CHAPTER – III

CONCEPTUAL FRAMEWORK OF RURAL HEALTH-CARE MANAGEMENT

This chapter discusses the framework of rural health-care management explaining the mechanism of primary health-care centre, rural health-care policies, ASHA workers and community participation. It gives the overview of the rural health-care centre infrastructure development, health-care services delivery, health-care services Performance in rural centre and involvement in Community Participation programme. The key issues in rural health-care management of performance of health-care services are explained in detail.


Managing is one of the most important human activities. From ancient times, human beings began forming social organisations to accomplish aims and objectives they could not accomplish as individuals. Managing has been essential to ensure the coordination of individual efforts. As society continuously relied on group effort, and many organised groups have become large, the task of managers has been increasing in importance and complexity. Consequently, managerial theory has become crucial in the way managers manage complex organisations. The central thesis of this study is that although some managers in different parts of the world could have achieved managerial success without having basic theoretical knowledge in management, it has to be unequivocally emphasized that those managers who have mixed management theory in their day-to-day practice, have had better chances of managing their organisations more efficiently and effectively to achieve both individual and organisational objectives. Therefore, managers of contemporary organisations sought to appreciate the important role they play in their respective organizations to achieve the set goals. Secondly, there is need to promote excellence among all persons in organizations, especially among managers themselves. To address these concerns, the study will proceed along the following spectrum: management will be defined for purposes of conceptual clarity;
management objectives, functions, goals, and essentiality will be highlighted; the importance of managerial skills and the organisational hierarchy will be sketched; the importance of women in the organisational hierarchy will be emphasised; reasons for studying management theory will be enumerated; the different management theories, the core of the study, will be discussed at length; the significance of management as a practice will be contextualised; and ‘the way forward’ in form of a conclusion will be offered.

3.1.1. Definition of Management

Management is the art, or science, of achieving goals through people. Since managers also supervise, management can be interpreted to mean literally “looking over”, i.e., making sure people do what they are supposed to do. Managers are, therefore, expected to ensure greater productivity or, using the current jargon, ‘continuous improvement’.

More broadly, management is the process of designing and maintaining an environment in which individuals, working together in groups, efficiently accomplish selected aims (Koontz and Weihrich, 1990). In its expanded form, this basic definition means several things. First, as managers, people carry out the managerial functions of planning, organising, staffing, leading, and controlling. Second, management applies to any kind of organisation. Third, management applies to managers at all organisational levels. Fourth, the aim of all managers is the same – to create surplus. Finally, managing is concerned with productivity – this implies effectiveness and efficiency. Thus, management refers to the development of bureaucracy that derives its importance from the need for strategic planning, coordination, directing and controlling of a large and complex decision-making process. Essentially, therefore, management entails the acquisition of managerial competence, and effectiveness in the following key areas: problem solving, administration, human resource management, and organisational leadership.

3.1.2. Management as a Practice

Managing, like all other practices – whether medicine, music composition, engineering, accountancy, or even baseball – is an art; it is know-how. It is doing things in the light of the realities of a situation. Yet, managers can work better by using the organised knowledge about management. It is this knowledge that constitutes science.
However, the science underlying managing is fairly crude and inexact. This is true because the many variables with which managers deal are extremely complex. Nevertheless, such management knowledge can certainly improve managerial practice. Managers who attempt to manage without management science must put their trust to luck, intuition, or what they did in the past.

In managing, as in any other field, unless practitioners are to learn by trial and error, there is no place they can turn to for meaningful guidance other than the accumulated knowledge underlying their practice; this accumulated knowledge is theory. For practical purposes, all managers must develop three sets of skills, namely, conceptual, technical, and human (Fleet and Perterson, 1994). Conceptual skills allow the manager to develop relationships between factors that other people may not see. Managers who have well-developed conceptual skills are able to apply different management theories to the same situation. For a manager to be technical, it implies that he or she should act professionally. Professionalism entails that the manager perform his or her duties within established procedures, rules and regulations. Any behaviour that compromises the manager’s professional ethics is certainly bound to interfere adversely with the organisation’s productivity. Lastly, a manager should be able to see members of the organisation as human beings who have needs and psychological feelings and emotions. These needs and feelings must be positively harnessed for the good of the organisation. Motivation of the employees, therefore, becomes a critical factor in increasing productivity.

3.2. Evaluating the Role of Primary Health Centres in India

In India, Primary Health Centres (PHCs) are the cornerstone of rural health-care. They are the first port of call for the sick and an effective referral system, besides being the main focus of social and economic development of the community. It forms the first level of contact and a link between individuals and the national health system; bringing health-care delivery as close as possible to where people live and work. Each PHC is targeted to cover a population of approximately 30,000 and is charged with the responsibility of providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services such as health, education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services,
immunisation, disease control and appropriate treatment in the event of illness of injury. The PHCs are hubs for 5-6 sub-centres that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are a part of the three tier health-care system. The PHCs act as referral centres for the Community Health Centres (CHCs), 30-bed hospitals and higher order public hospitals at the mandal and district levels.

Primary health-care services substantially affects the general health of the population. However, many factors undermine the quality and efficiency of primary health-care services in developing countries. In India, there are many reasons for poor performance of PHCs. The deterioration in health status is attributed to inadequacies in PHC implementation, and neglecting the broader issues. Some of the factors responsible for this state of affairs include: lack of political commitment, inadequate allocation of financial resources to PHCs, stagnation of inter-sectoral strategies and community participation, bureaucratic approach to health-care provision, lack of accountability and responsiveness to the general public and incongruence between available funding and commitments.

The current PHC structure is extremely rigid - making it unable to respond effectively to local realities and needs. For instance, the number of ANMs per PHC is the same throughout the country, despite the fact that some states have twice the fertility level of others. Moreover, political interference in the location of health facilities often results in an irrational distribution of PHCs and sub-centres. Government health departments are focused on implementing government norms, paying salaries, ensuring that the minimum facilities are available rather than measuring health system performance or health outcomes. Further, the public health system is managed and overseen by District Health Officers. Although they are qualified doctors, they have barely any training in public health management. Strengthening the capacity for public health management at the district and taluk level is crucial to improving public sector performance.

The lack of accountability stems from the fact that there is no formal feedback mechanism and incentive to treat citizens as clients. Patients often complain of rude and abrupt health workers that discriminate against women and minorities and those belong to the scheduled Castes or Tribes. The lack of accountability leads to absentee doctors, as it
is difficult to attract qualified doctors to rural areas, unresponsive ANMs, inconvenient working hours and little or no community participation.

The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary health-care system. In poor states, spending levels are low while expectations for coverage remain high. The incongruence between resources and targets result in lack of medicines. The current budget for essential drugs being Rs 75,000 per annum is insufficient to cater to a large number of patients, and limited doctor salaries. In order to improve primary care services, a number of approaches are used in developing countries. Capacity building and encouraging community involvement are some of the main factors. Capacity building aims to improve the knowledge and skills of primary care professionals and community involvement improves governance and accountability of public primary health clinics, which lead to increase in drug supply and improved provider skills. A widely used mechanism to improve primary health services is to resort to contracting. Contracting improves public services by utilising the private sector’s greater flexibility, to improve services and responsiveness to consumers, increases managerial autonomy, decentralises decision making of managers on the ground. It allows the government to focus less on service delivery and more on comparative advantage roles. Contracting can also improve the level of national equity as a government can create contracts that focus on delivering primary care services to vulnerable sections of the population.

Improved access to primary health-care and its gate-keeping function lead to less hospitalisation, less utilisation of specialist and emergency centres and less chance of patients being subjected to inappropriate health interventions. In low-income settings, the cost effectiveness of PHCs, compared to other health programmes, has been reinforced by World Bank findings. Selected primary health-care activities, such as infant and child health, nutrition programmes and immunization, appear to be ‘good buys’ compared to hospital care. Such interventions could drastically reduce the number of ‘preventable deaths’. The Bamako Initiative in Benin and Guinea demonstrate that, even in resource-poor settings, it is possible to implement and sustain basic PHC services.

Thus, it is evident that the success of health systems lies in tapping the existing potential and making appropriate structural changes. The role of primary care should not
be defined in isolation but in relation to the constituents of the health system. Primary, secondary, generalist and specialist care, all have important and inclusive roles in the health-care system and should be used to create a comprehensive and integrated model: one that combines universalism and economic realism with the objective of providing health coverage for all.

3.3. Primary Health-Care Management

The Primary Health-care system in India is very large and covers almost all the parts of the country. This system consumes large amount of resources and is the system which provides the services for primary care including preventive programmes. The system is mainly managed by doctors, some of whom have brief public health training. This study argues that given the lack of training for doctors in management it is imperative that the doctors who are put in charge of the PHC system receive reasonable skills and training in management so that the resources spent on the PHC system can be utilised well - in an efficient and effective manner. The study explains that despite movements towards selective packages of health-care and health-care reforms the idea of PHC as described in the Alma Ata declaration is attracting renewed interest. There are several reasons for this shortage in health workers, especially in developing country or states. In India the major thrust has been on improving the health status of children and women. Almost all the national programmes have been implemented either to control tropical diseases or are concerning maternal and child health besides family welfare. Over the years country has made substantial gains in not only improving health indicators but also developed extensive network of health-care delivery system existing throughout the country. The primary health-care has been developed to provide health-care services to the vast majority of rural people. The primary tire comprises three types of health-care institutions: Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC). The rural health-care infrastructure has been developed to provide primary health-care services through a network of integrated health and family welfare delivery system. Firstly, the transformative potential of strategies and approaches can make the fundamental changes necessary to improve health status. Secondly, the structures and practices of primary care sector are not necessarily compatible with notions of comprehensive primary health-care.
It is well known that doctors are technically more competent than any other supporting paramedical personnel. However, in rural India, people are more dependent on the latter. If we consider the elasticity coefficients as a measure of productivity, then in the rural health-care system Paramedical Staff are more productive than the doctors. If these coefficients are used to determine the programme’s efficiency, then within the labour input category paramedical staffs perform efficiently. So, productivity or efficiency in such a rural public sector service economy does not necessarily increase with the technical qualification or education of service providers. Geographical factors, social structure, family characteristics, and quality of care also work as the main determinants of the utilisation of health-care services. Education of the acceptors is also an important factor though its impact is negative. The study reveals that as education increases, people are likely to avoid public health facilities for reproductive health related services. This may be due to poor quality of services provided at the health centres. We should also consider other qualitative factors like privacy maintained while conducting medical examination, average waiting time at the health centres, time spent by a staff with a patient, All these problems must be addressed by adopting appropriate measures. Otherwise, primary health-care system in India will lose its credibility even among poor rural people who are not in a position to utilise private health-care facilities.

3.4. Pillars of Primary Health-Care

Definition

Primary health-care is essential health-care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self reliance.

The Alma-Ata declaration was the collective statement of 134 countries at an international conference hosted by the WHO or UNICEF. It was declared that “Health for All” should be promoted and this would be achieved if it is based on the implementation of PHC.

Based upon the Alma Ata declaration, primary health-care can be said to consist of seven core issues:
1. **Foundation of the Health System**: PHC is the first level of contact of individuals, the family and community with the national health system. It brings health-care as close as possible to where people live and work, and constitutes the first element of a continuing health-care process.

2. **Priorities**: This addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.

3. **Science/ Evidence-Based**: PHC should be based on the application of the relevant results of social, biomedical and health services research and public health experience.

4. **Culture Sensitivity/ Social Relevance**: PHC system of health-care delivery is a system of socially acceptable methods and technology and it reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities.

5. **Equity and Social Justice**: This is an integral part of the PHC system, that health-care should be made universally accessible to individuals and families in the community.

6. **Community Participation**: A system in which the people have the right and duty to participate individually and collectively in the planning and implementation of their health-care. This requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health-care.

7. **Sustainability and Self-reliance**: Health-care should be at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

3.5. **PHC Component Services**

The ideal health services based on PHC, in line with the PHC components, include:

1. Education concerning prevailing health problems and the methods of preventing and controlling them.

2. Promotion of food supply and proper nutrition.

3. An adequate supply of safe water and basic sanitation.
4. Maternal and child health-care, including family planning. In this context, family planning refers to services offered to couples to educate them about family life and to encourage them to achieve their wishes regarding:
   i. Preventing unwanted pregnancies
   ii. Securing desired pregnancies
   iii. Spacing of pregnancies and
   iv. Limiting family size in the interest of the family, health and socio-economic status.
5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic and epidemic diseases
7. Appropriate treatment of common diseases and injuries
8. Provision of essential drugs and supplies.

3.6. The Accredited Social Health Activist (ASHA) Programme

The Accredited Social Health Activist (ASHA) Programme is the major bedrock of the NRHM and aims to select, train and support a community-based change agent for at least every cluster of 1000 people in rural areas. This Community Health Volunteer is expected to be a locally selected woman who will catalyse a community-based process of behavioural change and facilitate better access to basic health services for poor households. She will disseminate knowledge, create awareness about health issues and their social determinants, engage closely with pregnant women, and other household members to negotiate, adopt appropriate care practices, mobilise community to participate in local health planning, and increase the utilisation and accountability of existing health services. In addition to her primary role as a promoter of desired health practices, she could also provide a minimum package of curative care as appropriate and feasible for her profile and make timely referrals.

In recent times, Community Health Workers (CHWs) have received renewed attention, both nationally and internationally, as research has established and emphasised the effectiveness of community strategies and household-level practices in promoting child survival and development. The study reveals, for instance, that collectively, three largely preventable and treatable causes - diarrhoea, pneumonia and a limited set of neonatal conditions - account for 82 percent of all child deaths and that malnutrition is an
underlying cause in around 52 percent of all cases. A number of household practices, such as improved nutrition and care during pregnancy, providing warmth and hygienic care to infants, breastfeeding and complementary feeding, the use of Oral Rehydration Salts (ORS), hygienic practices during food preparation, the use of insecticide treated bed nets for pregnant women and young children can have a significant impact on child mortality and malnutrition. As individual interventions, breastfeeding and ORS are especially effective, taken alone, they are each capable of averting 16 percent and 14 percent respectively of all child deaths in India. Most strikingly, analysis presented in The Lancet Child Survival Series, estimates that actions taken at the household and family level alone can prevent over 30 percent of child deaths and a similar proportion (up to 37 percent) of neonatal deaths. Aware and vigilant families are also more likely to ensure that their children get prompt and appropriate facility-based clinical care, further contributing to reduction in mortality cases. This is, therefore, clearly a priority area in high mortality resource poor settings and requires investment in creative, contextual and decentralized strategies to work with families and communities. In this context, CHWs, such as those who are currently joining the ASHA Programme, have a vital role to play. From a review of a range of past experiences, we have learned that wherever Community Health Workers have been appropriately identified, trained and supported, health and nutrition indicators have dramatically improved.

In addition to drawing strength from the latest scientific research, the ASHA Programme also builds on a rich history of civil society innovation in community health in India and in many other developing countries and is an attempt to translate earlier experiences and insights, a majority of which have emerged from smaller field-level initiatives, into large-scale processes of community participation in and ownership of health knowledge and services. Here, the critical challenge is to conceptualise and implement state-wide CHW programmes in regions with very weak health systems. Creating a space for such an activist - within the community, within the programme, and within the public health system - requires flexibility to both the community’s and individual’s needs, as well as commitment to providing continuous inputs and supportive structures. Most importantly, the health activist should occupy a unique position, one that is based in the community and yet has access to knowledge and resources from the larger
programme. At this stage in particular, when states such as Bihar, UP, AP and MP have already selected thousands of ASHAs across the districts, the quality of ASHA training and ongoing support must be accorded greater priority.

3.6.1. Coordination with Community by ASHA/AWWs

Currently, Anganwadi Workers (AWWs), under the Integrated Child Development Scheme (ICDS), are engaged in organising supplementary nutrition programmes and other supportive activities. The very nature of their responsibilities (with emphasis on supplementary feeding and pre-school education) do not allow them to take up the responsibility of change agents on health in their villages. Thus, a new band of community based functionaries, named as Accredited Social Health Activist (ASHA), is proposed to fill this void. ASHA will be the first port of call for any health related demands of the deprived sections of society, especially women and children, who find it difficult to access health services. It has been envisaged that states will have flexibility to adapt these guidelines keeping their local situations in view.

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. ASHA’s roles and responsibilities would be as follows:

1. To take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.

2. To counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunisation, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

3. To mobilise the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centres, such as
Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

4. To work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan. ASHA will arrange escort/accompany pregnant women and children requiring treatment/admission to the nearest pre-identified health facility, i.e., Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC/FRU).

5. To provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. ASHA will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.

6. Will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.

7. ASHA’s role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.

8. To inform about the births and deaths in the village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.

9. To promote construction of household toilets under Total Sanitation Campaign.

10. Fulfillment of all these roles by ASHA is envisaged through continuous training and upgradation of the skills, spread over two years or more.

3.6.2. Accredited Social Health Activists

1. Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.
2. ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

3. She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunisation, referral and escort services for RCH, construction of household toilets, and other health-care delivery programmes.

4. She will be trained on pedagogy of public health developed and mentored through a Standing Mentoring Group at the National level incorporating best practices and implemented through active involvement of community health resource organisations.

5. She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi workers, ANM, functionaries of other Departments, and Self-Help Group members, under the leadership of the Village Health Committee of the Panchayat.

6. ASHA personnel will be positioned all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.

7. She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

8. Induction training of ASHA to be of 23 days in all, spread over 12 months. On-the-job training would continue throughout the year.

9. Prototype training material to be developed at National level subject to State level modifications.

10. Cascade model of training proposed through Training of Trainers including contract plus distance learning model.

11. Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

3.7. Infrastructure Improvement in Health-Care Centres

The public health infrastructure of India has been growing since independence, but it is yet to match the basic health-care facilities in many other countries. While in
1947 the number of hospital beds was 3.2 per 10,000, the present number is 9 per 10000. This number is commendable, but still far behind that of other developing countries. The health-care system consists of primary, secondary and tertiary health-care centres, and the focus of public health-care has been on Primary health-care [NRHM], as well as centres providing health-care services and education.

Health is a state responsibility. However the central government does contribute in a substantial manner through grants and centrally sponsored health programmes/schemes. Various public health schemes taken out by the central government include the Rashtriya Swasthya Bima Yojana which provides health insurance to poor families who are unable to afford medical care or hospitalisation or cannot afford private medical insurance. As a part of the public health-care scheme, there are a number of hospitals which offer free services to the poor who are unable to pay for their treatment. The health system infrastructure needed for primary health-care encompasses the physical structures and the functional capacities needed to support all primary health-care activities. This includes health services infrastructure, such as facilities, including equipment; supplies and communications; health manpower, including education, training and supervision; planning, management and evaluation, financing information systems, including health surveillance and programme monitoring, and possibly action-oriented research. It is the infrastructure which makes it possible to assess the population’s health problems, to extend health-care to communities and to people and groups with special needs, to ensure that manpower is deployed according to need, and to monitor the effectiveness of programmes. The health sector and the primary health-care system has been managed mainly by the shallow structure of government health-care facilities and other public health-care systems in a traditional model of health funding and provision till now in India. But, it is unable to justify the demand for health security by over 200 million of the health insurable population in India, mainly due to service costs being out of reach to many people, absence of good and effective number of physicians, low rate of education programmes, less number of hospitals, poor medical equipment and, above all, the poor budget of government towards the health programmes.

Public Health-Care Infrastructure between 1950 and 2009. The rural health-care infrastructure has gone up from 725 facilities to more than 1,63,000 (Mavalankar &
Ramani, 2005) consisting of 4,510 rural sub district hospitals (known as community hospitals-CHCs). Today, 24,000 primary health-care centres and 1,46,036 sub health centres exist. Yet there is a shortfall of 16% in the number of primary health-care centres and sub health centres and high as 58% in the case of community health-care centres. Public health-care infrastructure is far from satisfactory as the delivery of services is hampered by several policy and management constraints. Of particular concern are the following:

1. Non availability of staff
2. Weak referral system
3. Recurrent funding shortfalls
4. Lack of accountability for quality of care
5. Poor logistic management of medicine and drugs

The utilization of massive public health--care infrastructure is abysmally low. Availability and access to public health facility is very poor for women, children and the socially disadvantaged sections of our society. The past unsatisfactory performance of our public health-care system in rural area is forcing even the poor to seek health-care from the private sector. In the study, only 20% of out patients and 45% -of inpatients availed the benefits from government health-care infrastructure while the rest obtained this from private sources. In Andhra Pradesh, public health-care infrastructure comprises of 164 rural sub district hospitals (called community hospitals-CHCs), 1570 primary health-care centres and 12522 sub health centres. There still remains a severe shortage of sub-centres, primary health centres, and community health centres. Lack of adequate health-care is also reflected in the low density of health-care personnel. The public health-care delivery system consists of a large number and a variety of institutions dispensaries, primary health-care institutions.; Primary health-care services represent a crucial entry point into the health-care system. The adjusted primary care staffing ratio - the ratio of population to full-time equivalent (FTE) primary care physicians in direct service - provides an index of the availability of primary care. State’s health-care services infrastructure delivers acute, primary, specialty, and long-term care. Infrastructure allows, but does not guarantee, access to services. The country has created a vast public health infrastructure of Sub-centres, Public Health Centres (PHCs) and Community Health
Centres (CHCs). There is also a large cadre of health-care providers (Auxiliary Nurse Midwives, Male Health workers, Lady Health Visitors and Male Health Assistants). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of health-care needs is still being provided by the private sector. Rural India is suffering from a long-standing health-care problem. The district health systems based on primary health-care provides an excellent practical model for health development, including an appropriate health system infrastructure. Within this model, the concerns with accelerating the application of known and effective technologies and the concerns with strengthening of community involvement and inter-sectoral action for health are both accommodated. The district health system provides a realistic setting for dialogue and planning involving both professionals and non-professionals involved in health and social development.

3.7.1. Strengthening Primary Health Centres (PHCs)

The National Health Mission aims at strengthening PHCs for quality preventive, promotive, curative, and supervisory and outreach services, through:

1. Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunisation) to PHCs
2. Provision of 24 hour service in at least 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.
3. Observance of standard treatment guidelines and protocols.
4. In case of additional outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of a second doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt needs.

3.7.2. Strengthening Sub-Centres (SC)

1. Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM and Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
2. Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.
3. In case of additional outlays, Multipurpose Workers (Male)/ Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norms, and upgrading the existing sub-centres, including buildings for sub-centres functioning in rented premises will be considered.

3.7.3. Strengthening Community Health Centres (CHCs) for First Referral Care

1. Operationalising the existing 3,222 Community Health Centres (30-50 beds) as 24 hour First Referral Units, including posting of anaesthetists.
2. Codification of new Indian Public Health Standards setting norms for infrastructure, staff, equipment, management, etc., for CHCs.
3. Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
4. Developing standards of services and costs in hospital care.
5. Develop, display and ensure compliance to Citizen’s Charter at CHC/PHC level.
6. In case of additional outlays, creation of new Community Health Centres (30-50 beds) to meet the population norms as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

3.8. Health-care in India: rural development

India has made significant progress in improving health-care, but there are huge challenges in extending basic services to the rural population. Of all the challenges India faces, improving access to basic health-care is a major issue. It is perhaps one of the most pressing ones from the human development perspective, as well as to ensure a solid foundation for future economic growth. Despite India’s dazzling recent economic performance, widespread poverty means that malnourishment and communicable diseases remain serious problems. Health-care indicators vary widely across states, partly reflecting the differing levels of resources available to state governments, but one trend that is totally consistent is that indicators are much worse in rural areas than in urban ones. The problem is, first and foremost, one of access. India has a rudimentary network of public hospitals and clinics. In any case, the government estimated there was a shortage of 4,803 primary health centres and 2,653 community health centres in 2006, but the issue is particularly acute in rural areas. Public hospitals are rare outside of large
cities a significant problem in a country where some two-thirds of the population still live in the countryside. According to a study conducted by the Confederation of Indian Industry, the formal health-care system reaches only about 50% of the total population. India is also desperately short of doctors, with only 645,825, or 0.6 per 1,000 people, in 2004, according to the World Health Organisation (WHO). Many locally trained physicians are tempted abroad by better pay and prospects. Moreover, health-care workers who do remain in India prefer the cities where job prospects and wages are better, resources are greater and the quality of life is far higher. The current Indian National Congress-led government has made the provision and availability of primary health-care to all one of seven policy priorities under its so-called “common minimum programme” designed to cater to the “aam admi” (“common man”). In other words, the main objective of government health policy is merely to achieve an acceptable standard of health among the general population. Its spending in this area is lavish, as can be seen from the figures below:

1. Rs67.1bn (US$1.3bn) for the WHO Child Growth Standards programme, which monitors child growth under the Integrated Child Development Scheme
2. Rs74bn (US$1.4bn) for the Rajiv Gandhi Rural Drinking Water Mission, which supplies clean drinking water to the least well-off homes in rural areas
3. Rs12bn (US$233m) for the Total Rural Sanitation programme
4. Rs120bn (US$2.3bn) for the National Rural Health Mission, which “aims to bring about uniformity in quality of preventive and curative health-care in rural areas across the country”

In addition, the interim budget allocated Rs409bn (US$7.9bn) to Bharat Nirman, the government’s flagship rural infrastructure programme. The scheme includes funding for improving supplies of drinking water alongside more conventional infrastructure issues like roads, housing and telephone.

3.9. Health-Care Community Participation Development

One of the most defining events in the global public health arena that gave community participation a prominent place in public health was the WHO and UNICEF sponsored conference on primary health-care (PHCs) at Alma Ata in 1978. The Alma Ata Declaration defined PHC as “essential health-care based on practical, scientifically
sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, Alma Ata Declaration, 1978). Some of the principles adopted at Alma Ata were proposed much earlier in the Bhore Committee Report 1946 that guided the formulation of the Indian National Health Policy 1983 (Deodhar, 1982). Following the Alma Ata conference, other developments, such as the Ottawa Charter (1986) and Agenda 21 (1992), have helped place community participation high on the political and public agendas of nations.

The emphasis on community participation ushered a paradigm shift in health planning and health-care delivery that called for the involvement of the community in both decision making and delivery of health services most appropriate to them. The ‘Health for All by the Year 2000’ campaign of the WHO having community participation at its core, led to the adoption of this concept by many countries as the means by which important health problems could be addressed. Further, national efforts emerged to establish and strengthen mechanisms for community participation in health through social policy, legislation and other public means (Oakley, 1989).

3.9.1. What is Community Participation

The term community participation has become so confused that it can mean anything from consultation of a few select power-holders, to citizen empowerment through developing responsibilities and decision-making options to local citizens (Smith, 1991). Studies have shown that: different people tend to understanding the concept differently and planners, even those in the same programme, have defined community participation in different ways (Rifkin, 1986). One practical way is to look at community and participation separately and then applying that understanding in defining the concept as ‘a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change’ (WHO, 2002). An essential understanding is that effective community participation in health entails a side-by-side
involvement of community members with health-care professionals and a responsible sharing of both power and responsibility.

3.9.2. Community Involvement in Rural Health-Care Management

The term ‘community participation’ is commonly understood as the collective involvement of local people in assessing their needs and organising strategies to meet those needs. There has been evidence to suggest that health and medical services have not made any remarkable improvement for a majority of the people in developing countries. For this reason, the idea of community participation was initiated by both health planners and field workers who are responsible for the implementation of the health-care services. Nevertheless, in other areas of human life, the concept of community and neighbourhood, centre for community action has remained popular embodying within its statute a philosophy of strengthening family or community life. In fact, the idea is as old as community's life and the members of the community while using the local resources can also solve their problems. Therefore, the idea of community participation can be consciously stimulated through educational and other means which is of recent origin. The stress on community participation is, in fact as recognition of the people who constitute the most important resource of any country and this very resource remains untapped till now. The term ‘community participation’, as commonly understood, as the collective participation in rural health service development is uncontested. According to the national goal, a minimum level of health that would permit every citizen to lead an economically productive and socially useful life is to be achieved by 2000 AD through primary health-care approach. For this purpose, at least eight essential components of primary health-care are to be implemented. These are:

1. Education of the people about prevailing health problems and the methods of preventing and controlling them;
2. Promotion of food supply and proper nutrition;
3. Adequate supply of safe water and basic sanitation;
4. Maternal and child health-care and family planning;
5. Immunisation against major infectious diseases;
6. Prevention and control of locally endemic diseases;
7. Appropriate treatment of common diseases and injuries; and
8. Provision of essential drugs.

For successful implementation of these components, organization of the following eight types of supportive activities will be very important:

1. Community involvement and participation
2. Intra- and inter-sect oral coordination
3. Development of effective referral support
4. Development and mobilization of resources
5. Involvement of managerial processes
6. Health manpower development
7. Medical and Health Services Research including innovative Approaches
8. Development and application of appropriate technology.

"Community participation is an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assumes responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary."

3.9.3. Dimensions of Community Participation

From the available experiences, it is observed that the community may be involved in a variety of ways as noted below:

1. The services may be organised on a community basis with wide and easy access of the people to the services provided,
2. The community may contribute to the operation and maintenance of services.
3. The community may participate in planning and managing the services.
4. The community may make inputs into overall policies, strategies, and work plan of the programme.
5. The community may help in overcoming factionalism and interest conflicts in the community and promote emergence of a cohesive group capable of engaging in cooperative efforts for the benefit of all.

3.9.4. Advantages of Community Participation in Primary Health-care

1. A group of people belonging to the same entity and having a common perception of collective needs and priorities, and the ability to assume responsibilities for
decisions made within the community can play an important role in community participation.

2. Experience from within the country, as well as from different parts of the world, has clearly demonstrated that community participation can make significant contributions to bringing about greater development in areas including health of the citizens.

3. It increases understanding of the user-perspective in the management of health. The members of the community, who are chosen by the community and are appropriately trained, act as frontline workers being in direct contact with the beneficiaries. It also renders the services more accessible and acceptable to the people.

4. It promotes and strengthens self-reliance in matters of delivery of health services. The community may be able to mobilise human, financial and material resources to supplement the extra-community resources being provided by the governmental or non-governmental agencies. This minimises the sole dependence of the community on professional and bureaucratic structures. Participation also develops a sense of responsibility for the health-care programme.

5. For the organisation of the preventive and promotive aspects of primary health-care, the people in the community are the main actors.

6. Various non-health sectors contribute significantly to health development. The integration and coordination of different sectoral activities, necessary for making an adequate and sustained impact on health, can be brought about only at the community level through community actions and organisation. Community participation in health can act as a catalyst for further developmental efforts.

3.9.5. Community Participation – Limitations and Challenges

It is important to understand that community participation is a dynamic process and there exist a host of influencing factors or determinants that can dictate the nature of outcomes of development or health programmes and their sustainability. Planners and professional development actors need to understand that in community participation, the emergence of issues from the community is a dynamic process where goals and strategies
change over time (Hunt, 1990). The existing socio-cultural, political and economic environments within a community are likely to affect the degree of participation, the sustainability of which can be achieved only as long as the relevant actors remain committed (Morgan, 2001). For instance, formation and cohesion of SHGs may be affected in countries with prevailing vertical and hierarchical social structures (India, Bangladesh). Further, communities entrenched in caste, class and gender hierarchies are likely to limit women’s participation in health (Lahiri-Dutt and Samanta, 2002) and may well affect participation by minority groups. Poverty is another issue that restricts people from participating in decisions that affect their health (Macfarlane et al, 2000). Hence, having an understanding about the underlying issue/s within a given context may benefit programme planners in improving the prioritisation and planning process, while engaging with the community.

In community participation, there is also a risk of conflict if the community’s expectations clash with professional attitudes and behaviour of bureaucratic structures (Hunt, 1990), thus lessening the chance of success of a programme. This raises another issue of community ownership, an essential requirement, the absence of which can lead to failure or non-achievement of programme objectives. “Community ownership means that local people must have a sense of responsibility for and control over programmes promoting change so that they will continue to support them after the initial organising effort” (Flynn, 1995,). A case to note is the Life Abundant Programme sponsored primary health-care project in rural Cameroon that became sustainable due to the community assuming ownership and leadership of the project (Eliaison, 1999). In some countries, structural, economic and social constraints may limit the extent and capacity of communities to participate in health or development programmes. As seen in Niger, social constraints, such as the lack of knowledge and access to health-care by the community people, were some of the obstacles that Acute Flaccid Paralysis (AFP) surveillance programme faced (Ndiayeet, 2003). A study by Cruz, et al (2003) taking a case in Nepal, showed that, even though it was possible to overcome constraints like poor health knowledge and skills through training and capacity building of community health volunteers, another constraint (weak health system) hindered the extent of progress of the intervention that overcame the first constraint.
3.9.6. Community Participation and Health-Care Service Delivery

Essential to the well-being of all people are the effective delivery of basic services such as health, education, water and sanitation. Accessible, quality services contribute to the achievement of the Millennium Development Goals and to the achievement of human rights. Yet, widespread evidence shows that services are falling short of the needs of poor people in a large number of countries - with negative impacts on human development outcomes. In addressing the failure of services, one key point is that the failure of services is not just technical. It is the result of the lack of accountability of public, private and non-profit organisations to poor people.

As set out in the 2004 World Development Report, “Making Services Work for Poor People”, it is possible to assess and approach service delivery through an accountability model for service delivery that includes three groups of stakeholders: (i) citizens, as clients, influence policymakers; (ii) policymakers influence service providers; which in turn (iii) deliver services to the citizens who are also clients of the services.

Sources: (Ndiayeet, 2003)

Service delivery failures result when any of these relationships break down. For instance, service failures may occur when citizens are unable to influence public action through the long route of accountability (break on the left side of the triangle), when there is non-payment of salaries to service providers (break on the right side of the triangle) or when there are difficulties in implementing services, such as poorly trained or absent teachers, part of the short route of accountability (break on the bottom of the triangle).
Community participation as a concept focuses on the idea that involving stakeholders in decision-making about their communities and broader social issues has important social, economic and political benefits. In the 1980s and 1990s, for a variety of reasons, public sector donors, policymakers, as well as both Northern and Southern NGOs, emphasised the value and potential benefits of participatory approaches. Their interest in participation emerged from a range of concerns: failures in state-led development. The risk with an approach to economic development or service delivery that focuses too much on ‘community participation’ in that it may idealise the internal coherence and solidarity in communities, and miss the essential tasks of supporting effective, accountable and transparent public institutions. Community participation processes include an identification of stakeholders, establishing systems that allow for engagement with stakeholders by public officials, and development of a wide range of participatory mechanisms. Stakeholders are individuals who belong to various identified ‘communities’ and whose lives are affected by specific policies and programmes, and/or those who have basic rights as citizens to express their views on public issues and actions. The proponents of participatory approaches highlight the value of engagement with stakeholders in terms of greater local ownership of public actions or development projects, as well as the potential.

Each local context reflects the dynamics between various groups that help determine how inclusive and exclusive, conflictive or cooperative, community relations tend to be. For example, recent research in Indonesia found that the relative trust that communities in Eastern Java had in local government, and the relative lack of local conflict between communities and different identity groups meant less interest in participation. In other parts of Indonesia, however, the differences of identity and in-migration led to mistrust and conflict dynamics that heightened after the 1997 financial crisis. In India, there are notable differences in community level interactions that connect with political dynamics, as outlined in an essay on Kerala, Andhra Pradesh and Uttar Pradesh. Among the key goals of community participation to be assessed through the previous studies in this research are: improving technical efficiency; improving allocative efficiency; and improving mechanisms of accountability. Community participation initiatives are related to technical efficiency through such areas as
overcoming information asymmetry, providing communities with information on quality through various forms of Monitoring and Evaluation, and ensuring that resources are spent for necessary technical resources by service providers. Improving various dimensions of allocative efficiency includes: greater attention to the priorities of communities, increased transparency on budgets and public resources through such mechanisms as public budgeting and Public Expenditures Tracking systems, and a subsequent reduction on ‘rent seeking” by those in positions of power. Finally, improving accountability involves creating increased transparency from community involvement with public sector agencies, community participation in school management, and community participation in public hearings.

3.10. Health-care Utilisation in Rural Andhra Pradesh (Rajiv Aarogyasri Community Health Insurance Scheme (RAS))

The Government of Andhra Pradesh has invested in the Rajiv Aarogyasri Community Health Insurance Scheme as a means to reduce burdensome health expenses incurred by the state’s below-the-poverty-line population. Among the many challenges India faces in improving the health of its population is lowering the financial burden of seeking health services. Out-of-pocket spending on health is the dominant form of health-care financing in India and reaches inordinately high levels. Households with members requiring hospital care face financial catastrophe: the cost of hospitalization in India has been estimated to reach almost 60% of individuals’ total annual expenditures – with around 40% of individuals, nationwide, borrowing money or selling assets to pay for expenses – and results in almost one-quarter of those hospitalized falling below the poverty line (BPL) (Peters, 2002). In 2004, only the richest 20% of urban households spent less than 10% of income on health (a twofold increase compared to the previous decade) and around 40% of low-income residents – urban or rural – who do not seek care cite financial hardship as the primary driver for that decision (Yip & Mahal, 2008). There are many drivers of such a high degree of financial risk to patients in India. One factor is that insurance or other forms of pre-payment, which might lower the financial burden of seeking health-care, are not yet well-developed in India. The second is lack of accessibility to “free” care available through the public system’s primary health-care network. For decades, the government vastly underfunded India’s public health system
(spending just 1% of the GDP on health) and currently only one-third of that spent by other lower-middle income countries (WHO, 2008), which has resulted in an “ailing” primary care system (Peters, 2002; De Costa & Diwan, 2007; Yip & Mahal, 2008; Dalal & Dawad, 2009). Despite a renewed commitment to investment in primary care structures under the National Rural Health Mission (NRHM), widespread shortages of skilled health-care professionals at lower-level facilities remain, while poor governance, including historic lack of financial investment and poor supervision, contribute to poor quality of services provided, shortages of drugs, and high levels of staff absenteeism (MOHFW, 2007; Yip & Mahal, 2008). Which is due in large part to the long-standing “benign neglect” of the public system – is dominance of the private sector and heavy reliance on higher-level health facilities. Over three-quarters of health expenditures take place in private facilities (De Costa & Diwan, 2007), and even the poor – who frequent public primary health centres (PHCs) to a greater extent than the rich for outpatient care – still seek care in private facilities almost 80% of the time (Peters, 2002). As the public sector provides the bulk of primary care among licensed providers and with 75% of physicians working in private compared to public facilities (National Health Profile, 2008), heavy reliance on the private sector results in patients not only paying out-of-pocket for services, but doing so in higher-cost facilities (e.g., private hospitals).

In 2007, the Government of AP (GOAP) introduced the Rajiv Aarogyasri Community Health Insurance Scheme (RAS) to address this constellation of factors and reduce the financial burden of spending on health to the state’s poorest citizens. The GOAP introduced RAS as a major part of the Rajiv Health Mission, a programme to improve access of BPL families to treatment for specified diseases that require hospitalisation and/or are relatively expensive to treat (i.e., all procedures covered are emergency/life-saving in nature and require specialist physicians and/or equipment not available in most district government hospitals). Currently covering almost 950 surgical procedures and therapies through an established network of health-care providers (primarily private), the GOAP fully finances the scheme which is implemented by the Star Insurance Company under a public-private partnership framework. All members of BPL families – who are identified based on the state’s previously existing ration card systems – are eligible as beneficiaries with an annual benefit per family of Rs 2 lakh
(BPL families may also receive additional funds in certain cases in which costs exceed the maximum benefit). Importantly, it is an entirely cashless system from the point of view of beneficiaries: the modest annual premium of Rs 400 is paid for by the state government and approved care is provided for free at the point of service.

There are indications that the roll-out of RAS has significantly diminished barriers to BPL patients in accessing high-cost health-care. An unpublished evaluation conducted in 2009 indicated that, as of September, 2008, the benefits of RAS had been availed of by approximately 11% of the BPL population in AP and appeared to particularly benefit those living in rural areas, with 87% of beneficiaries having rural addresses (almost 15% above the state average). Beneficiaries overwhelmingly reported satisfaction with RAS, and close to 90% reporting improvement following treatment of their conditions (most common conditions treated were cardiac, cancer and neurological interventions). However, the evaluation also noted wide variations in claims paid for individual procedures covered by the RAS and that more than one-half of interventions financed by the RAS took place in less than 10% of participating RAS network hospitals (located primarily in AP’s four largest cities). It was additionally noted that patients in AP spent on an average Rs 10,085 for hospitalisations in urban settings and for a wide range of conditions that, in large part, are not covered by RAS (IIPH-Hyderabad, 2009).

3.11. Mobile Based Primary Health-care System for Rural India

Access to health-care and equitable distribution of health services are the fundamental requirements for achieving the Millennium Development Goals and the goals set under the National Rural Health Mission (NRHM) launched by the Government of India in April 2005. Many areas in the Country, predominantly tribal and hilly areas, even in well-developed States, lack basic health-care infrastructure limiting access to health services at present. Over the years, various initiatives have been taken to overcome this difficulty with varied results. Many States/NGOs have successfully tried out operationalising Mobile Medical Units. Taking health-care to the doorsteps is the principle behind this initiative and is intended to reach underserved areas. Under the NRHM, provision of Mobile Medical Unit (MMU) in each District is one of the strategies to improve access. For North Eastern States, due to their difficult hilly terrain, non-approachability by public transport, long distances for reaching the health centres
necessitate the need of MMU with specialised facilities for the patients requiring basic specialist examination. Otherwise, the basic purpose of taking the health-care to the door step of the needy people in rural areas would be defeated due to difficulties in conducting diagnostic examination. The States are expected to address the diversity and ensure the adoption of the most suitable and sustainable model for the MMU to suit their local requirements. States are also required to plan for long term sustainability of the intervention. Every Mobile Medical Unit has to provide the following services:-

3.11.1. Curative:
1. Referral of complicated cases; Early detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic Communicable diseases and non-communicable diseases, such as hypertension, diabetes and cataract cases, etc.;
2. Minor surgical procedures and suturing;
3. Specialist Services such as O&G Specialist, Paediatrician and Physician.

3.11.2. Reproductive & Child Health Services:
1. Ante-natal check up and related services e.g. injection - tetanus toxoid, iron and folic acid tablets, basic laboratory tests such as haemoglobin, urine for sugar and albumin and referral for other tests as required;
2. Referral for complicated pregnancies;
3. Promotion of institutional delivery;
4. Post-natal check up;
5. Immunization clinics (to be coordinated with local Sub-centres/PHCs);
6. Treatment of common childhood illness such as diarrhea, ARI/Pneumonia, complication of measles etc.;
7. Treatment of RTI/STI;
8. Adolescents care such as lifestyle education, counseling, treatment of minor ailments and anemia etc.

3.11.3. Family Planning Services:
1. Counselling for spacing and permanent method;
2. Distribution of Nirodh, oral contraceptives, emergency contraceptives;
3.12. Primary Health-Care Services in India.

In India, although there are many reasons for poor PHC performance, accessibility is one of the major obstacles. The public health system is managed and overseen by District Health Officers. Although qualified doctors may be available, PHCs have barely able to adequately utilise their services due to non-usage of IT and mobile access. The rural primary public health infrastructure has recorded an impressive development during the last 50 years of independence. The network consists of 1, 45,000 sub-centres, 23,109 primary health centres and 3,222 community health centres, catering to a population of 5000, 30,000 and 1, 00,000 respectively (and 3000, 20,000 and 80,000 population in tribal and desert areas). Each PHC is targeted to cover a population of approximately 25,000 and is charged with the responsibility of providing promotive, preventive, curative and rehabilitative care. This implies offering a wide range of services, such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunisation, disease control and appropriate treatment for illness and injury. Each PHC is the hub for 5-6 sub-centres that cover 3-4 villages and are operated by an Auxiliary Nurse Midwife (ANM). These facilities are a part of the three tier health-care system; the PHCs act as referral centres for the Community Health Centres (CHCs), 30-bed hospitals and higher order public hospitals at the taluka and district levels.

3.12.1. Health Education/Promotion

The Ministry of Health has paid special attention to health education as an effective method for changing unfavourable attitudes and behaviour that would negatively influence the health and well-being of individuals and the community at large. To meet this challenge, the Ministry established a Department of Health Education under the preventive health sector with representation in all medical districts. The departments’ responsibility is to develop national plans to raise the awareness of the public on all matters pertaining to their health and well-being. The implementation of these plans in the form of programmes and specific activities is supervised by the department.

The health education component of all prevention and control measures is multifaceted, Targeting different groups of the population including different methodologies (conferences, courses, lectures and workshops, national awareness weeks. Examples of
these include: Cancer National Awareness Week, outreach activities, sporting events, publications and media use). It is important to note that there is no reference centre for health education in neither the community nor a radio and television production unit which broadcasts awareness programmes via the various media channels. Because of the diversity of nationalities and languages, public communication is a challenge. Although health education has been recognised as an essential element to support health-care services, it still lacks proper definition of why, where, what, how and who. Although isolated and uncoordinated activities for utilisation of health education exist, there is no attempt at joining forces in a well studied programme. The information and telecommunication infrastructure in health-care institutions is weak.

3.13. Quality of Health-Care Services in Rural India: The User Perspective

Developing nations have been focusing on relevant infrastructure, technology, disease control, and health outcomes in terms of deaths and disability-adjusted life years - largely ignoring the service quality aspect from the patient’s viewpoint. However, researchers opine that real improvement in quality of care cannot occur if the user perception is not involved. Patients’ perception is significant as it impacts their ‘health-seeking behaviour’ including utilisation of services, seeks involvement in issues directly related to them, enables the service provider to meet their expectations better, and provides relevant information to the policy makers to improve the quality. The Studies in developing nations in Asia, such as Sri Lanka (Akin & Hutchinson, 1999), Nepal (Lafond, 1995) and Bangladesh (Andaleeb, 2000), have confirmed the impact of perceived quality of health-care services on the utilization. Evidently, quality of health-care is important and demands continuous attention. Keeping this in mind, the current study aims to measure the perception of users availing rural health-care services in India with a view to provide valuable information to the policy makers about the areas that need attention for improvement in quality of health-care. Furthermore, it seeks to further develop an analytical framework for the measurement of perceived quality of health-care. The findings illustrated some interesting differences in user perception regarding service Quality and how they varied between different health-care centers and according to the demographic status of patients. It was observed that:
1. ‘Health-care delivery’ and ‘financial and physical access to care’ significantly impacted the perception among men, while among women it was ‘health-care delivery’ and ‘health personnel’s conduct and drug availability’.

2. With improved income and education, the expectations of the respondents also increased. It was not merely the financial and physical access that was important but the manner of delivery, the availability of various facilities and the interpersonal and diagnostic aspect of care as well that mattered to the people with enhanced economic earnings.

3. What was most astonishing was the finding that the overall quality of health-care services is perceived to be higher in Primary Health-Care Centres than in Community Health-Care Centres (CHCs). Inadequate availability of doctors and medical equipments, poor clinical examination and poor quality of drugs were the important drawbacks reported at CHCs.

The current study demonstrates that the instrument employed was reliable and possessed the power to discern differences in the opinion of people on the basis of demographic factors and point out the quality differences in different health-care centres. It could be employed to evaluate health-care quality perception in other rural and urban regions of the country and to assess the perception of users towards private health-care centres. Further, research could be conducted on price-quality relationship. The government and policy makers are urged to consider the perceptions of patients as well in order to affect improvement in the quality of services and subsequently increase their utilization. The current study demonstrates that the instrument employed was reliable and possessed the power to discern differences in the opinion of people on the basis of demographic factors and point out the quality differences in different health-care centres. The selection of the respondents on the basis of convenience may have limited the precision of the study but the findings urge the government and policy makers to consider the perceptions of patients as well in order to affect improvement in the quality of services and subsequently increase their level of utilisation. Immediate steps need to be undertaken to ensure availability of doctors, medical equipments, and good quality of drugs. The study was, however, limited to certain areas of Andhra Pradesh. Therefore, it is suggested that similar studies be carried out in other rural and urban regions of the country and include
the private health-care service providers as well. Further, researches could be conducted on price-quality relationship.

3.13.1. Quality of Health-Care Services Delivery

In fifteen years since the Alma Ata Declaration, in which the international community committed itself to providing primary health-care (PHC) for all, major efforts have been made in nearly all developing countries to expand PHC services. This has been achieved through increased resources allocated by both national and international sources, expanded health worker training, and major health system reorganisation. Dramatic increases in outreach and health coverage have been reported by most countries, many of which have posted modest declines in infant and child mortality and some reductions in selected morbidity. However, the reported improvements have not always been commensurate with the resources expended. Furthermore, not enough has been done to assess service quality or to ensure that resources are having an optimal impact. A better quality delivery system can help health programme managers to define clinical guidelines and standard operating procedures, to assess performance compared with selected performance standards, and to take tangible steps toward improving programme performance and effectiveness. Quality of care must be defined in the light of the provider’s technical standards and patients’ expectations. While no single definition of health service quality applies in all situations, the following definitions are helpful guides: The quality of technical care consists in the application of medical science and technology in a way that maximizes its benefits to health without correspondingly increasing its risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favorable balance of risks and benefits.

3.13.2. Primary Health-Care in India: Quality

The quality of health-care in India is an immensely neglected area of study, though recent efforts have begun to focus on it. Quality of health-care services is a complex variable, encompassing as it does tangibles such as availability of drugs and equipment and intangibles such as courtesy and respect shown by providers to the patients. In India, the quality of health-care services provided by the public health system is extremely low in almost all the criteria on which quality can be judged – infrastructure, availability of drugs and equipment, regular presence of qualified medical personnel and treatment of
patients. Instead of being supportive and palliative of people’s health, it will not be
remiss to say that the health system itself poses a hazard to its intended beneficiaries,
especially the poor who are often as reluctant to use public health services as the rich.
Quality of health-care services provided can be assessed along the following dimensions
(which are by no means exhaustive): (i) an adequately equipped and easily accessible
public health facility, (ii) appropriate and timely clinical care, and (iii) patient satisfaction
with health-care received and the outcome of treatment. Ultimately, the real test of the
quality of health-care services is how it affects health outcomes, especially of the poor.
Let us now discuss some aspects of the quality of publicly provided primary health-care
services in India.

The role of the government in ensuring that its country’s health-care system
provides optimal services for its population has been greatly emphasised upon (The
World Health Report, 2000). Improvement in the quality of primary health-care services,
apart from increasing accessibility and affordability, has become a matter of grave
concern for the developing nations in the recent years. However, the meaning of quality
in health-care system has been interpreted differently by different researchers. Ovretveit
(1992) identified three “stakeholder” components of quality: client, professional, and
managerial. From the client’s viewpoint, it is the meeting of the patient’s unique needs
and wants (Atkins, Marshall and Javalgi, 1996) at the lowest cost (Ovretveit, 1992),
provided with courtesy and on time (Brown, et al., 1998). While professional quality
involves carrying out of techniques and procedures essential to meet the client’s
requirement, managerial quality entails optimum and efficient utilisation of resources to
achieve the objectives defined by higher authorities. According to the Institute of
Medicine (2001), quality in health-care is, “the degree to which health services for
individuals and populations increase the likelihood of desired health outcomes and are
consistent with current professional knowledge.” Meeting the objectives of both
physicians and patients has been equated with the concept of quality in health-care by
some researchers (Morgan & Murgatroyd, 1994), while others have focused on user
perception, technical standards, and provision of care (Boller, et al., 2003; Hulton,
Mathews and Stones, 2000). Quality of care comprises: structure, process, and health
outcomes (Peabody, et al., 1999). There are eight dimensions of health-care service
delivery: effectiveness, efficiency, technical competence, interpersonal relations, access to service, safety, continuity, and physical aspects of health-care (Brown, et al, 1998). The concept of quality is multifaceted, connoting different meanings to different stakeholders such as government, service provider, hospital administration, and patients. It impacts their ‘health-seeking behaviour’ (National Commission on Macroeconomics and Health Report, 2005) including utilisation of services (Haddad & Fournier, 1995; Reerink & Sauerborn, 1996), seeks involvement in issues directly related to them (Calnan, 1988), enables the service provider to meet their expectations better (Calnan, 1998), and provides relevant information to the policy makers to improve the quality. Studies in developing nations in Asia, such as Sri Lanka (Akin & Hutchinson, 1999), Nepal (Lafond, 1995) and Bangladesh (Andaleeb, 2000), have confirmed the impact of perceived quality of health-care services on the utilization. Evidently, quality of health-care is important and demands continuous attention. Keeping this in mind, the current study aims to measure the perception of users availing rural health-care services in India, with a view to provide valuable information to the policy makers about the areas that need attention for improvement in quality of health-care. Furthermore, it seeks to further develop an analytical framework for the measurement of perceived quality of health-care.

3.14. The Health Service Provider

From the provider’s perspective, quality care implies that he or she has the skills, resources, and conditions necessary to improve the health status of the patient and the community, according to current technical standards and available resources. The provider’s commitment and motivation depend on the ability to carry out his or her duties in an ideal or optimal way. Providers tend to focus on technical competence, effectiveness, and safety. Key questions for providers may be: How many patients are providers expected to see per hour? What laboratory services are available to them, and how accurate, efficient, and reliable are they? What referral systems are in place when specialty services or higher technologies are needed? Are the physical working conditions adequate and sanitary, ensuring the privacy of patients and a professional environment? Does the pharmacy have a reliable supply of all the needed medicines? Are there opportunities for continuing medical education?
3.15. Services Delivery in Rural Health-Care Centres

Minimum assured services cover all the essential elements of preventive, promotive, curative and rehabilitative primary health-care. All the following services have been classified as essential (Minimum Assured Services) or desirable (which all States/ UTs should aspire to achieve at this level of facility. Appropriate guidelines for each National Programme for management of routine and emergency cases are being provided to the PHC. All the support services to fulfill the objectives will be strengthened at the PHC level.

3.15.1. Minimum Requirement for Delivery of Health-Care Services:

The basic minimum requirements are being projected, based on the basis of 40 patients per doctor per day, the expected number of beneficiaries for maternal and child health-care and family planning and about 60% utilisation of the available indoor/observation beds (6 beds). It would be a dynamic process in the sense that if the utilisation goes up, the standards would be further upgraded. As regards, manpower, one more Medical Officer (may be from AYUSH or a lady doctor) and two more staff nurses are added to the existing staff strength of PHC to make it 24x7 services delivery centre.

3.15.2. Facilities

The document includes a suggested layout of PHC, indicating the space for the building and other infrastructure facilities. A list of manpower, equipment, furniture and drugs needed for providing the assured and desirable services at the PHC has been incorporated in the document. A Charter of Patients’ Rights for appropriate information to the beneficiaries, grievance redressal and constitution of Rogi Kalyan Samiti/Primary Health Centre Management Committee for better management and improvement of PHC services with involvement of Panchayati Raj Institutions (PRI) has also been made as a part of the Indian Public Health Standards. The monitoring process and quality assurance mechanism is also included.

3.15.3. Medical Care:

1. OPD services: A total of 6 hours of OPD services, out of which 4 hours in the morning and 2 hours in the afternoon. Time schedule will vary from state to state. Minimum OPD attendance should be 40 patients per doctor per day.
2. 24 hours emergency services: appropriate management of injuries and accidents, First Aid, Stabilisation of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions.

3. Referral services

4. In-patient services (6 beds)

3.15.4. Intra-natal Care: (24-hour delivery services both normal and assisted)
   i) Promotion of institutional deliveries
   ii) Conducting of normal deliveries
   iii) Assisted vaginal deliveries including forceps / vacuum delivery, whenever required
   iv) Manual removal of placenta
   v) Appropriate and prompt referral for cases needing specialist care.
   vi) Management of Pregnancy Induced hypertension including referral
   vii) Pre-referral management (Obstetric first-aid) in Obstetric emergencies that need expert assistance (Training of staff for emergency management to be ensured).
   viii) Minimum 48 hours of stay after delivery.

3.15.5. Nutrition Services (coordinated with ICDS)
   a) Diagnosis of and nutrition advice to malnourished children, pregnant women and others.
   b) Diagnosis and management of anaemia, and vitamin A deficiency.
   c) Coordination with ICDS.

3.15.6. Promotion of Safe Drinking Water and Basic Sanitation
   i. Disinfection of water sources and coordination with Public Health Engineering department for safe water supply.
   ii. Promotion of sanitation including use of toilets and appropriate garbage disposal.
   iii. Testing of water quality using H2S- Strip Test (Bacteriological)

3.15.7. Basic Laboratory Services:
Essential Laboratory services including:
   i. Routine urine, stool and blood tests (Hb%, platelets count, total RBC, WBC.)
ii. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc.
iii. Sputum testing for mycobacterium (as per guidelines of RNTCP)
v. Rapid diagnostic tests (pregnancy) and RDK for Pf malaria in endemic districts
vi. Rapid tests for pregnancy.
vii. RPR test for Syphilis/YAWS surveillance (endemic districts).
viii. Rapid test kit for fecal contamination of water
ix. Estimation of chlorine level of water using ortho-toludine reagent
x. Blood Sugar
xi. Desirable:
   xii. Blood Cholesterol
   xiii. ECG.

3.15.8. Monitoring and Supervision:
   (i) Monitoring and supervision of activities of sub-centre through regular meetings / periodic visits, etc.
   (ii) Monitoring of all National Health Programmes
   (iii) Monitoring the activities of ASHAs
   (iv) MO should visit all Sub-centres at least once in a month
   (v) Health Assistants Male and LHV should visit Sub-centres once a week.
   (vi) Checking for tracking of missed out and left out ANC/PNC, etc., during monitoring visits and quality parameters (including using Partograph, AMTSL, ENBC, etc) during delivery and post delivery stages.

3.15.9. Functional Linkages with Sub-Centres
   (i) There shall be a monthly review meeting at PHC chaired by MO (or in-charge), and attended by all the Multipurpose Health Workers (Male and Female) and Health Assistants (Male and female).
   (ii) On the spot Supervisory visits to Sub-centres.
   (iii) ASHAS and Anganwadi Workers may be appreciated if they attend the meeting
   (iv) Medical officer should orient ASHAs on selected areas of health-care.
3.16. Essential Infrastructure

The PHC should have a building of its own. The surroundings should be clean.

The details are as follows:

3.16.1. PHCs Building

**Location:** It should be centrally located in an easily accessible area. Hence, all new PHC Buildings should be located accordingly. The area chosen should have the facility for electricity, all weather road communication, adequate water supply and telephone. If PHC is already located, another health centre/SC should not be established to avoid the wastage of human resources. PHC should be away from garbage collection, cattle shed, water logging area, etc. It should be well planned with the entire necessary infrastructure. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450 sq. metres, depending on whether an OT facility is opted for.

3.16.2. Waiting Area

1. This should have adequate space and seating arrangements for waiting clients / patients
2. The walls should carry posters imparting health education.
3. Booklets / leaflets in local language may be provided in the waiting area for the same purpose.
4. Toilets with adequate water supply separate for males and females should be Available.

Safe drinking water should be available in the patients’ waiting area. There should be proper notice displaying wings of the centre, available services, and names of the doctors, users’ fee details and list of members of the Rogi Kalyan Samiti / Hospital Management Committee. A locked complaint / suggestion box should be provided and it should be ensured that the complaints/suggestions are looked into at regular intervals and the complaints are addressed. The surroundings should be kept clean with no water-logging in and around the centre and vector breeding places.

3.16.3. Outpatient Department:

1. The outpatient room should have separate areas for consultation and examination.
2. The area for examination should have sufficient privacy.
3. In PHCs with AYUSH doctors, necessary infrastructure, such as consultation room for AYUSH Doctor and AYUSH Drug dispensing, should be made available.

4. One room for Counseling of Family Planning clients.

3.17. Role of Anganwadi as a Facilitator of ASHA:

Anganwadi Worker (AWW) will guide ASHA in performing the following activities:

Organizing health day once/twice a week. On health day, the women, adolescent girls and children from the village will be invited for orientation on health related issues such as importance of nutritious food, personal hygiene, and care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailments and importance of immunisation etc. IEC activity through display of posters, folk dances, etc, on these days can be undertaken to sensitize the beneficiaries on health related issues, including HIV/AIDS. Anganwadi worker will be depot holder for drug kits and will be issuing it to ASHA. The replacement of the consumed drugs can also be done through AWW.

3.18. Universal Immunisation Programme:

The duties of personnel drafted for such programmes include the following: (i) Administer DPT vaccines, oral Poliomyelitis vaccine measles vaccine and BCG vaccine to all infants and children in his area in collaboration with health worker female, (ii) Assist the health worker female in administration of tetanus toxoid to all pregnant women, (iii) Assist the health supervisor male/health supervisor female in the school health programme and educate the people in the community about the importance of immunization against the various communicable diseases.

3.18.1. Primary Medical Care

The basic task of those engaged in primary medical care is to provide treatment for minor ailments, provide first aid for accidents and emergencies and refer cases beyond his competence to the Primary health centre or the nearest hospital.

3.18.2. Health Education

Educate the community about the availability of maternal and child health services and encourages them to utilise the facilities.
1. Carry out educational activities for MCH, Family Planning, Nutrition and Immunisation, control of blindness, dental care and other national health programmes like leprosy, Tuberculosis and NCD programmes, with the assistance of the Female Health Worker.

2. Arrange group meetings with the leaders and involve them in spreading the message for various health programmes.

3. Organise and conduct training of women leaders with the assistance of the Female Health Worker.

4. Organize and utilise Mahila Mandal, Teachers and other women in the Community in the family welfare programmes.

**3.18.3. Promoting Food Supply and Proper Nutrition**

The duties of one engaged in the area of nutrition include: (i) identify cases of malnutrition among infants and young children (0-5 years) in one’s area, (ii) give the necessary treatment and advice or refer them to the anganwadi for supplementary feeding, (iii) refer serious cases to the PHC, and (iv) educate the community about the nutritious diet for mothers and children from locally available food. The poor nutritional status of the people particularly of the pregnant and nursing mothers, and the infants and children can be substantially improved by organizing and conducting nutrition education programmes in the community and in the schools; by encouraging people to make kitchen gardens and community gardens, and by educating the people on food hygiene. Steps also need to be taken to encourage growing locally more foods such as cereals, pulses, vegetables, fruits, milk, fish and poultry products through cooperative and other efforts so as to make these easily accessible and affordable to the people. Simultaneously, the purchasing capacity of the families might be improved through a variety of income generating schemes. In addition, for the moderately and severely malnourished groups, special nutrition programmes are to be organized. In these endeavors, functionaries from other sectors such as agriculture, animal husbandry, irrigation, banks and cooperatives, social and women's welfare, panchayat, voluntary organizations and other community groups can play a very significant role.
3.18.4. Supply of Safe Water and Basic Sanitation Measures

Safe water and to carry out analysis of water. Arrangements should be made for regular purification of water through chlorination etc., before using for drinking and other household purposes. People at all levels, including village leaders, women and school children should be educated on continuous basis about the importance of proper maintenance of water and the use of safe water. Observation of personal hygienic practices should be emphasised. It would be important to organise the people and resources for constructing household and community latrines, and making arrangements for collection and disposal of human and animal wastes. Proper and imaginative disposal of waste water is also very important. Construction of composting facilities, soakage pits and the use some of the waste resources in kitchen gardens would be helpful. Proper educational programmes on all these aspects for the children, youths and adults and the mothers should be organised in a systematic manner. In these programmes cooperation of the workers of other sectors such as Irrigation, Engineering Department, Village Industries, Agriculture, Education, Social and Women's Welfare, Panchayats and Cooperatives would be most vital. Active community participation in organising all the above activities and programmes would be the key to success.

3.19. Availability of Manpower in Rural Health-Care Centre

To ensure round the clock access to public health facilities, Primary Health Centres are expected to provide 24-hour service with basic Obstetric and Nursing facilities. Under NRHM, PHCs are being operationalised for providing 24 x 7 services in various phases, by placing at least 3 Staff Nurses in these facilities. If the case load is there, operationalisation of 24 x 7 PHCs may be done in a phased manner, according to availability of manpower. This is expected to increase the institutional deliveries which would help in reducing maternal mortality. Select PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing the number of Medical Officers. Preferably, such PHCs should have the same IPHS norms as for a CHC. All 24 x 7 PHCs providing delivery services would also have newborn care corners and provide basic newborn care services including resuscitation, prevention of infections, provision of warmth and early and exclusive breast feeding.
3.20. Quality Assurance in Rural Health-Care Centre

Periodic skill development training of the staff of the PHC in the various jobs/responsibilities assigned to them can ensure quality. Standard Treatment Protocol for all national programmes and locally common diseases should be made available at all PHCs. Regular monitoring is another important means. A few aspects that need definite attention are:

I) Interaction and information exchange with the clients/patients:
   1. Courtesy should be extended to patients/clients by all the health providers, including the support staff
   2. All relevant information should be provided as regards the condition/illness of the client/patient.

ii) Attitude of the health-care providers needs to undergo a radical change so as to incorporate the feeling that the client is important and needs to be treated with respect.

iii) Cleanliness should be maintained at all points.

3.20.1. Accountability in Health-Care Centre

To ensure accountability, the Charter of Patients’ Rights should be made available in each PHC. Every PHC should have a Rogi Kalyan Samiti/Primary Health Centre’s Management Committee for improvement of the management and service provision of the PHC (as per the Guidelines of Government of India). This committee will have the authority to generate its own funds (through users’ charges, donations, etc.) and utilise the same for service improvement of the PHC. The PRI/Village Health Committee/Rogi Kalyan Samiti will also monitor the functioning of the PHCs.

3.20.2. Preventive and Promotive Work

The Medical Officer will ensure that all the members of his/her health team are fully conversant with the various National Health & Family Welfare Programmes including NRHM to be implemented in the area allotted to each Health functionary. He/she will further supervise their work periodically both in the clinics and in the community setting to give them the necessary guidance and direction. He/she will prepare operational plans and ensure effective implementation of the same to achieve the laid down targets under different National Health and Family Welfare Programmes. The MO will provide assistance in the formulation of village health and sanitation plan
through the ANMs and coordinate with the PRIs in his/her PHC area. He/she will maintain close liaison with Block Development Officer and his/her staff, community leaders and various social welfare agencies in his/her area and involve them to the best advantage in the promotion of health programmes in the area Wherever possible, the MO will conduct field investigations to delineate local health problems for planning changes in the strategy of the effective delivery of Health and Family welfare services. He/she will coordinate and facilitate the functioning of AYUSH doctor in the PHC.