan for future activities.
- Monitor programme implementation.
- Identify the areas which may need more input and attention.
- Identify the major causes of disease.
- Analyze the inter linkages between health and other sectors of development
- Identify new cases of diseases which were hitherto unknown.
- Assess cost efficiency and effectiveness.

- Assess people's knowledge, attitude and practice.

However, the HIS can become more useful only when it is used to change the conditions that are inimical to the development of people. But this can happen only when people begin to share, process and own the information and the knowledge. People's most powerful weapon is their knowledge. The knowledge that makes them aware of their oppressive forces and shows them the path of liberation. As it has been demonstrated by CRHP, it is possible to empower people through HIS provided the poor are enabled to participate actively in the process of health development.

Information is a critical factor in monitoring and evaluation. In the subsequent section let us learn the process and methods of monitoring and evaluation.

11.5 MONITORING AND EVALUATION OF HEALTH CARE PROGRAMMES

The function of monitoring and evaluation is carried out effectively when an appropriate health information system is established. In this section let us discuss briefly the meaning and process of monitoring and evaluation.

11.5.1 Monitoring

The success of implementation of any programme depends on a sound monitoring system. It is an effectively management tool to ensure the planned activities are implemented as per the schedule. The meaning of monitoring will be more clear if we understand some of the definitions and characteristics of monitoring.

1) **Concept of monitoring:** Monitoring is a tool for measuring actual programme inputs, activities and outputs undertaken during the course of project implementation as per the original design of the programme/ project. It is also a tool for identifying and analysing problem areas and making appropriate amendments and corrective interventions.

2) **Elements of Monitoring**

   - Monitoring starts and ends with a programme. It is concurrent in the sense that it is required from implementation to completion of a programme at regular intervals.
   - Monitoring is required for immediate use and mid course correction
   - It is symptomatic and an early warning system as it helps in identifying the symptoms which indicate whether the programme is being implemented successfully or not.

3) **Participatory Monitoring:** Normally, monitoring is considered a function of the project holder or the implementing agency. However, in the recent past, particularly in community based health care programmes, the beneficiareis are also encouraged to participate in the process of monitoring as active partners. According to Huizer (1983) "Participatory monitoring involves the beneficiaries of a project in measuring, recording, collecting, processing and communicating information to assist both project management personnel and group members in decision making". Participatory monitoring system ensures that inputs are ready on time; work plans are followed as closely as possible; adjustments can be made, and corrective action taken where necessary; people who need to know are kept informed; constrains and bottlenecks can be foreseen, and timely solutions found; and resources are used efficiently and effectively.

   For ensuring effective participation of beneficiaries, the tools for monitoring must be as simple as possible. To evolve a participatory monitoring system some of the projects use symbols and diagrams. The following figures are given as examples.

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MONTH	Pills	Copper-T	Condom	Abstinance
January				
February				
March				
April				
May				
June			✓	

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Unit 11 Figure 1: Monitoring the use of temporary methods of family planning.

COMMUNITY FORESTRY MONITORING CHART Month ______	NURSERY	TREE PLANTING	FERTILIZER	EXTENSION SUPPORT	GROUP MEETINGS	LOAN REPAYMENTS	FUELWOOD	FOODER	FRUITS	SOIL IMPROVEMENT	VISITORS
5			✓	✓	✓						
4	✓										✓
3							✓	✓		✓	
2									✓		
1		✓				✓					

Unit 11 Figure 2: One month chart for monitoring progress in a community forestry project.

11.5.2 Evaluation

Evaluation is an important function of health care management system. In the recent past, evaluation has become not only the function of the institutions/agencies delivering health care services but also the function of the target community. The shift from institution-based evaluation to participatory evaluation has added new dimensions to the process and methods of evaluation. Therefore, in this lesson attempt has been made to describe the meaning, purpose, types, methods and process of participatory evaluation.

1. Concept and Purpose

Evaluation is basically an ex post function when the programmes have been implemented and events/activities concerned have occurred. In simple terms, evaluation is a performance or achievement audit which assesses the whole gamut of activities associated with programme formulation, implementation and impact and compares the observed results with those anticipated.

Broadly evaluation can be classified into two types.

They are (i) formative evaluation and (ii) summative evaluation

Formative Evaluation: It is basically concerned with the formulation of projects/programmes. It is service-oriented and helps planners (agency staff and community) through identification of potential problems and areas where programmes need improvement. In other words it aids the planners to improve upon the programmes which were implemented earlier. Thus, formative evaluation is undertaken in order to indicate the need for the continuance of the programmes/projects.

Summative Evaluation: It aims at selection of projects from a set of projects for deciding on the continuance or termination of the project. Summative evaluation is final in the sense that it may recommend either the termination or the continuance of the project.

Evaluation is concerned with assessing the outcome of the programme. While assessing the outcome, the main concerns of the evaluation are whether:

- the beneficiaries have realized the expected benefits
- the beneficiaries are better of compared to the non-beneficiaries on the relevant indicators.
- the observed results are the outcome of the programme
- there are changes noticed in the behavioural dimensions of the target population
- there have been any adverse unintended effects of the programme
- the observed results can become the basis for future plan of action
- the problems/factors impeding the programme can be overcome
- the benefits are commensurate with the costs

2. Participatory Evaluation

Evaluation of health care programmes must be participatory in nature mainly because the programme is community-based, the members of the community have the right to know the outcome of the programmes, and they are capable of taking any corrective measure for the future. Therefore, "participatory evaluation is a process of collaborative problem-solving through the generation and use of knowledge. It is a process that leads to corrective action by involving all levels of users in shared decision-making". (Narayan, 1993) In other words, participatory evaluation is carried out in partnership with the community, and the observed results are carefully interpretted to community members so that they are able to replan and redirect the programme with the assistance from the project/program staff. (Lankester, 1992). According to Deepa Narayan, the main features which make an evaluation 'participatory' are the following:

1. **Collaboration:** Between the programme staff and beneficiaries and the key members of other agencies involved in the programme.

2. **Problem-Solving Approach:** The assumption here is that a particular program is evaluated not merely to assess the outcome or to satisfy the desires of the donor agencies. Rather the purpose of evaluation is to enable the community members to evolve action plans to solve the problems identified.

3. **Generating Knowledge:** Participatory evaluation aims to generate knowledge. However, the knowledge generated is based on the information given by the people. Since the information given by the people is transformed into knowledge, the right to knowledge should rest with the people rather than the agency/ institution. The people should be enabled to know how their information is transformed into knowledge and how useful the knowledge is for evaluation.

4. **Releasing Creativity:** People are creative and imaginative. Therefore, while they are participating in the evaluation process, they must be enabled to release and actualise their creative mind in order to make the evaluation something unique and unconventional.

5. **Using Multiple Methods:** In participatory evaluation, the methods are not predetermined and no unimodel method is applied. Depending on the situation/problem, many methods may emerge from the people for evaluation. The principle here is the user preference. Since the users are mostly the members of the community, the choice of methods is left entirely to the people. Therefore, the methods become electic and adaptable to meet the specific needs and objectives of the evaluation.

6. **Experts as Facilitators:** Unlike the conventional evaluation, the participatory evaluation does not accept anyone as an expert. However, the staff, representing the agency/institution, by virtue of their level of education and position, assume their role as experts. But in participatory evaluation, they should act as facilitators rather than as experts. This would reduce the gap between the agency staff and the members of the community which is a prerequisite for changing evaluation into a participatory endeavour. As facilitators, the agency staff are expected to share ideas, help people consider options and choose the best alternative and let the community members take over the entire process of evaluation. However, what makes an expert a facilitator is his/her ability to respect others' views, listen, communicate clearly, tolerate ambiguity and to be humble.

Check Your Progress 4

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. Mention two basic differences between monitoring and evaluation

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....

2. Give three reasons for using participatory evaluation

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3. Indicators

Indicators form an important component of monitoring and evaluation. Indicators are the variables reflecting a phenomena, problem or changes in a given situation. No

evaluation can be done without the help of possible indicators. Before we begin to see some of the indicators, which are normally used to evaluate health care programmes, let us understand the types and characteristics of indicators.

- Types of indicators

Evaluation is primarily concerned with assessing the following aspects. They are (i) efforts, (ii) performance (iii) adequacy (iv) efficiency (v) sustainability (vi) replicability and (vii) change or impact. Hence, the types of indicators should reflect these factors. The following table presents the meaning and examples of each factor.

Table 11.3 Meaning of different aspects of indicators with examples

Sl.No	Aspects of Indicators	Meaning	Indicators (examples)
1	Effort	It refers to the total inputs to the programme such as the coverage of population, manpower, financial resources etc.	How long it takes how many TBAs to visit what number of homes in a week. Hence, the indicators are the no. of TBA and duration of home visit per TBA.
2	Performance	It refers to the total output generated by the programmes implemented.	No. of children immunised, no.of mothers who had safe deliveries, no.of home visits made by TBAs etc.
3	Adequacy	It refers to the relationship between output and the total need.	For example, the programme was to cover all the under 5 children, say 250, for immunisation. But only 200 children were covered. Therefore the coverage was not adequate.
4	Efficiency	It refers to the single input-output ratio i.e., the minimisation of effort and maximisation of performance. However, in order to measure efficiency, we must take into account effort, performance and adequancy.	It means whether resources and activities are being put to the best possible use to achieve the objectives. For example, if the objective of an immunisation programme was to cover 500 under 5 children with the assistance of 2 TBAs in two years.If the all the children are covered, then the programme is efficient.
5	Sustainability	It refers to the people's capacity to run the programme, if necessary even after the managerial, technical and financial assistance have been phased out.	Amount spent by the agency per year per programme, resources available with the community, no. of trained persons available with the community, the institutional arrangements established by the community etc.
6	Replicability	It refers to the capacity to duplicate the process and benefits of a set of program activities in other (new) areas after their effectiveness has been demonstrated and found useful.	Acceptability, financial feasibility, availability of staff etc.
7	Change/ Impact	It refers to the impact of programme activities on the target population. Change can be either positive or negative.	Mortality and morbidity rates after the completion of the programme etc.
8	Quality	It refers to the safety measures taken to ensure effectiveness of the services provided.	No.of sterilised materials used by the medical, paramedical and TBAs, cold chain measures taken for immunisation, non use of banned drugs etc.

9	Utilisation	It refers to the number of people using the available services and the efforts taken to provide the existing services to the target population.	No. of persons attending the clinics/ dispensaries/hospitals, no.of pregnant women sought the sevices of trained TBAs at the community etc.

4. Process of Evaluation

The process of evaluation includes the following steps. They are (I) preparing an evaluation plan/design, (ii) data collection, processing and analysis, (iii) reporting and (iv) action.

i) Evaluation Plan/Design

The plan / design of an evaluation should cover the following. (In this section, we shall consider evaluating an immunusation programme)

- Main features of the community
  - Population and sex ratio
  - Caste/class structure
  - General health problems
  - Specific health problems
  - Existing health care facilities
  - Role of the external agency/institutions
  - Duration of the project/programme
- Objective

Mention the general and the specific objectives. In this case the main objective of evaluation is to assess the impact of immunisation programme on the children (0-5 years) and the mothers (15-45 years). The specific objectives may be to:

- identify the number of children and mothers covered by the immunisation programme.
- determine the prevalence rate of diseases affecting children for which they were immunised
- assess the efforts taken by the programme (input)

- **Participants**

The plan should specify the type and number of participants who will be involved in the evaluation. This being a participatory evaluation, the community should be adequately represented.

- **Methods**

The participants of the evaluation are expected to identify suitable methods of evaluation and mention them in the plan. The choice of methods is determined by the objectives, indicators, availability of information and the feasibility. While we discuss the indicators, we may mention the appropriate methods to be used in this evaluation.

- **Indicators**

The following objective wise indicators along with methods/tools are suggested for evaluating an immunisation programme.

Table 11. 4: Suggested indicators and methods for evaluating an immunisation programme

No.	Objective	Indicators	Methods/Tools	Source of Information
(1)	(2)	(3)	(4)	(5)
1.	To identify the coverage	Number of children given all immunisation Number of pregnant women given injection T.T.Drop-out rate	Household survey or verifying with the records kept at the health centre	Immunisation Register
2.	To determine the prevalence of diseases such as T.B, measles, polio etc, among children	Number and frequency of recurrence of diseases. Distribution and prevalence of diseases by age and sex	Household survey or verifying with the records kept at the health centre	Records kept at the health centre and the target families.
3.	To assess the input	Number of staff.Facilities for transport, cold storage etc.Coordination with other agencies.Personnel and financial support from the community	Interview guide/ group discussion/ observation	Health Centre and community
4.	To determine the awareness among mothers	Proportion of mothers knowing information such of immunusation schedule, diseases prevented etc.	Interview schedule/ KAP methods	Mothers in the community

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- Time Schedule

The time schedule for each activity to be carried out for the evaluation is to be prepared collectively. While preparing the time schedule the factors to be considered are (i) availability of participants (evaluators), nature of activity, urgency of the evaluation, and purpose of evaluation etc.

- Assigning tasks

Before carrying out the evaluation, the tasks/activities identified are to be assigned to the participants of evaluation. This means to decide who will do what, when and how. This will help you to monitor your evaluation activities.

- Work calendar

On the basis of the tasks assigned, prepare work calendar so that you may know the details of completing your assignments day wise. Following is a suggestive example of a work calendar.*

Monday	Tuesday	Wednesday	Thursday	Friday
Forenoon	*Forenoon*	*Forenoon*	*Forenoon*	*Forenoon*
Meeting the community leaders	Administering the tool for collecting data (pre-testing)	Discussing the data with the team members	Modifying the tool	Meeting the community data collection

Afternoon	*Afternoon*	*Afternoon*	*Afternoon*	*Afternoon*
Meeting the community leaders and some of the respondents	Administering the tool for collecting data (pre-testing)	Discussing the data with the team members	Finalizing the tool	Data collection

- (I) Work calendar, preferably, is to be prepared for each week.

  (ii) The work calendar is determined by the quantum of work assigned and the maximum duration permitted.

ii) **Data Collection, Processing and Analysis**

The next step in evaluation is collection, processing and analysis of data as per the time schedule with appropriate tools and methods. It will be useful if the processing and analysis of data is done with the help of computers, especially when the data is very large.

iii) **Reporting**

Mention clearly the possible chapters/sections with appropriate headings, type of presentation aids such as charts, graphs, diagrams, pictures, case studies etc., and the length of the report. An evaluation report may normally contain:

- Background information including the origin, objective evaluation, when and how, main activities and resources.
- Methods chosen

For an effective presentation keep the report short and clea Use short sentences. Plan spacing and layout, use sub-headings and emphasise on key points.

iv) **Action**

Every evaluation must lead to a follow up action with the active involvement of the community using appropriate corrective measures. The follow up action must be entirely based on the outcome of the evaluation. This is necessary in the case of formative evaluation. In the case of summative evaluation the reasons for closing the project/programme must be explained to the community/stake holders.

Activity 3

Prepare a plan for evaluating a T.B control programme implemented by an NGO working in your area.

11.6 LET US SUM UP

In this unit, we have discussed four important components of managing a rural health care programme. They are (I) implementation, (ii) health information system, (iii) monitoring and (iv) evaluation. Proper implementation is the foundation for the success of any programme. Some of the key functions of implementation are coordination, deployment of personnel, allocation of resources, and information management. We have dealt at length, the meaning and purpose of designing an information system for a community based programme. In the last section of this unit, we have discussed the meaning of monitoring and evaluation, the importance of identifying suitable indicators and the process of evaluation. The key message we have attempted to give through this unit is the participation of the community in managing a rural health care programme at all levels.

11.7 KEY WORDS

1. **Participatory Rural Appraisal (PRA):** PRA is a process and a tool by which the members of a particular community are enabled to know, understand and analyse certain factors influencing their well being with in a short span of time using simple techniques which they themselves use with the help of an external agent/facilitator. In other words, it is an awareness building process both for the community and the external agent.

2. **Sentinel:** Sentinel is a centre used for the purpose of surveillance of a disease.

3. **Deployment** Placing right persons in right place to carry out the assigned tasks and functions.

4. **Supervision:** " A process of ensuring staff competence, effectiveness and efficiency, through observation, discussion, support and guidance."

5. **Coordination:** "The process of bringing the activities of different persons into relation with one another so as to achieve a common goal."

11.8 SUGGESTED READINGS

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Annexure I

Socio Economic Profile of Families

Anual Income Date:_______________

Village__________________ Head of Family__________________ Caste________________

S.No.	Head of other family member	Age	Sex	Education		Occupation					Temporary Diseases					Chronic Diseases						Medicine			Treatment		
				I	L	OL	LL	SO	SM	O	C	F	D	AC	O	TB	BR	JP	AP	CA	O	CRHP	PRVT	GOVN	HERB	WC	SH

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I	- Illiterate	TB	- Tuberculosis	O	- Other	CRHP	- Comprehensive Rural Health Project
L	- Literate	BR	- Bronchitis	C	- Cough	PRVT	- Prove Hospital
OL	- Own Land	JP	- Joint Pain	F	- Fever	GOVN	- Government Hospital
LL	- Land Labour	AP	- Abdominal Pain	D	- Diarrhoea	HERB	- Herbal
SO	- Skilled Occupation	CA	- Cancer	AC	- Accident	WC	- Witch Craft
SM	- Service	O	- Other	O	- Other	SH	- Spiritual Healers and Others

S. No.	Name	Immunization				Antenatal Care						Infact Death	Family Planning			Drinking Water		Toilet		Women's Club Member		Yount Farmers Club Member		Other
		TR	PO	MS	BCG	Cal Year	ATP	SF	US	SB	AB		EC	OC	ST	CT	SF	L	OP	Yes	No	Yes	No	Special Information

TR Triple
PO Polio
MS Measals
BCG BCG
Cal. Year Calander Year
ATP At Present
SF Safe
US Unsafe
SB Still Birth

AB Abortion
EC Elegible Couple
OC Oral Contraceptive
ST Sterlization
CT Contaminated
L Latrine
OP Open

Village Health Worker's Daily Report

Date:

From
To

S No.	Village	Uner Five				Above Six						Pregnant		Delivery		Family Planning				TB		Lepr.		Death	Family Visit	Hel. Edu.
		D V	F C	E	S D	A P	E	F C	S D	M L	O	N W	O L	S F	U S	O P	C N	S T	O	N W	O L	N W	O L			

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DV Eiarrhoea, Vomiting
FC Fever, Caugh
E Eyes
SD Skin Diseases
AP Abdominal Plain
ML Malaria
O Other
NW New

OL Old
SF Safe
US Unsafe
OP Oral Pills
CO Condoms
ST Sterlization

Annexure 3

Antenatal Care & Teatment

Village Date:________________

S No.	Name	Age	Parity	Living		Died		Still Birth		Abortion	NPV	TT		Iron Tablet	Complication	Special Care	Remarks
				M	F	F	M	M	F			1	2				

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M - Male
F - Famale
NPV - Non Project Village

Safe Delivery & Post Natal Care

Village

Date: ____________

S No.	Name	Age	Parity	Living		Died		Still Birth		Abortion	Date of Deliver	Sex		Birth		Delivery Conducted by
				M	F	F	M	M	F			Male	Female	Safe	Unsafe	

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Annexure 5

Village-wise Care for Eyes

Village

Date: ____________

S.No.	Name	Age	Sex	Night Blindness	Cataract etc.	Remart

Annexure 6

Toral Detection of Leprosy Patients

Village   Date: ______________

S.No.	Name	Age	Sex	Skin smear for AFB		Regualarity for treatment					
				+ve	-ve	JAN	FEB	MAR	APR	MAY	JUNE

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AFB - Acid Fast Bacilli

Annexure 7

Village-wise Tuberculosis Detection List

Village

Date: ____________________

S. No.	Name	Age	Sex	Sputum Test	Regularity of teatment monts					
					JAN	FEB	MAR	APR	MAY	JUNE

Annexure 8

Village-wise Death Registration List

Village Date: ____________________

S.No.	Name	Age	Sex	Date of death	Cause of death

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Under Five-Immunization

Village

Date: ____________

S. No.	Name	Age	Sex	Triple		Polio			B.C.G.	Mesale	Remarks
				1	2	1	2	3			

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Village-wise Consolidated Information of Health Care Service

Page:________________

S.No.	Name	Age	Sex	Caste	Village		Under 5		ANC		TBC		HD		FP		EYE		General		Diagnosis
					P	NP	N	R	N	R	N	R	N	R	N	R	N	R	N	R	

P - Project
NP - Non Project
N - New
R - Revisit
HD - Hasen's Disease
FP - Family Planning

UNIT 12 COMMUNICATION AND HEALTH EDUCATION : AN OUTLINE

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12.0 INTRODUCTION

The importance of communication in health education has been extensively discussed and now universally accepted. However, it is the integration of these elements in primary health care programmes in rural areas and the selection of appropriate methods and media that require more concerted efforts. Development of appropriate, need based strategies for health education programmes and their ongoing implementation and assessment within the rural indian context present an important challenge.

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12.1 AIMS AND OBJECTIVES

Health education is crucial to primary health care and the effectiveness depends largely on communication. After reading this unit, you will be able to:

i. enumerate the principles of health education,

ii. discern the role of communication in health education,

iii. integrate effective learning methods and media into health education programmes based on local resources,

iv. design and assess health educational activities as an integral part of primary health care programmes.

12.2 HEALTH EDUCATION : DEFINITIONS, OBJECTIVES AND PRINCIPLES

In order to understand the importance of health education in primary health care, let us first try to know the concept, objectives and principles of health education.

12.2.1 Definitions

A persual of some of the definitions needs two important features of health education. They are (i) health education as a process of self awareness and (ii) as a process of community empowerment and action.

1. **Self Awarness**

According to a WHO definition "Health education, like general education is concerned with changes in knowledge, feelings and behaviour of people. In its most usual forms it

concentrates on developing such health practices as are believed to bring about the best possible state of well being."

Health education is a process primarily concerned with promoting healthy behaviour. It is a process that aids and informs people to find out their health needs and motivates and facilitates them to adopt suitable health related behaviour. It is relevant for promotion, prevention, detection, treatment and rehabilitation programmes and can be practiced with individuals, families and communities. Health education is incomplete unless it encourages community involvement and an important choice by the people themselves.

2. **Community Empowerment and Action**

The definition given by the International Union for Health Education (1988) implies that : "Health Education is the combination of planned social action and planned learning experiences designed to enable people to gain control over the determinants of health, health behaviour and social conditions that affect their health status and health status of others".

It is a process by which one enables an individual or group of individuals to realise the health needs and matches them with the required health related behaviour for the attainment of positive health. Thus although provision of accurate information is an important part of health education, it is also concerned with other factors that influence health behaviour which include the availability and choice of resources, community leadership, social support from families and the extent of self-help possible. This also include the use of a variety of methods to help individuals and communities understand their own situations better in order to choose actions that will improve their health. Information, communication, motivation and media are integral components of health education.

12.2.2 Objectives

There are three primary objectives of health education which are closely inter-related. They are:

1. **Provision of Information:**

An important objective of health education is the provision of need based and accurate information regarding health promotion, disease prevention, detection and treatment and rehabilitation. Health education messages in any community must be acceptable, understandable and possible for persons to act upon. This can lead to an increased level of awareness regarding the nature of health problems, needs and associated responsibilities.

2. **Motivating People :**

Provision of information must necessarily be directed to motivating people to make choices and decisions that bring about relevant changes in their behaviour and life styles. Health education can provide learning experiences to influence attitudes, information and practices to motivate change.

3. **Facilitating Action**

Persons should be encouraged to utilise existing services in a health/development project. Services, schemes and facilities are only useful when well utilised by motivated individuals in communities who undertake action for self-help to improve their own health status.

12.2.3 Principles

There are certain principles which give direction to health education.

1. **Health Education Should be Need Based**

One of the fundamental principles of learning is that people listen to information which is directly related to immediate needs and interests. A health education programme based on the felt needs of a community is likely to be more effective than one planned in isolation. By using information available from formal and non-formal sources, community needs can be analyzed. This may involve a diagnosis of different influences including beliefs,

attitudes, perceptions, prejudices, and socio-economic conditions that affect the needs of a given population.

2. **Selection of High Priority Target Groups at Risk:**

The selection of target groups in a community which are at high risk is important in order to identify their specific needs and plan an appropriate strategy to reach them within available resources. In a rural community, this selection will not only depend on project objectives but also on the social structure, problems and needs of each group.

3. **Planning of Health Education Programmes is Vital for their Effectiveness**

Unplanned health education is a wasteful effort. It must be preceded by a targeted educational diagnosis, content and methods to match needs with solutions and resources. It is an ongoing process of designing, implementing and evaluating and reviewing the effectiveness of the programme. It carries learners from the known areas to the unknown or unfamiliar.

4. **Levels of Understanding :**

The educational content of health education must be based on the levels of understanding, gradually carrying the learner into the unknown or unfamiliar areas of learning.

The needs and levels of understanding of various sections within the community will differ according to age, experiences, literacy, socio-economic conditions, existing knowledge, beliefs, perceptions etc.

5. **Community Involvement :**

Health education is not the pouring down of information but an opportunity for community dialogue, reflection and analysis of past experiences in order to take decisions to solve problems and promote healthy behaviour. This process of modifying incorrect ideas and associated attitudes and practices needs to be sensitively dealt within. In practice, however, several approaches are often used. The extent of involvement of key community individuals and groups in the design and implementation of the education programme greatly influences its acceptability and effectiveness.

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6. **Learning by Doing :**

Participants in the health education process learn maximum by doing rather than seeing or hearing. Experimental learning is a valuable process that affects both the outcome and effectiveness.

7. **Community Culture and Leadership :**

The design of health education programme must take into consideration of the nature of existing customs, traditions and culture within communities. The selection of family members and community within the at-risk population to promote active leadership in the health education process is important. It is important also to determine which community leaders–political, religious, traditional healers, school teachers, health workers etc. influence decisions affecting health, nutrition or fertility.

8. **Appropriate use of Communication Media:**

The appropriate use of communication media can promote a useful dialogue and free exchange of information during the health education process.

An important choice on the use of communication medium must be based on learning principles that apply to selected populations. A variety in media selected is essential to sustain learner interest and involvement. (Ref. Section 12.4.4)

Check Your Progress 1

Notes: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1) Mention the two salient features of the definitions of health education.

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2) Why health education is called a means for community empowerment and action?

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3) Mention the important principles of health education.

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12.3 HEALTH EDUCATION AND PRIMARY HEALTH CARE

As you may see in this section health, education is regarded as one of the key elements of primary health care.

"Education concerning prevailing health problems and the methods of preventing and controlling them" is listed as the first of the eight essential activities of Primary Health Care. (WHO/UNICEF 1978).

Health education is fundamental to primary health care. It is the understanding of the basis of a healthy life that can enable people to make rational decisions regarding their needs and lifestyles. Primary health care constitutes eight inter- related elements :

Health Education, Water and Sanitation, Nutrition, Immunization, Control of Endemic diseases, Maternal and Child Health & Family Planning and Provisions of Essential Drugs.

Health education is central to all components.

Primary health care is an approach. The way in which the principles, elements and strategies of primary health care develop are different for every country.

India's National Health Policy (GOI 1983) recognises the importance of health education in primary health care programmes:

"The recommended efforts, on various fronts would bear only marginal results unless nationwide health education programmes backed by appropriate communication strategies

are launched to provide health information is easily understandable form, to motivate the development of an attitude for healthy living".

Thus, the most vital role of the primary health care worker is to educate people to change their behaviours in order to prevent disease and maintain good health.

The emphasis has shifted from the passive public and focus on individuals and curative care towards community involvement and prevention.

12.4 COMMUNICATION IN HEALTH EDUCATION

As health education is central to primary health care, communication is the essence of health education.

12.4.1 The Communication Process

Communication essentially deals with the transfer of information including ideas, emotions, knowledge and skills from a person or persons to another or others.

The process of communication is influenced by four different components;

i. Sender or communicator

ii. Receiver of the message or communicatee

iii. Message between the communicator and comunicatee

iv. Channel i.e. the route by which the message is transmitted

For effective communication it is important both to impart information clearly and to ensure and be aware whether the information has been received and understood by the communicatee. Effective communication implies also the feedback mechanism by which the communicator gets back from the communicatee the reactions or responses to indicate the message has been received and understood clearly.

1. Source or Sender

The **source** or **Sender** of the communication may be one individual or a group of selected individuals. As the messages originate from the sender or communicator, these must be organised for the benefit of the receiver. The process of arranging ideas and preparing the message for transmission of ideas into a message by the source is called encoding. People are exposed to communications from different sources and are more likely to believe a communication from a trusted or credible source. In a rural community trust and source credibility may come from personal qualities or activity, person's position in the family or community, qualifications and training as well as extent to which characteristics such as background, language, age, experience, culture experiences are shared with the receiver. Thus health workers from "outside" areas who are strangers to the community may not be effective in their health education efforts.

2. Message

The **message** is the information or idea likely to evoke a response in the comunicatee and is considered as a stimulus. A good message must be appropriately selected in line with the communication objectives, interests and needs of the target population. It should be clear, specific, timely and appealing.

3. Receiver

The **receiver** of the message decodes the stimulus and interprets it. The decoding process is influenced by individual perception. The processes that occur in the receiver of the message are : Recognition, Perception and Comprehension of the message. Thus, communication methods effective with one audience may not be effective with another. Receiver or audience characteristics that need to be taken into account are their educational level, literacy, beliefs, interests, values and practices, influence patterns and power structures within the community, readiness to change, openness to new ideas, patters of communication and preferences for media e.g. traditional folk media, mass media, audio-visuals etc.

4. Channels

Channels of communication imply the medium. The choice of the medium is influenced by its ability to carry the message, cost and availability. A variety of well selected channels can sustain the communication process. These include two main groups of media : interpersonal and mass media.

The primary health care worker must be able to communicate effectively with a variety of persons in a rural community keeping in view different age groups, professions, political classes and socio-economic backgrounds. The rural workers should be able to respond to a message so that the sender of the message knows he / she has been understood. So, also an adequate response must be given with sensitivity to non-verbal and verbal messages.

Communication with a variety of persons involves :

1. Knowing the language of given individual or group of persons.
2. Selecting messages and non-verbal communication appropriate to a given setting.
3. Being sensitive to the non-verbal communication of a given culture.
4. Selection of appropriate channels of communication.

5. Communication Barriers

Communication**barriers** are roadblocks which hinder the sending or receiving of messages. They can be numerous and need to be identified and removed for effective communication. Common barriers can be organization or personnel and can be broadly classified as :

Physiological (difficulties in expression, hearing), Environmental (noise, distance, poor visibility, overcrowding, complexity of channels), Psychological (perception differences, emotional disturbances) or Cultural (poor understanding of language, background, levels of knowledge and understanding, customs, traditions and practices).

12.4.2 Information Education and Communication Programmes :

Information, Education and Communication (IEC) is a pre-planned, concerted educational endeavor with specific objectives focused towards specific programme goals in order to reach specific audiences either in individual, group or mass settings through skillful use of proper methods and media. At the district level, there is a need to determine IEC needs, design messages and define a suitable strategy for implementation according to local needs and to monitor and evaluate IEC programmes. The IEC team at the district level comprises of the District Mass Education and Information Officer, the Deputy Mass Education Officers and the District Extension Educators (Male and Female).

Educational approaches at Mass, Group and Individual levels with the use of appropriate methods and media targeted towards specific groups can facilitate behavioural changes. To ensure the adoption of specific programmes, positive forces can be strengthened, negative forces minimized and neutral forces encouraged.

12.4.3 Approaches to Health Education :

Persons in a community belong to different socio-economic groups, traditions, beliefs, attitudes and levels of knowledge and may not be reached with a uniform communication approach. Depending on local circumstances a mixture of different approaches need to be developed.

i. **Interpersonal Approach :**

Interpersonal or 'person to person' communication involve face-to-face interaction between the source and the receiver. These could be one-to-one interaction, communication in small group (less than 12 persons), intermediate size group (between 12-30) or large group (more than 30). As the size of the group increases, feedback and discussion becomes more difficult. Large groups involve more one-way flow of information and are mainly useful for providing simple facts. As direct feedback is possible in a two way communication process, it is possible to respond to local needs in a community and facilitate changes in attitudes and behaviour. Working with people or the Interpersonal approach includes home visits, group discussions, role plays, group demonstrations, lectures and public meetings.

ii. **Individual Approach :**

The individual approach, face-to-face interaction or personal contact is flexible enough to be adapted to the individual's needs. Such contacts help the health educator to understand and modify where necessary the attitudes and beliefs that an individual holds against a proposed practice, to relate these to the individual needs, identify barriers seen by the individual in adoption and remove them. The success of this approach depends largely on the educator's skill in the interview techniques. It helps to reach the deeper attitudinal and motivational core of the individual. This approach has been found useful to explain the health service facilities available, educate eligible couples on family planning and provide follow-up to family planning acceptors and long term drug regimen followers.

As individual contact for all community members is difficult, appropriate channels of communication need to be selected like influential leaders, community health workers, trained dais, school teachers, mahila mandal and youth club members.

Advantages :

This approach allows a first hand knowledge of rural health and related problems and promotes a great goodwill among the community. More influential members can be selected and utilised positively. The percentage of adoptions to advocacy rendered is high.

Disadvantages :

This is a comparatively more costly method as the number of contacts possible are limited and time consuming. Several visits to individuals might prejudice other clients against the health educators.

iii. **Group Approach :**

In the group approach, a free exchange of ideas and thoughts by group members in an atmosphere of acceptance is possible. These include group discussions and methods that can bring about changes in health attitudes. Group discussions can be conducted during mahila mandal meetings, antenatal and under five clinics, village leader meets etc. in order to discuss mutual concerns, issues or problems and plan out feasible action programmes.

Advantages :

This approach can be used to generate interest and increase understanding and awareness about specific issues, problems and ideas, to develop leadership and motivate a group to action.

Disadvantages :

This approach is rather time consuming and can be affected by village factions that might hinder its effectiveness. There is also a need to deal with leadership rivalry who may oppose group activities.

iv. **Mass Approach :**

The characteristic of mass media is that it does not involve direct face-to-face interaction between the source and the receiver. These include broadcast media (radio, television, films) and print media (Newspapers, books, leaflets, and posters).

These methods may not be suitable to reach out selectively to specific groups in a community e.g mothers, children, agricultural labourers etc. or local communities with region specific problems. The main effects of mass media could be an increase in awareness of knowledge rather than changes in attitudes or behaviour. In the mass approach a large audience can be reached by selected communications media in a comparatively short time. These media can be used singly or in combination to increase levels of awareness among people. In order to be effective, this approach should be planned as an integral part of an educational effort in sequence with other activities. The mass approach has been found to be more effective when community level contacts are followed up soon after. (Refer section : 12.6.2).

Advantages :

Through this approach one is able to reach large target audiences within a short period. It is possible to disseminate uniform messages in a relatively cheap manner.

Disadvantages :

Selective perception and retention is an important limitation in the use of this approach. While mass media has been proved to increase information levels, it is not effective in bringing about changes in attitudes and practices.

Although this approach may motivate a small proportion of an audience to adopt specific health practices, a sustained programme of education, persuasion and motivation in a face-to- face situation is necessary.

12.4.4 Methods and Media :

Information, Education and Communication activities need to be planned to create learning situations in which communication can take place between the teacher and the learner. A good health educator makes use of the most effective means so that the learning task can be handled jointly by the community and the worker. The effectiveness of interpersonal communication can be improved using visual aids. These include flip charts, models, flannelgraphs, leaflets, charts, blackboard slides, films etc. Visual aids can be used to stimulate people's interest, reinforce verbal messages, make ideas easier to understand, aid to remember information, to facilitate participatory learning and problem solving skills.

During the selection of methods and media one has to give consideration to :

- Background of the audience
- Literacy status
- Communication patterns
- Village leadership and power structures
- Culture and message content
- Purpose for selection of methods and media
- Available resources

The three tables given at the end of unit present the salient features of methods and media normally used in IEC.

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Check Your Progress 2

Notes: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1) Explain IEC

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2) What is the difference between encoding and decording?

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3) What are the advantages of flip charts and files?

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12.5 DEVELOPING STRATEGIES FOR HEALTH EDUCATION PROGRAMMES IN HEALTH CARE

Since health education is a significant contributory factor in health care evolving appropriate strategies assumes importance. The strategies for health education largely depends on planning.

12.5.1 Planning Health Education Programmes :

Planning skills for health education programmes are not only to be developed by health education workers but also by the community itself. When the community is involved in the planning process more initiative can be taken in planning its own programmes. During the planning process, it is important to emphasise the use of appropriate technology, community involvement, partnership between the community and health education workers, and the need to coordinate different levels of health planning. Several important elements are required to develop an appropriate strategy for health education programmes as has been explained below :

1. **Diagnosis or assessment of health needs, problems, attitudes and behaviour of individuals, families and communities at risk.**

Information collection from selected individuals in a community is essential in order to diagnose or assess their health needs and problems. The collection of information at the beginning of a programme enables one to measure any changes or improvements at mid term or at the end of the programme. The information required includes : the most important problem as perceived by the individuals or groups one is working with, other problems as identified by individuals, community workers and possible causes for problems, local beliefs, behaviour and values that affect health, decision making about local problems, availability of health-care services and their location, existing groups: mahila mandals, youth groups and organisations, main occupations and levels of understanding among selected groups, leadership patterns, local mechanisms of sharing information.

2. **Identification of the types of behaviours that can be changed through education and their extent.**

In order to change specific behaviours through health education it is necessary to identify those that promote health and others that lead to illness with their underlying reasons. As behaviour is closely linked with the way of life or culture of a community, existing healthy practices can be encouraged as alternatives to unhealthy ones. If no appropriate or acceptable alternatives exist, the next choice could be that of slightly modifying harmful behaviour rather than substituting completely new practices for old familiar ones.

It is essential that the communities have a clear understanding of their role in the implementation of strategies for solving health problems. Health education should facilitate the dialogue with the community through culturally and socially acceptable forms of communication. (WHO, 1983).

3. **Selection of priorities, objectives and action** :

For a programme to succeed, it is important to set priorities and objectives for action to target the programmes towards those most in need and optimum utilisation of resources. Needs and problems identified must be based on how serious a problem is, availability of resources, future benefits and the degree of people's concern. Communities should be

involved in setting priorities for health education and related objects for future action so that it is more likely that the health behaviour they decide upon will fit into the local culture and will be targeted towards individuals and groups at risk, most receptive to the introduction of ideas affecting health behaviour and most likely to be able to change once new ides have been accepted. These characteristics will indicate the primary target for the educational programme and ensure success with the group early in the programme and increase the chance of success with a more difficult group at a later stage.

Decisions on the most appropriate strategy will be based on reasons behind behaviour that causes health problems as well as other factors such as local culture, economic problems etc. As problems often have several causes, different strategies may need to be developed. Some methods will work better for certain types of problems as explained below : (WHO 1988A)

Problem	Action needed	Possible educational methods
Lack of knowledge	Information	Posters, radio, press talks, displays
Influence of other people	Support	groups discussion , clubs family counselling.
Lack of skills	Training	Case studies, educational games, demonstrations.
Lack of resources	Development	Community surveys, community meetings, resource linkages
Conflict with values	Clarification of values	Role play, educational games, stories

4. **Identification and selection of resources** :

Resources necessary for promoting health and conducting health education programmes can be identified both from inside and outside the community. Resources from within the community include : place to hold meetings, clinics, discussions such as the village school and hall; individual and group contributions in terms of money, materials, local skills (carpentry, art, masonry, weaving etc.) transport. Health education resources that could be available from within the community include : local and traditional form of community such as proverbs, stories, fables, puppetry. Local artists can also be involved in developing health educational materials.

Resources from outside the community include funds, technical assistance and skills, materials such as cement, vaccines, drugs and equipments. Once resources have been identified, it is important to link people with them through interpersonal relationships and good communication skills. Outsider resources for health education purposes include mass media (newspapers, radio, TV) educational materials (posters, films) and communication equipment. In order to form functional linkages, individuals, groups and communities need to be informed with background information including the names and addresses of these agencies, description of types of available resources, selection criteria and requirements from clients. The health educator should be able to identify and select which of the available resources are to utilised, gauging the extent of availability from the community members themselves in order to encourage self reliance.

A plan of action then needs to be put together to include the problems, priorities, objectives and resources indicating the specific tasks to be completed by whom and by when.

5. **Selection of appropriate content and methods** :

The selection of appropriate content and methods for health education will depend on the situation and selected problem in the community. The messages of the health education programme need to be understandable, acceptable and possible for the people to act on. The choice of health educational method will depend on :

- The readiness and ability of people to change,
- Community involvement,
- Appropriateness to local culture,
- Availability of resources,
- Mixture of methods required,

- Suitability of methods to the characteristics (age, sex, economic status, religion etc.) of selected target group.

6. **Evaluation of health education programmes with the participation of persons involved.**

The evaluation of health education programmes can assess the degree of success of each aspect of the programme using suitable specific measures. Observation, interviews and record analysis can supply suitable information for evaluating a health education programme. This should be an ongoing process so that problems can be corrected as soon as possible. The final results will indicate the extent of changes in behaviour and whether these are within the initially set educational objectives. At the end of the programmes evaluation can include whether the action went according to the plan prepared at the initial stages, the extent of people's participation, their acquisition of new skills and availability of resources on time. The evaluation can also reveal the extent to which the problem has been eliminated or reduced in the selected community and future direction on steps to be taken to improve the programme. A review of the plan of action may indicate any unreported difficulties earlier in the programme, disturbing community events that prevented people's participation, local disagreements that obstructed team efforts, inappropriateness of selected activities to local culture, unrealistic time frames etc. Thus when sources of difficulties are found, the participating groups can revise plans or prepare new plans based on previous findings. It is important that the evaluation component be built into the programme at the planning stage before starting implementation so that the required information can be collected effectively to assess change.

7. **Review of the Process of Planning**

Through a review of the process of planning, it is possible to identify the steps and process of planning and coordination of the levels of planning. An important need remains to foster communication and establish links between people and the various resource agencies. Communication among the agencies themselves is also important so that the most effective use of resources can be made at regional, state and district levels.

12.5.2 Integrating Education into Health Care Programmes :

Health education programmes need to be planned with skill, ingenuity and imagination in order to integrate them into health care programmes. The extent of curative, preventive or promotive aspects of each programme will differ as will the development aspects. There are many pre-requisites to ensure the effective integration of health education with other programmes. The health educator should be familiar with the objectives and strategies of the selected programme under consideration, the roles and responsibilities of different levels of functionaries involved and their background, selection of target beneficiaries according to priorities and response. The steps for the educational diagnosis explained above will include the identification of health care related knowledge, attitude and behaviour of the target community, resource linkages and factors in the community and project personnel that will enhance or hinder the educational programme. This information will determine the contents and messages for health education, appropriate methods and media.

Health education is an important component of any programme and it can play a major role in promoting :

i. Good health practices e.g. breast feeding, infant weaning, oral rehydration, use of safe drinking water, food hygiene

ii. Recognition of early symptoms of disease and promoting early referral

iii. Use of preventive services i.e. antenatal and child health clinics, immunization

iv. Correct use of medicines and appropriate followup with long term regimens e.g. in Tuberculosis and Leprosy.

v. Community support for primary health care and government programmes.

12.5.3 School Health Programmes

Although health education need not be limited to any particular setting, persons in different settings will have different needs. School health programmes are important and provide an opportunity of integrating health services and education components to promote the role of teachers and children as agents of change in the school and community. During the implementation of school programmes the integration of elements, collaboration between the health and education sectors and the extent of community contact determine various approaches that have been developed. These include the Curative approach, Education approach, Outreach approach and the Comprehensive approach (Desa 1991).

In order to produce a real impact a school health programme must be a comprehensive one comprising the following mutually reinforcing components :

i. Provision of a healthy environment in schools and effective environmental sanitation.

ii. Periodic health checkups and appropriate referral services.

iii. Provision of safe water supply.

iv. Health and nutrition education.

v. Contact and communication with the community to ensure that the school becomes an entry point to the community.

12.5.4 Nutrition Education

The nutritional status of a population is a crucial indicator in determining the health status of individuals in a community. Poor nutritional status leads to functional impairment, inability to cop with environmental hazards, decreased productivity, disability and less resistance to infections. (Reddy and Mahatha, 1992). The primary factors having a direct bearing on the nutritional status include education, mass media, economic resources, social roles, food distribution patterns, quality and quantity of food. Health and nutrition education is an important tool to enhance the level of awareness of individuals to bring about a change in their behavior patterns to prevent malnutrition and enhance the child survival rate. The primary aim of nutrition education is the establishment of good habits through the acquisition of knowledge and changes in eating habits, attitudes and values with regard to food (Devadas et al 1982). Any effort to reduce malnutrition requires an integrated approach to supply educational, health and nutritional services. Nutrition education should be based on the needs and existing practices (with associated reasons) in the community. In order to convey appropriate messages to the community through person-to- person discussions or group education these should be based on the needs, interests and existing practices of individuals in the community seeking the support of motivated people in the community who can actively assist and participate in the nutrition education process (GOI, 1991).

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12.6 ASSESSING HEALTH EDUCATION PROGRAMMES

Factors that influence human behaviour and how people learn and change are the core concern of education. However, the demands and expectations of culture and society create conditions within the context of which one learns to learn. Various learning tasks are facilities or restrained by different factors. Not all learning results in behaviour change, so also all behaviour change need not be the result of learning. Thus a range of educational interventions need to be designed and evaluated to provide help to the learner in different situations. (WHO 1988b).

12.6.1 Elements of Evaluation

The assessment of a health education programme should focuses on the most significant changes expected and brought about by the programme. Evaluation undertaken can be Immediate, Short-term or Long-term. Allocation of a reasonable proportion of resources in terms of money, manpower and time is important for the assessment of health education. If

the evaluation component is built into the programme its costs are smaller and not easily distinguishable from programme costs. Expensive or long-term programmes may justify more expenditure on evaluation because in such programmes much resources may be wasted if they are not evaluated (Scotney 1976). Evaluation needs to be done on an ongoing basis so that the appropriate changes can be made in the health education programme. A baselines obtained at the initial stages can be used to measure changes brought about due to the programme.

Evaluation can cover the following components of the programme :

i. **Organisational Structure** : These would include number of staff training; organisational charts, reporting and supervision mechanism; extent of collaboration with other sectors and agencies;

ii. **Health Education Process** : The stages in the health education process, the content and methodology used and the extent of community involvement are important aspects in an evaluation strategy.

iii. **Products or End Results** : The end products of a health education programme would include specific behaviour changes based on educational objectives set during the planning stages of the programme.

The aim and purpose of health education is to bring about health related behaviour maintenance of good health. The ultimate impact of health education will be changes in health behaviour or adoption and sustenance of new practices. The acquisition of proper information, changes of ideas or knowledge and internalisation of useful ideas are as important as changes of behaviour. Hence the evaluation of any health education programme is to measure changes in knowledge, attitudes and behaviour sustain a significant impact.

An accurate evaluation of a health education programme can indicate whether the following criteria are satisfied :

Relevance : This aspect will indicate whether the programme has been need based and relevant to the existing culture of the rural community.

Coverage and progress of health education activities: This coverage refers to the community population or area to be covered with the content and events of the health education activities that have been planned. Such an evaluation will assess whether the target group has been reached and to what extent.

Efficiency : An investigation of the efforts made for a particular health education activity in terms of people, time, money, materials and technologies can reveal the economic feasibility of the programme (Ramachandran and Dharmalingam 1990).

12.6.2 Case Studies

Case studies often help us to get an indepth view of health care programmes. We shall see the following three case studies.

A. Nutrition Health Education and Environmental Sanitation:

The Nutrition Health Education and Environmental Sanitation (NHEES) project initiated in five states (1975-80) and expanded to 10 more states and union territories have been a major project to identify strategies for quality improvement in teaching methods and materials, curriculum and modalities at the primary education levels and through community contact programmes. The strategy included two types of intervention programmes:

- Development of a curricular package and methodology which could help develop proper knowledge, habits, practices, skills and attitudes of primary school children.
- Introduction of an intervention programme for the members of the community on selected aspects of nutrition, health and environmental sanitation i.e. methods of food preparation and conservation for daily use, inculcation of health habits and practices, an increased community awareness on breast feeding, existing health services available at the primary health care centre etc.

Specific messages relevant to the adult audience especially women were identified for intensive delivery with the help of teachers and children (e.g. breast feed your child as long as possible, start supplementary food when your child is four to six months old, get your child immunized before the first year etc.).

A variety of materials such as charts, posters and pamphlets based on target population needs and usefulness for visual communication were developed in regional languages focusing on these messages. These were distributed through 25% of schools to households in the villages using door-to-door contact by primary school teachers, monthly community meetings, exhibitions, fairs, etc.

The **Evaluation Study** was conducted to :

a. determine the magnitude and extent to which the desirable knowledge, understanding, application, skills, practices and attitudes towards nutrition, health and environmental sanitation were developed in the pupils exposed to the curricular package.

b. to determine the effect of messages on nutrition, health, environmental sanitation delivered to community members and their reinforcing effect on pupil achievement.

c. to determine the effect of certain factors such as sex, attendance, parental income, advantages and disadvantaged status, parent's education and occupation on pupil achievement.

Data Collection : Pupil achievement tests (PAT) were constructed to measure the total achievement of pupils and their achievement in terms of knowledge, understanding, application and skills relating to nutrition, health environmental sanitation. A questionnaire-cum-interview schedule comprising 47 questions were developed to record the information of households in respect of community knowledge, understanding and practices before and after the community contact intervention. Pupil information blanks were used to collect information relating to sex, attendance, during of stay in school, social status, religion, parent's education, occupation and income. School information blanks were used to collect information about the types of schools, available facilities and teacher training.

Findings

While the evaluation revealed problems related to administration and management, positive behaviour changes were recorded among children and community members. However, the infusion of positive outcomes in the primary education system met with a limited or no success.

As a consequence of the community contact intervention, a significant number of households :

- continued breast feeding as long as possible and avoided bottle feeding
- added supplementary food while feeding the babies from the age of 4 months onwards
- immunized their children before the end of the first year
- included in the daily diet of their children a variety of available foods in adequate amounts distributing them in at least 3 regular meals
- used safe water for drinking and cooking
- used drainage water for reasoning food plants and made provision for a soak pit
- provided sanitary facilities in the school and community and adopted hygienic practices (urination, defecation and spitting)
- kept their school, home and village surrounding clean and made provision for composite pits
- did not pollute the water sources
- kept their bodies clean and took special care with nails and teeth.

Thus the study indicates a positive impact suggestion that it is possible to change perceptions and practices related to nutrition, health and environmental sanitation through such interventions programmes (Bhattacharya 1991)

ii. Media Reach and Effectiveness in Family Welfare Programmes

An interesting study was undertaken by 6 national institutes in 7 states with varying performance in family welfare to assess the reach and effectiveness of different modern mass media, interpersonal communication channels and traditional folk media. The study covers the following 18 types of masses and interpersonal communication media used in 7 major states; Bihar, Gujarat, Karnataka, Maharashtra, Orissa, Tamilnadu and Uttar Pradesh:

1.	Interpersonal channels	a.	Home visits
		b.	Group meetings
2.	Traditional folk media channels	c.	Drama
		d.	Puppet show
		e.	Kirtan/Bhajan/Qawali
		f.	Yatra
		g.	Nautanki
		h.	Tamasha
3.	Mass media	i.	Radio
		j.	Films
		k.	Exhibition
		l.	Television
		m.	Poster
		n.	Wall painting/Hoarding
		o.	Pamphlet/Leaflet
		p.	Newspaper
		q.	Magazine
		r.	Telephone

The study attempted to find out how far family planning communication strategies had been in educating communities in different aspects of the national family planning programme. The essential components were communication, provision of contraceptive methods and suitable delivery of services. An important emphasis has been on the use of communication media and forms to reach selected communities.

Methodology :

A multi-stage stratified random sampling method was used for the evaluation study. In the rural areas sampling was done at the district, Primary Health Centre, village and household levels. While interpersonal media (Home visits and Group meetings) were found to be useful methods in communicating family welfare activities, it was found that the lack of regular contacts could not exploit their effective use. The use of traditional media was found to be highly acceptable and required greater use. The acceptability of TV (48%) as a medium of communication for family planning was found to be less than Radio (51%). 80% of the respondents were found to be in favour of the use of films, while more than 75% preferred the use of wall paintings/ hoardings in Information, education and communications activities. The use of printed material was found to be low and limited and more accessible to urban rather than rural populations. The use of exhibitions was found to be very successful as 89% of visitors sought more information on family planning. It is suggested that a more intensive use of interpersonal communication media as compared to mass media would be useful.

The evaluation also investigated the impact of communication programmes on rural and urban populations. The creation of motivation and psychological readiness to accept family planning methods was found to be discouragingly low. It was found that the communication package developed needed to enlarge the knowledge base to stress the removal of misconceptions, fears and apprehensions about various family planning methods.

iii. Tamilnadu Integrated Nutrition Project :

The Tamilnadu Integrated Nutrition Project (TINP) targeted at the 6-36 month age group is being implemented in 5 districts of Tamilnadu since 1980. The Communication components has been integrated with growth monitoring and delivery of nutrition services through a network of Community Nutrition workers (1 CNW/1500 population),

12.8 Key Words

Encoding : The process of assanging ideas and prepring the messages for transmission of ideas into a message by the sender or source.

Primary Health Care : (Definition is given in unit 1 of Block 1)

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Table 1 Method of IEC

Method	Advantages	Disadvantages	Remarks
1. Home Visit	Establishes good personal relationships between field workers and families. Can provide informaiton about rural families to participate in public functions, demonstrations and group works.	Field worker can not visit every family in the community. Only families in accessible localities can be visited	Records should be kept for families visited. Schedule of home visits should be devloped to assure allocation of time for field work activities. Reading material should be given to families visited.
2. Role Playing	Faction and opinions can be presented from different viewpoints especially on controversial issues. Can encourage people to re-evaluate their stand on issues and can invite audience participation. Promotes group insight into personal relations.	Cannot be used in community meetings. Some role-players may feel upset by playing a role they do not agree with. Requires careful preparation for the selection of the issue and actors. Careful preparation is essential.	Can only be used in training courses. Follow-up discussion should focus on the issue rather than on actors performances. Source material about the issue should be provided to the actors to prepare their arguments.
3. Drama	Group can be active "learning by doing". Can attract attention and stimulate thinking if situations are effectively dramatized.	Actors require attention in tranining and preparing script. Preparations might be too difficult for the field worker. Difficult to organize because it requires considerable skills and careful guidance by the field worker.	Should be restricted to one issue. Can only be used during training courses. Can be used as entertainment if well prepared before a public meeting.
4. Demons-tration (with a small group)	Participants can be active and learn by doing. Convinces the audience that things can easily be done. Establishes confidence in field worker's ability.	Requires preparation and careful selection of demonstration topic and place. Outside factors can affect demonistration results and consequently might affect demonstration results and affect confidence in field worker.	Demonstration process should be rehearsed in advance. Audience should participate in actual process. Educational materials should be distributed to the participants at the end of the demonstration. Should be suitable for people to attend.
5. Case Study	Can illustrate a situation where audience can elicit local initiatives if the case corresponds to local problems.	Difficult to organise. Reworking of events and personalities might reduce the effectiveness of the case. Some audiences may not identify themselves with the case.	Should be clearly prepared. Can be used in training course. Questions and discussion should lead to recommendation for audience action. Audience should be encouraged to prepare case studies relevant to its experience.

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Method	Advantages	Disadvantages	Remarks
6. Group discu-ssion.	Builds group consciousness. Individual members or the group can understand where each member stands in regard to the discussed issue : provide chances for exchanging opinions and increase tolerance and understanding.	Some members may dominate. Sometimes difficult to control to keep focusing on the main issue. Requires trained leaders.	Should be used with an interested audience to discuss a definite problem. Procedure should be flexible and informal. Summary of discussion should be presented at the end of discussion. Discussion should be made by group members regarding its stand on the issue discussed. Requires the selection of good chairman.
7. Public meetings & lec-tures	Easy to arrange. Reach many people. Can have more than one speaker. Create public interest and awareness. Stimulate follow-up discussion.	Audience is usually passive. Speakers may not understand audience's needs. Difficult to assess success. Audience might not learn the main points.	Handouts should be used. Presentation should be clear. Use visual aids when possible. Audience should be encouraged to raise questions and the speaker should establish two-way communication.

Table 2: Mass Media in DEC

Method	Advantages	Disadvantages	Remarks
1. Radio	Radio technology is available in most countries and can reach mass audience cheaply. Receivers are inexpensive and available in the remotest communities. Messages can be repeated at low cost. Easy to reach illiterate audience. Can be used to support other channels of comunication. Efficient to announce events and development activities, and if properly used, can mobilse audience to participate in public events and projects of value to the community.	One-way channel. Complicated teachnical issue. Difficult to illustrate. Audience reaction, participation or interest in messages delivered difficult to assess. Require special skills & continuous training of radio personnel. Content may not be tailored to small communities and tends to be general in nature and is usually prepared for national audience, or language group thus reducing relevance to local problems. Difficult to use material broadcast as a reference without investment in radio documentation. Texts or radio programmes are usually needed for effective follow-up. This is not always possible.	Radio messages should often be supported by personal followup. Radio effectiveness increases if messages used in group discussions (e.g. farm forum) or regular training courses. Desirable for radio to cover local events, assist in explaining and promoting local projects and development efforts. Programming should maintain balance between national and local coverage interviews and lectures, news and profile coverage of development issues.

Method	Advantages	Disadvantages	Remarks
2. Tele-vision	Its novelty attracts audience and can be the main captivator in rural communities. Can be used to explain complicated messages because of its combination of sound and picture. Programs can be repeated at no cost. It is suitable for mixed presentation of issues. Suitable for motivation through utilization of folklore art and music, communite events & animted public speeches & debates. Efficient in bring issues to public attention and participation in development effort. Successful in creating awareness.	Expensive to operate. Receivers not available in many rural areas & among poorest population groups. Has traditionally been used for entertainment & politics more than for development and educational purposes. Programming skills more likely to be available for entertainment. Educational programs may face severe competition from entertainment. No audience participation. Present state of technology in many developing countries does not allow immediate coverage or timely relay of local community actions & events. Requires more planning and technical, creative and communication skills than other media. Difficult to use material televised as a reference without investment in television documentation. Texts or television programmes are needed for follow-up. This is not possible.	Local television station can play an important role in development. More edicational training is required for staff. Easy to exchange information, & programs are scheduled in advance. Well documented, with heavy involvement of and focus on local problems. Very effective for activating group learning when used in viewing centrers or as part of multimedia campaign for education-information and motivation.
3. Cinema	Captures attention well. Reaches big audiences in selected countries and can be very cheap (particularly travelling cinemas). Can reach lowesst strata in certain countries & even have large rural audience.	Is expensive in some countries & may only reach certain sub-groups in the target audience (such as the rich, youth, females). Distribution can be problem. May be distracting setting for educational messages.	Great care must be taken in preparing the film clips.
4. Folk theatre	Culturally relevent in some countries is easily available and inexpensive. Often more credible to the traditional elements of society than the modern India.	Can lose control of message. Format can distract from content.	Flexibility of the form can vary from country to country. One of the best uses is often a combination with a modern medium such as television, radio or supported by loudspeakers.

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Method	Advantages	Disadvantages	Remarks
5. News-papers	Can provide detailed information. Easy to present technical data in clearly designed text. Important topics can be covered in a series of articles. Can influence the attention of audience by where they place information and on what page. Influential in creating awareness and mobilizing public opinion. Material published can be shared and used as reference Can be used to support radio and television for education purposes and follow-up on lessons, issues and topics discussed by the other two media.	Can be used by literates only. Difficult to reach isolated communities. Can be expensive for poor families. Requires special writing & editing skills, which are not always available. Like all other mass media, it is one way communica- tion channel. Feedback is difficult because or audience reluctance or inability to contact the editor. Difficult to publish at regional level. Small communi-ties can not afford to publish their own news paper without continuous support from national government.	Best source of information if topics of development are covered on regular basis. Can be used to establish community local papers and bulletin boards. Can be circulated to community members to reduce cost per individual family. Could be used to support literacy classes : sectors could be prepared especially for poor readers and semi-literates.
6. Wall Paint-ings. Bill boards	Potentially available to large audience. Low cost. Can be reached if well located	Can be easily ignored. Limited to simple messages.	Message must be extremely well designed and pretested. Sitting is critical to be able to reach the kind of people intended.
7. Films	Use of sight and sound can attract audience's attention. Can make great emotional appeal to large audiences.	Good films are rare. Equipment costly to buy and maintain. One-way communication unless properly used. Requires skill in running film projectors.	Best if combined with discussion groups. Much work to be done regarding getting good films made. Attention should be given when getting audience to evaluate the film. Films should be used for stimulating discussion rather than for teaching alone.
8. Video	Can be used to introduce new ideas to selected audiences. Excellent tool for micro-teaching. Can introduce complicated concepts and technical issues in a series of presentation; can record field operations and activities & use them on numberous occasions; can be used to teach skills and change attitudes. Feedback to the bradcaster can be	Is expensive. Forum members tend to drop out. Break down in hardware is common, and batteries are often exhausted. Forum requires highly skilled personnel and extensive hardware. Restricted to communities where trained field agents are available. Requires continous servicing and maintenance and updating. Can become negative tool for	Forum requires continuing attention from professional organizers. Most successful in small group learning. Group discussion leaders must be carefully slected & trained. Tranining materials & programe must be carefully organised & kept in order. Its efficiency increases if used in combination with booklets & hand outs at the end of the

Method	Advantages	Disadvantages	Remarks
	immediate and relatively accurate. Can be handled by model farmers and community leaders; can build useful libraries for teaching in the case of literacy and adult education classes.	development if it fails to attract different sub-groups in the community (such as the poorest, & religious or racial minorities). Sometimes, because of difficulty in finding needed materials or training manpower, many events in the community go by without being recorded or utilized.	discussion. Should be used to teach special skills, for structured instruction and where possible, as a tool to generate participation among a rural community or one that is for other reasons isolated from ongoing programs or slow to cooperate.

3. Other Media and Materials in IEC

Method	Advantages	Disadvantages	Remarks
1. Publications & loose leaflets.	Excellent for indepth presentation and technical information. Can cover more than one topic. Easy reference & can be directed to specific audiences. Can be illustrated & made attractive. Can support other media for education purposes.	Expensive. Can only be effective if well designed & produced. Poorly printed publications may be expensive but not read. Require special editing, design & production skills.	Should be used to support special compaigns, such as literacy and adult education. Most useful if topics are covered in series of publications. Could be used successfully in group discussions & as back up for public meetings. Can also be used for in service training of field staff and to keep up morale, particularly if field staff are widely dispersed.
2. Film strips	Much cheaper and easier to work than films. Easily made from local photographs. Encourages discussion.	Usually sight only. Not so dramatic as motion pictures. Could be expensive.	Can have recorded commentary. Strip can be cut up and individual pictures mounted as slides; then can be selected and re-arranged.
3. Slides	Have all the advantages of film strip plus more flexibility & can be more typical. They can be used in a series to illustrate.	Could be expensive. Difficult to have them on all subjects of teahcing.	They should be used after careful preparation of logical sequence and a good commentary.
4. Flannel Board	Can be portable and mobile. Can be prepared by expert in advance. Little skill required in actual operation. Could be used to make presentation more dynamic.	Can only be used for what it is prepared. Cannot adapt to changing interest of group. More elaborate equipment than ordinary blackboard. Difficult to keep up-to-date.	Very useful but only for the prepared talks. Audience can participate. It should be used step by step. Flannel materials should be stored properly for future use. Flannel graphs should be numbered according to their order in the presentation.
5. Bulletin Board	Striking, graphic, informative, flexible, replaces local newspapers. Keeps community up-to-date with information.	Requires preparation and attention to community needs.	Should be combined with maps, talks and photographs. Very suitable for posting articles, announcements and news of development in the community.

Method	Advantages	Disadvantages	Remarks
6. Flip Charts	Cheap and simple. Can be stopped at will for analysis. Can be prepared locallly. Ideas could be illustrated in sequence. Illustration on flip chart could be used many times for different audiences in diffeent sessions.	Soon torn, can only be seen by a few at a time. Can be difficult to illustrate complicated ideas.	Should not be overlooked for illustration of simple sequences especially with small group. Lectures should be prepared in advance for the use on several occasions.
7. Models	Appeal to several senses. Can be used in various occasions & situations. Can illustrate ideas in detail.	Not many workers can build them or use them properly.	Useful models and exhibitions could be buitl up locality. Should be used in familiar places-centres.

(Source: Perret H 1982. Using Communication Support in Projects: The World Bank's experience. World Bank Working Paper No.551)

12.10 MODEL ANSWERS

Check Your Progress 1

1. ii) Self-awareness

   ii) Community empowerment and action

2. Health education is a community empowerment process as it enables an individual or group of individuals to realise the health needs and matches them with the required health related behaviour for the attainment of positive health. It enables people to gain control over the determenats of health, health behaviour and social condition that affect their health status.

3. The important principles of health education are:

   i) Need based

   ii) Selection of high priority target groups at risk.

   iii) Planning of health education programmes.

   iv) Levels of community involvement.

   v) Learning by doing.

   vi) Community culture and leadership.

   vii) Appropriate use of communication media.

Check Your Progress 2

1. Information, Education and communication (IEC) is a pre-planned, concerted educational endeavour with specific objectives focussed towards specific programme goals in order to reach specific audiences either in individual, group or mass settings through skillful use of proper methods and media.

2. The major difference between encoding and decoding is that the former relates to the sender and the later relates to the receiver. In encoding the sender transmits an idea into a message. In decoding the given message is interpreted by the receiver according to her/his perception, beliefs and values.

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3. Advantages

Flip charts	Films
Cheap and simple	Use of sight and sound can attract audience's attention
Can be stopped at will for analysis	
Can be prepared locally	
Ideas could be illustrated in a sequence	Can make great emotional appeal to large audiences
Could be used for many times for different audiences in different sessions.	

Check Your Progress 3

1. Health education promotes good health practices
   - Helps people to recognise early symptoms of disease and promoting early referral
   - Helps people to use preventive services
   - Enables people to use correct medieval and appropriate follow up
   - Helps people to have control over the determinants of health and health seeking bahaviour.
2. Evaluation of health education programmes should include:
   - Organisational structure
   - Health education process
   - End results
   - Relevance
   - Coverage and progress of health education activities
   - Efficiency

UNIT 13 NGO EXPERIENCE IN HEALTH CARE

Contents

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13.2 History and Evolution of NGOs
13.3 Special Features of NGOs
13.4 Innovative Experiments of NGOs in Health Care
13.5 Let Us Sum Up
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13.7 Suggested Readings
13.8 Model Answers

13.0 INTRODUCTION

In the social sector, particularly in the health sector, the role of non-governmental organisation (NGOs) has been highly acclaimed. NGOs experience in health care has not only contributed to health development but also has influenced the health care delivery system of the government. However the major contribution of NGOs is the involvement of people in health prevention and promotion. This is possible as NGOs have been able to convince the people that health is an integral part of development process. In this unit an attempt is made to present briefly the experiences of some of the NGOs in health care. Kindly note that the strategies and approaches followed by the NGOs mentioned in this might have changed since the time we wrote this unit.

Regardless of the current status (whether existing or not) and the strategies of the NGOs mentioned in this unit, their experiments are used for their significant contribution to alleviate the health problems of the people living in their target area.

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13.1 AIMS AND OBJECTIVES

This unit aims to acquaint you with an important sector in the health field - the non-governmental organisations (NGOs), and their unique and innovative experiences in providing health services to every nook and corner of India. After reading this unit you will be able to :

- trace the evolution of NGO sector in our country
- enumerate the different types of activities of the NGOs
- enumerate their strengths and problems
- identify the various approaches and models followed by some of the NGOs in helth care

13.1 INTRODUCTION

The Non-Governmental Organisations (NGOs) or Voluntary Organisations (VOs) as they are often called, are non-profit making, service-oriented organisations working in various health and health related areas.

Since India is a vast country with the second largest population in the world, there are various problems related to distance, language, culture, religion, belief systems, economy, illiteracy etc. Government, however efficient it may be, cannot provide the different types of health services which are required by the different communities, different States and age

groups in the various parts of India. The Voluntary Organisations or NGOs play a complimentary or supplementary role in providing health services relevant to the different pockets of the interior areas of India.

The main asset of the voluntary organisations is that they are in the midst of people, living with them and provide services to them.

13.2 HISTORY AND EVOLUTION OF NGOs

Before we discuss the history and evolution let us understand the concept of NGOs.

13.2.1 Concept

The term voluntarism is derived from the Latin word - "Voluntas" which means "will". All voluntary associations are the expression of human impulse the i.e. will to do something to translate a specific social vision into reality.

The voluntary effort comes out of a highly personalised inner dynamism and creativity for a social cause. When this vision is shared by a core group of individuals, it results in the establishment of voluntary organisation.

NGOs or voluntary organisation (VOs) are non-profitmaking, service oriented organisations working in various health and health related areas. NGO can be defined as a social service and developmental institution motivated to meet the needs of the most disadvantaged in society, either through direct services to the people or through facilitative indirect services to other voluntary organisations or government.

The voluntary organisations are usually field level organisations who work closely with the community in the interior areas. Most of them are small groups working on specific issues like awareness creation, providing immediate relief during calamities like floods, drought etc. Their main function is to involve people in their programs, provide services at their door steps. There is a lot of human touch and devotion to the services they provide.

On the contrary, the government with massive funds, huge infrastructure and a battalion of personnel, has its own problems of bureaucracy and is far away from the realities of the people in the field. The voluntary organisation with all their limitation have done yeoman service to the health sector in India. Their innovative ways of finding solution to local problems for example, the idea of Village Health Workers sprouted in the voluntary sector. This idea was picked up by the government and due recognition was given to these cadre of grassroot level workers to provide primary health care in villages, which forms the broad base of the pyramid of health services in India. In the area of training, communication and conscientization and many new innovative, low cost, simple techniques were evolved by the voluntary sector which is effective, relevant and accepted by people in various places. It is easy to adapt and replicable in other parts of the country.

There are an estimated 70,000 voluntary organisation in India, of which about 5,000 are working in the field of health and medical services. These figures are debatable as different sources give different data. They vary in size from a small voluntary organization with one or two staff serving a few villages to medium sized organisations serving 1 lakh population or large organizations with thousands of staff and serving several districts or states - covering millions of people.

13.2.2 Evolution

India has the longest history and the widest experience of NGOs working with the rural poor.

It has a great tradition of voluntary service and inspite of rapid changes, the urge to serve fellow-men is still strong and widespread. Right through the ages, this tradition has connoted a feeling of social obligation on the part of individual towards his less fortunate brothern. The evolution of NGO movement can be traced to pre and post independence era.

Pre-Independence era

Religion emphasised the virtue of 'Dan' or free gift which encompassed different forms of social service. Giving cash assistance to the needy, imparting knowledge, providing food, and shelter to pilgrims, care of the sick and destitute were considered to be righteous acts. The Hindu and Muslim rulers gave importance to social services like providing food building shelters, digging wells etc. However, in India, NGO intervention amongst communities in an organised manner may be traced to christian missionary activity. Their work is very old but it proliferated a great deal during the British rule.

Modern health care was started in India with the arrival of missionaries. They attempted to meet the felt needs of the deprived and exploited communities through their compassion, hope and benefits like health, education and nutrition through their curative centres developed on the model of western hospitals.

The small one doctor dispensaries grew into the mission hospitals and medical training centres at Vellore and Ludhiana. Missionary doctors who began small dispensaries to serve the sick, gave an informal on the job training to widows and orphans to help them care for patients. This was made more formal by setting up examining boards for nurses in some parts of India, particularly in south India. These boards provided new models which have been accepted or adopted for the entire country through the State nursing councils.

These Christian medical institutions are known for excellence in patient care, compassion, concern, commitment and competence. Community Health Care has often been pioneered by Christian workers.

North Arcot district in Tamilnadu has acclaimed as a pioneer district in voluntary health action in India. The Missionary Dr. Ida Scudder's Christian Medical College Hospital and its affiliates are the excellent examples of voluntary health service for the masses.

More recently many Christian Institutions have begun training a variety of workers for community health and development work. These include village health workers, rural community organisers and a whole series of grassroot level workers.

It was only in the 19th Century that serious non-christian NGOs began to evolve. They began with the efforts of Vidyasagar and Ram Mohan Roy to bring reform within Hindu Society. With the emergence of Arya Samaj and Ramakrishna Missions indigenous NGOs began to evolve in India.

During India's freedom struggle a large number of NGOs (Gandhian/ Sarvodaya Organisations and Marxist groups) emerged in fields of wide ranging activities especially in rural areas. Until the late 60s NGOs of this type by and large followed welfare or charity approach.

Post Independence era

In the late 60's the strategy changed from charity approach to one of a community empowerment approach whereby local resources (mainly manpower) were to be used for the community development. It was in the health sector that this new orientation first emerged. This new approach has been attributed to three characteristics :

- against anything free of charge
- project based involvement.
- professional in character

Since the early 70's there is an increasing trend to provide health care services at cost at the door step of consumers through village level workers. This was a period of experimentation in community health.

In the seventies health or medical work as an entry point for NGOs into rural areas has gained importance. During this period in the field of health two developments took place.

(i) The practice of using village level workers for the delivery of primary health care, demonstrated as a novel idea by the NGOs found its supporters and ultimately led to the acceptance of it in the government policy.

(ii) Increasing number of NGOs adopting health as a major area of work or as an important component in rural development, the role of NGOs in health emerged as a separate entity. NGOs were willing to accept the community health approach which has to some extent decentralised and deprofessionalised health care delivery system.

In this phase for the first time they started feeling that they must create their own lobby in parliament or in government circles to get their recommendations accepted.

As it moved through the 80s the NGOs concentrated more on consumer action so that the existing system becomes more efficient and accountable. It is mainly due to the fallout of civil liberties movement. This led to the gradual formation of three types of voluntary groups :

a) groups that began to explore options and evolve alternative approaches and methods. The focus was on education, health, environment, and women.

b) supportive groups and networking groups for training.

c) groups that focused on lobbying, advocacy issue raising, communication, action and policy research.

Thus by the early 1990s the voluntary health sector is a rich, diverse and still growing entity - consisting of a large core of alternative health care providers and a group of supportive centres.

13.3 ORGANISATIONAL SET UP

Some of the especial features we shall learn in this section are (i) the organisational set up, (ii) activities and programmes (iii) key roles, (iv) limitations and (iv) linkages between government and NGOs.

13.3.1 Organisational Set Up

Most of the NGOs are registered bodies under the Societies Registration Act. This act was passed in 1860, which gave legal and corporate status to voluntary action in India.

Majority of the NGOs, nearly three fourth of them work in rural areas while a quarter of them are state level, regional or national level organisations.

Each NGO or voluntary organisation has a constitution and Memorandum of the Association containing the rules and regulations and its executive committee and general body.

- **Membership**

The general body of a voluntary organization consists of general membership fees or subscription according to the constitution of the organisation. They may be :

- ordinary members
- life members
- institutional members
- associate members, etc.

The entire responsibility of planning, guiding, implementing and monitoring of the work of the organisation vests with the general body. The office bearers (committee members or board members) are elected every three or five years in the general body, to execute its functions. The committee is responsible for the day-to-day functioning of the organisation.

In addition certain committees would be formed according to its rules to conduct its affairs. For example fund-raising committee, building committee, etc.

- **Administration**

The Chief Executive or Director is supported by a team of staff to carry out the activities of the organisation. The personnel policy helps in the day-to-day administration, recruitment

of staff, salary scales etc. in some medium and large voluntary organisations, while it is totally absent in small organisations.

Selection, implementation, monitoring and evaluation of the programs taken up by NGOs is done in two different ways. In small organisations since there is dedication and spirit of service, the work goes on and on without any of the above managerial inputs with a missionary zeal. While in the medium and large NGOs the monitoring and evaluation is conducted either by themselves or with the help of an outside agency.

Since time, energy and finance are involved in this exercise, small groups cannot afford to do so. In short, some of the grassroot level NGOs do not attach much importance to this aspect of management. The pros and cons of this attitude of NGOs is explained in details in the assets and problems of NGOs of this unit.

- **Financial resources**

One of the major constraint of NGOs is finding funds for the project. Besides the constraint of sustaining their programs they have problems of sustaining their staff, maintaining their infrastructure like buildings, vehicles and equipments.

The sources of funds for NGOs are as follows :

1. **Community financing**
   a) fee for service
   b) health insurance

2. **Self financing**
   a) income generating schemes
   b) interest on corpus funds
   c) consultancy fees - charged for services rendered to other organisations.

3. **Government funding**
   – from central or state governments under the various schemes and programs.

4. **Foreign donor agencies**
   – mostly from Western Countries e.g. Action Aid, Oxfam etc.

5. **Fund raising**
   a) donation from industries
   b) charity shows like cultural programs etc.

13.3.2 ACtivities and Programs

The activities of voluntary organisations is a combination of the following areas :

a) Training grassroot level workers like village health workers, dais etc. and develop village based health cadres.

b) Organising village communities like mahila mandals, yuvak sanghs to enhance the participation of the community

c) Involvement of local/spiritual healers and traditional medicine men of the indigenous system of medicine.

d) Various forms of imparting health education to the community with the help of folk media like puppetry, karagam, burrakatha, street theatre, jatha etc.

e) Producing effective health education materials which are simple, low cost and relevant to the local needs.

f) Evolving appropriate modifications and innovative methods in health technologies to suit local needs and constraints.

g) Tapping community resources for financial, material and labour to support the cost and management of health programs.

h) A large number of them have linked health action to a much broader strategy of development which includes all forms of education, water supply, agricultural extension and income generating activities and cottage industries.

Fields of work of NGOs include :

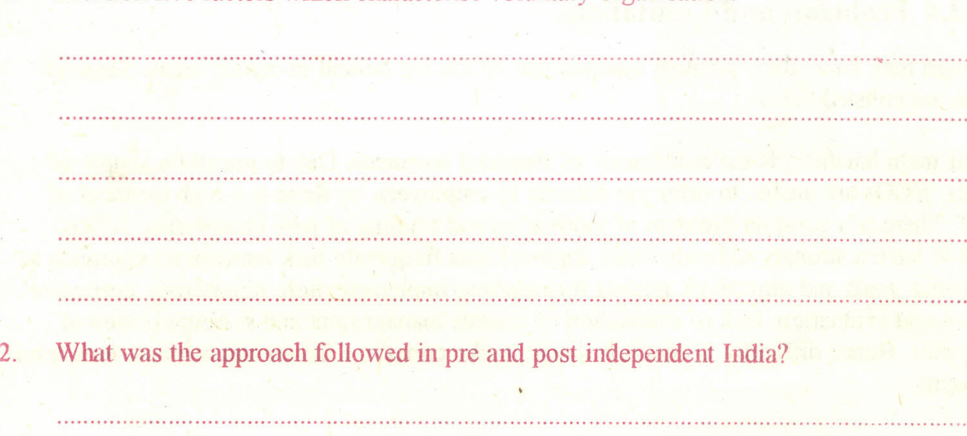
- Conscientization.
- Consumer Protection
- Drug Deaddiction
- Drinking Water
- Family Planning and Population Education
- Group formation
  * women (self-help groups)
  * youth
- Health Education
  * communication
- Leprosy control and rehabilitation
- Medical care
- Nursing
- Nutrition
- Primary Health Services
  * immunization
  * child care
  * maternal & child health care
- Health Systems Research
- Training of Rural Health Cadres
- Welfare of the handicapped
  * blind
  * deaf
  * orthopaedically handicapped
  * mentally retarded

Check Your Progress - 1

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. Mention five factors which characterise voluntary organisation.



2. What was the approach followed in pre and post independent India?

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3. Mention the two major developments which took place in the health sector in seventies.

13.3.3 Assets

Voluntary health organisations have played a significant role in the development of health care in India. Their main assets are :

a) Their capacity to obtain the services of devoted workers, particularly doctors.

b) To tap private financial resources for the development of health.

c) Demystifying education and conscientization.

d) To work out operational experiments or alternative health care models in their area. This is due partly to the personnel they can command and partly to the greater academic and administrative freedom they ordinarily enjoy.

e) Wherever voluntary agencies are working they have already analysed the local problems and in consultation with the community have come up with inexpensive grassroots level solutions.

f) NGOs have developed expertise in many non-traditional areas to plan their own schemes instead of expecting government to do so.

g) NGOs enjoy certain virtues such as nearness to the community, dedication, human-touch in dealing with social problems.

h) NGOs are highly action oriented and therefore they have a high degree of experience in field work.

i) They provide immediate response in times of crisis.

13.3.4 Problems and Limitations

Though they have many positive qualities the NGOs lag behind in certain areas. Some of them are enlisted below :

Their main handicap is the inadequacy of financial resources. Due to uncertain supply of funds, NGOs are unable to offer job security to employees, so there is a high turnover of staff. There is a constant problem of motivation and training of new incumbents. NGOs tend to have a strongly individualistic approach and frequently lack managerial approach to prioritize goals and objectives, project formulation, implementation, monitoring, corrective action and evaluation, lack of orientation to records management and systematization of activities. Hence difficulty to monitor timely, make corrective action and evaluate long term impacts.

Due to inter-action with government through grants-in-aid and introduction of professionalism in voluntary work, some of their virtues guided by voluntarism and compassion are getting eroded.

Despite valuable contribution made by NGOs at different levels in different fields, there has not been sufficiently documentation of their contribution, problems and difficulties, except for a few articles and reports. Process documentation is urgently needed for the NGO sector.

13.3.5 Government and NGOs

The government has realised that voluntary organizations are indispensable allies in the delivery of health care not only because they supplement government services but also because there is much to be learnt from their experiences, expertise and innovative ventures. The government is also aware that to-date, no systematic efforts have been made for establishing proper rapport and coordination with voluntary organizations and evolving processes for effectively integrating their efforts and activities into the national health care delivery system.

The National Health Policy (1982) makes a conscious statement for rehabilitating the role and importance of voluntary health actions at all levels and voluntary organizations vis-a-vis governments role and responsibility in this area.

The paper on 'The Approach to the Seventh Five Year Plan' of the Planning Commission lays down broad parameters open for action by NGOs. It includes planning, education, implementation including provision of services and resources both technical and financial supplementations.

The World health organization (WHO) has always considered NGOs as valuable partners in Health Development. It has encouraged practical collaboration in tripartite effort among governments, WHO and NGOs to implement strategies aimed at achieving 'Health for All by the year 2000'.

Voluntary organizations can assist in identifying needs and priorities of people at the grassroots level and help communicate them to policy makers and planners in the government. Various fora should be made available so that on the one hand, planners have access to ideas about people's needs, and on the other hand, grassroot level workers are able to influence and shape policies with regard to their own health. Voluntary organisations can thus play an advocacy role presenting people's needs and interests to the government. However, there are problem both at NGOs and government level.

13.3.6 Problems at NGO level

i) **Lack of mutual understanding**: Much NGO work is not visible and there is sometimes mistrust of NGOs and their intention. On the other hand NGOs are impatient with the bureaucratic constraints of the government and often avoid an open dialogue. Many NGOs fear a loss of identity and freedom of action, arising out of government coordination efforts.

ii) **Lack of resources**: Very often procedural or bureaucratic difficulties prevent a timely and strategic transfer of funds from governments to NGOs. This problem hinders the process of partnership and delivering the goods at the local level.

iii) **Lack of dialogue**: Lack of appropriate mechanism for dialogue and joint collaboration are mainly due to differences in policy perceptions and ideology.

Therefore in order to encourage and make the best use of the natural strength of the NGOs, ways and means must be continuously sought to overcome the difficulties and obstacles that still prevent their full participation and collaboration in the process. It is difficult to identify and evaluate mutually acceptable parameters or indicators of certain types of NGO services.

13.3.7 Problems at Government level

On the other hand there are issues within the government setup which hinders the smooth collaboration between NGOs and government.

i) **Lack of experience:** Inadequate or lack of experience within government of working with community at the field level.

ii) **Lack of reporting systems:** Difficulty to establish mutually acceptable channels of reporting, monitoring and establishing accountability.

iii) **Lack of support for monitoring:** Difficulty to monitor and evaluate multiple small scattered projects due to inadequate government staff, finances and remoteness of the project.

iv) **Red-tapism:** Procedure / red-tapism orientation of most of the officials.

v) **Lack of specific cadre:** Lack of specific official levels in the state government designated to deal with NGOs and provide guidance to them.

vi) **Inapproprite orientation:** Lack of orientation and understanding of government officials about the functioning and ethos of the voluntary sector.

In the words of Rami Chabbra, "assigning to NGOs an equal partnership role with government is yet largely at the level of rhetoric or at best exists in the higher echelons of the bureaucracy. It has failed to percolate down the line, particularly at the field level, where day to day cooperation between NGOs and government must become a reality for the objective of Health for All to be realised".

Check Your Progress - 2

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. List out any four assets of NGOs.

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2. Mention any three problems at government level.

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13.4 INNOVATIVE EXPERIMENTS OF NGOS IN HEALTH CARE

Innovative experiments of NGOs in health care are many. However, we shall, due to paucity of space, discuss six of them. Let us begin with comprehensive Rural Health Project (CRHP), popularly known as Jamkhed Model in Maharashtra

13.4.1 Comprehensive Rural Health Project (RHP), Jamkhed

In the words of Carl. E Taylor, Professor Emertius at School of Hygiene and Public Health, the Johns Hopkins University, USA, CRHP is not merely a health project, but a living example of empowering 250000 people living in the villages around Jamkhed to solve their

own problems. Today CRHP has been acclaimed as one of the best models in Primary Health Care in the world. The founders of CRHP are the prestigious Ramon Magsaysay Award Winners (1979) Dr. Raj Arole and late Dr. Mabele Arole. CRHP is an example of commitment to empower the poor and demystification of modern medicine.

Aroles, after their medical education in Christian Medical College, (CMC) Vellore, and the Johns Hopkins University, USA, had every opportunity to work in a high tech hospital anywhere in the world. Instead they decided to go to Jamkhed, in Ahmed Nagar district, Maharastra at the invitation of the leaders of Jamkhed in 1970. Jamkhed is one of the poorest areas in Maharastra. What they started as a modest service oriented health care programme in 1970 grew into a people's movement for development spreading to 175 villages. Over a period of twenty years they could reduce IMR from (1972) to 28 in 1992. About 92 percent of the children under five are given immunization. The percentage of women covered for prenatal care is 96 and 98 percent of the deliveries are attended by trained birth attendants.

Arole's attribute their success to the dedicated and committed team of health workers. That is why Mukhtabai Pol, one of the health workers at Jamkhed was, invited to Washington to share her experience. The following excerpt from the book 'Jamkhed' would reveal the power and wisdom of health workers who have transormed Jamkhed under the leadership of Aroles.

"In a huge conference hall in Washington DC, over a thousand participants listen with rapt attention to Muktabai Pol, a village health worker form Jamkhed, India. The listeners include officials from WHO and UNICEF, ministers of health, health professionals and representatives of universities from many parts of the world. Muktabai shares her experience of providing primary health care in a remote India village. She concludes her speech by pointing to the glittering lights in the hall. "This is a beautiful hall and the shining chandeliers are a treat to watch," she says. "One has to travel thousands of miles to come to see their beauty. The doctors are like these chandeliers, beautiful and exquisite, but expensive and inaccessible." She then pulls out two wick lamps from her purse. She lights one. "This lamp is inexpensive and simple, but unlike the chandeliers, it can transfer its light to another lamp." She lights the other wick lamp with the first. Holding up both lamps in her out stretched hands she says, "I am like this lamp, lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole earth. This is Health for all."

The audience rises to its feet in a standing ovation".

Aroles believed that health is beyond medicine and they believed that health could be an entering wedge into total socio-economic development. They believed and demonstrated that the very poor have a great capacity for change and can effectively take positions of leadership if given a chance and support.

Aroles have learnt the following principles while working in Jamkhed. Perhaps you may follow them if you wish to emulate Jamkhed model.

- The perceptions of poor and marginalised people are different from those of the elite and educated.
- It is not hard technology but often social action that improves health.
- The input of social sciences in primary health care must be emphasized.
- Health education should be related to the resources and culture.
- Rural communities are capable of planning and maintaining their own health.
- Medicine needs to be demystified and knowledge should be shared freely with people so that they can attain and maintain good health.
- Self-confidence must be promoted at all levels of the health team.
- Community participation does not mean confrontation.
- Taking advantage of community enthusiam leads to progress.
- It is essential to train grassroot workers who are culturally acceptable, available and accessible.

- Planning needs to be flexible.
- There must be a balance between curative, promotive, and preventive health services.
- Primary health care needs the support of secondary and tertiary services.
- Scientific knowledge must be applied to develop technology appropriate to the needs and resources of the community.
- Accept the slow pace of development.
- Integration and equity in health care.
- Primary health care means empowerment.

"Come, women, come! Bring your pots with you, the river of knowledge is freely flowing. Fill your pots and share it with everyone you meet". This is the song the health workers of Jamkhed sing to make 'health for all' a reality'.

13.4.2 Action for Welfare and Awakening in Rural Environment (Aware) Telengana Region, Andhra Pradesh

AWARE is an organisation exclusively serving the tribals and socio-economically depressed groups in Telengana region of Andhra Pradesh. Started in 1975, it is associated with more than 1,750 villages with a total population of nearly a crore. It seeks to create self sustaining rural and tribal communities through a process of their socio-economic and psychological invigoration. In its strategy of total development, health has an integral place.

AWARE started its work in sensitization and generating awareness in order to improve the utilization of services already in existence through social education. AWARE would jolt the people out of their apathy and try to mainstream the developmentally outcast groups in psychological as well as material terms. AWARE's modalities are, in a sense, indirect. They are aimed at devising systems that can furnish a basis from where the target population can itself take off. Their ultimate objective is to create alert, sustainable and autonomous communities and to reach them to a point where they can function on their own steam without further catalyzing help from AWARE.

Awareness is generated through various informal discussion, group meetings of Gram Sabhas. The focus is on subjects of topical relevance such as agriculture, rural marketing, legal rights, community health etc. Camps are also held for training in community organisation, modern agricultural methods and health workers.

The community education centre: The focus is on building the capability in the people for perceiving and solving problems. The issues discussed are - land and water use, caste inhibitions and atrocities, status of women and so on.

Economic production : AWARE supports minor irrigation works such as tanks, check dams, digging wells, lift irrigation, better farming etc. Marketing has always been a channel of rural exploitation. AWARE encourages communities to set up cooperative marketing systems through which farmers can buy and sell their produce and also familiarise themselves with marketing procedures and financial management. The small scale cottage industry in involved in making baskets, leaf plates, shoes and pottery. The rural vocational training centre trains tribal youth as carpenters, fitters, disel mechanics, welders and electrical mechanics. These trades are required directly to service the need of the tribal economy and to meet the recruitment requirements of industrial plants that are coming up in the neighboring areas of the tribal belt.

The basic needs program: This programme comprises of community health, women and child welfare, disaster and cyclone relief, legal assistance for weaker sections. The wayside clinic set up by AWARE during cyclone relief work grew into a big community health centre (CHC). Field analysis led to the conclusion that scabies, diarrhea, amoebiasis were the more common diseases due to water pollution. Creating an awareness of the benefits as well as sources of clean water became the focus of preventive action apart from treating the diseases.

The practical experience and knowledge gained from treatment and survey work serves as a useful resource for developing health education and training materials which reflect the local health context and needs peculiar to the project area.

By disseminating health knowledge the CHC's must also become 'community information centres' for example the doctors during a visit may initiate a discussion with assembled men, women and children. Often the topics discussed are land, schooling, poultry and finally health of the community.

The floating community health centre: If innovative methods are a yardstick, AWARE's boat hospital operating out of Kunavaram village is a winner. In the rugged Bison Hill Range on either side of the River Godavari, AWARE has a novel idea for reaching health care to the Koyas and Konda Reddis - the two key tribal groups. There are no roads nor any other means of easy access to these 300 villages. The only communication was the mobility offered by the river which AWARE grabbed and utilized it in an efficient way. The boat has facilities for minor operations, inpatient care, laboratory for urgent diagnostic work. There is a doctor who is aided by the ANM and a compounder. The crew is efficient and knowledgeable in boat maintenance and repair. The people who do not have any other health facility, await eagerly for the arrival of the boat to their village banks.

AWARE believes that development must be seen as an 'unfolding' of people and humanization of personal and group relations. One of the drawbacks of AWARE is inadequate health intelligence activity which is crucial to gauge the performance of the programme and its principal actors. The rich experience of AWARE and the excellent mixture of health and development activities for the overall development of the people will be lost if it is not recorded. The initiatives could be replicated in other parts of India. Unless the field experience is backed by adequate recording, analysis and documentation, it could be a disadvantage in the long run. AWARE has demonstrated to every one that health and life are inter-dependent and integrated. Factors that affect the quality of health range from food, shelter, work and education to general living conditions. AWARE succeeded in showing that all these must develop synergistically for the people to remain healthy.

Check Your Progress 3

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. What are the factors responsible for the sucess of CRHP, Jamkhed?

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2. What are the programme activities of Aware?

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13.4.3 Child-in-Need Institute (CINI) 24 - Parganas District West Bengal

CINI, started in 1974, caters to the needs of semi-urban and rural population living around the southern outskirts of Calcutta. It serves a population of over 86,000 living in 50 villages. The land is low lying with heavy rains inundating large areas of it, and inadequate roads, rendering many areas inaccessible for prolonged periods. People are generally poor and most of the households, more than 75% earn less than Rs.69/= per capita per month ! Almost 45% are rural landless labourers.

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It was estimated at the start of the project, that nearly 70% of children suffered from various grades of malnutrition. The commonest causes of mortality among children were diarrhea, respiratory illness and measles.

CINI runs a comprehensive project covering health, nutrition, education, maternal and child health, community organization for health and development and provision of organizational, logistic and training support to develop income generating activities in the area.

CINI is famous for its Thursday morning clinic at Daulatpur. It has become a familiar fact of life for the people of the area. Services are provided for growth monitoring, treatment of common childhood diseases and preventive measures like immunization, health and nutrition education.

Over many years, hundreds of women and children coming from long distances have been served. The biggest tribute to CINI's work is that, these poor women endure the inconvenience of travel and time lost in order to bring their children regularly to a centre where they know they will be served. The emergency ward and nutrition rehabilitation centre, receive admission from distant villages and slums. About 700-800 cases are admitted each year. There is strong emphasis on imparting appropriate skills to mothers to equip them with the know-how for maintaining the health of their children. The mothers stay with their children in the centre for 4-6 weeks until their children are cured. They are responsible under CINI's supervision for cleaning, cooking and caring for their children and restoring them to good health, a learning process which will have a lasting effect on the mother's competence in child management. Dr.Chaudhri, the moving spirit behind CINI says "We want to demystify medicine and to get away from the idea that health means hospitals. We want to show that people's health is in people's hands". The nutrition rehabilitation centre reflects this belief with women, rather than CINI staff, taking care of themselves and of their children. The motto, from 'DESPAIR TO HOPE' is demonstrated in this centre.

One of CINI's primary objectives is to carry out relevant ongoing field research in Maternal and child health (MCH), in collaboration with Indian Council of Medical Research (ICMR) and Nutrition Foundation of India (NFI). Some of their studies include 'factors responsible for differences in health and nutritional status of children among families with similar economic and educational status', 'the effects of women's workload and economic conditions on the nutritional status of children' etc.

CINI believes that the role of voluntary organisations is essentially to come out with innovative approaches and to support the governments large programs. CINI developed close links over the years with the state and central governments to avoid over centralization in planning and implementing government programs at the field level. Some of the collaborative programs include :

- Assistance from state government to assist in flood relief operations and train Sishu Kalyans.
- The state government relies on CINI to handle all the training aspects for all their anganwadi workers and supervisors of the ICDS programs.
- Implementation of National Smokeless Chullah Program and Rural Landless Employment Gurantee Scheme of the Government of India.
- Loan distribution under fisheries and farm activity development.

On similar lines there are many areas of collaboration with government which are going on smoothly year after year. The impact made by CINI is tremendous. The evaluation survey conducted by an independent agency in 1990 showed the following results :

> "In terms of health awareness of mothers virtually every mother was aware of the immunization schedules for children, the utility of oral rehydration therapy and methods of family planning. More than three fourth of mothers know about the need for growth monitoring. Maternal mortality is virtually nil in the project area. Infant mortality rate has decreased to well below the 'Health for all' goal of 60 per 1000 live births".

CINI is different from other NGO's since it undertakes field research with professional research institutions and scientifically prepares the research reports which is done in their

own project area. It is useful in two ways (i) to know the causes of a particular problem so that new emphasis or focus could be given to that area or (ii) the impact of a particular program. It is also a kind of process documentation which is extremely essential for any program, but very often missing in NGOs.

It is due to all the above pioneering efforts in areas where others feared to tread CINI boldly carried on its activities and it is duly recognized both nationally and internationally. It received the 1985 'National Award for Child Welfare' and was nominated by the Ministry of Health and Family Welfare, Government of India, for the SASAKAWA Health prize at the 39th World Health Assembly in 1985.

13.4.4 Health For One Million (HOM), Trivandrum, Kerala And Kanyakumari, Tamilnadu

Health for One Million program was started in 1976. The program was drawn basically from the established model with a few more items called"GOBIFFFRED"

G = Growth Monitoring	F = Food Supplement
O = Oral Rehydration	F = Family Planning
B = Breast Feeding	R = Rehabilitation
I = Immunization	E = Ecology
F = Female Education	D = Development

The success of HOM is attributed to the systematic functional structure it has evolued. The functional structure includes:

"HOM" Centre coordinator	Coordinator (Supervises 10 organizers. She evaluates and supervises the functions of organizers, promoters and volunteers and participates in their meetings)
Organizers	(Represents 20 promoters. Their meeting takes place once a month.)
Promoters	(Represents zonal level with 5 units and their volunteers. Their meeting takes place once a month).
Volunteers	(Volunteers are village level workers incharge of 20 mother leaders. Conducts fortnightly meetings)
Mother Leaders	(Each mother is a leader of 10 families and conducts fortnightly meetings with the women in their unit)
Project Population	(Called units. Each unit consists of 200 families or 1000 people)

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The above structure facilitates the flow of information from top to bottom and again from the lower level to the top level without any hindrance. They have pioneered in a two-way innovative communication process in their project. The reporting procedure is part of a two-way communication which picks up messages at each stage of transmission and promotes interchange of views and ideas which are the basis for action.

The cycle of communication starts with the flow from the coordinators' monthly meeting with the organisers. The activities are assessed, based on reports of the mother leaders fortnightly meetings at the units, filtered through the volunteers meetings at the centres and the promoters meetings at the zonal level.

Possibilities of future developmental action are figured out to help advance planning. From the latest field data collected, a statistical update is prepared. Topics for discussion at the field level are suggested in light of recent government schemes etc. The result of this exercise is a monthly 'HOM bulletin" printed in Malayalam and Tamil.

The field unit is free to respond to the above process in whatever way it likes and to provide an updated report on performance and statistical data. A bunch of copies of the bulletin travels through the organisational layers, breaking up into smaller bunches until single copies reach the volunteers at the individual units. The content of the bulletin is introduced by volunteer at the meeting of mother leaders.

Health education materials called "HOM NOTES" which comes along with the bulletin are explained to the mothers. Each mother leader meets nine other women, discuss the issues in the notes and bulletin for the next meeting where decisions are taken reflecting the view of hundreds of women. The blank spaces in the bulletin are filled and the bulletin starts on its return journey through the volunteer, promoter and organizer incorporating as it goes, the comments, if any, of all the different levels of groups and ultimately back to the coordinator. The Coordinator ultimately culls useful information and statistical data, assesses the work of the unit and sends the paper to the HOM centre for reference. It takes one month for the bulletin to complete its circular course. (Sample is given below).

The bulletin serves many purposes :

1) Education through correspondence relating to one's own activity
2) Monitoring tool
3) Evaluative control mechanism
4) Channel for data collection
5) Help for advance programming
6) Medium for exchanging information and opinion

This exercise is an excellent example of people's participation in the development and management of a program. The opinions and views of the ordinary women is taken care of and incorporated in bulletin, while simple information which the mothers need is constantly fed through the notes which helps in updating her knowledge. The bulletin serves as an efficient tool for collecting data at the grassroot level and disseminating information at various levels. The flow of information and decision is perfect with each link in the chain like mother leaders, volunteers, promoter, organizer and coordinator pooling in their ideas to complete the cycle.

When people are able to monitor and control their activity, that in itself is a measure of the people's development.

HOM Bulletin - A Sample

Bulletin No. 5/1991 | May 2/1991
Name of the unit -------------- | No. of the unit

Bulletin of March studied, used and returned : Kanyakumar - 15; Nagercoil - 15; Pilankalai - 5; Martandam - 15; Kirathoor- Ambilikonam 20+30

Report on GOBIFFFRED Activities

1.0 Health education

1.1 Dates on which the Fortnightly meetings of Mother Leaders were held

1.2 Number of participants

1.3 Topic of the HOM - Note taken

1.4 How many copies of the HOM-Note taken

1.5 How many copies of the HOM-Note distributed

1.6 How many families listened to Radio talks on Health & Development

2.0 Nutrition awareness

2.1 How many houses have kitchen garden — 1115 total so far this year

2.2 How many families in your unit — Total families in Tamil Region 8396

3.0 Family Planning (Natural)

3.1 How many families know NFP method — Total 3584

3.2 How many families follow NFP method — Total 2194

4.0 Environmental Health

4.1 How many families have safe drinking water within 200 yards — Total 930

5.0 Breast feeding habit

5.1 Number of new born babies — Total during this year 125

5.2	Their average birth weight	Average as per last bulletin 2.8 kg.
5.3	How many of them get mother's milk	Total so far 121
6.0	**Growth monitoring**	
6.1	Number of children under 5 year	Total 1278
6.2	How many have been weighed and charted	Total so far 1228
6.3	Children with normal weight	Total 1007
	Children with 1st degree malnutrition	142
	Children with 2nd degree malnutrition	54
	Children with 3rd degree malnutrition	25
7.0	**Oral Rehydration Therapy**	
7.1	Children under 5 affected with Diarrhea	Total 353
7.2	Children under 5 treated with ORT	Total 347
8.0	**Immunization**	
8.1	Children under 5 fully immunized	Total 1213
9.0	**Rehabilitation of the Disabled**	
9.1	Number of disabled children under 15 years	Total 265
9.2	Number of children with visual disability	Total 25
9.3	Number of children with hearing disability	Total 60
9.4	Number of children mentally retarded	Total 23
9.5	Number of children with epilepsy	Total 128
9.6	Number of children with other disabilities	
0.0	**Income generation activities**	
0.1	Goat rearing	
0.2	Bee keeping	
0.3	Poultry farming	
0.4	Rabbit rearing	
0.5	Community shops	

Next Organisers' Meeting June 6, 1991 at Martandam, Christu Raja Puram.

Signatures of the Sister/ Priest/ Helper	Signature of Volunteer / Promoters/Organiser

13.4.5 Raigarh Ambikapur Health Association (RAHA) Madhya Pradesh

RAHA started in 1969 in two district in eastern Madhya Pradesh with a population of 2.5 million. The Oraon tribals form 52% of the total population in the project area.

In their community health program, the activities are:- training of village health workers, traditional birth attendants, school health program, TB Control Program, Grihini program and Balwadi program.

By far the most novel program of RAHA is the Medical Insurance Scheme (MIS). The scheme was launched in 1980. In the beginning the idea of the collective effort and solidarity to carry one another's burden was very difficult to inculcate. But, later on, when the people realised that the scheme is for their own benefit and that it is actually providing low-cost-health care for local treatment, the response was tremendous.

The yearly membership fee started with Re.1/= per person per year. Presently all the members have agreed to pay yearly "the value of two kilos of rice per person". It can be done in cash or kind. This linking to a common market commodity avoids the needs for frequent change in the fee, allows for minor local variations, fosters early collection (during harvest time) and shows a yearly increase in real value to match the increasing cost of treatment. The membership grew from 2000 in 1980 to 70,508 in 1991 and is still growing. The money collected is kept at the local health centre. The members are regularly informed through the VHWs of expenses incurred or income received.

The Medical Insurance Scheme operates in a two-tier system.

1) The local insurance fund at the health centre level is called the 'SAMARITAN FUND' and is locally managed.

2) The 'CENTRAL FUND' which takes care of the hospital referrals, is centrally managed.

However, it is fed by yearly contributions from the different SAMARITAN FUNDS.

The objectives of the SAMARITAN FUND are :

a) To give free treatment to the members

b) To finance all other preventive measures as required

c) To foster early treatment (this would encourage the people to come to the centre in the early stages for treatment since it is free).

One point to be noted is that the whole family should join in order to avail of the MIS facilities.

The Central Fund - Part of the money collected for the SAMARITAN FUND (i.e. Rs.2/= per person) is paid to the Central Fund from which the hospital bills of members are usually met.

The method of referral is as follows:

Normally a sick person first reports to the VHW of his/her area, who, when the need arises informs the nurse or sends the patient to the health centre. Depending on the case, the nurse has then to decide whether the patient needs to be transferred to the referral hospital. The patient comes to the OPD (Out Patient's Department) of the Hospital with a 'RAHA REFERRAL CARD' giving essential data. If treated in OPD only, the patient pays the bill **only** up to Rs.100/= and the rest is borne by RAHA's MIS. If admitted by the doctor, he pays Rs.100/= as his share of the bill while **RAHA pays the balance** upto Rs.1250/= from the M.I.S.

No individual patient acquires the right to be admitted. Only the doctor decides when and how long a patient needs to be admitted. In case of admission, the patient, however, has to arrange for his / her own food and other requirements. RAHA closely monitors the system so that this unique, novel scheme functions properly at various levels. This is a simple, low-cost, system which is not just an insurance scheme. It acts as a catalyst for community participation. The model could be copied easily or modified to suit the needs of other NGOs.

13.4.6 The Uttari Rajasthan Milk Union Limited (URMUL Trust), Bikaner District, Rajasthan

Bikaner district is spread over an area of 27,244 sq. kms. in Western Rajasthan. The area forms a part of the great Indian desert of Thar. Less than 30% of the area is cultivable.

The first and perhaps the most striking, is the distribution of population. The scattered nature of communities and the seasonal settlement patterns make it a challenge for any organization to deliver services to the people. The second feature is migration of people either within or outside the state in search of work. There is a very high population growth rate and the female literay rate is the lowest in this state compared to the whole country. With this backdrop, URMUL Trust started its work in 1986.

A large irrigation project, the Indira Gandhi Canal has brought considerable changes to the lives of the people in the area. Some advantages include access to water, increased income and improved living conditions. Some negatives include, disintegration of the traditional social fabric and increased work loads for women. Because of the canal, people moved to scattered and interior remote villages which is inaccessible by road.

Medical facilities are scanty, as both personnel and materials are in short supply. Up to 25% of the auxiliary nurse- midwife posts in the district are vacant. The Trust sees the role

of providing a primary health care service as an entry point through which a range of development services can be made available.

To carry out its plan, the trust uses a three-tier strategy. At the village level the communities identify a local woman often a 'dai' (traditional birth attendant), to be their village health worker of 'SWASTHYA SAATHIS'. The Trust trains these women to provide pre-natal and post-natal care and conduct safe deliveries, provide education regarding immunizations, growth monitoring, nutrition and family planning and treat minor ailments. She is provided with a 'safe birthday kit' and a medicine chest.

The SWASTHYA SAATHI also act as a link between the professionals working for the Trust and the village community. She propagates low-cost home remedies such as Oral Rehydration for prevention of diarrhoea, steam inhalation for colds etc. She also assists women participating in the income generation program by monitoring the quality of products and by ensuring that they have access to raw material and production facilities whenever required. In Bajju, an 'illiterate' Swasthya Saathin named Dhapu supervises four villages in her cluster. She uses a Camel Cart to get around. Dhapu takes applications from villages relating to land disputes and water and forwards them through the Trust to the Canal Bureaucracy.

The second tier consists of extension workers who visit villages regularly. In addition to supporting and supervising the 'SWASTHYA SAATHIS' they provide a range of preventive, promotive and curative care.

The program physician and field managers make up the third tier. They provide medical care, supervision, training and administrative support.

Health service include apart from the ones mentioned above, tuberculosis identification and treatment, distribution of vitamin A, Iron and folic acid tablets to deal with Anemia, opium deaddiction, curative and referral services to hospitals.

Opium addiction is a serious problem in the area, especially in the village around Bajju where traditional hospitality includes passing around and partaking of opium. It is also used as a pain killer and sometimes as an incentive to work. The Trust uses partly medical, partly spiritual group therapy, to foster Drug deaddiction. So far one hundred and sixty persons have given up their habit. All are followed up in their homes regularly.

Malnutrition is rampant in this district. Studies have shown that there is increase in the case of malnourished women and children. A survey carried out showed that due to late weaning (24 months!) and overdependence of breast-ilk is the cause of malnutrition. Understanding their poor condition, URMUL Trust found a low-cost appropriate, easily available and affordable weaning food for children which was readily accepted by the community. The supplementary food is called 'URMUL-MIX' containing groundnuts, bajra, moth (a local pulse) and jaggery, all available locally, is either blended with milk or baked into rotis. An analysis carried out by the National Institute of Nutrition, Hyderabad, indicated that the mix contains enough protein to meet 35% of the child's daily requirement. Thus a Chronic problem was solved very easily by using simple local resources.

The impact of the health program of URMUL Trust is seen clearly in the following comparative statement.

Health Program	In 1986 situation before UT	In 1992 The improvement
Immunization Coverage :		
* D.P.T.	7.7%	74.45%
* B.C.G.	6.8%	66.37%
* Measles	6.4%	55.3%
Infant mortality rate (per 1000)	127	30
Maternal mortality rate (per 1000)	6	2
No. of persons deadicated for drugs	—	160

Other development activities include wool spinning and weaving, non-formal education, adult literacy, water harvesting, community organization - women and youth groups.

The unique characteristic of this project is the upliftment of women and empowering them to see the world beyond their veil. URMUL Trust is also a good example of how low-cost, appropriate technology from local resources could be used successfully like the URMUL-MIX. The integration of health and development is also efficiently mingled in this project.

LIST OF ADDRESSES OF VOLUNTARY ORGANIZATIONS GIVEN AS CASE STUDIES IN THE UNIT

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6. Program Director
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   Lunkaransar - 334603
   Bikaner District
   Rajasthan

Check Your Progress 4

Note: (i) Space is given below for your answer

(ii) Check your answer with the ones given at the end of this unit

1. Expand Gobifffred?

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2. HOM Means? ....

3. Mention any three functions of HOM bulletin.

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4. Medical Insureance scheme was started by ....

5. What is Samaritan Fund? What are its objectives

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6. What is the three-tier strategy of URMLL trust.

....

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13.5 LET US SUM UP

NGOs have a challenging role to play in the field of development. They have to play both complementary and supplementary roles in health care. Their prime role, however is conscientisation of all concerned - policy makers, professionals, practitioners and people at large - both providers as well as beneficiaries. However, in the wake of self mystified medical profession, a profiteering pharmaceutical industry, a conservative bureaucracy or an innocently unconcerned general public, the tasks of the voluntary organizations is uphill and the role they have to play in ushering in sustainable health for all is readily challenging!

In this unit, we have seen the history and evolution of NGOs, their organizational set up, their activities and programs, their assets and problems. We have also seen the possibilities of collaboration between government and NGOs and their hindrances. The six case studies of innovative projects from various parts of the country would have given you a birds eye view of the contribution of NGOs in supporting the health care system in India.

After going through this unit, you will agree that the poignant truth of Rober Frost's lines comes alive:

"The woods are lovely dark and deep

But I have promises to keep

and miles to go before I sleep

and miles to go before I sleep

Yes, the voluntary organisations still have to cross several hurdles to empower people to take care of their own health and development.

13.6 Key Words

Demystification : Making any science, particularly the medical science simple and easy so that people can understand and follow.

Conscientisation : Enabling the rural community, particularly the poor to be critically aware of their own situation by which they know the forces exploiting them but also begin to feel the need for collective action to free themselves from the exploitative forces.

Deaddiction : Process of enabling one self to be free from a particular harmful habit to which he/she is addited.

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13.8 MODEL ANSWERS

Check Your Progress 1

1. Expression of human will to translate a specific social vision into reality.
   - Non-profit making
   - Service oriented Meets the needs of the most disavantaged in society.
   - Meets the needs of the most disacvantage in society.
   - Believes in people' participation.
2. The approach followed in the pre-independence era was charity oriented whereas it is community empowerment in the post-independence era.
3. The two major developments are: (1) practice of involving village level health workers for primary health care and (ii) increased recognition of health as an important sector in rural development by the NGOs.

Check Your Progress 2

1. Immediate response in times of crisis
   - Conscientisation of the poor oppressed.
   - Evolving alternative experiments and models.
   - Dedication and human touch in dealing with social problems.
2. Lack of reporing system.
   - Lack of support for monitoring.
   - Inappropriate orientation.

Check Your Progress 3

1. Strong commitment to serve the poor.
   - Demystification of medical education.
   - Building a strong cadre of health workers.
   - Perceiving health as an integral part of over all development of the community.
   - Health is seen as a process of community empowerment.
2. Minor irrigation
   - Cooperative marketing.
   - Cottage industries
   - Basic needs programme

Check Your Progress 4

1. Gobifffred= Growth monitoring
   Oral dehydration
   Breast feeding
   Immunization
   Female education.
   Food supplement.
   Family planning
   Rehabilitation.
   Ecology
   Development.

अन्नाद् भवन्ति भूतानि पर्जन्यादन्नसंभव ।
यज्ञाद् भवति पर्जन्यो यज्ञः कर्मसमुद्भवः ॥ १४ ॥

From food creatures become; from rain is the
production of food; rain proceedeth from
sacrifice; sacrifice ariseth out of action 14

— Bhagvad Gita, Third Discourse

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