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Rural Health Planning in India

M. Marikkani, M.Sc., M.A., M.Phil.

R. Murugesan., M.Sc., M.A., M.Phil., Ph.D.

C. B. Muvendhan, M.B.A.

Abstract

Rural Health is an important commodity not only at the individual level but also in terms of the micro- and macroeconomic scale of a country. Improvement of health status is therefore on the political agenda of every government. Health planning in India is an integral part of national socio-economic planning. The guide-lines for national health planning were provided by a number of committees dating back to the Bhole committee in 1946. These committees were appointed by the Government in India from time to time to review the existing health situation and recommend measures for further action.

Establishing health care planning in India is a key to improving the health of the Indian Population. The Ministry of Health and Family Welfare has been facilitating Health needs in India by establishing various schemes and organizations. The Government is conscious of the

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need for dynamic Indian health planning and management. All these programmes communities could only participate in the benefits but were not involved in the planning or implementation.

The outline of programmes was determined by the central policy makers. The influence of local government employees was limited. Their lack of training and, therefore, lack of knowledge regarding the basic principles of primary health care made it difficult to strengthen health prevention and promotion. The curative focus of care prevailed. The influence of stakeholders like local party members or other powerful people affected the location of health centres.

1. RURAL HEALTH SYSTEM RESEARCH AND GEOGRAPHY

Rural Health System Research in developing countries focuses on quality outcomes of different health care interventions like decentralization and the Primary Health Care Approach. In Geography the research in health care has been reestablished in the 18th century (see Barrett 1991, 1993, 1996, 2002; Burnett 2004).

From the historical development of medical geography the following issues become clear. Medical geographers research the links between health indicators and place characteristics in order to understand the features shaping the health of people. Describing ecological, cultural, religious or political circumstances of the research area is an important part of the research methodology. Comparison of regions or localities in view of their health systems or disease patterns as well as studies on spread and migration of infections can be seen as the geographical basis of the subject.

In modern medical geography or ‘post-medical’ geography the emphasis has slightly changed. The development of ‘post-medical’ geography of health was advocated by Kearns (Kearns 1993). The emphasis of ‘post- medical’ geography is to take up a broader social geographic perspective in research. Social environment, socio-economic status and the perception of a place has gained importance in his view and calls for refocusing the “attention on the social context of health and disease”.

Rather than concentrating on spatial distribution of health care, medical geography should focus on inequalities in health status (see Hayes 1999). ‘Post-medical’ geography in his

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opinion has come into existence through a new understanding of place which incorporates both the subjective and the objective meaning of a place.

In his call for reforms, Kearns criticizes the geographical approach to analyze spatial relationships without questioning the characteristics of places themselves. Medical geography has not been very influential outside its own discipline due to its “technocratic perception” (Bennett 1991: 340). However, the discipline has much more to offer than the technologies of spatial analysis only (Mohan 1998: 113).

Socio- demographic, economic, and political factors are interrelated with health. Medical geography delivers not only the instruments for multidisciplinary research but also offers a theoretical basis upon which researchers can operate. Besides logical positivism and the scientific method, medical geography can and should also use phenomenology, realism, structuralism and others to understand the underlying processes and methods which shape the health system (Mayer 1993: 587).

Research on participation and decentralization in health care is a relatively new field of medical geography which looks into the interactions between politics and health (Verhasselt 1993: 121). It is part of the geography of health care delivery. Geography of health care delivery engages with health system analysis, spatial distribution of health services, planning and optimizing health care resources, study of accessibility and utilization of health services and traditional medicine (Ibid.).

Since research on participation and decentralization deals with the social and political context of health it follows Kearns call for a ‘post-medical’ geography. At the same time it uses the strengths of other sub-disciplines of geography, like cultural or social geography. Medical geography cannot be seen as detached from geography as such. Therefore, the strengths of geography in spatial analysis are incorporated in this discipline. “Medical geography uses the concepts and techniques of the discipline of geography to investigate health-related topics. Subjects are viewed in holistic terms within a variety of cultural systems and a diverse biosphere.” (Meade/ Earickson 2000: 1). The issues of medical geography explained above culminate in this definition which includes all important aspects of the discipline.

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Apart from presenting a general overview of various Committee reports and available models of healthcare, this study analyses the process of health policy implementation of the new National Health Policy 2002 in India, with special reference to Tamilnadu. However, this presentation on Tamilnadu is only illustrative and not comprehensive.

The Primary Health Care Approach and decentralization are the theoretical background for health care reform in India. Both approaches incorporate participation as an important measure to enhance equity in health care and, thus, to improve the quality of the health services. Several attempts to employ community participation in past reforms have not shown the desired outcomes.

The framework chosen for research is not logical positivism, which is the prevailing philosophy for empirical sciences, because its “hypothetico-deductive” method is not useful for this study (see Mayer 1993; Baer 2002; Bennett 1991). Logical positivism requires that observable and replicable objects are studied from which law-like statements can be formulated (Mayer 1993: 580). Thus, logical statements are verified with empirical methods. While this framework is suited for studies of disease patterns, where causal relationships can be formed, it is insufficient for the complexity of policy analysis.

So, this study will rather use a postmodernist framework, which is better suited for this purpose. The postmodernist framework is sceptical of overarching principles and against the overvaluation of causality and rationality as determinants of social processes (Wessel 1996: 30). Although elements of critical rationalism, structuralism or rationalism prove also useful for this research and are partly incorporated in postmodernism, none of them is sufficient on its own. Theory-building and falsification or verification processes, central to a critical rationalist framework, are acclaimed methods in empirical research in geography.

2. RURAL HEALTH PLANNING IN INDIA

Rural Health planning in India is an integral part of national socio-economic planning. The guide-lines for national health planning were provided by a number of committees dating back to the Bhore committee in 1946. These committees were appointed by the Government in India from time to time to review the existing health situation and recommend measures for

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further action. A brief review of the recommendations of these committees, which are important landmarks in the history of public health in India, is given below.

The Alma Ata Declaration on primary health care and the National Health Policy of the Government gave a new care the central function and main focus of its national health planning in India, making primary health care the central function and main focus of its national health system. The goal of national health planning in India was to attain Health for all by the year 2000.

3. RURAL HEALTH PLANNING AND FACILITIES

There are two basic factors which are to be kept in view while planning for rural health care facilities.

- The first is that the community should have good health (The indicators are birth and death rates, incidence of diseases etc.)
- The second is that sufficient number of health services units with adequate facilities must be available within reasonable distance.

Mere presence of a health care unit does not serve the propose. The facilities available in these centres and the actual number of patients, who make use of these services, indicate the quality of services. The quality of service in terms of nurses, compounders, doctors and beds can be best understood by comparing the available facilities in the area with the standards. For this purpose Mudaliar Committee recommendations can be taken into account.

4. RURAL HEALTH CARE PLANNING IN INDIA

Establishing rural health care planning in India is a key to improving the health of the Indian Population. The Ministry of Health and Family Welfare has been facilitating Health needs in India by establishing various schemes and organizations. The Government is conscious of the need for dynamic Indian health planning and management. Innovative healthcare and development programs are the need of the hour. For this, major organizations like the National AIDS Control organization have been established by the Health Ministry. The areas to focus on in Health Planning have been laid down by the Ministry's National Health Policy. Some of them

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are mentioned below:

- Increasing Healthcare programs: To be implemented in various socio-economic settings of different States of India
- Increasing Public Health infrastructure: More hospitals, Outdoor medical facilities, Medical equipments
- Efficient doctors and nurses: To ensure minimum standards of Patient care
- Family Medicine: Establishing more personnel for family healthcare
- Low cost drugs and vaccines: Keeping in view of the possible globalization induced high costs
- Mental health: Need for increase in hospitals and professionals
- Health research: Medical innovation and specialization is needed
- Disease control: More database needs to be collected in this regard in order treat and prevent diseases
- Women's health: Adequate access to public healthcare facilities is a necessity which in turn will improve family health as well.

"However, the challenges are unique with this population in India. A majority (80%) of them are in the rural areas thus making service delivery a challenge, feminisation of the elderly population (51% of the elderly population would be women by 2016), increase in the number of the older-old (persons above 80 years) and 30% of the elderly are below poverty line," the note said. In the sub-centres, male health workers will be trained to make domiciliary visits to the elderly in areas under their jurisdiction. They will give special attention to the elderly who are bedridden and provide training to the family in looking after the disabled. They will arrange for

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suitable supportive devices and provide them to elderly disabled people to make them ambulatory. The district hospital will provide regular dedicated OPD services to the elderly besides setting up a 10-bed geriatric ward. "With increasing life expectancy, demographic ageing is an emerging phenomenon which will hit India hard in the coming years.

List of National Health Programs organized by the Health Ministry are National Vector Borne Disease Control Program (NVBDCP) , National Iodine Deficiency Disorders Control Program, National Leprosy Eradication Program, National Program for Control of Blindness, National Filaria Control Program, National Program for Prevention and Control of Deafness, National Cancer Control Program, National Aids Control Program, Universal Immunization Program (RTI ACT, 2005), Revised National TB Control Program, and National Mental Health Program.

Some additional endeavours for health planning in India are Medical Health Division, Hospital Services Consultancy Corporation, SC/ST facilities, Central Government Health Schemes, Prevention of food adulteration, establishment of food and drug testing laboratories, L.R.S. Institute of Tuberculosis and Respiratory Diseases, National Rural Health Mission, etc.

Good health planning in India will enable the country to establish a Healthcare system which will be socially acceptable, medically sound, and cost-effective enough for every Indian.

The following Committees have offered several steps to achieve a better healthcare system for India.

5.1. BHORE COMMITTEE, 1996

The government of India in 1943 appointed the Health Survey and Development Committee with Sir Joseph Bhore as Chairman, to survey the then existing position regarding the health conditions and health organization in the country, and to make recommendations for the future development. The committee observed: 'if the nation's health is to be built, the health programme should be developed on a foundation of preventive health work and that such activities should proceed side by side with those concerned with the treatment of patients.' Some of the important recommendations of the Bhore committee were;

(1) Integration of preventive and curative services at all administrative levels;

(2) The committee visualised the development of primary health centres in 2 stages:

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- 1 As a short- term measures, it was proposed that each primary health Centres in the rural areas should cater to a population of 40,000 with a secondary health Centre to serve as a supervisory, coordinating and referral institution. For each PHC , two medical officers , 4 public health nurses, one nurse , 4 midwives, 4 trained dais, 2 sanitary inspector, 2 health assistance, one pharmacist, and 15 other class iv employees were recommended.
- 2 A long-term programmes (also called the three million plan) of setting up primary health units with 75-bedded hospitals for each 10,000 to 20,000 population an for nard secondary units with 650-bedded hospitals, again, regionalized around district hospital with 2500 beds, and
- 3 Major changes in medical education which includes 3 months training in preventive and social medicine to prepare “social physicians”

Although the Bhore Committee’s recommendations did not form part of a comprehensive plan for national socioeconomics development, the committee’s Report continuous to be a major national document, and has provided guidelines national health planning in India.

5.2. MUDALIAR COMMITTEE, 1962

In 1956, the Government of India appointed another committee knows as “Health Survey and Planning committee”, popularly known as the Mudaliar committee (after them name of its chairman, Dr. A.L.Mudaliar) to survey the progress made in field of health since submission of the Bhore committee’s Report and to make recommendation for future development and expansion of health service. The mudaliar committee found the quality of services provided by the primary health centres inadequate, and advised strengthening of the existing primary health centres before new centres were established. It also advised strengthening of sub divisional and district hospitals so that they may effectively function as referral centres.

The main recommendations of the Mudaliar Committee were:

- 1 Consolidation of advances made in the first two five year plans;
- 2 Strengthening of the district hospital with specialist services to serve as central base of regional services;
- 3 Regional organizations in each state between the headquarters organization and the

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district in charge of a Regional Deputy or Assistant Directors – each to supervise 2 or 3 district medical and health officers;

- 4 Each primary health centre not to serve more than 40,000 population;
- 5 To improve the quality of health care provided by the primary health centres.

5.3. CHADAH COMMITTEE, 1963

In 1963, a committee was appointed by the Government of India, under the chairmanship of Dr. M.S.Chadah, the then Director General of health service to study the arrangements necessary for the maintenance phase of the National Malaria Eradication Programme. The committee recommended that the “vigilance” operation in respect of the National Malaria Eradication Programme should be the responsibility of the general health services, i.e. primary health centres at the block level. The committee also recommended that the vigilance operations through monthly home visits should be implemented through basic health workers. One basic health worker per 10,000 populations was recommended. These workers were envisaged as “multipurpose” workers to look after additional duties of collection of vital statistics and family planning, in addition to malaria vigilance. The Family Planning Health Assistants were to supervise 3 or 4 of these basic health workers. At the district level, the general health services were to take the responsibility for the maintenance phase.

5.4. MUKERJI COMMITTEE, 1966

As the states were finding it difficult to take over the whole burden of the maintenance phase of malaria and other mass programmes like family planning, smallpox, leprosy, trachoma, etc, due to paucity of funds, the matter came up for in Bangalore in 1966. The Council recommended that these and related questions may be examined by a committee, of Health Secretaries, under the Chairmanship of the Union Health Secretary, Shri Mukerji. The Committee worked out the details of the BASIC HEALTH SERVICE which should be provided at the block level, and some consequential strengthening required at higher levels of administration.

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5.5. JUNGALWALLA COMMITTEE, 1967

The Central Council of Health at its meeting held in Srinagar in 1964, taking note of the importance and urgency of integration of health services, and elimination of private practice by government doctors, appointed a Committee known as the “Committee on Integration of Health Services” under the chairmanship of Dr. N. Jungalwalla, Director, National Institute of Health Administration and Education, New Delhi to examine the various problems including those of service conditions and submit a report to a central Government in the light of these considerations. The report was submitted in 1967.

The committee recommended integration from the highest to the lowest level in the services, organization and personnel. The main steps recommended towards integration were:

- 1 Unified cadre
- 2 Common seniority
- 3 Recognition of extra qualifications
- 4 Equal pay for equal work
- 5 Special pay for specialised work
- 6 No private practise, and good service conditions.

5.6. SINGH COMMITTEE, 1973

The Government of India constituted a committee in 1972 known as “The Committee on Multipurpose Workers under Health and Family Planning” under the chairmanship of Kartar Singh, Additional secretary Ministry of Health and Family Planning, Government of India. The committee submitted its reports in September 1973. Its main recommendations were:

- 1 That the present Auxiliary Nurse Midwives to be replaced by the newly designated “Female Health Workers”, and the present-day Basic Health Workers, Malaria Surveillance workers, vaccinators, Health Education Assistants (Trachoma) and the Family Planning Health Assistants to be replaced by “Male Health Workers”
- 2 The programme for having multipurpose workers to be first introduced in areas where malaria is in maintenance phase and smallpox has been controlled, and later to other areas as malaria passes into maintenance phase or smallpox controlled.

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- 3 For proper coverage, there should be one primary health centre for a population of 50,000;
- 4 Each primary health centre should be divided into 16 sub-centres each having population of about 3,000 to 3,500 depending upon topography and means of communications;
- 5 Each sub centre to staff by a team of one male and one female health worker.

5.7. SHRIVASTAV COMMITTEE, 1975

The Government of India in the Ministry of Health and family planning had in November 1974 setup a 'Group on Medical Education and Man Power' popularly known as the shrivastav committee:

The group submitted its report in April 1975. It recommended immediate action for:

- 1 Creation of bands of para-professional health workers from within the community itself to provide simple, promotive, preventive and curative health services needed by the community;
- 2 Establishment of 2 cadres of health workers, namely – multipurpose health workers and health assistants between the community level workers and doctors at the PHC;
- 3 Development of a 'Referral Services Complex' by establishing proper linkages between the PHC and higher level referral and service centres, viz taluk\tehsil, district, regional and medical college hospitals, and
- 4 Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of the University Grants Commission.

5.8. RURAL HEALTH SCHEME, 1977

The most important recommendation of the Shriastav Committee was that primary health care should be provided within the community itself through specially trained workers so that the health of the people is placed in the hands of the people themselves. The basic recommendations of the Committee were accepted by the Government in 1977, which led to the launching of the Rural Health Scheme. The programme of training of community health workers was initiated

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during 1977-78. Steps were also initiated (a) for involvement of medical colleges in the total health care of selected PHCs with the objective of reorienting medical education to the needs of rural people; and (b) reorientation training of multipurpose workers engaged in the control of various communicable disease programmes into unipurpose workers. This “Plan of Action” was adopted by the Joint Meeting of the Central Council of Health and Family Planning Council held in New Delhi in April 1976.

5.9. THE PARTICIPATORY APPROACH IN THE NATIONAL HEALTH POLICY 2002

The National Health Policy 2002 (NHP) is the new health reform approach succeeding the National Health Policy 1983. The state of the public and private health system has been examined in the previous chapter. The problem areas have been depicted. The new health policy acknowledges the financial constraints of the states, inequality in access to the public health system for urban and rural areas and for vulnerable sections of society and it admits that public health infrastructure is far from being satisfactory (MoHFW 2002b: 5-9).

The recommendations for reform include more decentralization and participation. The government urges the states to decentralize the implementation of public health programmes to local self-government institutions (Panchayati Raj Institutions- PRI) by 2005. NGOs and other institutions of civil society are wanted for involvement in the public health programmes because of their high motivational skills. More than 10 % of the budget for disease control programmes will be given to them.

Detailed plans for their involvement in the National Health Programmes have been described above. Furthermore, the handing over of public health service outlets for management by these institutions is encouraged. In practice, that would mean that they can take over the physical infrastructure (building) and will receive the normative funds earmarked for the institution. PRIs and NGOs will also be included in IEC activities for health issues where interpersonal communication of information is important to bring about behavioral change. They will target on population groups which are normally not reached with mass media and especially focus on community leaders and religious leaders who can impart knowledge to their communities. Annual evaluation of NGOs to monitor their impact is planned. Hence, on the one

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hand PRIs and NGOs will be used to deliver health services and to participate in the health programmes. On the other hand they will have to motivate and inform the community to participate.

The decentralization type of devolution to PRIs will be accompanied by delegation of central functions to the states and deconcentration to the district level within the states. The encouragement of the private sector to take over public functions is an additional measure (privatization).

The critique on the National Health Policy 2002 (NHP) especially points to its silence on certain issues (see Gupta 2002; Nair 2002). “Health for all” is not mentioned in the policy, neither is any reference to Alma Ata made. Community health workers do not play a role in the new policy anymore. In Gupta’s view the policy seems to turn away from the Primary Health Care Approach as such (Gupta 2002: 215). He attests the NHP 2002 to be “biased towards urban specialist-based healthcare” and that its rhetoric on community participation “is replete with ‘top-down’ prescriptions” (Ibid. 215-216). Hardly any groups outside the Central Health Ministry have been involved in the policy-making process. The ‘top-down’ approach is also visible in the central government’s approach to continue managing all public health programmes, despite acknowledging the failure of vertical programmes (MoHFW 2002b: 8, 23). NHP 2002, furthermore, lacks details about the actual devolution to PRIs.

Although, NHP 2002 correctly assesses the failures of NHP 1983 and the problems of the public health sector, its strategies for improving the public health care systems are weak and vague (see Nair 2002). However, more funds for primary health care and equity are still among the essential goals of NHP 2002. The critiques already highlight that the NHP 2002 is contradictorily in itself. Dandona certifies NHP 2002 the absence of a conceptual basis for reform (Dandona 2002: 226).

Stakeholders and beneficiaries have not been taken into account. The contradictory health policy reflects the inner conflict of the government between maintaining control and decentralizing power. While the government realizes that it has to give up some of its functions to lower levels within and outside its own hierarchy to improve the performance of the public health system. It is also reluctant to give up too much power out of the fear of loosing its

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influence and position. Even though this is a problem faced by all governments, it can hinder effective policy-making and its implementation.

6. PLANNING CYCLE

Planning is the broad foundation on which much of the management is based. Planning may be defined as a process of analysing a system, or defining a problem, assessing the extent to which the problem exists as a need, formulating goals and objectives to alleviate or ameliorate those identified needs, examining and choosing from among alternative intervention strategies, initiating the necessary action for its implementation and monitoring the system to ensure proper implementation of the plan and evaluating the results of intervention in the light of stated objectives. Planning thus involves a succession of steps.

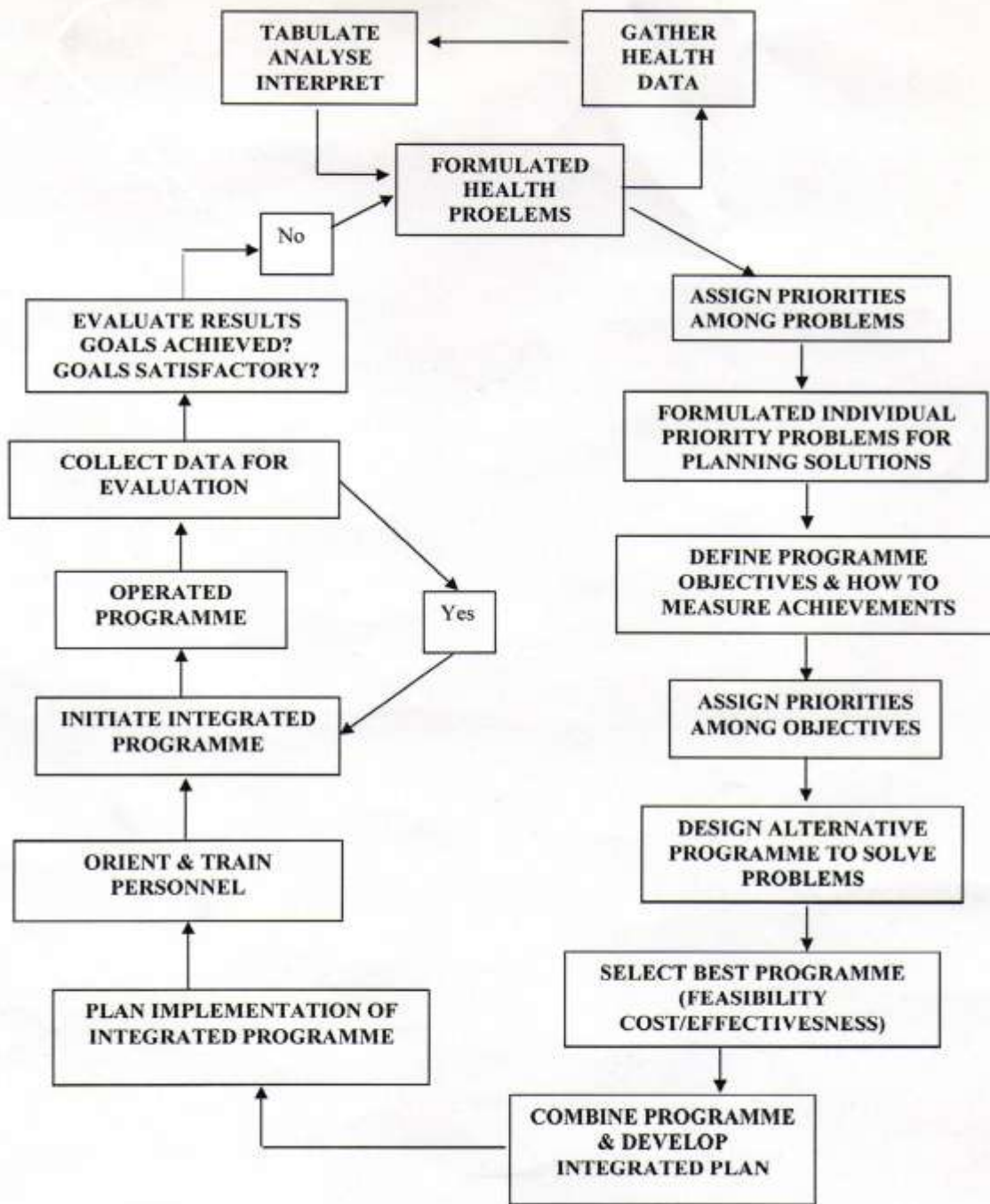
FIGURE -1

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SOURCE: Preventive and Social Medicine (2002)

The following section gives a bird's view of service and service providers, etc. in Tamilnadu as an illustration of the results of the programmes initiated by the Central and State Language in India www.languageinindia.com

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7. INFRASTRUCTURE AVAILABILITY IN SCS, PHCS AND CHCS IN TAMIL NADU, 2008-2009

Table -1

S.No	Health Facility Having	% Having the Facility		
		SCs	PHCs	CHCs
1	Own building	75%	96%	100%
2	Water supply	100%	100%	100%
3	Electricity	100%	100%	100%
4	Functional generator	-	90%	60%
5	Toilet	100%	100%	100%
6	Labor room	-	100%	100%
7	All Weather approach road	-	100%	100%
8	24-Hr Delivery Facility	-	100%	100%
9	Telephone	-	34%	100%
10	Functional vehicle	-	50%	80%
11	Operation theatre	-	27%	80%
12	OT for Gynaec	-	-	0%
13	OPD Gynaec	-	-	40%
14	Linkage with Blood Bank	-	-	100%

Note: Figures in bold are estimated values on basis of findings of the sample survey of health facilities in Tamil Nadu in April, 2009 due to unavailability of the data from secondary sources.

Source: MOHFE, GOI and our sample survey 2009.

It can be seen from Table 1 that most of the PHCs and CHCs have their own buildings. The availability of essential amenities such as water supply, electricity and toilets at the health facilities in Tamil Nadu is quite. All the PHCs and CHCs have labor rooms and 24 hrs delivery facility. About 40% of the CHCs and 10% of the PHCs do not have a functional generator, and 20% of CHCs and 50% of PHCs do not have functional vehicles. The OT (operation theatre) facility is also absent in more than 70% of PHCs and about 20% of CHCs.

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**AVAILABILITY OF MEDICAL PERSONNEL IN HEALTH FACILITIES IN
TAMIL NADU, MARCH 2009**

Table - 2

S.No	Personnel	% Having the Facility with at least one person		
		SCs	PHCs	CHCs
1	Multipurpose Worker / ANM (Female)	91%	100%	100%
2	Multipurpose Worker (Male)	17%	40%	60%
3	HA (Female) /LHW	-	100%	20%
4	HA (Male)	-	24%	0%
5	General Doctor	-	100%	60%
6	Staff Nurse	-	90%	100%
7	Laboratory Technicians	-	80%	100%
8	Obstetrician & Gynecologist	-	-	40%
9	Pediatricians	-	-	40%
10	Pharmacist	-	80%	100%
11	Anesthesiologist	-	-	40%
12	Radiographers	-	-	60%

Note: Figures in bold are estimated values on basis of findings of the sample survey of health facilities in Tamil Nadu in April, 2009 due to unavailability of the data from secondary sources.

Source: MOHFE, GOI and our sample survey 2009.

We find from table 2 above that unlike the infrastructure of health facilities of Tamil Nadu, the manpower position is not very satisfactory. We find all the levels of the health institutions lack the availability of the required manpower. While the sub-centers and PHCs mainly have insufficient paramedical staff, the CHCs also have a crunch of the specialist doctors. Availability of better physical infrastructure in public health facilities can become more or less ineffective in providing quality health service due to inadequate human resources.

8. GROWTH OF THE RURAL HEALTH CARE PLANNING

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M. Marikkani, M.Sc., M.A., M.Phil., R. Murugesan., M.Sc., M.A., M.Phil., Ph.D., and
C. B. Muvendhan, MBA.

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In this section we discuss the demographic changes, epidemiological shifts, and availability of infrastructure since 1951. Under demographic changes we have to look about the life expectancy, crude birth rate (CBR), crude death rate (CDR), and infant mortality rate (IMR).

The life expectancy at birth in 1951 was 36 years, whereas in 1981 and 2000 A.D. the life expectancy became 54 years and 64.6 years respectively. It shows that within the 60 years interval the life expectancy is near to double which implies some improvements in health sector, but in comparison to China the achievement is far away. Similarly the CBR and CDR in 50s was 40.8 and 25 whereas in 2000 it became 26.1 and 8.7 respectively. More or less it is satisfactory but if we look into the natural population growth rate it becomes painful. In 50s the growth rate was 15.8 whereas in 2000 it became 17.4 per thousand populations. But in the case of IMR it was 146 per thousand in 50s whereas in 2000 it became 70 per thousand, whereas in China and Srilanka it is only 41 and 18 per thousand.

On January 4, 2005 the UPA (United Progressive Alliance) cabinet approved the formation of a National Rural Health Mission (NRHM) with so many visions in mind which seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states which have weak public health indicators as well as weak health infrastructure. It promised to raise the public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personal into functional hospitals meeting Indian public health standards in each block of the country.

9. RURAL HEALTH CARE REFORM IN INDIA

Rural Health is an important commodity not only at the individual level but also in terms of the micro- and macroeconomic scale of a country. Improvement of health status is therefore on the political agenda of every government. In India health has been a major policy issue since independence. The development of rural health infrastructure, immunization programmes and the extension of water supply and sanitation led to health gains. Major achievements include the rise

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of life expectancy, decline of infant mortality and crude birth rate as well as eradication of smallpox. Nevertheless, the health situation in the country is not satisfying for several reasons. First of all targets set in the five-year plans and in the National Health Policy 1983 have not been met. Although India has established national health programmes for special diseases like tuberculosis or malaria, the responsibility for the health system lies in the hands of the federal states themselves. Therefore, economical performance of the respective state and the priority level health has within the state government are the decisive factors for health care spending. It is not surprising that huge differences in health system performance and quality exist between the states. Within the states the health system is often characterized by an urban-rural dichotomy. Concentrations of public and private health care facilities in the urban areas and missing facilities in remote rural areas have thus become a common feature of the Indian health system.

Furthermore, the burden of disease is disproportionately placed on the poor. Mortality rates, fertility rates and undernourishment are double as high in the poorest quintile of the population. They receive fewer subsidies and have to spend a higher share of their household incomes for health services. While successes in communicable disease control are noticeable and mortality rates declined, inequality in access to and in quality of health care has not decreased. On the contrary, the gap between rural and urban areas and between the richer and the poorer part of society has widened. Even the Ministry of Health acknowledges that the public health system showed only limited success “in meeting the preventive and curative requirements of the general population”

In view of this situation India introduced a health care reform in 2002. The new National Health Policy focuses on decentralization and community participation as measures to improve the quality of health care and to achieve comprehensive primary health care (see MoHFW 2002b). Community participation and decentralization are the leading principles of health care reforms in developing countries since the 1970ies. Heavily promoted by the World Health Organization and later the World Bank they are perceived as the solution for low health system performance and thought to improve equity in the health care system. Even though decentralization and community participation are the leading strategies for health care reforms, studies about their impact on quality of health care and health status do hardly exist.¹

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Decentralization is perceived as inherently good by policy makers, therefore, its goals are neither questioned nor is the process as such sufficiently. However, few studies are an exception.

10. COMMUNITY PARTICIPATION AND PRIMARY HEALTH CARE IN INDIA

Community participation is not only an influential concept for health care reforms but also the byword of today in development cooperation. Contrary to former development policies implementing programmes in a “top-down” manner, community participation puts emphasis on “bottom-up” planning. Thus, development cooperation tries to model its projects close to community needs. India has collected experiences with community participation since the 1970s. None of programmes was able to improve the quality of health care to the desired extent. Nevertheless, it seems that community participation could gain ground again. The success of India’s health care reform now largely depends on the implementation of this concept.

Given the importance of these principles, it is surprising how little is known about their real bearing on health systems. The reason could be that it is not only difficult to establish causal relationships between decentralization or community participation and health status, but also to quantify the two processes. The amount of theoretical literature on the two concepts is large. To fill the gap between the theoretical concepts and the implementation outcomes, research into the ground realities of decentralization and participation is needed. This research requires a holistic view into economic, cultural, social and political processes on different spatial scales (see Rifkin 1988).

Modern geography with its emphasis on spatial dimensions and its manifold intersections with other scientific fields delivers the required tools for it (see Werlen 2000). Linking national policy to local places in order to analyse community participation uses the geographical concept of space as a social construct. Local places are thus shaped by socio-economic processes at the micro and macro level. Furthermore, it is at the scale of locales at which social processes are realized (see Massey 1994). Hence, success or failure of India’s National Health Policy will be decided at this scale.

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The implementation process of the new health policy has already started. Similar decentralization measures and attempts to introduce community participation have been fostered in the different states. The stage of implementation varies among them. Information about the realization of the National Health Policy differs. While at central levels the process seems to proceed in a fast and efficient manner, new policies and guidelines have been introduced, the situation at the local level presents a different picture.

Here decentralization and community participation strategies seem to meet obstacles which were not envisioned by the policy makers. Furthermore, information from secondary sources about policy implementation at the local levels is difficult to get and tends to be biased. Information is the key to successful reforms. Therefore, information from primary sources needs to be collected to assess the status of decentralization and community participation at the local levels.

Comparison of states and regions within the states are further helpful to monitor differences and detect similarities. The impact of policy processes on the quality of the health care system is likely to manifest in the long term only. Hence, impact assessment would not make sense at the current stage. Rather, process monitoring is needed to assess health care reform (Rifkin 1988: 933).

Analysis of the prerequisites for successful participation can give an insight into existing mechanisms and power structures shaping the implementation process. Furthermore, it is necessary to determine the problems of the public health sector to identify areas where quality Community Participation and Primary Health Care in India improvement is needed. Last but not least it is the social, political, and economical reality at the basis which determines the success of health care reforms. While the direct impact of decentralization and community participation on quality of health care system is not part of this research, a general discussion about possible outcomes of India's health care reform will take place based on the process monitoring.

11. CONCLUSION

Despite several attempts India was not able to realise comprehensive primary health care as it was promoted in Alma Ata. Partial success has been achieved with some of the programmes

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implemented like UIP, ICDS or CHV (see above). In all these programmes communities could only participate in the benefits but were not involved in the planning or implementation. The outline of programmes was determined by the central policy makers. The influence of local government employees was limited. Their lack of training and, therefore, lack of knowledge regarding the basic principles of primary health care made it difficult to strengthen health prevention and promotion. The curative focus of care prevailed. The influence of stakeholders like local party members or other powerful people affected the location of health centres. Hence, the distribution of resources was not even. Equal access according to need and equal utilization according to need is, thus, not possible. The highest rating for equity was achieved with UIP, when a universal coverage in immunization services was reached for all beneficiaries. However, UIP as a vertical programme was not linked to other health issues even within the health sector. The multisectoral approach was missing in all these programmes. If multisectoral programmes were tried out like in the Community Development Programme or the Minimum Needs Programme either health did only play a minor role or the focus was solely on earth issues. In a way the development in India described above also reflects progress in other developing countries. Successes in immunization programmes and oral rehydration therapy in the 1980ies and failures to control communicable and non-communicable diseases, in particular HIV/AIDS, tuberculosis and malaria, indicate the problems with the implementation of the Primary Health Care Approach.

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M. Marikkani, M.Sc., M.A., M.Phil.
kani85a@gmail.com

R. Murugesan., M.Sc., M.A., M.Phil., Ph.D.
mothrmr@gmail.com

C. B. Muvendhan, MBA

Centre for Rural Development
Annamalai University
Annamalai Nagar – 608 002
Tamilnadu, India

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