CHAPTER V

VOLUNTARY HEALTH ORGANISATIONS
The complex of community health organisations may be seen as a system with individual organisations or system parts ranging in the kinds and frequency of their relationships with one another. This system is enmeshed in ever larger systems - the community, the state and so on.\footnote{Anitai Stazioni, \textit{A Sociological Reader on Complex Organisations}, Holt, Rinehart, Winston, New York, 1969.} Prevention and cure of disease constitute the fundamental principles and the ideal orientation of the public health system. Several individual, private and quasi-governmental agencies desire their respective goals or objectives from this larger orientation. In order to achieve its specific objectives, however, an agency especially outside the governmental public health parameters must possess or control certain elements. It must have clients to serve, it must have resources in the form of specialised knowledge or equipment or the funds with which to procure them and it must have the services of people who can direct these resources to the clients.

Few, if any, organisations have access to all these elements to enable to attain their objectives fully. Under conditions of such limited availability, organisations tend to select on the basis of expediency or efficiency, particular functions or specific areas that permit them to achieve their ends as fully...
as possible. Though scarcity of resources compels a voluntary organisation to confine itself to particular functions, it can seldom carry them out without establishing relationships with other organisations of the health system or without integrating to a certain extent its efforts with the layer public health structure. The reasons for this are clear. In a social welfare sphere like health only the governmental public health machinery could procure all the elements directly from the community or outside. Nevertheless, certain organisations though in a limited way control and mobilise substantial resources to achieve related health objectives that assist and reinforce the general health system to achieve the greater objectives.

The objective of this chapter is to study the role of such voluntary agencies of all categories in the sphere of health which reinforce or strengthen the public health machinery in achieving the goals of primary health care and the nature of such inter-organisational relationships in Tamil Nadu.

Voluntary agencies have a long history of involvement in the promotion of human welfare and well-being and were aptly referred to as a "private enterprise for social progress." These agencies originate spontaneously, voluntarily and without any compulsion to fulfill the particular needs of some groups.

of people. They are flexible and possess the virtue of service and dedication. Their programmes cover a diverse range of functions embracing human welfare in the field of health and they include strictly professional, specialised and technical organisations.

A voluntary health agency may be defined as an organisation that is administered by an autonomous board which collects funds for its support, chiefly from private sources and expends money with or without paid workers in conducting a programme directed primarily for furthering public health by providing health education or by advancing research or legislation for health, or by a combination of these activities.\textsuperscript{3} The elements exchanged or provided by health organisation may be classified into three categories (1) referral of cases, clients or patients (2) the provision of labour services, including the services of voluntary clerical or professional personnel, and (3) providing resources other than labour services including funds, equipment, information on technical matters.\textsuperscript{4}

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Voluntary Health Agencies perform certain characteristic functions by virtue of their limited organisational structure.

(a) Participation of beneficiaries: Voluntary organisations are nearer to the people or have easier and quicker access to them and get a better response in implementing programmes. Most of them possess a better communication strategy than that which characterises official agencies. The mobilisation of the energies and resources of the beneficiaries is the key factor in increasing their welfare and self-reliance. One reason for this is that it is possible for most voluntary agencies, being free of bureaucractic constraints to increase people's involvement by motivating them to participate in the decision-making, implementation, monitoring and evaluation of the health programmes. Further these agencies adopt rapidly and effectively to the local conditions and the dispensations of the beneficiaries. Thus voluntary organisations provide a framework of citizen participation without which they would only be empty forces. 5

(b) Creating Health consciousness: Apart from the physical involvement of the beneficiary, the agencies also foster a certain awareness in the people concerning the health issues in terms of their physical health and the environment. This

includes the realisation of their social responsibilities and commitment in maintaining the health of the community. A crucial aspect in this area is the extent to which voluntary organisations act as channels of communication between the people and the governmental health machinery. Ignorance of the purpose and objectives of the general health system is an important reason for the indifference on the part of the people. However, the major disadvantage of the voluntary agencies are their limitation in reaching out to a greater portion of the population. This is due to their limited organisational scope.

(c) Effective policy formation through interpretation of public opinion: Voluntary agencies are in a unique position to present the real health needs of the people to the various official decision making and policy making bodies. They can also interpret health care plans based on their interaction with institutions, agencies, organisations at the local, national and international levels. From the planners point of view the question of co-ordinating voluntary institutions with government plans is of substantial importance. The fact that voluntary health agencies are generally located in the rural areas has the advantage of making for a better spread of available health services.

(d) Advancing health legislations: In a welfare State, public health laws are as indispensable as security laws. Health legislation needs radical changes to cover the entire population under health care. Voluntary agencies can mobilise public opinion in support of such legislation. These agencies can prepare the people to act as a pressure group to compel the government to enact relevant health legislation. A political system remains in equilibrium only if it channelises the demands of the people into policies and decisions beneficial to the people.

(e) Avenues of experiments: Perhaps the most significant aspect of the voluntary agencies, more than their actual provision of services is their capacity to initiate health projects on experimental basis, they act as sort of catalysts in a certain way. Attempted and operated in a limited way, these projects could become models for expanded future application that form a part of the public health programmes.

(f) Lastly they serve as vital instruments to transfer or channelise resources from the affluent sections of the community to the more indigent sections. As mentioned earlier most voluntary organisations command a certain amount of material resources, especially finance which are employed or invested in
the welfare sector. Health improvement necessarily leads to the socio-economic upliftment of the depressed sections of the population. Thus voluntary agencies also contribute towards the bridging of social disparities.

Voluntary organisations, based on the nature and degree of autonomy, governmental connections and area of operations, could be classified into (1) quasi-governmental voluntary agencies, which refers to those organisations that receive governmental patronage and assistance financially, materially or either ways. These agencies thus possess inbuilt mechanisms of co-ordinating with the official health machinery. More often than not, such areas of co-ordination and operations are stated clearly and are well demarcated.

**QUASI GOVERNMENTAL VOLUNTARY AGENCIES:**

**Mini Health Centres:** As a project to encourage the involvement of voluntary agencies and groups, the mini health centres constitute the most important quasi-governmental voluntary agencies. They also constitute one of the most enterprising methods of enhancing primary health care services in the rural areas. The scheme was started in 1974 by the Government of Tamilnadu with the purpose of delivering comprehensive primary health care to the villages by involving voluntary
MAP SHOWING THE MINI HEALTH CENTRES FUNCTIONING IN TAMILNADU:

MINI HEALTH CENTRES: 54
and private organisations. This was directed towards enhancing community participation by deploying the services and efforts of non-governmental agencies.

A mini-Health Centre (MHC) is organised to cater to the health needs of a minimum population of 5000 or 1000 families. The estimated cost of establishing a MHC is Rs. 18,000. The procedure is that half of this amount would be advanced by the Government as grant and the other half is to be met by the voluntary organisations. Any registered voluntary organisation could apply for establishing a mini-Health Centre to the Director of Public Health and Preventive Medicine. The organisation should start the centre within a month of receiving the Director's sanction. However, certain conditions need to be fulfilled in establishing a centre. These conditions state that

1. there should be no medical or health institutions in those villages where the centre is proposed to be located;

2. a building with at least 3 rooms should be selected for the centre. The cost of the building is the responsibility of the voluntary organisation and exclusive of the estimated cost;

3. the selected village should also have buildings to accommodate the staff;
4. the equipment and furniture should be as far as
far as possible procured by the voluntary agency; and

5. registers and forms should be printed by the voluntary
agencies.

The organisation of the ANC consists of a part-time
doctor who visits the ANC either in the forenoon every day of
the week or spends the full day twice or thrice a week. He is
assisted by one male health worker and one female health worker
who are generally full-time workers and three lay first aiders
who are part-time workers. The doctor may also be in charge
of two to three centres. The first aiders are health workers
who should be selected from the local village community in which
the ANC is located. The other staff are qualified sanitary
inspectors and nurses.

Every type of preventive and curative services that can
be reasonably expected of a unit with minimum facilities is to be
rendered by the centre. The salient components of the medical
care include -

a) treatment of minor ailments;

b) domiciliary treatment for t.b. and leprosy;

c) routine medical check-up for all adults above
   30 years;
d) ante-natal clinics for women;
e) search for parasitic incidence in children;
f) school health examination; and
g) referral of cases for specialist consultation.\textsuperscript{7}

The health and medical care are delivered on a permanent and continuous basis and not in a sporadic manner of camps or visits. The staff is expected to involve in intense promotion of health awareness through health education and maximum rapport with the local community.

Another unique feature of this scheme which ensures more committed and purposeful community participation is the system of nominal health insurance scheme that most of the mini-centres implement in their respective areas depending on the economic status of the family. The agency concerned decided its own method in this regard, but no compulsion involved. The District Health Officers and other officials of the Directorate periodically inspect the MHC to provide guidance and advice.

The response from the voluntary organizations regarding this scheme has been appreciable. There are at present 226 mini health centres in Tamilnadu in all the districts. 50 of these are managed by private hospitals. The other agencies

\textsuperscript{7} Kabir, R. M., \textit{Mini Health Centre for Rural Health Services}, Directorate of PHOs, Tamilnadu, 1984, p.15. Also vide appendix AIV for details of equipment in each Mini Health Centre.
that sponsor the centre can be divided into educational institutions, social welfare institutions, religious organisations and individuals.

As these centres are smaller organisations with greater managerial skills in terms of the sponsoring organisations being endowed with adequate resources, they are able to provide more effective and expeditious services in the area of primary health care. However, even the mini Centres concentrate only on the curative services like the general health system. The accent is more on treatment of disease and distribution of prescription of drugs. This is more evident from the fact that only 100 centres had the staff of first aises who were to principally render preventive and promotive services. Further, as most of the staff work on a part-time basis, most of the mini-centres are situated nearer the cities and urban centres and don't venture deep into the rural heart land.

PRIVATE VOLUNTARY ORGANISATIONS:

The second category of voluntary agencies are Private organisations which are totally independent of the government or any other public agency except in certain matters of procedure routine. They operate on their own resources in terms of money, manpower and materials.

The Voluntary Health Service, Madras:

The Voluntary Health Service (VHS) is a registered non-profit society working on many modern ideas of improving the existing facilities for medical relief, education and research. Registered in 1953, it started functioning from July 1953. All the technical proposals regarding the health projects emanate from an expert committee or experienced doctors. The executive body is the Central Committee which has as its members leading citizens elected or nominated by the society donors. The properties and funds are vested in the Board of Trustees. 9

The VHS operations are based on the concepts of preventive care, family health, community participation and medical research. The agency operates the following projects:

**Medical Aid Plan:** This plan adopts a particular area or a village where a nominal health insurance scheme is operated based on family contribution and provides comprehensive medical care in that area. The medical care is rendered by a Medical Centre which also undertakes medical education and medical research. The plan also includes a student Health scheme under which the medical centre undertakes medical inspection of schools, involving immunisation of children. The agency also runs a 120 bed hospital in the Madras City which 

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offers free services to those earning less than Rs.100 per
person.

The most important activity of the VHS with regard to
primary health care is the training of all health personnel in
health education and other preventive techniques. This process
is also extended to village and community leaders who are
oriented with some of the fundamental health problems and the
means of tackling them.

However, the most significant endeavour of the VHS is
the extensive research and studies conducted on rural and
community health. The agency consists of an exclusive research
unit which investigates problems in the effective delivery of
primary health care and also evaluates the official health
machinery and various institutions.

The VHS is more an institution that serves as an advisory
agency and serves as an information centre for matters regarding
health care delivery. Even in practice the emphasis is more
on curative aspects, as most of the operating units of the
agency are medical and curative centres. The agency has brought
out two detailed surveys during January 1983 about the rural
health structure in Tamilnadu with recommendations and suggestions
to rectify the plans in the existing scheme of things.10

10. Rural Health Services in Tamilnadu, Report of the Voluntary
K.J. Hospital — Rural Health Unit:

K.J. Hospital is a private 150 bed hospital in Madras City. It is one of the most well-equipped medical institutions. Registered under the Hospital Registration Act in 1970, it was fully concentrating on curative and medical services. The hospital is under individual private management.

During February 1981, the hospital started the Rural Health Unit. It is more of a mobile health scheme. A team of medical personnel consisting of a doctor, a nurse and a pharmacist tour the villages in the immediate vicinity of the city at a distance of about 30 to 40 kms. every day and conduct clinics. Tours are undertaken 4 days a week according to a schedule to cover about 10 villages.

The major functions of the unit is to diagnose the villagers treated with individual details regarding the background, nature of the disease, treatment given, drugs consumed and duration of recovery. This is a very important factor in providing follow-up action and as an information regarding all the health related problems of a specific area. It also provides an accurate cost-benefit analysis in terms of the expenditure on drugs per patient and in answering accurately the nature of

11. Inaugural Souvenir, Rural Health Unit, K.J. Hospital, Madras, February 1981.
the medical problems. This is an aspect that has been neglected with impunity at the primary health centres.

**Christian Medical College - Rural Health Project, Vellore:**

The Christian Medical College, Vellore, is one of the prestigious private medical institutions in the State. It was established by the Christian Mission.

The rural health project was started in 1950 and is conducted both by the doctors and the medical students belonging to the hospital. A group of 6 doctors and 12 medical students set up medical camps in the villages around Vellore once a week continuously for two days. They carry out extensive diagnostic and treatment activities covering about 4 villages during each camp. About 600 patients are treated including maternity cases.

This system also provides a unique opportunity to the medical students to be acquainted with typical rural medical and health problems. There is again not much of preventive orientation to this project.

**International Agencies:**

International agencies constitute the third variety of voluntary agencies. As the name denotes there are global

organisations with a world wide net-work engaged in a variety of health and related social activities ranging from providing direct health services to assistance through aid. These agencies more often than not venture into voluntary health operations through the governmental machinery. They combine the elements of quasi-governmental and private agencies in their operations.

World Health Organisation (WHO):

The W.H.O. came into existence on the basic principle that health and disease have no political or geographical boundaries. WHO has its origin in the League of Nations health organisation, which was transferred to the U.N. in 1946 after the war. And in April 7, 1948, twenty-six of the sixty-one member governments ratified the Constitution and the W.H.O. was born as a specialised health agency of the United Nations. 13

The main objective of the W.H.O. is the attainment of the highest level of health for all people. The preamble of the Constitution states:

"Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, region, religion, political belief and social condition."

The achievement of any state in the promotion and protection of health is of value to all and the extension to all people of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Governments have a responsibility for the health of their peoples which can be fulfilled only with the provision of adequate health and social measures. 14

Thus W.H.O.'s work covers a wide spectrum of activities, ranging from the fight against most of the world's diseases to the award of fellowships, from the monitoring of the environmental conditions deteriorated to health to the collection of international statistics, from the training of health personnel to multi-lateral research endeavours.

The major functions of W.H.O. in order to achieve its objectives are -

a) to act as the directing and co-ordinating authority on international health work;

b) to establish and maintain effective collaboration with specialised agencies, governmental health administration, professional groups and such other organisation as may be deemed appropriate;

c) to assist governments in strengthening health services;

d) to promote in co-operation with other specialised agencies where necessary, the improvement of nutrition, housing, sanitation and other aspects of environmental hygiene;

e) to study and report on administration and social techniques affecting public health and medical care from preventive and curative point of view;

f) to establish and revise when necessary, international nomenclatures of disease of cause of death and of public health practices; and

g) to standardise diagnostic procedures as and when necessary and to generally take all necessary action to attain the objectives of the organisation.

The W.H.O. assisted projects fall in the following broad categories:

a) control of communicable diseases, which includes eradication or control programmes, laboratory facilities and vaccine production;

b) education and training of professional, technical and auxiliary staff and man-power development;
c) co-ordination of medical research and supporting services, and collaborating in research projects; and

d) development of public health services, which include public health administration, organisation of medical care, environmental sanitation, drug control and vital health statistics. 

India through the Regional Official of the W.H.O. at Delhi has been the recipient of W.H.O. assistance in a number of projects, especially in terms of prevention and control of communicable diseases and environmental hygiene. This has been mostly by way of providing technical guidance and financial assistance.

The W.H.O. has so far implemented three projects in Tamilnadu from 1977 to 1979 in constructing low-cost sanitary facilities in the rural areas with no drainage facilities. It has thus stressed the aspect of environmental hygiene. This project is now under implementation in 50 villages.

The W.H.O. lends its rich technical and expert advice and assistance in enhancing the general health climate in a developing milieu. It, therefore, reinforces a long term aspect of primary health care in a real way.

15. Goel, S.I., Levels and aspects, op.cit., p.84.
CARE is a highly service oriented international agency sponsored by the government of the United States to provide nutrition to the children of the developing countries. It was started in 1960 and operates through its regional office at New Delhi. All CARE projects are directed through the machinery of the respective state governments which receives the assistance.

The main objective of the programme is to provide nutritious food to all pre-school children (0 to 6 years) and thereby is basically a feeding programme. The programme was implemented in Tamilnadu since 1965. The feeding programme was implemented through the PHCs, sub-centres and Panchayat Unions. The specific objective of the programme was to combat mal-nutrition among the pre-school children. The scheme was implemented through 3,322 feeding centres, which includes those run by the government and the local bodies covering one lakh beneficiaries.16

This was the first feeding programme for pre-school children ever to be implemented in the State and its significance arises from the fact that it covered the most vulnerable age group. The programme however was withdrawn when the Chief Minister's Nutritious Noon Meal Scheme was implemented in Tamilnadu in 1983.
United Nations Children's Fund (UNICEF)

UNICEF is about the most popular and widely operating international agency of the UNO associated with health care delivery to children all over the world. The UNICEF was established in December 1946 at a time when millions of children were facing a serious crisis of malnutrition, all over the world as a result of the Second World War. Initially, its efforts were largely directed towards the European children. In October 1953, the General Assembly of the UNO decided to continue the UNICEF programmes indefinitely and expanded the operations to cover all the children of the world, especially developing countries.16

The primary objective of the UNICEF is to assist developing countries meet the health and nutrition needs of the children and youth in a multi-sectoral manner. UNICEF's cooperation with the governments of the developing nations falls under two major categories, firstly assisting in planning and designing the services for children, secondly delivering materials and equipment for health services. Its supply of resources are directed at improving the health care of the children, their nutrition, and their drinking water supply/early education, in short all the elementary services that represent the necessary first step for human development.

Child health which is the major area of its activity accounts for 55% of its total expenditure. The primary goal of the child health project is extending and reinforcing the coverage of maternal and child health services, immunisation and environmental sanitation. These services are rendered mainly through the PHCs. The earliest and most popular of the UNICEF schemes was the distribution of milk powder for children below 10 years of age to the tune of 1,000 tonnes per month. Besides, it supplies 2,000 doses of the DPT vaccine per month to every PHC. It further conducts periodical training programmes for the auxiliary staff of the PHC especially Health Visitors and Maternity Assistants. 120 Maternity Assistants and 140 Health Visitors were trained under the UNICEF programme in 1980.18

In 1977 UNICEF provided stipends to train 1,700 village level nutrition workers, delivered some 2,800 tonnes of food (wheat, flower, oats, and milk) for distribution through the sub-centres and other feeding units. The most important


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contribution of UNICEF to the cause of primary health care is

the supply of jeeps to 50 PHCs in 1960. This provided greater

mobility to the PHC personnel to carry the health services even
to the remote corners of the Block area. 19

All UNICEF programmes are co-ordinated with and imple-
mented through the government institutions, however, the UNICEF
maintains a field office at Madras with a project officer to
officially co-ordinate the programmes and to act as a liaison
officer with the other governmental and non-governmental agencies.

There is no gainsaying the fact that the UNICEF proved
to be one of the greatest promoters of primary health care in
almost all its dimensions. In fact, it has provided a direction
and impetus to primary health care and health care delivery in
general. It has provided the initiative and technical assistance
in almost all the vital areas of health services and further
serves as a repository of valuable health information by conduct-
ing surveys, projects and evaluation of the health conditions in
the State. It, therefore, makes it imperative for the health
machinery in the State to maintain continuous and sustained
association with such organisations for the further development
of the quality of health care.

19. Administrative Report, Public Health, Government of
Tamil Nadu, 1963.
Danish International Development Agency (DANIDA):

The DANIDA is a department of the Ministry of Foreign Affairs, Government of Denmark. It collaborates with various governments in the developing countries at the Federal and regional levels in implementing rural health and development programmes. A unique feature of this agency is the novel approaches and ideas it brings to bear upon its experimental projects in the area of primary health care delivery. These projects however are carried out in compliance with the prevalent local cultural milieu and in accordance with the guidelines laid by the health policies at the National and State levels.

DANIDA maintains an office in Madras City with a project officer, co-ordinating officer and a programme executive with a secretarial staff. The Head Office is located at New Delhi. The Regional Office is headed by an IAS Officer of the State cadre who is designated as the 'Director'. Thus the agency works in full co-operation with the State Government.

The major area in which the DANIDA operates in Tamilnadu is in maintaining 'Maternity and Child Health' Centres. At present there are 92 DANIDA sponsored centres which are completely financed, equipped and staffed by it.20

In 1973 the MNH undertook a comprehensive rural health and family welfare project in two districts of Tamilnadu, namely, Salem and South Arcot. The aim of the project was to evolve a new strategy and framework to strengthen the health and family welfare delivery system in selected rural areas of the state. It recommended a model plan, after extensive studies describing the needs and demands of the areas and listed out norms and methods for the extension of the health and family welfare infrastructure both in terms of the physical facilities and staffing pattern.

The MNH besides assisting the Government by reinforcing the structure of primary health care delivery provided indispensable advise and recommendation for improvement based on extensive, empirical investigations. These endeavours, if not in the immediate present tend to influence and re-orient the health policy, planning and administration to provide more effective and viable health services, especially to the rural population.

Thus voluntary organisations play no mean part in the health administration of the State and especially in the area of primary health care. However, there lies a vast difference in the degree and the extent to which this is achieved by the
various types of agencies described above. International agencies by far contribute more and play a pivotal role in supplementing the general health structure. They also exercise a perceptible influence on the working of the public health machinery.

The major reasons for this are the considerable resources at their disposal, the relatively permanent nature of their activities and the well-organised backing they receive from their parent governments. By virtue of their international standing and the wherewithal they possess, they also receive greater sponsorship by the state Health Department. Thus the international agencies definitely decreases the burden of the government in catering to the health needs of the state. In quite a few areas like mobile health and nutrition, they have provided the initial 'take off' impetus to the health programmes that constitute crucial functions of the health activity.

The other quasi-governmental and private agencies in relative terms have not made much of an impact on the overall health delivery structure. Though, there is as yet no accurate information regarding the financial issues in terms of the amount of private share in health expenditure, it is clear from the extent of the functioning of these agencies that absence
of these will not make much of a difference in the quality of health care delivery, under the prevailing circumstances. This is due to the lack of effective collaboration between these agencies and the government and amongst the agencies themselves. This also results in duplication and overlapping of services in the same area. There is a definite need for greater co-ordination of these agencies if the potential advantages accruing from their efforts are to really improve and strengthen the health care delivery.

Further these agencies again operate with strong curative predilections and do not reach more than the periphery of the rural population, more because preventive and promotive services require greater efforts which may prove to be more expensive than even sophisticated clinical services. Finally it is extremely difficult for voluntary agencies to attract and retain committed and qualified personnel who can operate the services therein to the utmost. However, voluntary agencies constitute a vital source of resources, information and effort which need to be effectively and rationally tapped in order to convert them into one of the essential bulwarks of the primary health care system.