CHAPTER FIVE

HEALTH PROGRAMMES
AND PEOPLE
CHAPTER V

HEALTH PROGRAMMES AND PEOPLE

I  Health Campaign

Health campaign is meant to improve the health status of the people. Health is an important component of total development and it can be achieved through proper and better health care. Health care includes not only medical care but also services for promotion of health, prevention of diseases, their early diagnosis and rehabilitation. These, together known as comprehensive health care, comprise a variety of personal and impersonal health programmes.

Medical care, as defined by WHO, is a "programme of services that should make available to the individual, and thereby to the community, all facilities of medical and allied sciences, necessary to promote and maintain health of mind and body. This programme should take into account physical, social and family environment with a view to the prevention of disease, the restoration of health and the alleviation of disability"\(^{(1)}\).

Comprehensive health care includes all health campaigns in the area, comprising promotive, preventive
and curative services. However, its contents vary from country to country and are influenced by general and ever changing national state and local health problems. In the Indian context, it includes the following health programmes:

a. Family Planning
b. Maternal and Child Health (MCH)
c. Health Education
d. Immunisation
e. Environmental Sanitation
f. Programme for Control of Blindness
g. T.B. Control programmes
h. National Filaria Control programmes
i. National Malaria Eradication programmes

II **Major Health Programmes and their organisation**

1) **Family Planning**

India is the first country in the world to have a state sponsored population control programme. It has also perhaps, the most extensive network of birth control, along with mass communication, training and research. The Indian government has given first priority and high concern to this programme. However, Family Planning
programme has been subjected to many stresses and strains. There has been substantial modification in the programme and its organisation.

Family Planning, according to the expert committee (1971) of the WHO is a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote health and welfare of the family group and thus contribute effectively to the social development of a country.\(^2\)

The UN Conference on Human Right in 1968 recognised Family Planning as a basic human right.\(^3\) The Bucharest Conference \(^4\) held in August, 1974, on the issues of world population, endorsed the same view and stated in its plan of action that "All couples and individuals have the basic human right to decide freely and responsibly, the number and spacing of their children and to have the information, education and means to do so"\(^5\)

Even though, the Indian Government has not recognised health as a human right, it gives due importance to this health programme. The main reason for this is, the majority problems of the country like poverty and unemployment are related to its growing population.
Realising the significance of the programme, the Government started the programme and up to 1961 it was being implemented as a part of the health programme, however it could not make any dent.

In 1961, therefore India invited a U.N. Mission on population activities to visit the country and to advise on the steps to be taken to propagate the small family norms among the people. The recommendations of the mission were considered by a committee appointed by the Government. It was decided to have the family planning programme as a vertical programme with separate administration at the Central level.

**Organisation**

Health and Family Planning activities are covered by Health and Family Welfare Department. Family planning organisation at the Union level is presided over by the Union Minister for Health and Family Planning. The body comprises of the Ministers of State for Finance, Social Welfare and Home Affairs. The following chart set out the F.P. organisation at central level.
Family welfare bureau have been set up in each state. At the state level, the Directorate of Health Service is the higher authority. The Family Planning organisation has been set up at the district too. The following charts shows the organisational set up in a State.
Chart V.2: Organisation for Family Planning in a State

State Cabinet Committee

State Family Planning Council/Board

Department of Health
Minister for Health
Secretary to Government

Directorate of Health Services
Director of Health Services

State Family Planning Bureau
Additional/Joint/Deputy Director of Health Services in-charge of MCH & FP

Audit Party
Operation Planning and Training
Division Asst. Director of Health Services

Education and Information Division
Mass Education and Communications Officer

Administrative and Stores Division
Administrative Officer (FP)

Statistics Division
Demography and Evaluation
Chart V.3 : Organization for Family Planning in a District

State Directorate of Health Services
   Director of Health Services

   Joint/Deputy Director of Health Services
   State Family Planning Bureau
      Additional/Joint/Deputy Director of Health Services

   District Health Organisation
      District Medical Officer

   District Action/Implementation Committee
   District Family Planning Bureau
      District Family Planning Officer

   Administrative Division
      Administrative Officer
   Education and Information Division
   Field Operations and Evaluation Division

   Stores Administration
   Mass Education and Information Officer
      Mobile FP Units
      Mobile Mobile Evaluation
   District Extension (Services) (Sterilization)
   Educators

Functions

The Department of Family Welfare has a wide ranging functions. It collects, on a monthly basis, data from all the service delivery points through the district and state officers. This data includes the number of IUD, insertions, the number of condoms distributed and the number of medical termination of pregnancy cases performed. Besides, FP camps are conducted directly throughout the state. The programme mainly focuses on the
implementation at the grassroots level, through PHC, with the help of the field staff which includes Health Supervisors, Health Inspectors and Multi-purpose workers.

The Family Planning services also include propagation of the message of small family concept and family planning to the community. Motivating eligible couples to small family norms is also an important function of this programme.

The Family Planning Programme in Kerala

In Kerala, the programme started in 1955. When the programme began, only eleven family planning clinics were attached to the hospitals in the whole of Kerala. However, since 1970, the State has made rapid progress in the implementation of the programme. It has helped the state to raise life expectancy, particularly that of a female, to over 70 years and to reduce the birth rate and mortality rates to the lowest level, in the country, especially those of mothers and children. The following graphs would help to realise the participation of the people in the programme through acceptance of Family Planning methods.
Graph V.1: Acceptance of F.P. Methods


The diagram (V.1) shows the state decadal progress of FP.

Diagram V.1: Decadal progress of FP Methods
2) **Maternity and Child Health**

The extensive prevalence of poverty in India both among the rural and urban population is well known. In many states, morbidity rates among mothers and children are shockingly high. They are particularly very high, among the poor in rural areas.

Considering the problems of Mothers and Children, the MCH programme has been started in the country. Because of the direct relationship between infant mortality and acceptance of small family norms, the Government has decided to integrate the Mothers and Child Health Programmes with the Family Planning Programme.

The main objective of maternity care is the delivery of a healthy baby without injury to the mother. The MCH services include:

a. Ante-natal or pre-natal care,
b. Intra-natal care
c. Post-natal care
d. Care of the new born
e. Family Planning Services.

Ante-natal or pre-natal care is the care of a woman during pregnancy. Ideally, this care should commence from the time of conception and should continue through out the
period of pregnancy. Intra-natal care is care of the mother at the time of delivery. The aim of this programme is to ensure that mother receives the best available care during labour and thereby prevent maternal and child mortality and morbidity. The post-natal care means, the care of the mother after the delivery. The care of the newborn baby and family planning service is also included in the programme.

**Development of Maternity Child Health Services**

When Primary Health Centres were established in 1952, MCH services were only a part of PHC services. At that time, apart from having one ANM (Auxillary Nurse Midwives) at the headquarters of the PHC, three ANMs were posted at three sub-centres, each covering a population of about 20,000. This enlargement of the staff was aimed at extending the service under MCH throughout the country.

Considering the urgency of the health problem, MCH activity was given the highest priority. However, when faced with the problems of population growth, MCH was sacrificed in an effort to somehow get cases for Family Planning. However, MCH programme was later strengthened by the inclusion of a number of preventive services for mothers and children.
Staffing (Kerala Pattern)

At the district level, there is a District Public Health Nurse to supervise the work of MCH. At the major PHC level there are 10 Public Health Nurses and 15 Junior Public Health Nurses working for the programme and under the supervision of the Medical Officer in charge.

Eversince the service began, the programme was almost a success in Kerala, more particularly, in the Kottayam district. The target achievements for each services of MCH is nearly above 60%. The following table shows the target and achievement of MCH activities in Kerala.

Table V.1: Targets and Achievements of MCH Activities

<table>
<thead>
<tr>
<th>Sl.</th>
<th>Activities</th>
<th>1987-88 Target</th>
<th>1988-89 Acht %</th>
<th>1989-90 Target</th>
<th>1989-90 Acht %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>TT for Pregnant Women</td>
<td>6.022</td>
<td>6.09 101.1</td>
<td>6.21</td>
<td>6.57 105.8</td>
</tr>
<tr>
<td>2.</td>
<td>D.P.T</td>
<td>5.464</td>
<td>5.51 100.9</td>
<td>6.03</td>
<td>5.63 93.4</td>
</tr>
<tr>
<td>3.</td>
<td>D.T.</td>
<td>4.000</td>
<td>3.17 77.2</td>
<td>4.00</td>
<td>2.79 69.8</td>
</tr>
<tr>
<td>4.</td>
<td>Polio</td>
<td>5.464</td>
<td>6.87 125.8</td>
<td>6.03</td>
<td>5.85 97.0</td>
</tr>
<tr>
<td>5.</td>
<td>BCG</td>
<td>5.464</td>
<td>5.43 99.4</td>
<td>6.03</td>
<td>6.00 99.5</td>
</tr>
<tr>
<td>6.</td>
<td>Measles</td>
<td>5.239</td>
<td>3.19 60.9</td>
<td>6.03</td>
<td>3.99 66.3</td>
</tr>
<tr>
<td>7.</td>
<td>Typhoid</td>
<td>4.000</td>
<td>2.57 64.2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8.</td>
<td>TT (10 years)</td>
<td>2.360</td>
<td>2.70 114.6</td>
<td>2.36</td>
<td>2.43 102.9</td>
</tr>
<tr>
<td></td>
<td>16 years</td>
<td>1.700</td>
<td>2.24 131.7</td>
<td>1.70</td>
<td>2.02 118.7</td>
</tr>
<tr>
<td>9.</td>
<td>Prophylaxis against nutritional anaemia (initiated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- All members</td>
<td>6.800</td>
<td>5.62 82.7</td>
<td>6.80</td>
<td>7.16 105.3</td>
</tr>
<tr>
<td></td>
<td>- Children</td>
<td>6.910</td>
<td>6.29 91.0</td>
<td>6.917</td>
<td>7.56 109.5</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Trivandrum
3) Health Education

Health Education is an essential tool for community health. Every branch of community health has health educational component. Health Education is "a process which affects changes in health practices of people and in the knowledge and attitude related to such changes"(6). It involves a series of steps - not a single procedure. It is also concerned with establishing or inducting changes in the knowledge, attitude and behaviour that promote healthier living.

According to WHO, there are three main aims for Health Education. These are (a) To ensure that health is valued as an asset in the community (b) To equip the people with skills, knowledge and attitude to enable themselves to solve their health problems by their own action and efforts and (c) To promote development and proper use of health services. These objectives together inculcate awareness among the people.

Generally, Health Education is carried as a three level function viz., individual, group and general public.
a) Individual Health Education

Doctors and nurses, who are in direct contact with patients and their relatives, perform this function. The greatest advantage of this type of education is that one can discuss, argue and pursue the individual to change his behaviour.

b) Group Health Education

There are many groups viz. mothers, children, patients, industrial workers. These group can be educated on matters of relevance. The choice of subject in group teaching is very important. For instance, mothers may be made aware about baby care, school children about oral hygiene, a group of T.B patients about tuberculosis and industrial workers about accidents.

c) Education of the General Public

The education of the general public, rests on the effective use of "Mass media of communication". It covers posters, health magazines, films, radio, television, health exhibitions and health museums. But "Mass media are generally less effective in changing human behaviour than individual or group methods."

(7) Considering intensity and
deep reach is concerned, however, mass media is very much useful in reaching large numbers of people, with whom, otherwise there could be no contact. For effective Health education, mass media should be used in judicious combination with other methods.

**Importance of the Programme**

Among the various Health programmes, Health Education would always stand on the top. Through Health Education, one can prevent health problems at least reduce their frequency and seriousness. Many of the illnesses today are the result of faulty personal or community habits, like excessive eating and drinking, lack of exercise or heavy smoking. A successful Health Education would influence attitudes of individuals. Also, it has an "access to as many people as possible to parents, young children, adolescents, adults, elderly persons, teachers, employees, employers and all the sections of the community."(8) This, Health Education wins friends and influences people.(9)

**Health Education Bureau**

Health education is an essential tool of community education. As 80% of Indian population live in rural areas, it become the responsibility of the Government to
guide Health Education activities in the general interest of the people. Realising its importance, the Health Education Bureau was established in the Central Ministry of Health in 1956 with the assistance of the Technical Co-operation Mission of USA.

Kerala Health Education Bureau

The State Health Education Bureau was set up in 1960. The function of the bureau have been manifold. It is functioning at the Directorate of Health Services and is under the supervision and control of the Director. The Asst. Director of Health Services (Health Education) helps him. He is assisted by the Additional Director of Health Services and a team of a Technical Officer, School Health Education Officer, Social Scientists, Sub Editor and the supporting staff. The Central Health Education Bureau provides guidance and leadership for the activities besides providing education materials.

The Media and Publicity Division of the Bureau is concerned with the planning of activities of the Bureau and purchase and distribution of materials, whereas the District Health Education unit guides and assist the regular public health personnel in extending health education and organising filmshows, exhibition and the like.
4) **Immunisation**

Communicable diseases still exist in India. Immunisation programme, therefore is still important. It is a fact that, immunisation programme is responsible for reducing the incidence of communicable diseases to a considerable extent. Children are especially victims of these diseases. "Children on the whole are more susceptible to infectious diseases because of their peculiar immunologic responses"(11). The programme plays a vital role in health activities, by building immunity among the people. It also helps to decrease the transmission of diseases from one person to another.

In the wake of successful eradication of small pox from the country, India launched the expanded programme on Immunisation in January 1978.(12) The major object of the programme is to reduce morbidity and mortality from diphtheria, pertussis (whooping cough) tetanus, poliomyelitis, measles, tuberculosis and typhoid fever, so that these diseases would cease to be public health problems.

This programme is now being implemented through hospitals at district, Taluk, PHCs and its sub centres. The Government of India has given more emphasis on the programme and has launched the Universal Immunisation
Programme under the National Immunisation mission in 1985. The main aim of the programme is immunisation of all children below one year of age against vaccine preventable diseases and hundred percent coverage of pregnant women under Tetanus Toxoid. Maintenance of universal prophylaxis, against women and children by providing treatment against nutritional anaemia and also better management of diarrhoeal diseases are also equally important aims of the programme.

Immunisation Programme in Kerala

Immunisation programme in the State was started in 1978 as expanded programme on Immunisation (EPI) to cover 33 community blocks every year in a phased manner. The objective was to reduce morbidity, mortality and disabilities due to Diphtheria, Pertussis, Tetanus, Poliomyelitis, Tuberculosis and Typhoid fever by providing free vaccination services to all eligible children and pregnant women.

In Kerala, Universal Immunisation Programme was launched on Nov.1985 first, in the selected districts of Palghat and Idukki and by 1988 all the 14 districts were covered by the programme. Medical colleges in the state were involved in the programme in a big way, so that the huge man power of medical students could be utilised
for intensive coverage in cities and even in villages.

The programme was implemented with a massive support of the people. Due to the better educational and economical status, people were appreciative and interested in the programme. This is the reason why the target was realised in the state, more particularly in the Kottayam District.

The main immunisation services and their achievements are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Achievement</th>
<th>%</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.P.T</td>
<td>600000</td>
<td>549452</td>
<td>82.7</td>
<td>1985</td>
</tr>
<tr>
<td>D.T</td>
<td>600000</td>
<td>591798</td>
<td>98.6</td>
<td>1985</td>
</tr>
<tr>
<td>T.T</td>
<td>500000</td>
<td>585766</td>
<td>111.72</td>
<td>1985</td>
</tr>
</tbody>
</table>

In the Kottayam district of Kerala, the programme achievement is comparatively good as seen from the following figures.

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Achievement</th>
<th>%</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.P.T</td>
<td>39000</td>
<td>34310</td>
<td>88.0</td>
<td>1985</td>
</tr>
<tr>
<td>D.T</td>
<td>40000</td>
<td>36551</td>
<td>91.4</td>
<td>1985</td>
</tr>
<tr>
<td>T.T</td>
<td>35000</td>
<td>37117</td>
<td>106.0</td>
<td>1985</td>
</tr>
</tbody>
</table>
Some of the districts have achieved better results than others because of their small area and compact population.

There are two types of immunisation services provided by the hospitals viz., active and passive. Active immunisation is more beneficial, since it lasts longer (e.g. effective for whooping cough). Passive immunisation is useful in giving immediate protection because antibodies are inducted in this type of immunisation (e.g. used for whooping cough for infant).

5) Environmental Sanitation

Environmental Sanitation is "the control of all those factors in man's physical environment which exercises or may exercise a de teri ous effect on his physical development, health and survival" (WHO). The term Environmental Sanitation is now being replaced by the term Environmental Health, which is an important component of community health. At present "Environmental Health" as a component deserves much attention within the health programme. In India as in developing countries many of these diseases are due to poor Environmental Sanitation i.e. unsafe water, polluted soil, unhygienic disposal of human excreta and poor housing. Air pollution is also a growing concern in big cities. High death rate, High infant mortality rate, high sickness rate, poor standard of
Health care in fact are largely due to defective Environmental Sanitation. Improvement of Environmental Sanitation is therefore, crucial for prevention of diseases and promotion of health of the communities.

Sanitation programmes

There are a few programmes implemented under Environmental Sanitation. The National Water supply and Sanitation Programme and the Rural Water Supply Programme are examples of these programmes. The National Water Supply and Sanitation programme was launched in 1954, by the Government of India, as part of health planning to assist states in providing adequate water supply and sanitation facilities. A special programme known as the 'Central Accelerated Rural Water Supply Programme also was started in 1972 as a supplement to the National Water Supply and Sanitation Programme. As the name suggested it aims to accelerating, the supply of drinking water to the rural areas.

Health Education emerges as an weapon in the hands of the government to create among people, a desire for higher standards of life. This is supported by the realization of improved standard of health sanitation, including Environmental Sanitation.
III Community Response to Health Programmes:

The effectiveness of a programme lies with its effective selling to the people. How people perceive it, how they define it, how they concur with its priorities - answers to these questions are translated into success or failure of a programme. Health programmes are no exception to it.

a) Officials

Officials were aware of various health programmes operated in the district. They could reproduce names of all the programmes of health operated in the districts. Though not specifically surprising, this however indicates their operational involvement in the functioning of the department. The district is operating all the health programmes which are implemented at the State level. The main programmes are Family Planning, MCH, Immunisation, Health Education, Environmental Sanitation etc.

A good number of officials 30 out of 50 i.e. 60% said that, due to proper and well planned implementation of health programmes, the district's birth rate could be controlled, and the district also recorded a significant decline in the death rate. Further, the district could
achieve infant mortality below 28 per 1000, which is an index to measure the control of population growth. This is about three and half times lower than the national rate. These achievements clearly indicate the impact of the health programmes in the district. However, the remaining 20 respondents (20 out of 50 i.e. 40%) were not that happy with the performance of health programmes. They said that even though the health campaign has been an overall success, compared with other districts, like Trichur, Pathanamthitta and Ernakulam, achievements of the districts are low. "There is room for improvement and we need not be complacent about the achievement" they said.

Responding to the experience of operational difficulties in administrating health campaigns, majority of the officials (35 out of 50 i.e. 70%) did not find any difficulty while operating health programmes. Whereas, 15/50 (i.e. 30%) identified a few operational difficulties like the lack of supportive staff, and operational equipment, which are essential for the better implementation of health programmes.

About voluntary agencies and their role in the operation of health programmes, the 'officials' were satisfied with their co-operative efforts. 28 out of 50
(i.e. 56%) stated that voluntary agencies play a complementary role in the implementation of health programmes. They co-operate with various programmes carried out by the hospitals. Besides, they conduct and arrange separately some health programmes like free medical camps, Health Education programmes etc. Some officials (ten in number – 20%) felt that there was sometimes overlapping of functions but their efforts could be coordinated to realise a still better output. However, some respondents (12/50 i.e. 24%) were a little sore with the working of voluntary organisations. They felt that such organisations were keen on publicity only and confined themselves mainly to the Health Education programme not to health programmes as such.

In general the programmes were successful, though with varying degrees. The officials felt that all the health programmes were successful in one way or the other. Some programmes were a 100% success. The programmes like Immunisation and Family Planning are such programme where the achievement is above the target. It is rather difficult to locate a health programme which has been a total failure.

b) Non-officials

The non-officials also seemed equally aware of various health programmes operated in the district. They could name the following programmes.
State Level
a) Family Planning  
b) Health Education  
c) Immunisation  
d) MCH  
e) Environmental Sanitation  
f) National Malaria Eradication Programme  
g) National Filaria Control Programme.

District Level
Immunisation  
Family Planning  
Environmental Sanitation  
M.C.H  
Malaria Eradication Programme  
Health Education

The district, it seems, is implementing all the health programmes and the non-officials collectively are aware of this. It is possible that individually they may not remember all the programmes in their appreciation, priority and therefore awareness would differ from individual to individual.

Non-officials priority is reflected in the following tabulation.

Table No.V.2 Priorities in the programmes by non-official

<table>
<thead>
<tr>
<th>Significant Programmes with high priority</th>
<th>No. of respondents</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Family Planning</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>Immunisation</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
As table shows, 20 respondents (i.e. 40%) felt that Health Education programme needs priority because it can mobilise the people and make them aware of health problems. Eight respondents (16%) regarded immunisation programmes with priority. To them, prevention of diseases was the immediate task. However majority of the respondents accorded Family Planning Programme the highest priority (22 respondents i.e. 44%) as they felt that over population is the main problem. Accepting Family Planning as a significant programme, it is also clear that there is a growing appreciation for Health Education as a long term investment.

According to the non-officials, the most successful health programmes were Family Planning and MCH programmes (56 %). The positive impact of Immunisation also received attention (20%). However to some respondents (24%) all the health programmes recorded success in the district. The main reason of success to them was the massive participation of the people and staff. The non-officials role in making in the programme a success is equally important. They extended support to the authority promote funds for the programmes and give direction through deliberations in the Hospital Development Committee.

Health programme would record still better success and impact if some of the weak links in administration are
strengthened. The non-official thinking is on the following lines:

1) Deploy more field staff in rural areas. Programme should not be deprived of personnel.

2) Propagate about the health programmes. There is need for more extension work about Health and Health Education.

3) Use the support of the Non-Governmental Organisation for all programmes. Make programmes more participative.

4) Decentralise some administrative powers to field level. This will make their role more effective.

c) Clients

With all the claims of the official and non-officials, the feelings, reactions and judgement of the people - who receive these services and people for whom these services are meant give insight in the working of the programme. The clients, in general, could not list all the programmes of health. However, could remember a few, especially those that were wide spread affecting a larger clientele or those, to which they were specifically exposed. The programme of Health Education had the highest frequency alongwith sanitary work and Family Welfare - (42 out of 70, i.e. 60%). Then comes Family Planning, MCH and
Immunisation with 28/70 responses (i.e. 40%). The pattern of awareness of health programmes does not differ much in case of people who mostly visit Private Hospitals. These hospitals mainly conduct Health Education and Immunisation programmes. Major health programmes are as the case is operated through public hospitals.

However, the rating of the programmes as distinct from its awareness shows a different picture.

Table No.V.3 Rating of programmes by clients

<table>
<thead>
<tr>
<th>Different Programmes</th>
<th>Govt. Hospitals</th>
<th>Private Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>MCH</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Health Education</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Immunisation</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>

As the above table indicates, the majority of the respondents have given highest rating to the Family Planning programme (in Govt. Sector 55% and Private Sector 70%). The next programme which they feel more important is the Immunisation programme. Both sectors Public and Private, equally supported (20%) this programme. The MCH
programme as it reaches every family and its inmates should have been more reflected in frequency rating. It seems that the impact of the programme falls short of its potential. Health Education is more covered by Public hospitals than Private hospitals. The thrust of Family Planning Programme is naturally reflected in the highest rating, it has received from the respondents.

Respondent's rating regarding operational success of these programmes also follows a similar pattern.

Table No.V.4 Operational success of health programmes

<table>
<thead>
<tr>
<th>Health Programmes</th>
<th>Govt. Hospitals</th>
<th>Private Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Family Planning</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>b) Immunisation</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>c) MCH</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>d) Health Education</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>e) Environmental Sanitation</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>

Here too, Family Planning and Immunisation top the list. 34% of the clients from public and 47 from private hospital, in case of Family Planning and 20% and 27% respectively in case of immunisation programme.
a) **Family Planning**

All the respondents appreciated the importance of Family Planning and have expressed faith in the health impact of 'Small Family' concept. A good number (31%) could also give the exact figure of financial incentive for undergoing family planning operations. A majority (69%) showed awareness of the incentives though they could not tell the exact amount.

Answering on the question "Do you think that staff and authority are committed to their service"? (Q.No 6.4) 48/70 i.e. 68% of the clients said 'YES' while 22/70 i.e. 32% said 'NO'. People have good opinion about the staff. They however expected more commitment from them. Some could even identify indicators of success. Nearly 29% of the respondents said that the birth rate has fallen and normally, there are 2 or 3 children per family, in the district. However considering extension work of the programmes and generally high rating of its success, more respondents should have been in a position to answer and to identify more indices of success of the programme.

Giving suggestions to improve the Family Planning Programmes effectively, the respondents made the following suggestions:
a) To allot more funds for all the schemes from the Government.
b) To induct more staff in the programme, especially paramedical staff.
c) To provide facilities like vehicle and other modern equipment for the scheme.

Weak funding is proverbial for government scheme. This is further reflected in inadequate staffing and inadequate infrastructure facilities. With inadequate communication facility and inadequate equipment, such programmes which rely on extension and effective demonstration suffer heavily. In a way, these are also some of the weak areas in administration of health programmes, in general.

b) Immunisation

Immunisation programme has been another important health programme. Eventhough, people were aware of its importance, in general, they were not able to identify different immunisation programmes within the broad coverage. They could identify some Immunisation programmes for children like small pox vaccination, Diphtheria Pertussis - Tetanus (DPT), polio etc. For adults, they could identify only the Tetanus Toxoid (TT) programme.
Also they were not much aware about the implementation of the programme through hospitals. Only 15 out of 70 respondents (21.42%) could answer correctly. Hospital field staff collects the list of eligible people and advise them to attend the nearby hospital. However, as the interaction between the hospital field staff and people was live. They were aware of their participation in making the programme a success. People were also cooperative with the field staff, as they visited their homes. It seems that people have not applied their mind fully to the impact of the programme and therefore have not come up with suggestions for its effective implementation eg. public coverage through mass media, electronic media, seminars or discussions on Health Education and the role of Panchayat in organising such gatherings.

c) **Mother and Child Health Programme (MCH)**

It is an important programme reaching to an individual family and target is the mother and the child. As such people should have been more aware of this programme than any other health programme, in comparison. Detailing various services under the programme, 26% of the respondents referred to family welfare services and care of the new born babies. Some (10%) referred to anti-natal
and post-natal care. But it is strange that the majority of the respondents could not easily identify any services under this programme. As in other programmes, there should be a good deal of extension work that this programme needs. The field staff makes people aware of the programme. The PHC and its sub centres play an important role in implementing the programmes. The success of such programmes rests on popular response which in turn depends on their awareness.

The respondents felt that the programme had an impact on health status of the district. They could identify three broad areas of impact. (Difficulty with the respondents is that they are not used to thinking evenly, clearly and logically on various aspects of the programme). They could identify the impact of the programme but could not ascertain their role equally clear.

Table No.V.5: Impact of MCH Programme on Health Status

<table>
<thead>
<tr>
<th></th>
<th>No. Resp.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Health of Mothers and Children</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Infant death rate reduced</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Maternal and infant mortality rate reduced</td>
<td>27</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
As the above table shows, 18/70 i.e. 26% of the respondents said that the major impact of the programme in the district was that it helped to improve health of mothers and children. 25/70 i.e. 36% of the clients said that infant, death rate has become low. while majority of the clients 27/70 i.e. 38% felt that the major impact of the programme was that reduced the maternal and infant mortality. People think clearly as the programme closely approach their homes. This also explains little divergence in frequency rates for different types of impact.

Responding to the question "How could the programme be more effectively implemented", (Q.No.D.8.5), the respondents have given following suggestions:

a) Need for more field staff in the area.

b) Make available better equipment and facilities like vehicle, telephone etc.

c) Conduct good extension for the programme.

d) Need for effective Health Education.

e) When the supervision conducts guidance and counselling, more effective supervision is expected.

Emphasis on Health Education, propagation (extension) work and equal emphasis and providing infrastructure facilities in these responses, is worth noting.
d) Health Education

Health Education is making people aware about general health inputs, consequences in case of their absence, and expected popular role in sustaining the level of health awareness. It is an extension work done through seminars, public talks, group discussions, audio-visuals and distribution of pamphlets and display of posters.

A quick question was asked to the respondents as to "Who directs Health Education programme in the hospital" (Q.No.D.9.1) with an idea to ascertain their minimum level of awareness of the programme and its instrumentality.

Table No.V.6 : Awareness on Health Education

<table>
<thead>
<tr>
<th>Instrumentality</th>
<th>No. Resp.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Superintendent of the Hospital</td>
<td>24</td>
<td>34</td>
</tr>
<tr>
<td>b) Health Supervisor in the area</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>c) Health Inspector in the field</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>d) District Education Officer directly directs</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>
Strangely, the responses were divided and divided much more evenly. The frequency for Hospital Superintendent is the highest (34%). It is followed by the Health Supervisor of the area (29%) and the Health Inspector in the field (26%). About ten respondent stated that the programme was run by the District Education Officer (11%). Health Education programme is rated high by the non-official leadership (Table No.V.2). This divergence indicates the gap in the conceptualization and the actual implementation of the programme. Health Education programme is implemented through schools (40%) and through PHC sub centres (60%). Schools normally conduct seminars and lectures, while the main activities carried by a PHC or its sub-centre are distribution of pamphlets, organisation of group discussions and audio-visual shows.

The programme has contributed to the health status of the district, even though its awareness level is low as far as the clients are concerned. The non-officials and officials are concerned about the social utility of the programme and the general high level of literacy makes the programme go. For its effective implementation, people felt that
a) All hospitals should exhibit posters and distribute pamphlets and give more stress on the importance of the health.
b) More film shows should be arranged in the rural area for easy and quicker understanding of the significance of the programme.
c) School Health Education system needs to be strengthened.

IV Health For All By 2000 A.D.

The WHO has been working in the field of health, propagating and sponsoring health programmes with a global perspective. 'Health For All By 2000 A.D.' has been such an ambitious project which highlights health needs of the Third World Countries and proposes an action plan to fight the problem. For people who work in health field, their perception about this world-wide programme of health naturally has a bearing on perspective health planning.

1. Officials

The Officials were asked a question "What is your idea about health development? Can you locate its key indicators"? (Q.No.A.3.1) Majority of the respondents have given satisfactory answer to the question.
They could look at health development as a total development of the human being both mentally and physically. But there was a sizeable number, who felt that they were merely medical practitioners and did not know anything regarding it. The main ingredients of the action plan according to the officials are:

a) Nutrition  
b) Sanitation  
c) Availability of potable water  
d) Health Education about the importance of the health.

Health programme are planned for total development of health. The Official had different priority perception as far as the ingredients are concerned. And this difference is natural.

Table No.V.7: Core Programme for Health For All.

<table>
<thead>
<tr>
<th>Priority Programme</th>
<th>No. Resp.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Family Welfare</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>b) Health Education</td>
<td>22</td>
<td>44</td>
</tr>
<tr>
<td>c) Immunisation</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As table shows, 18/50 i.e. 36% of the officials, have given priority to Family Welfare Programme. They felt
that over population creates all the health problem, and as such, needs to be tackled on priority basis. 22 respondents (44%) however have said that 'Health Education is an important Programme'. They feel that Health Education can change people's thinking, attack superstition and finally make health concept rational. This would enable government to enlist more popular participation and thereby deal effectively with the health problems. 10 respondents, (20 %) expressed their appreciation of Immunisation programme as a good preventive measure to reduce impact of epidemic diseases. They regarded immunisation as a crucial programme in this regard.

Officials were aware of the international programme of 'Health for All' but all were not able to spell about its components. Some of them however could mention the following components.

a) Health Education concerning health problems
b) Promotion of food supply and better nutrition.
c) Adequate supply of safe water and basic sanitation
d) Family Welfare programmes.
e) Immunisation against the infectious diseases.
f) Appropriate treatment of common diseases.
g) Provision of essential drugs.
The Officials were confident about realising the programme 'Health For All' by administering it through hospitals. The programme has accordingly identified the following areas. (a) Family Planning (b) MCH, (c) Immunisation, (d) Health Education, (e) Environmental Sanitation.

The Officials felt that the programme could be fully realised with the following corrective/supportive measures.

a) Provide more facilities to Primary Health Centres.
b) Allocate more fund to Health Services.
c) Pay more attention and emphasis on health programme like Immunisation and Family Welfare.
d) Strengthen field staff in all PHCs.

A good number of officials (22/50) i.e. 44% looked more confident and remarked that the targets have been already realized.

2) Knowledgeable persons

Knowledgeable persons, like officials, are aware of the international programme of 'Health for All'. They also identified family welfare, Health Education and Immunisation as its major components.
Table No.V.8: Core programme for Health For All.

<table>
<thead>
<tr>
<th>Core Programme</th>
<th>No. Resp.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Welfare</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>Health Education</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Immunisation</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As the table indicates, majority of the Knowledgeable persons 28/50 i.e. 56% considered 'Family Welfare Programme' as the core programme. They said that through this programme, over population problem could be tackled and it could become a powerful country. 20 out of 50 (i.e. 40%) respondents stated that Health Education is the 'Core programme'. To them, education is an essential tool to make people understand the significance of the health care. Two respondents (4%) considered the Immunisation programme as a core programme. The reason was that, the programme could prevent diseases; Prevention being always better than cure. In a sense, all programme are crucially important. The rating reflects the individual preferences. Family Welfare Programme is more comprehensive, covering many component activities. This probably is the reason why it got the highest count. People, in general, felt that the Health For All covered
with range of activities and there was no need to add any more programmes. They stated that many health programmes were already started and to strengthen the existing health programmes was more urgent than inducting any new programme. They felt that out of the wide range of programme a 'Core' could be finalised and implemented. This would help to achieve the goal without much delay.

3) **Clients:**

People who were receiving health services at hospital, public or private were, in general, aware of the campaign 'Health for all' and its administration through the hospital superintendent. However, they were not able to identify programmes under it. Normal programmes identified were Family Planning (54%), MCH (26%), Immunisation and Health Education (20%).

The clients who visit private hospitals, seemed to answer, this question in a better way. All of them were aware of the programme. They say that the campaign 'Health For All' is initiated by the Central Government and the State level authorities conduct the programme throughout the state. Identifying detailed programmes under this campaign, they said that Family Welfare and Immunisation needed more encouragement.
Both public and private clients have different perceptions about the priority programme in the district under the scheme 'Health for All'.

Table Ni.V.9: Core programme for Health For All.

<table>
<thead>
<tr>
<th>Priority Programme</th>
<th>Public Hospitals (70 clients)</th>
<th>Private Hospitals (30 clients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.Resp. %</td>
<td>No.Resp. %</td>
</tr>
<tr>
<td>Family Planning</td>
<td>36 52</td>
<td>18 60</td>
</tr>
<tr>
<td>Health Education</td>
<td>8 11</td>
<td>4 13</td>
</tr>
<tr>
<td>MCH</td>
<td>12 17</td>
<td>0 0</td>
</tr>
<tr>
<td>Immunisation</td>
<td>14 20</td>
<td>8 27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70 100.00</strong></td>
<td><strong>30 100</strong></td>
</tr>
</tbody>
</table>

As the table indicates, clients from both the groups (public and private) felt that Family Planning Programme has been the priority programme under Health For All in the district. 36 (52%) and 18 (60%) government and private hospital clients respectively opined in favour of it. Next in demand comes the programme of Immunisation with 20% and 27% clients respectively. MCH is the programme primarily administered through public hospitals. Unfortunately the clients from private hospitals do not support MCH programme as 'Core'(0% response). Health Education
is basically an extension programme and its results are reflected in the success of other health programmes. However, its rating should have been higher, considering the higher literacy level in the State.

As public organisations, government hospitals run the majority of programmes like Family Welfare, Health Education, Immunisation, MCH programme. Blindness control programme, School Education and Malaria Eradication programme. Private hospital, concentrate more on immunisation, health education and to some extent on MCH.

V **Hospital Development Committee**

Hospital Health Committees are an innovative experiment in Kerala. These have been in existence for a long time. A part of the committee are nominated by the Government. The nomination is made on political affiliation as well as on social involvement of the members. Staff also is adequately represented - it's representation is mainly ex-officio. It has comprehensive functions of advisory, supervisory and assisting nature. The Committee is constituted at the District, Taluka and the PHC level.

The Hospital Development Committee work as a body to keep a constant vigil on hospital functions. It assists
hospital administration in the conduct of health programmes. This assistance may come by way of voluntary services or supporting financial contribution in order to meet emergencies and thereby ensure steady development of the hospital. However, the general impression is that, these committee were functionally ineffective and seldom met, inspite of directives laid down by Government.\(^{(18)}\)

Constitution of Committee at District, Taluk and PHC level

1) The District Hospital Level

The District hospital enjoys a strong body of Hospital Development Committee. The Committee comprises of non-officials and official members. The non-officials members in the Committee are:

a. One M.L.A. from the district (nominated by the State Government).

b. The Mayor/Chairman of the local corporation/municipality.

c. The Chairman of the Development Committee of Taluk Level hospitals under its jurisdiction.

d. A representative of the local Indian Medical Association.

e. Two members from each recognised political party.
The official members in the Committee are:

a. The Collector of the District.
b. The District Medical Officers of Health.
c. The Superintendent of the District hospital who will also act as Convener of the Committee.
d. The Superintendent of the women and child hospital wherever it functions, who will also act as a joint convener.
e. One elected representative of the doctors each from District Hospital, and W & C Hospital.
f. One executive Engineer from PWD and Electricity Board.

The Chairman of the Committee shall be elected from amongst non-official member of the committee concerned.

2) Taluk Hospital Level:

The non-officials member of the Committee are:

a. The Local M.L.A.
b. The Chairman of the Municipality
c. The Chairman of the Development Committee of the PHC under its jurisdiction.
d. One representative of voluntary social organisation (nominated by Government).
e. Two members from each recognised political party.

Official members of the Committee are:

a. The Superintendent of the hospital (who will also act as Convener of the Committee)
b. The Assistant Engineer PWD
c. One Assistant Engineer from State Electricity Board.
d. One representative elected from amongst the Medical Officers and one representative elected from other staff members.

The Chairman of the Committee shall be elected from amongst the non officials members of the committee.

3) PHC Level:

The Hospital development Committee at PHC Level, consists of the following members:

Non-official members of the Committee are:

a. The M.L.A. of the constituency where the PHC is located.
b. The Panchayat President (the Panchayat where the PHC is located).
c. Two members from each recognised political party.
The official members of the committee are:

a. The Block Development Officer.

b. The Medical Officer in charge of PHC.

c. The Assistant Engineer, Building and Road.

d. The Assistant Engineers from State Electricity Board.

e. A Senior Public Health Nurse.

The Chairman of the Committee shall be elected from the non-official members.

Rights and Duties of the Committee

a. To locate shortcomings, if any, in the amenities and services provided and in the functioning of the institutions. Also devise ways of solving them.

b. To strive to maintain orderliness and cleanliness in the institutions and their surroundings.

c. To assess monetary requirements for improvement and organise ways and means to collect requisite funds.

d. To exercise vigilance in preventing malpractices.

e. To help organise health education and mass medical campaigns.

f. To organise voluntary Blood Banks and Drug Banks, Public Comfort stations.

g. To run canteens and medical stores to provide supplies at the fair prices. Whatever profits that are acquired go well to augment funds of the committee.
h. Any welfare activity including donations, initiated by individuals or voluntary organisations.

i. Greater involvement in the maintenance of social discipline in institutions.

The Committee meet as often as necessary and send reports to the D.M.O. in the case of committees that work at taluka level and PHC level. The District level committee sends its report to Director of Health Services. This helps prompt attention and implementation of the recommendations. It is a convention that the committee meets at least once in three months. The recommendations of the committee are invariably given due consideration by the concerned authorities, the reasons for delay or failure in implementation of the recommendations, if any, is recorded and is communicated to the committee by the concerned authorities.

The hospital Superintendent who is the convener of the Committee prepare the agenda for the meeting. The itenary is as follows:

a) Measures to improve the functioning of the hospital
b) Organisation and conduct of Health programmes
c) Maintenance of the building and furniture.
d) Demand for filling up vacancies of the staff
e) Collection of funds for the programmes.
Non-officials views of the Committee

Efforts were made to gauge awareness of the non-officials and their genuine interest in the working of these committees.

The non-officials have been aware well of the composition of these committees, though they were not clear about political party position on these committees. 56% of the respondent however, could reply correctly. In case of the strength of elected members and nominated member, majority of answers were right, 84% in case of answer pertaining to the strength of elected members and 90% with reference to the nominated members on the committee. Government nominates member on these committees. Normally, 4 to 6 meeting are held during the year (70% respondents). May be due to nomination and selection on party basis, members shown little interest in the functioning of these committees. 41 respondents out of 50 (82%) stated that they could attend up to 2 meetings in the year. And there was no respondent who attended more than 4 meeting. This indicates the general lack of interest of the members in the working of these committees.

The Chairman's attitude is in general co-operative (56% responses). Since he is a political party member,
there is however a possibility that he is included to the party-line of thinking and thus prone to lend support to his people. Still, the overall impression is that his attitude is encouraging and co-operative.

Political consideration and group interests may affect the functioning of the Health Committee. The following table shows the extent, the chairman's ruling is influenced by party considerations and group interests.

Table V.10: Political parties and groups interest influence the ruling of the Chairman.

<table>
<thead>
<tr>
<th>Party influence</th>
<th>No. Resp.</th>
<th>%</th>
<th>Group Interest</th>
<th>No. Resp</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerably</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Partially</td>
<td>40</td>
<td>80</td>
<td>12</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Negligibly</td>
<td>8</td>
<td>16</td>
<td>38</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
<td>50</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

As the table indicates, both political party and group interest, influence committee functioning. Majority of the respondents felt that political party interest do influence the ruling of the Chairman (80% in 40/50). However, group interest do not (38/50 i.e 76%) influence committee functioning.

A similar question was posed to the overall tone of the deliberations in the committee as distinct from the
attitude of its chairman (Question No.B.2.13). The following table indicates their responses:

Table V.11 Influence of political party consideration

<table>
<thead>
<tr>
<th>Variables</th>
<th>No.of Resp.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Political party consideration</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>influence to a great extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Political party consideration</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>influence to some extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Political party consideration</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>do not influence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

As the table indicates, political party considerations do not significantly influence the decision making at the subject committee level accordingly to the non-officials. 32, 64% replied that party considerations do not influence the decision making of Health Development Committee. It is to be noted that only 4/50, (8%) of the non-officials said that political party considerations influence a great extent. Equally, 14 respondents felt that it affects to some extent and the percentage (28%) is not small to be neglected. It seems that in a course of time, political party influence would become an important considerations. And the chairman would translate party
thinking in decision making.

The non-officials gave the following suggestions to improve committee function:

a. The agenda of the meeting has to be distributed at least one week before the meeting.

b. Government should provide incentives to the members for participating in the meeting and cover meeting expenses.

c. At the same time, if a member remains absent for the committee consecutively for three times, his membership should be cancelled.

d. Hospital authority should take effective steps in the light of the deliberation of the Hospital Development Committee. And there should be follow up measure.

e. There is a need for extension and propaganda of the working of the Hospital Committee.

VI The Voluntary Health Organisation and Implementation of Health Programmes:

Voluntary health organisations occupy an important place in community health programmes. It is "administered by an autonomous board which holds meetings, collects funds for its support chiefly from private sources, and extends money whether with or without paid workers, in
conducting programme directed primarily for furthering public Health by providing health services or health education or by advancing research services or legislation for health or by a combination of these activities". Such organisations are spread in every field including health and in every nation. All voluntary agencies have a positive role, as Alexis De Tocqueville points out that "in a democracy, the individual is essentially powerless and weak inspite of all his freedom, unless he is voluntarily associated with others for (political) purposes". It makes clear that voluntary organisation have a significant role in democratic process.

Classification of Voluntary Health Agencies:

Charity and development largely sum up the motivation in general and serve as the basis of classification of these agencies. The Health organisation can be mainly divided into three groups:

a. Disaster, relief or charity (e.g. Arya Samaja dispensaries, Christian charity organisation etc.)

b. Development oriented organisations (e.g. religious and secular institutions like private trust, business houses organising hospitals and medical colleges).

c. Political activist groups (e.g. sub-political groups, like student, youth movements).
The first group (charity group) is seen as "ameliorative" while the second, development-oriented organisation is viewed as technical or professional approach aiming at the improvement of poor people (21). The third (political activist group) aims at structuring by fighting against exploitation and organising and mobilising people for this fight.

Functions

The functions of voluntary health organisations have been divided into six headings.

a. Supplementing the work of official agencies.
b. Pioneering
c. Education
d. Demonstration
e. Guiding the work of official agencies,
f. Advancing Health legislation.

a) **Supplementing the work of official agencies**

Official agencies may find it difficult in extending health services already under operation. There would be financial difficulties on procedural or statutory wrangles. Voluntary health organisation come to rescue as they are supplementing strength to the work of official
agencies i.e. lending personnel, or by contributing funds for special equipment supplies or services.

b) **Pioneering**

A voluntary Health Association can explore ways and means and break new grounds. Research in one form of pioneering, which voluntary association carried in Family Planning Programme. When research established its importance, the government accepted family planning as a national policy.

e) **Education**

Health Education is a crucial factor in realising and raising health status. Official agencies cannot cope with this problem which is extensive and expensive. Voluntary agencies have come to the picture and shared the responsibility.

d) **Demonstration**

Voluntary agencies contributed substantially to health programmes through organising demonstration and experimental projects. One such example is that of demonstration of bore hole latrines by the Rockefeller
Foundation, in connection with hook work problem. At present with modifications, a bore hole latrine has become an essential part of environmental sanitation programme in India.

e) Guiding the work of official agencies

Voluntary health agencies have rich information and accumulated experience, collected and stored through their own work. This comes to help government health officials, as they design and improve their programmes. Health committees even consist of the representatives from voluntary health agencies.

f) Advancing Health Legislation:

Voluntary Health Agencies can and do mobilize public opinions and initiate legislation on health. They conduct and arrange public meetings to discuss on health problems. These efforts are ultimately reflected in better health legislation.

Voluntary Health Agencies at Work

In India, a number of the Voluntary Health Agencies are working in the field of health. The important amongst these are (a) Indian Red Cross Society (b) The Hind Kusht
Voluntary agencies help and strengthen hospital administration in the implementations of health programmes. In Kerala, many such agencies are functioning with the active participation of the people. The major agencies to mention, would be National Service Scheme in Colleges (N.S.S.), Scouts and Guides organisation in schools, Mahila Samajams, Rotary Club, Lion's Clubs, The Chamber of Commerce, The Junior Chambers, Youth Clubs, Cultural Organisations, Sports Clubs, Religious organisation etc.

Voluntary organisation cooperate with the efforts of the government in the administration and extension of health activities. These voluntary agencies are actively associated in the implementation of programme and people.
are well aware of their association and involvement. Collectively, these agencies support almost all the programmes of health operated in the district (Kottayam) choosing one or the other programme for individual association.

<table>
<thead>
<tr>
<th>Voluntary Agencies</th>
<th>Association with the programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mahila Samajams</td>
<td>MCH &amp; Family Planning</td>
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<tr>
<td>Lion's Club</td>
<td>Family Planning</td>
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<td>Rotary Club</td>
<td>Health Education</td>
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<td>Immunisation</td>
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<td>Arts &amp; Sports Club</td>
<td>Free Medical Camp</td>
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<td></td>
<td>Health Education</td>
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<td>Family Planning</td>
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<td>Charity organisation</td>
<td>MCH</td>
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<td>Immunisation</td>
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<td>School Health Programme</td>
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These voluntary Agencies thus working in health field conduct programmes like Family Planning, Health Education and Immunisation in rural areas with the help of hospital authorities. They support authority by contributing funds for special equipment, supplies and construction activities. The Lions clubs and the Rotary Clubs are very sound financially. They help most of the Primary Health
Centres in rural areas by providing funds for constructing new wards, operations theatres and the like.

The Mahila Samajams are very active. They work in the field of Family Welfare, organising and conducting camps and seminars and also help health officials in implementing the health programmes. The Mahila Samajams and Youth Clubs take much interest in organising educational and service activities and also take up Health programmes.

XII Community Participation in Health Programmes:

Community participation is imperative for the successful implementation of health programmes. It is the process by which individuals and families become aware and assume responsibility for their own health welfare. Popular participation is the index of success of the programme which at the end assures better health. It not only improves health but improves understanding. Basically it is an educative process. "Community participation is an educational and empowering process in which the people in partnership with those able to assist them, identify problems and needs and increasingly assume responsibilities on themselves to plan, manage and control and assess the collective actions".(22)
The aim of community participation is "People's health consciousness and knowledge which are expected to increase and result in better health practices among individuals, families and communities in place of existing harmful or ineffective ones". Community participation brings about improvement in community level health infrastructure, such as a water supply and sanitation.

Community participation rests on the help of voluntary associations. These agencies can make community aware of the positive implications of the various programmes conducted through the hospital, including care, prevention, health education and family welfare activities.

If the people voluntarily involve in the programmes of the hospital, many of the obstacles affecting their work would be removed. Hospital organisation then, no longer, need to worry about the acceptability of its programmes. When the community is properly aware of the services which the hospital is able to render, it will be able to take better advantages of the services available.

Role of Community Participation in Health Programmes

Educating people about health matters is one of the important roles of community participation. Health
education to the community can be a prime function of the Health workers. It is a fact that, health education in schools and adult education sessions can incorporate basic knowledge, preventive-curative, about health problems. Members of the community, both individually and collectively can play a very important role in the promotion of these activities.

Community participation would help improve food supply and nutrition level of the poor, also particularly of the pregnant and nursing mothers and the infants and children. In the field of Family Welfare, community can do much by mobilising people for accepting the small family norm. It can play an equally vital role in the areas of prevention and control of locally communicable diseases.

Community participation has been called as the heart of primary health care, and has been considered as an important component of community health programme. (24) It helps to increase acceptability of the programme and assures fuller and participative utilisation of the services. Educational and motivational campaigns makes the programme an enduring one.
Community participation and involvement in Health programme is overall satisfactory in Kerala. It is of course, because of the good network of educational institutions in the state. The high level of literacy has ensured the success of programme like the propagation of small family norm among eligible couples, removal of misunderstandings about family planning operation. This is done through individual contacts, group discussions, and voluntary agencies like Mahila Samajams and Youth Clubs bear the maximum load in this respect.

The Family Education Centres and Youth Clubs are taking much interest in organising educational and services activities and also follow up programmes. Educational kits, film scripts are used during discussion classes. Health programmes like immunisation and family welfare are also being conducted in rural areas with in the help of voluntary agencies. At the district hospital and taluk hospital levels, Superintendent of Health is in-charge of community participation. At the PHC, level Medical Officer in-charge, supervises and encourages community participation.

Health programmes are comprehensive by nature and need to be operated at different levels so as to reap the
maximum advantage. The target is achieving a state of body and a state of mind individually and collectively. Health administration need to realise this task and need to rise up to this expectations. If it has to come up to this expectation, it should not only have desire for reaching this level but should professionally gear itself so as to make it able to reach the level. Hospital Administration is s crucial variable in this process and there is a growing awareness about its salience in the Third World Countries.
REFERENCES

4. Ibid.
5. Ibid.


14. Ibid.


22. Ibid., P.109.
