An attempt has been made in this chapter to discuss the
(i) concept and strategy for achieving 'Health for All by
2000'; (ii) evolution of the health policy in brief: (iii)
review of formulation and implementation of health policy:
(iv) statement of the problem and objective of the study:
(v) conceptual perspective; (vi) methodology and (vii)
limitations of the study.

1.1 THE CONCEPT AND STRATEGY FOR ACHIEVING 'HEALTH FOR ALL
BY 2000'!

Health in the expression "Health for All" means —
the availability and provision to all, services normally
associated with individual and community health which is
viewed as the necessary precondition for the creation and
maintenance of socially and economically productive life.

Primary health care approach is considered to be the
basis for achieving 'Health for All' especially in the de-
veloping countries. The Alma Ata Conference described
primary health care as: "essential health care based on
practical, scientifically sound and socially acceptable
methods and technology made universally accessible to indi-
viduals and families in the community through their full
participation, and at a cost that the community and country
can afford to maintain at every stage of their development in
the spirit of self-reliance and self-determination. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of continuing health care process" (WHO-UNICEF, 1978: 3-4).

It is, therefore, natural that primary health care should deal with the main health problems of the people and provide comprehensive, promotive, preventive, curative and rehabilitative services to all those who need such services. The nature and extent of these services will depend on the kind and magnitude of the problems, values, scientific and technological development, and above all, what the people desire to have. The essential components included are proper nutrition, adequate and safe water, basic sanitation including personal and food hygiene; maternal and child health including family planning; immunization against communicable diseases; prevention and control of local endemic diseases; education concerning health and health related matters; and appropriate and timely treatment and care for common diseases and injuries (WHO-UNICEF, 1978: 4).

The Alma Ata Declaration was accepted by the Government of India in their own health policy document (National Health Policy, 1983) which calls for the achievement of 'Health for All by 2000 A.D'. The primary instruments of this policy are the Primary Health Centres (PHC's), for a manageable block of
Having stated the strategy for achieving 'Health for All' through primary health care approach, it needs to be examined as to how far our country is following this, and with what results. In this context it would be appropriate to look at the policy developments in the field of health.

The major objective of the study is to gain insights into the role and potential of the PHCs as instruments of the NHP. This is being attempted by indepth case study of one PHC in Andhra Pradesh. I am acutely conscious of the fact that one case cannot bring forth a conclusive evidence on the actual potential of the PHCs as the policy instrument. However, it should, nevertheless provide one an understanding of the working of PHCs.

Before we take up the specific case study we would like to briefly present the background to the evolution of the policy and the public health system in India.

1.2 EVOLUTION OF THE HEALTH POLICY AND THE PUBLIC HEALTH SYSTEM

The idea of developing Primary Health Centres (PHCs) as the focal point for providing comprehensive, curative and preventive health services in the rural areas in India was

* For a detailed presentation of the evolution of the health policy, see appendix V : 74-110.
presented by the 'Health Survey and Development Committee' (1946) also known as the Bhore Committee. It was conceived as an organization that was relatively simple to provide health services for the rural population of the country.

Since then the PHC organization has been subject to many changes based on the recommendations of the various committees setup by the government from time to time to review its progress and suggest future course of action. Quantitatively, there has been a significant increase in the establishment of PHCs and sub-centres, and the number of medical and paramedical personnel. Qualitatively, there have been four major changes (GOI, 1987). Firstly, many special mass campaigns related to communicable disease prevention have been integrated with PHCs, in terms of their staff as well as functions. Thus there have been national programmes for specific health problems related to tuberculosis, malaria, leprosy and blindness prevention. Secondly, there has been a functional integration of work of the personnel at PHCs. This has led to the creation of male and female Multipurpose Workers. Thirdly, a twenty-five bed hospital has been developed for every four PHCs in the country and; finally, and perhaps most importantly, a decision was taken by the Government of India in 1977 to entrust people's health in people's hands by offering opportunities to village communities to choose from among themselves a person who would work as a Community Health Volunteer (CHV. now called Health Guide). The government authorities also arranged for
the training of CHVs, paying them an honorarium and supplying some drugs and equipment.

However, the progress achieved, up to the early 80's in the area of primary health care and in general the health status of the people, had not been encouraging. The demographic and health profile of the country still constituted a cause for serious and urgent concern. The high rate of population growth (see table 1.1 & 1.2), high mortality rates for women and children continued to have an adverse effect on the health of the people and the quality of their lives. Efforts at raising the nutritional levels did not bear fruit and malnutrition continued to be exceptionally high.

Table 1.1:
Birth Rate, Death Rate and Natural Growth Rate in India (1976-1983):

<table>
<thead>
<tr>
<th>Year</th>
<th>Crude Birth Rate R</th>
<th>U</th>
<th>C</th>
<th>Crude Death Rate R</th>
<th>U</th>
<th>C</th>
<th>Natural Growth Rate R</th>
<th>U</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>35.8 28.4 34.4</td>
<td></td>
<td></td>
<td>16.3 9.5 15.0</td>
<td></td>
<td></td>
<td>19.5 18.9 19.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1981</td>
<td>35.6 27.0 33.9</td>
<td>13.7</td>
<td>7.8</td>
<td>12.5</td>
<td>21.9</td>
<td>19.2</td>
<td>21.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1982</td>
<td>35.5 27.6 33.8</td>
<td>13.1</td>
<td>7.4</td>
<td>11.9</td>
<td>22.4</td>
<td>20.2</td>
<td>21.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td>35.3 28.3 33.7</td>
<td>13.1</td>
<td>7.9</td>
<td>11.9</td>
<td>22.2</td>
<td>20.4</td>
<td>21.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

R=Rural, U=Urban, C=Combined.

Source: Health Information India - 1988: 30-31
CBHI, DGHS, Ministry of Health and Family Welfare,
GOI, New Delhi
Table 1.2:

Infant Mortality Rates in India (1976-1983):

<table>
<thead>
<tr>
<th>Period</th>
<th>Infant Mortality Rate (per thousand live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
</tr>
<tr>
<td>1976</td>
<td>139</td>
</tr>
<tr>
<td>1981</td>
<td>119</td>
</tr>
<tr>
<td>1982</td>
<td>114</td>
</tr>
<tr>
<td>1983</td>
<td>114</td>
</tr>
</tbody>
</table>

R=Rural, U=Urban, C=Combined.

Source: Health Information India - 1988: 37
CBHI, DGHS, Ministry of Health and Family Welfare, GOI, New Delhi

Table 1.3:

Notified cases of cholera and positive cases of Malaria in India (1976-1983):

<table>
<thead>
<tr>
<th>Year</th>
<th>Cholera Cases</th>
<th>Cholera Deaths</th>
<th>Malaria Cases</th>
<th>Malaria Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>17,492</td>
<td>861</td>
<td>64,67,215</td>
<td>59</td>
</tr>
<tr>
<td>1981</td>
<td>6,073</td>
<td>200</td>
<td>27,01,141</td>
<td>170</td>
</tr>
<tr>
<td>1982</td>
<td>4,693</td>
<td>217</td>
<td>21,82,302</td>
<td>187</td>
</tr>
<tr>
<td>1983</td>
<td>9,202</td>
<td>432</td>
<td>20,12,605</td>
<td>239</td>
</tr>
</tbody>
</table>

Source: Health Information India - 1988: 151-154
CBHI, DGHS, Ministry of Health and Family Welfare, GOI, New Delhi
Malaria which was almost eradicated had staged a comeback (see table 1.3). It was estimated that there were eight million active cases of tuberculosis in the country of which two million were believed to be infective sputum positive cases. The population at risk of filariasis had increased from 25 million in 1953 to 136 million in 1975. India had one-third of the leprosy affected persons in the world and half of its population was at risk of the disease. Although cholera had been significantly reduced other water borne diseases still account for a large proportion of morbidity and mortality, especially among children. Acute diarrhoeal diseases alone were believed to take away 1.5 million lives each year. Communicable and non-communicable diseases therefore still had to be brought under control (ICSSR-ICMR, 1981: 6-7).

The situation as prevalent during the early 80's, according to health administrators and experts, was due to the wholesale adoption of the western models of health care (hospital based and cure oriented) which are inappropriate and irrelevant to the needs of the people. The existing approach according to them had resulted in the development of a cultural gap between the people and the personnel providing care, and had enhanced dependency instead of self-reliance. In this context it was felt that an integrated, comprehensive approach towards future development of medical education, research, and health services required to be established to serve the health needs and priorities of
the country. *(ICSSR-ICMR, 1981 : 81-84)*

To put an end to the then existing all-round unsatisfactory situation, the NHP statement *(1983)* underlined an urgent need for restructuring the health services around the following broad approaches:

1. Provision of a well dispersed network of comprehensive primary health care services with the organized support of volunteers, auxiliaries, paramedics, and adequately trained multipurpose workers.

2. Large scale transfer of knowledge, simple skills and technologies to Health Volunteers, selected by the communities and enjoying their confidence.

3. Positive efforts to build up individual self-reliance and effective community participation by enlisting the support of local leaders, village elders, registered medical practitioners, local organizations like *mahila mandals* and youth clubs.

4. Establishment of a well worked out referral system to provide adequate expertise at the various levels of the organization setup nearest to the community depending upon the actual needs and problems of the area. This it was expected, would ensure the optimal utilization of expertise at the higher levels of the hierarchical structure.
5. High priority was be accorded to high risk groups, underprivileged segments of the population living in remote and underserved areas.

6. For proper utilization of primary health care services, the PHCs and sub-centres had to be geographically accessible to the people.

7. Inter-sectoral coordination of health was to be ensured between health and health related sectors like agriculture, 
   pharmaceuticals, housing, environmental sanitation, 
   nutrition, social welfare, education, medical education and 
   rural development. The policy also called for a decentralized primary health care system for harmonizing the activities of 
   the various sectors that jointly promoted development.

8. Full utilization of untapped resources through organized logistic, financial and technical support to voluntary 
   agencies active in the health field.

9. Greater emphasis was to be placed on communicable diseases (malaria, leprosy and tuberculosis), and establishment of a 
   nationwide network of sanitary-cum-epidemiological stations to tackle the entire range of poor health conditions.

10. Special efforts were to be made for the disabled to offer them mental health and medical care and physical and 
    social rehabilitation.

11. In addition to the above approaches the policy also emphasised the need for integration of indigenous systems of
medicine at appropriate levels in the delivery of primary health care services.

12. As a part of the concern, appropriate training of the health personnel oriented to the peoples needs was suggested. This was to form an integral component of the National Medical and Health Education Policy.

13. Establishment of practice by private medical practitioners.

14. Strengthening of ophthalmic care facilities at the peripheral and intermediate levels for control of blindness.

15. Strengthening of the health information system for assessing medical and health manpower requirements, monitoring and evaluating the various ongoing programmes.

16. Emphasis was to be placed on applied, operational research for improving the delivery of health services (NHP, 1983 : 33-50).

There has not been any further review of the health policy since 1983.

The burden of implementing the welfare programmes rests with the state governments, while resources and policy directives are provided by the central government. The Government of Andhra Pradesh has been broadly following the policies laid down by the centre with respect to medical and public health, with greater emphasis on the curative aspects
of health care. For further details, see appendix V: 74–107.

Although the National Health Policy aimed at achieving 'Health for All by 2000', studies have shown that the performance of the Primary Health Centres is still far from satisfactory and they have failed to achieve the purpose for which they were established.

From the rapid review of policy it is obvious that the institution of PHC's was the fulcrum around which the 'Health for All' was designed. How effective were these as the instruments of the policy. The studies reviewed in the following sections throw light on this problem in the context of policy formulation and implementation.

1.3 REVIEW OF FORMULATION AND IMPLEMENTATION OF HEALTH POLICY

For the purpose of this study the following literature has been reviewed which can be broadly classified under four major heads.

(1) those dealing with the evaluation of health policy

(2) those concerned with health administration – Prapulla Dutta (1955); Dutt, P.R. (1962); Raghu Ram N.V. (1971); Raghavender Rao (1975); Naik J.P. (1977); Park and Park,


Although the Bhore Committee had recommended establishment of a strong primary health care system, and had suggested an intersectoral approach to health services development, the experience of the last forty-four years had not been very encouraging.

In 1978, the Planning Commission undertook a review of the performance in the health sector, and identified several draw backs. According to the commission, our health care
delivery system did not take into consideration the social, economic, ecological factors, conditions of work etc., secondly, it was concentrated mostly in the urban areas; thirdly, it was based on medical education system which orients the doctors not for the health of the people but instead for medical practice; and lastly, it undermines the traditional health care systems, and encourages the use of drugs (Bose A, 1983: 35).

Many studies on the health policy (Qadeer, I, 1985; Banerji, D. 1985; Pannikar, P.G.K. 1976) have pointed out that health services were essentially curative oriented. capital intensive, hospital based, and urban oriented. Given this kind of an imbalance in the development of health services, "two types of subsystems existed simultaneously. One consisted of 'illequipped primary health centre network for the rural areas which is starved of resources, and the other was the better equipped hospital network in urban areas which gets the lions share of the total resources" (Qadeer, I, 1985: 205).

Studies (Ram and Dutta, 1976: 136-137; Reddy, 1989: 123-124; Mouli and Guruswamy. 1982: 28-37; Ashish Bose, 1987: 11-15) show that health policies have not taken note of problems of physical accessibility and logistic support which are essential to attained 'Health for All' by the year 2000. According to them, as far as planning for health was concerned the planners have adopted a uniform pattern for the establishment of primary health centres, and sub-centres
throughout the country based on population size.

In addition to these studies, the Indian Government sponsored a study group set up by the ICSSR-ICMR in 1980, to look into the social aspects of medicine with a view to suggest reforms which would lead to improvement in the health status of the people.

The Committee recognized that the implementation of health policy has been defective and that there is a wide gap between theory and practice in this regard. According to the committee, the health services functioned as two, different systems, one the modern, expensive, curative and highly professionalized health system, and the other, a conglomeration of semi-professionals, and paramedical personnel, based in primary health centres in rural areas which was expected to provide preventive services but is actually delivering poor quality curative services (ICSSR-ICMR, 1981:89).

The Committee also observed that the 'camp' and 'target' approach advocated by the present professional workers was highly disruptive, and should be replaced by continuous, and sustained activity which is effective (ICSSR-ICMR: 1981:114).

According to the committee report, medical education and the health care delivery system have gone their separate ways, and there was little congruence between the role of the
physician, and the needs of the society. The report also states that "the growth of the health services in the country had been haphazard, and unrelated to the needs of the poor. Overcentralization of authority and compartmentalization still continued to plague the services despite several efforts to bring about integrated comprehensive health care, and that the health personnel structure was still distorted (ICSSR-ICMR; 1981: 156-157).

Accessibility to health care institutions was determined not only by spatial distribution of services but also was determined by the social position that the person seeking treatment occupies in the community (Banerji, 1984).

Banerji (1984) also observes that the primary health care network as other welfare services were inaccessible to the poor. The overall image of the Auxiliary Nurse Midwife is that of a person who is quite distant from them, and was meant only for special people or for those who can pay for her services.

Studies conducted by the Public System Group, IIM, Ahmedabad, 1985 in the States of Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan, identified programme as well as non-programme factors which play an important role in the implementation of Family Welfare Programmes. The programme factors identified included (a) short term of Health Secretaries, and Directors coupled with political pressures at the state level; (b) inadequate powers to the District
Medical and Health Officers, and primary health centre Medical Officers; (c) Medical Officers strongly oriented towards clinical practice with very little training in public health, (d) poor infrastructure facilities (e) poor management information system (f) involvement of Medical Officers in private practice, and (g) lack of motivation and morale on the part of the primary health centre staff.

The non-programme factors identified included political disturbances in states; drought and scarcity; migration; support received from kingroups; level of education of the people; other welfare programmes operating in the area; income, religion, and caste. The group also pointed out that services provided at the primary health centres were highly unsatisfactory, and lack of concern for quality rather than lack of facility was responsible for poor performance.

According to the study, the training of the village Dais, and the Health Guides was not adequate as it was imparted through lower level functionaries, and the doctors (at the primary health centres) take very little interest. As a result, these functionaries were not performing the functions envisaged in the programme.

From the observations of the study sponsored by the division of human resource development research, and the ICMR, in 1989, it was clear that the quality of family welfare services rendered through the primary health centre network was poor, and that the maternal and child health
component was substantially weak in most instances. Even in those primary health centres where the availability of manpower, and infrastructural resources was adequate, it was observed that the quality of maternal and child health, and family planning services was still not satisfactory. The study recognizes that while enough attention was to be given for improving the manpower, and other infrastructural facilities, greater emphasis was required to enhance the managerial, supervisory, and technical skills of medical, and other health functionaries for improving both the quality, and coverage of maternal and child health, and family planning services. Further the study calls for continuous monitoring, and evaluation which are two very important tools for improving the performance - both qualitatively, and quantitatively.

According to some of the studies (Jorapur, P.B 1979 : Sholapurkar, et.al 1983) the primary health centre being the lowest administrative unit, and the sub-centre being the most peripheral service delivery point for various primary health care programmes, can deliver efficient and effective comprehensive health services provided some of the bottlenecks discussed above are removed.

1.4  STATEMENT OF THE PROBLEM AND OBJECTIVE OF THE STUDY:

The overall impression of the research scholars, research teams, government evaluation reports on the performance of Primary Health Centres, and in particular the
family welfare services is that they have failed to achieve the purpose for which they were launched. The studies (Public System Group, IIMA, 1985) have identified a number of factors responsible for the poor performance of these centres. However, a wholistic approach based on in-depth studies of the PHC's as an institution within the system of social relations is absent.

Most of the studies quoted above have evaluated the performance of these centres in terms of the Family Welfare Programme which includes family planning and maternal and child health services. Other important health programme components such as control of communicable diseases, school health, health education and environmental sanitation which are an integral part of primary health care services have not been given sufficient attention. In order to understand the functioning of a centre in its totality, appraisal of all primary health care components is essential. This kind of an exercise will show whether or not a particular Primary Health Centre is providing integrated comprehensive primary health care services at the doorsteps of the people through the organized effort of the health personnel and the community. If not, why?

Let us, at this stage, briefly discuss the structure of our thesis in the context of the holistic evaluation of the PHC as an instrument of National Health Policy.
First step in this would be to study the organization structure of the PHC to see how its functions are differentiated and coordinated to achieve its objective. Studying the organization structure alone is not enough, we also need to study the various important processes implied within the organization as a functioning whole such as - a) selection procedures (which ensure selection of right persons for the jobs); b) socialization and training procedures (which help the personnel to understand what the organization expects from them and enhances their ability to fulfill these expectations); c) evaluation of the performance of the personnel with regard to various activities; d) target setting practices which monitor the degree to which the objectives of the organization are being met and provide the means for remedial action; and e) supervision and supervisory practices to check whether the personnel are actually performing their job or not.

Apart from the organizational processes mentioned above, formation of groups based on differences in social background of the personnel, availability of resources to the PHC, working conditions of the personnel and their linkages with the beneficiary community could influence linkages at the grassroot level which in turn could be a positive factor in achieving the objectives of the organization. However, these are some of the areas which the studies (ICMR, 1989) have not adequately addressed. Therefore examining these would provide us with insights into the functioning of the
centres, and could give leads into the exploration of alternatives both at the level of implementation and at the level of policy.

Again the studies (Public System Group, IIMA, 1985) have not taken into account the perceptions of the beneficiary households at the village level regarding the outreach of services while evaluating the performance of the centres. Some studies (David, L.H and Narayana, G, 1983, 1985) have tried to logically show that there is a tendency to inflate performance figures; however these are not tested by interviewing beneficiaries. Our study takes into account the perceptions of the beneficiary households at the village level. This should prove useful for two reasons, firstly, it would show whether the centre is performing its role as designed and secondly, it would also show whether or not the services are functionally accessible to the people for whom they are meant, that is the poor and the underprivileged segments of the community.

Let us briefly present a resume of the argument thus far. The prime objective of the proposed study is to gain insights into the role and potential of the Primary Health Centre (PHC) as an instrument of the National Health Policy.
This objective can be achieved by examining some of the important components of the health care delivery system which include:

1. the analysis of the existing organization structure,
2. the recruitment, selection, training and social background of the personnel,
3. work load, programmewise performance of the personnel and target setting practices,
4. supervision and supervisory practices, and linkages with the community,
5. socio-demographic profile of the beneficiaries,
6. perceptions of beneficiaries regarding outreach and utilization of primary health care services at the village level.

In the sections below we shall examine each of the above components of the PHC in the context of the theory of formal organization.

1.5 **CONCEPTUAL PERSPECTIVE:**

In sociological terms one can conceptualize the Primary Health Centre (PHC) as an organization to understand and explain its role and functioning. The PHC like other formal organizations (as defined by various social and behavioural scientists—Blau and Scott, 1963; Etzioni, 1964; Parsons, 1960 et al) is composed of individuals and groups who have come together to achieve certain objectives employing
deliberate means to coordinate and direct the activities of the organization over a period of time.

The PHC according to the typology of Blau & Scott (1963) can be classified as a "service organization" where the clients or "public-in-contact" is the prime beneficiary. Its main objective is to provide integrated health care, both curative and preventive, and to serve as a focal point from which health services radiate into the area covered by the development block. It is supposed to educate the individual, the family and through them the community. This objective is expected to be achieved by providing the following services: (i) medical relief; (ii) control of communicable diseases; (iii) environmental sanitation; (iv) maternal and child health services; (v) family planning; (vi) school health; (vii) health education, and (viii) collection of vital statistics (GOAP, 1985: 1-2).

1.5.1 Organization Structure:

In order to fulfill the above objectives, the PHC has to depend upon a well articulated organization structure each component of which should be suitably designed to achieve the objective of the organization. Since the sub-centres are the most peripheral units which deliver services in the villages we shall start the analysis of the existing organization structure at this level and proceed upwards to the district and state levels. This is being done because these centres do not function in isolation but function as a part and parcel
of the broader healthcare organization. It is the district level authorities who are responsible for planning, executing, and evaluating all the programmes in the district as per the policy guidelines of the State Directorate. We will therefore analyze the structure at the district as well as the state level.

The organization analysis will be done from two points of view: (i) the structural perspective, and (ii) the behavioural perspective.

While it is possible that there are many ways in which the work in organizations can be performed, two major types of differential functions can be identified: those differing along the "horizontal" dimension of the organization, and those differing along the "vertical" dimension (Strother, 1963: 23).

The structural analysis, therefore, will be done taking into account the horizontal and vertical differentiation and integration with emphasis on coordination at different levels. Two aspects of coordination, intradepartmental and interdepartmental will be covered. This exercise will be essentially of a qualitative nature.

"Horizontal" differentiation refers to the division of activities among individuals and groups all of whom occupy the same authority, and responsibility level. In other words, this kind of differentiation can be labelled as "division of labour" (the various ways in which the personnel
may be grouped together in an organization. "Vertical" differentiation deals with differences along dimensions such as the amount of authority or power an individual has, to influence organizational actions, the degree of responsibility he has for these actions, and the number of personnel he or she supervises. Vertical differentiation within organizations provides for specialized types of coordinative activities. The division of labour on the horizontal plane creates the need for this type of function (Strother, 1963: 23-25).

Most organizations are confronted with the task of reducing instability, and unpredictability of individual actions. This is achieved by a system of authority, status and role differentiation. According to Katz and Kahn, compliance with authority becomes a generalized role expectation in organizations (Katz and Kahn, 1966: 203-204). "Roles" are sets of expectations that are attached to organizational positions. They provide a coordinative device both for the members who occupy the positions, to which the roles are attached, and for the other members of the organization who come into contact with them. For the occupants, the role helps to define the limits of the activities to be performed by providing a basis for deciding what should or should not be done. Others who come into contact with the occupant of a role, can adjust their own efforts in the context of the mutuality of their role - relationship. In most formal organizations the roles played
by the people are a "function of the social setting than of their own personality characteristics" state Katz and Kahn (1966: 174).

Given the horizontal and vertical differentiation of functions, the behavioural aspects within the structural framework assume importance.

**Differentiated** functions associated with **specific** 'roles' and 'statuses' are a necessary part of any organization. However, certain consequences that occur may or may not be **beneficial** to the organization. **Firstly**, the way in which functions are divided among the different **personnel**, especially with regard to the horizontal division of labour, strongly determines who will interact with whom. Sometimes the structure forces people to interact more with some persons rather than with others and also aids in the formation of informal groups within the organization. Though division of labour does not completely determine these interactions it could place certain restrictions on the **activity** of the personnel leading to disharmony within the organization. The longer the period of time over which particular patterns of interactions occur, the more stabilized they may become; often leading to the emergence of an informal structure within the formal structure of the organization. In this sense, the structure, and differentiated functions with their resulting interaction patterns cannot be considered as two separate entities.
Secondly, differentiated functions affect the attitudes of individuals in different positions within the organization. When a person must concentrate more on a specific aspect of the total work, he/she may develop certain dogmatic viewpoints about the importance of the specialized activities which are so much a part of his/her immediate experiences (Herman and Hulin, 1972; Schneider, 1972; Porter and Stone, 1973). The attitudes or viewpoints thus developed will, in turn, affect the individual's relations with other people; his/her motivation to perform effectively; and the degree of commitment to the organization as a whole. Thus differentiation of functions is one of the crucial factors influencing an individual's attitudes towards his/her job, colleagues, and the organization.

Differentiation of functions (horizontal and vertical), coordination of activities at different levels, and the infrastructural facilities available have been discussed in chapter II of the thesis.

1.5.2 Social background, selection and training of personnel:

To ensure the achievement of objectives, organizations need certain formal processes and one such process is related to personnel which includes social background of the personnel; recruitment and selection; socialization and training -(pre-service & in-service); experience in the present job; transfers; and emoluments. Besides these processes, the value orientations of the personnel towards
their job also affects their performance on the job.

Differences in social background characteristics of the personnel could impose certain constraints on inter personnel relationships, formation of groups and team work within the organization. As we have already seen hierarchical organization serves an important function for achieving coordination which it does by restricting the free flow of communication. These hierarchical obstacles to communication may foster consultation among peers and may give rise to an informal differentiation of status which may create obstacles in communicating with each other just as the formal status differences do. Therefore an attempt has been made to study the social background of the personnel. Social background broadly measured in terms of religion, caste, nativity, and educational qualifications gives an indication of the homogeniety and heterogeniety of personnel working in the organization. The social background characteristics have been discussed in chapter III of the thesis.

Recruitment involves finding manpower, and encouraging potential employees to seek jobs in the organization. Recruitment is done either by advertising or through employment exchanges or through professional associations. Here job specification serves as a major guide to select the right persons for the right job. This is important as it is bound to influence the working of an organization.

Once the selection process is complete, the personnel
and the organization have to mutually learn to adjust towards each other (socialization). This helps the personnel to understand their role in the organization, and their capacity to fulfill its objectives. Effective socialization can influence their commitment to the organization. One important and explicit means of promoting socialization of the new as well as the existing employees is 'training' - (both in-service and on-the-job). The employees need training to develop the necessary technical skills that are needed to carry out their job effectively. Thus a training programme should provide for the learners active participation, knowledge of results about his or her attempts to improve, a meaningful integration of the learning experience so that the trainee can transfer what is learnt to the job situation, and for practice and repetition in a situation that is similar to the job situation (Porter et al., 1975:211). Given these positive aspects, the effectiveness of training depends on the curriculum developed, nature of training, design of the programme, and facilities available.

Transfers and orientation of the members towards their job are two other important ways which could influence the overall performance of the PHC organization. Transfers are generally meant to ensure that an individual does not develop too deep loyalties with certain sections of the beneficiaries, and use the local influences for pecuniary benefits. At the same time the positive aspect of transfers is the general knowledge of different areas and aspects of
the organization. The experience gained from one area can be transferred to another area. However, the transfers when too frequent could be a seriously disturbing element in the system as well. Number of years of experience and transfers go together. Frequent transfers can influence the working of the organization either in a positive or a negative manner. Therefore it is important to know the number of times the personnel are transferred, and their perceptions and preferences regarding transfers.

Orientation of the employees towards their job is important as it could profoundly influence the functioning of the organization. Orientation involves attitudes, a member in an organization imbibes towards its functioning. This involves a) internalising the goals and values of the organization and b) learning appropriate ways of behaviour conducive to the health of the organization and its members. Orientation has been studied in terms of the employees personal preference vis-a-vis the priorities laid down by the organization with regard to the various primary health care programmes. The members of an organization usually weigh the advantages and disadvantages of being in service in terms of their satisfaction with regard to the job, promotions, salary, colleagues, cooperation from villagers and facilities available.

The recruitment, selection, training, transfers and orientation towards their job have been discussed in chapter III of the thesis.
1.5.3 Programme wise performance and target setting practices.

The performance of any organization should be measurable in simple and quantitative terms. All employees are expected to perform various tasks in their individual capacity as well as members of a team to ensure that the objectives of the organization are met. Performance evaluation is essentially a process by which the actual and expected performance can be compared. It is a process designed to both, facilitate information exchange, and influence performance. Data from such an evaluation helps in pinpointing the strengths, the weaknesses of the members, as well as their individual potential to grow further within the organization. It (the evaluation) can lead to a clearer definition of the job to be performed, and also helps in improving the relationship between the Supervisors, and the Workers regarding what constitutes acceptable performance.

Thus one reason why organizations need to appraise performance is that they need the information it yields in order to plan, coordinate, and administer training and development programmes to overcome the weaknesses of the low performers, and to increase the potential of the high performers. The performance appraisal process is also used by organizations as a way of influencing intrinsic, and extrinsic work. Rewards such as promotion, and pay increases are often tied to the results of performance appraisal in the hope of creating the belief that good performance leads to
desired rewards, In case of poor performance, the feedback may become difficult to accept especially if the employee hopes to obtain extrinsic rewards resulting in conflicting situation. From the superior's point of view, evaluating a subordinate's performance and giving a feedback may not be very pleasant especially when the feedback is negative. In such cases unpleasant interpersonal situations may develop between the supervisor's and their subordinate's.

The performance of the members can be evaluated from two perspectives. It can be looked at in terms of the activities the personnel perform and it can be seen also in terms of the results of that activity. Performance evaluation can focus either on results, or activities or both. Research findings on performance evaluation suggest that focussing on results produces a different impact than focussing on activities or on a combination of the two (Tosi, Rizzo and Carroll, 1970: 70-78).

Focussing on results often motivates employees to behave in ways which are dysfunctional from the point of view of organizational effectiveness but provides good scores on the measures, that is, workers tend to perform well only in those areas in which they are evaluated, especially if the evaluation determines whether or not they receive rewards. Evaluation based on results may fail to provide the information needed to counsel, and develop individuals.
Evaluation of performance which focusses only on the activities the person engages in, tends only to motivate the activity rather than what is being accomplished. Thus any performance evaluation system if it is to meet the objectives of the organization as well as its personnel must measure both activities, and results.

Sometimes there may be a wide gap in the expected and actual performance of the personnel. This could be because of, a) excessive work load, or b) too high targets. Excessive work load would include the population to be covered, number of villages to be covered, distance to be travelled from place of stay to place of work, time spent on travel and mode of transportation. With regard to target setting practices it is important to know as to who sets the target, what is the basis of target setting, and whether targets are given to individuals or the teams.

The workload, programmewise performance of the personnel, and target setting practices have been discussed in chapter IV of the thesis.

1.5.4 Supervision. Supervisory practices and linkages with the community:

Supervision and supervisory practices are often tied with control and delegation of authority. They have to be designed in order to help the members effectively meet organizational expectations as well as to check the degree to
which the personnel are actually doing so.

The supervisor is the critical link in the chain of command within the organization. To most Workers what the Supervisor says and does, represents the attitude of the organization. The Workers view the organization as favourable if their Supervisor is good, and unfavourable if their Supervisor is ineffective. A Supervisor therefore must have the necessary skill, and competence of the activities to be performed under his direction, and must set, and maintain standards of performance in terms of quantity as well as quality. He or she must be able to appraise the skill, competence, and contributions of the Workers he or she directs, and must be able to make decisions and at the same time create an assurance of fairness and equity for all the Workers of his or her team. The Supervisor must help, stimulate, motivate, control, and lead his/her team workers. In essence the Supervisor is the leader of his group and has to get the workers to do whatever work is to be done.

Supervision and supervisory practices can be examined in terms of frequency of interaction between Workers and Supervisors, amount of time spent, tasks supervised, type of instructions given, nature of controls exercised (recognition for good performance and reprimands for poor performance), and time spent at PHC monthly meetings.

Level of interaction and relationship between the personnel and village level workers has also been examined in
this chapter. This is important because the personnel are supposed to coordinate their work at the village level with the help of the village level workers. Maintaining proper communication linkages with the village level workers is not sufficient in itself and the Workers have also to maintain proper communication linkages with other prominent members of the village community, and voluntary organizations who could aid in the effective implementation of the primary health care programmes. This is because the villages in India exhibit certain unique features of unity and diversity in terms of its 'caste', 'class', and 'power' composition resulting in different types of relationships, and pattern of interaction between units.

Supervision and supervisory practices and linkages with the community have been discussed in chapter V of the thesis.

1.5.5 Sociodemographic profile of the beneficiaries:

An important component of all service organizations is its 'clients' or beneficiaries. Therefore provision of adequate health care services always depends on the interplay of the beneficiaries, the providers, and other social factors.

Whenever beneficiaries approach health personnel they have an image which reflects the societal definition of the health personnel's role and expectations. These perceptions are formed by the beneficiaries own experience or from
earing about experiences of other people (significant others), It is within this frame of reference that the beneficiaries attempt to evaluate the health personnel performance and also the performance of the organization as a whole. Therefore in order to understand the working of the HC organization in its totality it is important to study the beneficiary component,

As the primary health care services are meant to be delivered at the village level, the location of villages vis-à-vis the health centres, size of settlements and amenities available would show whether the centres are geographically accessible to the beneficiaries.

Examining the social background characteristics of the beneficiary households in terms of their caste, religion, income, occupation, type of family and size of the households could tell us who the users of these services are as they are essentially meant for the socially and economically backward sections of the community.

The sociodemographic profile of the beneficiaries, the location and amenities available to them have been discussed in chapter VI of the thesis.
1.5.6 Outreach and utilization of primary health care services as perceived by the beneficiaries:

Perceptions of the beneficiaries regarding the outreach and utilization of primary health care services to a large extent would reflect the performance of the personnel and also the PHC. Perceptions of the beneficiaries would provide information on the extent to which the general public is availing the various services being provided, the problems encountered in utilising the services, and what they expect from the health centre and its personnel.

The outreach and utilization of primary health care services as perceived by the beneficiaries has been discussed in chapter VII of the thesis.

1.6 METHODOLOGY:

The methodology used in this study is essentially case study method. We have chosen to study indepth one PHC in terms of its organization structure, its functioning, and its outreach and utilization by the beneficiaries. It is exploratory and uses both quantitative and qualitative indicators to describe the status of the PHC as a tool for implementing the policy which expects to achieve 'Health for All by the year 2000'.
1.6.1 Area of Study:

This study has been conducted in Ranga Reddy district of Andhra Pradesh. The district is primarily a rural hinterland for Hyderabad city, but is backward in terms of overall development. The district was previously divided into eleven taluks but now in the revised administrative setup the district consists of thirty seven revenue mandals.

The total geographical area of the district is 7,498 Sq.kms. and has a population of 15,82,062 according to the 1981 census. The district has 949 inhabited villages, and the density of population is 211 per square kilometre. The literacy rate for the district as a whole is 29.41%. However among the women the literacy rate is as low as 19%. If one looks at the amenities available in the district one finds that medical services, market facilities, communications, and posts and telegraphs are inadequate in villages which have a population of less than 5000. The table below gives a picture of the amenities available in the district.
Table 1.4:

Distribution of villages according to population range and amenities available in *Manga Reddy* District.

<table>
<thead>
<tr>
<th>Population range</th>
<th>Number of inhabited villages</th>
<th>Education</th>
<th>Number (with percentage) of villages having the amenity of</th>
<th>Medical</th>
<th>Drinking water</th>
<th>P &amp; T</th>
<th>Market</th>
<th>Communication</th>
<th>Approach by pucca road</th>
<th>Power supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 499</td>
<td>250</td>
<td>170</td>
<td>6</td>
<td>244</td>
<td>36</td>
<td>4</td>
<td>73</td>
<td>35</td>
<td>157</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>(26.34)</td>
<td>(68.00)</td>
<td>(2.40)</td>
<td>(97.60)</td>
<td>(14.40)</td>
<td>(1.60)</td>
<td>(23.20)</td>
<td>(13.50)</td>
<td>(37.30)</td>
<td>(60.00)</td>
</tr>
<tr>
<td>500 - 1,999</td>
<td>537</td>
<td>529</td>
<td>100</td>
<td>536</td>
<td>293</td>
<td>20</td>
<td>287</td>
<td>331</td>
<td>499</td>
<td>537</td>
</tr>
<tr>
<td></td>
<td>(56.59)</td>
<td>(98.51)</td>
<td>(18.62)</td>
<td>(99.81)</td>
<td>(54.56)</td>
<td>(3.72)</td>
<td>(55.31)</td>
<td>(61.64)</td>
<td>(97.34)</td>
<td>(60.00)</td>
</tr>
<tr>
<td>2,000 - 4,999</td>
<td>147</td>
<td>147</td>
<td>100</td>
<td>147</td>
<td>139</td>
<td>36</td>
<td>139</td>
<td>135</td>
<td>147</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>(15.49)</td>
<td>(100.0)</td>
<td>(68.03)</td>
<td>(100.0)</td>
<td>(94.56)</td>
<td>(23.81)</td>
<td>(80.44)</td>
<td>(*1.44)</td>
<td>(100.00)</td>
<td>(100.00)</td>
</tr>
<tr>
<td>5,000 +</td>
<td>15</td>
<td>15</td>
<td>13</td>
<td>15</td>
<td>15</td>
<td>6</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>(1.58)</td>
<td>(100.0)</td>
<td>(86.67)</td>
<td>(100.0)</td>
<td>(100.0)</td>
<td>(40.00)</td>
<td>(100.0)</td>
<td>(100.0)</td>
<td>(100.0)</td>
<td>(100.0)</td>
</tr>
<tr>
<td>Total</td>
<td>949</td>
<td>861</td>
<td>219</td>
<td>942</td>
<td>483</td>
<td>65</td>
<td>515</td>
<td>574</td>
<td>788</td>
<td>788</td>
</tr>
<tr>
<td></td>
<td>(100.0)</td>
<td>(90.73)</td>
<td>(23.00)</td>
<td>(99.23)</td>
<td>(50.00)</td>
<td>(6.85)</td>
<td>(54.27)</td>
<td>(68.48)</td>
<td>(83.53)</td>
<td>(100.0)</td>
</tr>
</tbody>
</table>

(Figures in brackets represent percentage)

Source: District Census Hand Book, 1981.
Medical facilities in Ranga Reddy District:

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Item</th>
<th>Year</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Civil Hospitals, and Dispensaries</td>
<td>1987</td>
<td>25</td>
</tr>
<tr>
<td>2.</td>
<td>Primary Health Centres</td>
<td>1987</td>
<td>9</td>
</tr>
<tr>
<td>3.</td>
<td>Sub-centres</td>
<td>1987</td>
<td>205</td>
</tr>
<tr>
<td>4.</td>
<td>Rural Health Centre</td>
<td>1987</td>
<td>1</td>
</tr>
<tr>
<td>5.</td>
<td>Mandal Primary Health Centres</td>
<td>1987</td>
<td>14</td>
</tr>
<tr>
<td>6.</td>
<td>Postpartum Unit</td>
<td>1987</td>
<td>1</td>
</tr>
<tr>
<td>7.</td>
<td>Number of Government Doctors</td>
<td>1987</td>
<td>71</td>
</tr>
<tr>
<td>8.</td>
<td>Total Bed strength</td>
<td>1987</td>
<td>620</td>
</tr>
</tbody>
</table>

(Source: District Medical and Health Office, R.R. District 1987)

For the district as a whole, there is only one doctor for a population of 23,000, and one bed for a population of 2,552.

1.6.2 Universe of study:

One Primary health centre located in the Hayatnagar Mandal of Ranga Reddy district has been chosen for the study. The reason for choosing this centre is that, (1) it is one of the best performing primary health centre, according to the District Medical and Health Office; (ii) it is more accessible when compared to the other primary health centres in the district, and (iii) it caters to a mixed population being closer to the City.
The study of Hayatnagar Primary health centre would therefore yield insights into the working of other primary health centres in the district. The primary health centre caters to a population of 55,421, according to the 1981 census, covering thirty five inhabited villages.

1.6.3 Sampling, data collection and analysis:

All personnel working in the primary health centre have been included in the study. In the primary health centre there are three Medical officers - one in-charge Medical Officer, another in-charge of the Family Welfare Programme and third in-charge of the Village Health Guides Scheme. All the three Medical Officers have been interviewed.

Below the Medical Officers are the first line Supervisors, one Block Extension Educator; one Block Health Inspector; and Seven Multipurpose Health Supervisors (men and women). Next in hierarchy are the fifteen Multipurpose Health Workers (men and women) in position of whom fourteen have been interviewed with the help of structured - interview schedules.

In addition to the full time field workers the programme also operates through the Village Health Guide* and midwives or Dais (trained). Thirty Village Wealth Guide* out of the forty in position, and twentyfour Dais out of the
twenty eight Dais trained, and in position, have been interviewed depending on their availability in the field. The table below gives the number of primary health centre personnel in position, and the number interviewed:

Table 1.6:
Number of Primary Health Centre personnel in position, and number interviewed:

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>Category</th>
<th>Total number in position</th>
<th>Total number interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Officers (women)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Multipurpose Health Supervisors (Men)</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>(Women)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Multipurpose Health Workers (Men)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>(Women)</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Village Health Guides</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>b.</td>
<td>Dais (trained)</td>
<td>28</td>
<td>24</td>
</tr>
</tbody>
</table>

The information from the primary health centre has been collected both from primary, as well as secondary sources. The primary data has been collected from the personnel with the help of interview schedules. Different interviews schedules were prepared for each category of personnel as their job functions differ. Each interview schedule included questions about their socio-economic background, orientation towards the primary health care approach, details of job experience, perception of the problems in the implementation of the different programmes, relationship with supervisors, information on infrastructural facilities and community participation. Most of the questions are closed and only a
few open ended. The interview schedules were pretested and the necessary changes were incorporated (see appendix I-III). Since the number of personnel interviewed is not large, the data has been analyzed manually for each category, and their performance has been discussed programme wise.

The secondary sources include registers and reports from the sub-centres and primary health centre. At the sub-centre level performance of workers for one year on all activities, number of villages, and population covered, registers and reports maintained have formed the part of data collection.

At the primary health centre level, the secondary data included facilities available, sanctioned and staff in position, materials received and distributed, expenditure of the primary health centre, target achievements under various programmes, camps held, and types of incentives given, have been taken into consideration. However collection of performance data posed problems as no proper records were maintained at the sub-centre level and even where it was available it was not in order. So most of the information had to be collected from the primary health centre records.

Apart from collecting data from the primary health centre personnel, data has also been collected from the households to study their perceptions regarding the outreach and utilization of primary health care services.
The household study however was limited to an area covered by three sub-centres as it was not possible to cover households within the entire primary health centre area. The three subcentre areas were chosen based on the availability of the health workers at the head quarters, availability of transport facilities, availability of other health care facilities in, and around the area. All the villages (numbering twelve) falling within the jurisdiction of the three sub-centres have been taken up for the survey to get a better representation of households from the sub-centre villages as well as other villages.

The twelve villages have a total population of 15,948, and 2,713 households. However for the purpose of the study, households with children between the age group of eleven months to two years have been chosen, as it is only these households who form the bulk of users as far as the sub-centre, primary health centre services are concerned. A total number of 471 households were selected from the household survey lists prepared by the Family Planning Association of India (FPAI) as the household registers at the sub-centre were not up to date in some cases, and were totally absent in some others.

The interview schedule for the households included questions about their socio-economic background, their per-
options regarding the outreach and utilization of primary health care services (see appendix IV). Information collected regarding utilization, and outreach of services has been limited only to a period of one year because most of the respondents were not able to recollect information beyond a period of one year.

Collection of data from households took a considerable amount of time as many of the women folk were available only during the early hours of the day, or late in the evenings. Most of them were engaged as agricultural labourers. Because of this, repeated trips had to be made to the villages.

The data collected from the households has been analyzed with the help of VAX computer at the Administrative Staff College of India, Hyderabad. The data was initially entered into the coding forms, and the programme had been written to get simple frequency tables in the first instance after which it has been subject to cross tabulations.

Apart from collecting data through primary and secondary sources, information has been collected from informal interviews, and observation of the ongoing activities at the sub-centres, and the primary health centre. The information thus collected has been used in the course of discussion to make the study more objective.
This study is basically limited to only one primary health centre in the district, based on which no firm generalization can be made regarding the functioning of other primary health centres in the district. However, it is hoped that the study, by providing a critique of the working of a rural primary health centre would assist the planners, and administrators in making these centres effective instruments in achieving the objectives as envisaged in the National Health Policy document.