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Health Care System and Strategies

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UNIT 9 PRIMARY HEALTH CARE DELIVERY SYSTEM

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9.1 INTRODUCTION

The primary health care services are delivered through a chain of health care delivery systems in each country at the national, state, regional, district, sub-district and community levels. In 1978, world leaders, at a meeting at Alma-Ata (now Almaty, Kazakhstan) considered primary health care (PHC) as the key approach to ensure 'Health for All' by 2000. This became popularly known as the Alma Ata Declaration. This is a global commitment for community-driven, quality health care accessible to all, both physically and financially supported by World Health Organisation. Primary Health Centres played a significant role in fulfilling health needs across the world. Thereafter, specific time-bound goals, namely Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs), were set for overall development of health sector. After 40 years of the Alma Ata declaration, in 2018 world leaders again joined at Astana (Kazakhstan) to rethink upcoming health challenges and a new vision to strengthen health care systems. In this unit you will study about primary health care concept, components, structure and functions both in the global and Indian contexts.

After going through this unit you should be able to:

- a) define the concept of primary health care and its essential components;
- b) describe the structure and functions of health system in your country, i.e. national, state, regional, district, sub-district, and community levels;
- c) list deficiencies and make suggestions for the improvement of the primary health care system.

9.2 PRIMARY HEALTH CARE: CONCEPT AND COMPONENTS

According to the Declaration of Alma-Ata, primary health care is broadly defined as 'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals

and families in the community through their full participations and at a cost that the community and country can afford to maintain at every level of their development in the spirit of self-reliance and self-determination' (WHO-UNICEF 1978). This has focused on eight health needs:-

- a) health education,
- b) healthy food and proper nutrition,
- c) basic sanitation and safe water,
- d) maternal and child health care including family planning,
- e) immunisation,
- f) prevention and control of endemic diseases,
- g) appropriate treatment of common diseases and injuries,
- h) provision of essential drugs.

Therefore, primary health care envisaged to cover everybody's health needs throughout their life including prevention, treatment, rehabilitation and palliative care. Health care customarily has the following three-tier pattern.

- **Primary health care:** This is the essential health care provided at the first level of contact of the individual or the family with the national health system,
- **Secondary health care:** This refers to an intermediate level of health care where specialist facilities are available to deal with complex health problems referred from the primary level.
- **Tertiary health care:** This is the highest level where super specialties are available, and, sophisticated investigating and therapeutic procedures can be performed.

Principles of Primary Health Care

- a) Equitable distribution of Primary Health Care
- b) Community Participation for achieving objectives of Primary Health Care
- c) Health manpower development for Primary Health Care System
- d) Use of Appropriate Technology
- e) Multi-sectoral (both inter- and intra-sectoral) co-ordination for attaining the goal of Primary Health Care.

As a follow up, the International Conference on Primary Health Care in 1978 held at Alma-Ata was the dawn of a new era for WHO and its member states. In order to shrink the gap between the “haves” and “have-nots”; achieve a more equitable distribution of health resources; and, attain a level of health for all the citizens of the world that would permit them to lead a socially and economically productive life, the conference identified primary health care as “the key to achieving an acceptable level of health throughout the world in the foreseeable future as part of social development and in the spirit of social justice”. The heavy burden of sickness, the high cost of health technology and the inadequacy of health services coverage called for a bold new approach. Primary health care offered a rational and practical means for both developing and industrialised nations to work towards the health-for-all goal. Primary health care has been

defined as the essential health care which is close to the people, where most of their health problems can be dealt with and resolved.

9.2.1 The Essential Components of Primary Health Care

In the Alma-Ata Declaration, it was stated that the primary health care should have at least the following eight essential components.

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

The purpose of primary health care was to provide for universal health needs through a community driven approach. Consequently it was observed that there was an improvement in life expectancy, infant mortality, immunization and decrease in maternal mortality, but Astana declaration on PHCs (2018) finds that these universal health goals could not be achieved till date owing to a paucity of health workers, socio-economic inequality, private health services for profit, disease-oriented programmes and other reasons. Keeping in mind these limitations, a bold new approach to primary health care was initiated under the leadership of WHO and UNICEF to achieve the sustainable development goals and to promote universal health with equity and efficiency.

9.3 STRUCTURE OF PRIMARY HEALTH CARE SYSTEM

The primary health care services delivery system in the country extends from the national level to village level. From the total organisation structure, we can slice the structure of health care system at national, state, district, regional and community levels. At the community level, the primary health care system comprises different institutions called primary health centres, health sub-centres and TBAs.

9.3.1 National Level

The organisation at the national level consists of two union ministries since 2014, i) the Ministry of AYUSH and the Ministry of Health and Family Welfare (MOHFW). The MOHFW ministry has two departments: (a) Health and Family Welfare, and (b) Department of Health Research; both ministries are headed by a Secretary. The MOHFW is supported by a technical wing, the Directorate General of Health Services (DGHS) and four other divisions. Since 2014, special attention has been given to traditional medicine and alternative medicine through ministry of AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy) for both cures of disease and prevention strategies. In this process, the education, research and special fund allocation are given to indigenous medicine and other alternative system of healing.

9.3.2 State Level

At the state level, the organisation is under the State Department of Health and Family Welfare in each state, headed by a minister and with a secretariat under the charge of a secretary/commissioner (Health and Family Welfare) belonging to the Indian Administrative Service. By and large, the organisational structure adopted by the state is in conformity with the pattern of the Central Government. The State Directorate of Health Services, as the technical wing, is an attached office of the State Department of Health and Family Welfare and is headed by a Director of Health Services. However, the organisational structure of the State Directorate of Health Services is not uniform throughout the country. For example, in some States, the programme officers below the Director of Health Services are designated Additional Director, Health Services, while in other states they are called Joint/Deputy Director, Health Services. But regardless of the job title, each programme officer below the Director of Health Services deals with one or more subject. Every State Directorate has supportive categories composed of both technical and administrative staff.

The area of medical education which was integrated with the Directorate of Health Services at the state level, has, once again, shown a tendency of maintaining a separate identity as the Directorate of Medical Education and Research. This Directorate is under the charge of the Director of Medical Education, who is answerable directly to the Health Secretary/Commissioner of the state. Some states have created the posts of director (*Ayurveda*) and director (Homoeopathy). These officers enjoy a larger autonomy in day-to-day work, although, sometimes, they still fall under the director of health services of the state.

9.3.3 Regional Level

In the States of Bihar, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, Karnataka, and others, zonal or regional or divisional setups have been created between the State Directorate of Health Services and District Health Administration. Each regional/ zonal setup covers three to five districts and acts under the authority delegated by the State Directorate of Health Services. The position of officers in charge of such regional/ zonal organisations differs, are known as Additional/Joint/ Deputy Directors of Health Services in different States.

9.3.4 District Level

In the recent past, states have re-organised their health services structures in order to bring all health care programmes in a district under unified control. The district level structure of health services is a middle level management organisation and it is a linkage between the state and regional level on one side, while the peripheral level structures like, PHC as well as subcentre on the other side. It receives information from the State level and transmits the same to the periphery by suitable modifications to meet the local needs. In doing so, it adopts the functions of a manager and brings out various issues of general, organisational and administrative types in relation to the management of health services. The district officer with overall control is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM & HO). These officers are popularly known as DMOs or CMOs, and are overall in charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalised at higher levels, i.e., state and centre. These DHOs/ CMOs are

assisted by Deputy CMOs and programme officers. The number of such officers, their specialisation, and status in the cadre of State Civil Medical Services differ from the state to state. Due to this, the span of control and hierarchy of reporting of these programme officers vary from state to state.

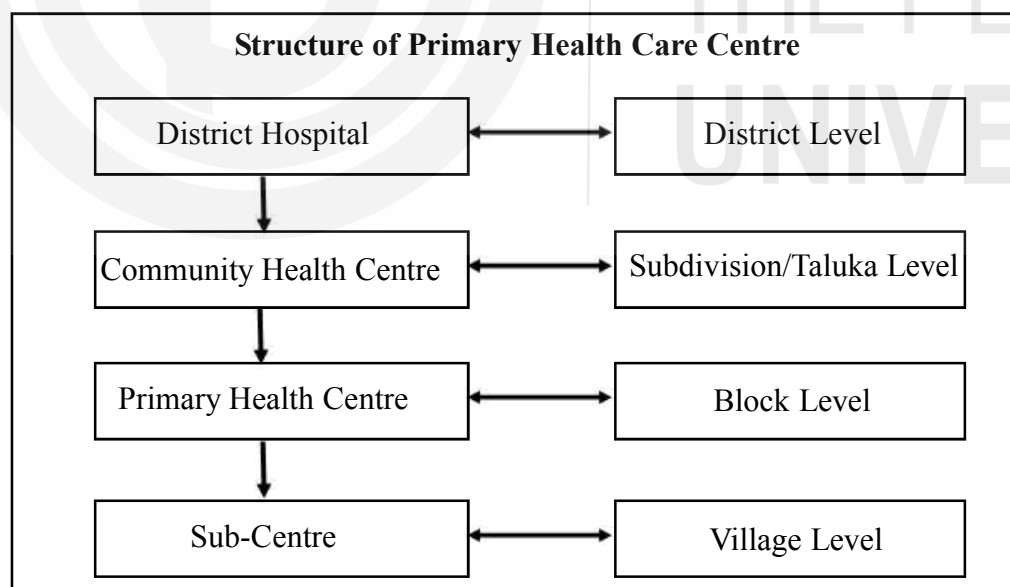
The major functions of district health administration are described below.

- To undertake preventive and promotive health activities in an integrated manner as prescribed under the separate State health programmes and as envisaged under the Multipurpose Health Workers (MPWs) Scheme.
- To make available medical care and family welfare services, free of cost to all sections of the community in the district, through the Primary Health Centres and down.
- To provide for such other health related services as may be required statutorily. For example, medico-legal work, postmortem, medical examination and certificate, supervision of jail hospitals etc.
- To organise preservice entry training for the paraprofessionals and paramedicals, and in-service training for health personnel working at the PHCs and sub-centres in the district.

9.3.5 Subdivisional/Taluka Level

At the *taluka* level, health care services are rendered through the office of Assistant District Health and Family Welfare Officer. Some specialties are made available at the *taluka* hospital. The ADHO is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into CHCs.

Box 1



9.3.6 Community Level

At the community level the primary health care service is delivered through community health centres (CHCs); primary health care centres (PHCs) and sub-centres. At community level, the CHCs provide effective referral support for a successful primary health care programme. For this purpose, one community health centre has been established for every 80,000 to 1,20,000 population, and

this centre provides the basic speciality services in general medicine, paediatrics, surgery and obstetrics and gynaecology. The CHCs are established by upgrading the subdistrict/ *taluka* hospitals or some of the block level PHCs, or by creating a new centre wherever absolutely needed. There are 3,346 CHCs functioning in the country.

- **PHC level-** At present there is one PHC covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. The PHC is the first contact point between village community and the medical officer. The PHCs are envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promoting aspects of health care. These are 23,236 PHCs functioning as on September 2005. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants - one male and one female, and the health workers and supporting staff. For strengthening preventive and promotive aspects of health care, a post of community health officer (CHO) was proposed to be provided at each new PHC but most states did not take it up.
- **Sub-centre level-** The most peripheral health institutional facility is the sub-centre manned by one male and one female multipurpose health worker. At present, in most places there is one sub centre for a population of about 5,000 (3,000 in hilly and desert areas and in difficult terrain). Sub-centres are provided with basic drug for minor ailment needed for taking care of essential health needs of men, women and children. Sub-centres programs tasks relating to interpersonal communication in order to bring out behavioural changes and provide services in relation to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control, and control of communicable disease programmes. There were 1,46,026 sub-centres functioning in the country in 2005.
- **Village level-** Though one says that the most peripheral health institutional facility is the subcentre, at the village level, for about 1,000 people there is one health guide and one trained *dai* or traditional birth attendant (TBA), both selected from the community. They are trained at the PHC and the sub-centre. These two village level functionaries are voluntary workers and not regular government employees. They receive technical support and continuing education from the multipurpose health workers (male and female) posted at the sub-centre. Administrative support and supervision are normally carried out by the village health committee or the village panchayat.

9.4 FUNCTIONS OF PRIMARY HEALTH CARE CENTRES

The primary health care delivery system consisting of community health centres (CHCs), primary health centres, and sub-centres are responsible for performing the following functions.

- i) **Provision of curative medical care, referral and laboratory services:** These services are available at the primary health centre (PHC) and community health centre (CHC) levels. A large number of outpatients are

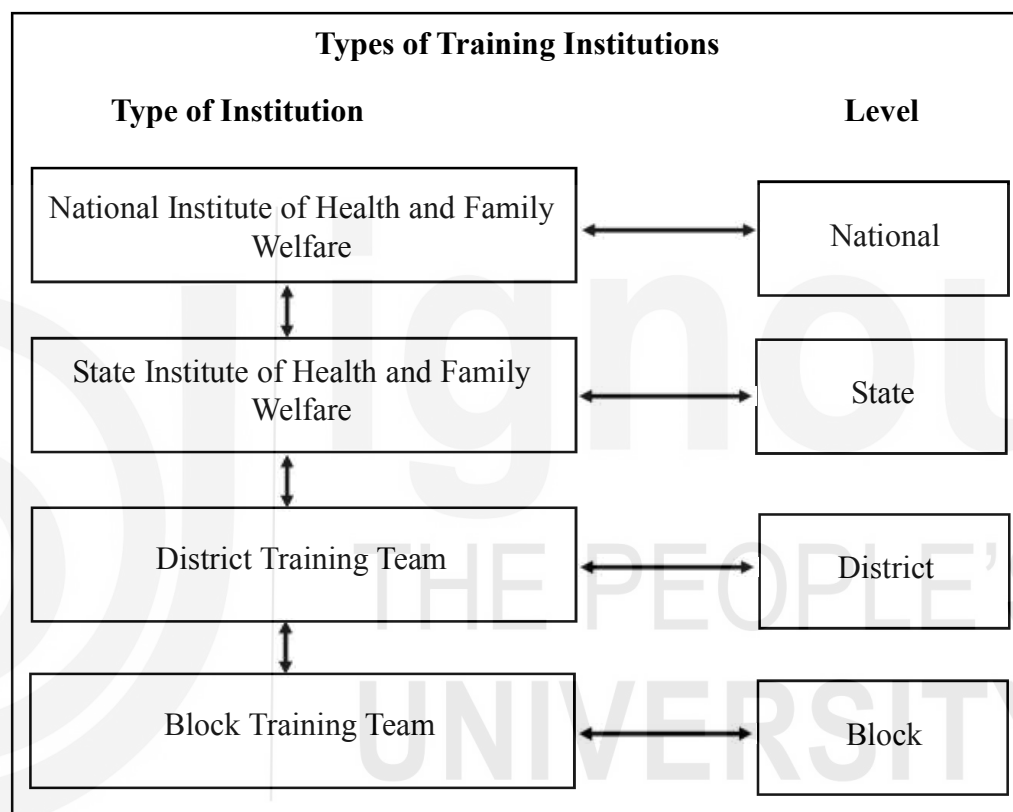
provided treatment at the CHCs and PHCs. Besides, they also provide treatment to the patients referred by the sub-centre and subsidiary health centres. At the PHC and CHC level the testing of blood, urine, and other testing laboratory facilities are available.

- ii) **The control of communicable and non-communicable diseases:** From the early natal stage, both forms of diseases are important public health threat in India. The CHCs and PHCs conduct large scale eradication and control campaign in respect of malaria, filarial, tuberculosis, leprosy, etc. The CHCs and PHCs staffs are also vigilant against outbreak of cholera, typhoid, dysentery, and infective hepatitis, HIV/AIDS, etc. These centres also provide services for the control of non-communicable diseases such as cardiovascular diseases, respiratory allergy, food poisoning accidents, etc.
- iii) **Reproductive and child health Care services:** These primary health Care delivery centres provide curative, preventive and motivating for health Care services to the ante-natal, natal and post-natal women and also children in the age-group 0-5 years. They provide vaccination services to women and children. Besides, they provide family planning services for the control of fertility. These centre are now a days playing active role in spreading health awareness regarding HIV/AIDS. Under the reproductive and child health programmes, these centres provide treatment for sexually transmitted Infections (STIs).
- iv) **Environmental sanitation and safe drinking water:** The primary health Care centres are providing education to the rural population about the environmental sanitation and safe drinking water. The sanitary inspectors at the PHC level inspects the sanitation condition of hand pumps and wells are being done from time to time.
- v) **School health services:** The primary health care centres conduct school health care campaigns in their areas. During the campaign, the health education is imparted to school children, i.e., personal hygiene, nutrition, HIV/AIDS, environmental, sanitation, and use of safe drinking water. Sometimes TT injections are given to the students. The de-worming of students in rural area school is done to control worm infection. In this regards, the *panchayat* can play significant role for the successful conduction of school health programme.
- vi) **Collection of vital statistics:** Maintaining accurate records of events such as, births, deaths, infant and maternal deaths, causes of deaths and morbidity in the area is an important function of PHC. The health supervisors and multipurpose health works maintain the data at the PHC levels. The aggregated data is sent to the district headquarters to maintain district-level data. The medical office at the PHC level is oriented at the district regarding the maintenance of vital statistics.
- vii) **National health programme:** A large number of health programmes have been launched in the country to improve the health conditions of the people. All these health programmes are implemented through the primary health care centres in rural areas. The most important among them are family welfare programme, reproductive, and child health programmes and other programmes concerning for control of malaria, filarial, leprosy, tuberculosis,

goitre, visual impairment, etc. Recently, the Government of India has launched the National Rural Health Mission for the promotion of health of the rural population.

- viii) **Training personnel:** Building of health personnel at different levels is an important activity of the health Care system. The government, with the help of different bilateral agencies such as the WHO, UNFPA, USAID, UNDP, etc. are not only established training institutions but also build up the capacity of health functionaries on different important aspects of primary health care from time to time. A flow chart of health capacity building under the IPP-VI & VII funded by the World Bank is given below:

Box 2



After reading the basic concept of primary health care, the structure and function of health care system national, state, district, CHC, PHC, and village sub-centre, now attempt the questions given in Check your Progress 1.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

- 1) What do you mean by primary health care?

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- 2) Describe the important functions of the primary health care delivery system.

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9.5 INDIA'S PRIMARY HEALTH CARE AND CHALLENGES

The last 40 years have seen improved maternal mortality, child mortality, immunization and a decrease in many diseases. However, today half of the world's people still lack full coverage of essential health services due to lack of health workforce to deliver primary health Care services, financial support, governance and socio-cultural factors. Out of 30 countries only eight spend at least US\$ 40 per person on primary health care per year. In 2018, Astana Declaration (Kazakhstan) agreed that there is a need to strengthen and reinforce PHCs to cover universal health care. Challenges observed in the Indian context are described below:

- i) **Education of people about health matters:** People, particularly in rural areas and urban slums, are not knowledgeable about health matters, such as, the prevailing health problems in the community and how to prevent and control these; the requirements for maintenance and promotion of health; the resources that are available, and how and when to utilise these. Socio-economic backwardness, ignorance, traditions, and superstitions act as barriers towards progressive thinking, including the development and the positive health. Health education efforts have been inadequate. Illiteracy, particularly among women, has acted as a barrier to communication in health and related matters. Appropriate educational programmes are to be organised for different groups of people. Health education for the community should be a prime function of the health workers and village level functionaries. In this endeavour, functionaries of other sectors such as social and women's welfare, education, agriculture and animal husbandry, *panchayats*, and voluntary agencies like *mahila mandals* and youth clubs can contribute significantly. Health education in schools and adult education sessions should incorporate various health problems.
- ii) **Promotion of food supply and proper nutrition:** Deficiency of nutrition of varying degrees in protein-calorie malnutrition, vitamin A and iodine deficiency and nutritional anaemia are prevalent in a wide section of population. Nutritional deficiencies are particularly noticeable among pregnant and nursing mothers, and infants and children. This dismal condition can be substantially improved by organising and conducting nutrition education: in the community and in the schools; encouraging people to make kitchen gardens and community gardens; and educating the people on food hygiene. Steps also need to be taken to encourage growing locally more foods such as cereals, pulses, vegetables, fruits, milk, fish, and poultry products through co-operative and other efforts, to make these easily accessible and affordable to the people.

Simultaneously, the purchasing capacity of the families might be improved through a variety of income generating schemes. In addition, for the moderately and severely malnourished groups, special nutrition programmes are to be organised. In these endeavours, functionaries from other sectors such as agriculture, animal husbandry, irrigation, banks and co-operatives, social and women's welfare, *panchayat* and voluntary organisations can play a very significant role.

iii) Supply of safe drinking water and basic sanitation measures: Many health problems have their roots in various aspects of community life and cannot be influenced by medical or health interventions alone. Safe and potable water is not available to a majority of the population. Many of the water-borne diseases prevalent in the country are preventable, but the importance of the use of pure and safe water as well as personal hygiene is not properly appreciated. Environmental sanitation is very poor, particularly in rural areas and in urban slums. In most places, there are no proper arrangements for disposal of human and animal wastes, sewage and sullage, etc. In these programmes, co-operation of the workers of other sectors such as irrigation, engineering department, village industries, agriculture, education, social and women's welfare, *panchayats* and co-operatives is most vital.

iv) Maternal and child care: Compared with developed countries as well as some developing countries, the Maternal Mortality Ratio (MMR) of 407 per 100,000 live births (1998) and dropped to 130 (2018) in India, however states rural area still having quite high MMR. Information on morbidity data on mothers is not available. Maternal care, ante-natal, natal and post-natal, in rural areas and urban slums is woefully inadequate. In rural areas, the majority of births (about 60 per cent) occur outside health institutions, and are attended by untrained birth attendants. Some of the important causes of maternal mortality are sepsis, hemorrhage, toxemia, illegal abortion, and malnutrition. Adolescent pregnancy is another area of maternal mortality about which you will read in a separate unit of this Block.

The Infant Mortality Rate (IMR) of 64 per 1000 live births (2000) in India was very high, dropped to 34 (2017) per 1000 live births. In rural areas, this figure is much higher. About 50 to 60 per cent of this is caused by mortality during the neo-natal period (0-28 days) and particularly in the first week of life. Several factors contribute to this mortality. These include poor maternal health during pregnancy, frequent child births, inadequate care of mothers at risk, poor infrastructure facilities, lack of care of newborn at birth, and practically no facilities for newborn care from primary to tertiary levels. Low birth weight infants either due to prematurely or due to intra-uterine growth retardation result from various factors such as low maternal weight and height, frequent pregnancies, maternal malnutrition and anaemia, chronic maternal diseases and pregnancy complications. Low birth weight, if particularly associated with premature birth, is a major underlying factor for neo-natal or infant mortality. Non-immunisation of pregnant women with tetanus toxoid may result in death due to tetanus neonatorum.

For dealing with this problem, the *dais* and female health workers and health assistants have to be properly trained in pre-natal and neo-natal care adopting a high risk approach. Proper facilities for referrals to the secondary and tertiary levels are also to be developed and organized. For the health Care

of children aged 0-5 years, i.e., the pre-school children, two types of intervention programmes are needed - prevention and treatment of malnutrition, and reduction of mortality due to diarrhoea, respiratory infections, and other infections preventable by immunisation. Malnutrition predisposes children to infection and malnourished children are exposed to three times higher rate of morbidity.

The strategies for reduction in the prevailing rate of malnutrition in pre-school children would be: to provide nutrition education to mothers; to detect cases of malnutrition and grade them; to rehabilitate grades I and II by supplementary feeding of grade III cases at sub-centres; and referral of grade III cases with diarrhoea to the secondary level of care. The strategies for reduction in infant mortality due to diarrhoeal diseases and respiratory infections would be :-to educate mothers about the prevention and treatment of diarrhoea and respiratory diseases; to train health functionaries about how to recognise and treat these disorders, and to judge which patients would need referral to higher levels of health services; to create facilities for secondary level care of referred cases; and to provide drugs, ORS (OralRehydrationSolution) and other supportive measures. All children, preferably below one year, must be immunised against tuberculosis, poliomyelitis, diphtheria, whooping cough, and measles.

- v) **Family planning:** Despite India becoming the first country in the world to take up family planning as an official programme in 1952, achievements over the past 33 years have not been remarkable. In 2016, the crude birth rate is around 20.4 per 1000 population. It is estimated that about 48.6 per cent of couples in the reproductive age group use contraceptive practices. Out of this, sterilisation has protected only five per cent, while nearly 27 per cent have been using spacing methods. More than 80 per cent of the acceptors of sterilisation had three or more living children. Obviously, the number of births averted by such contraceptive measures may not be substantial enough. Therefore, concentrated attention has to be given to younger couples with low parity- i.e., newly married couples, and one child and two child families for contraceptive protection with spacing methods. The acceptance and continued use of contraceptives are influenced by several factors such as the character of the method, including its advantages and disadvantages; individual and social acceptability, the provider's knowledge, skill and attitude; effective communication, motivation, and counselling; the nature and quality of delivery services including supply logistics and follow up care, and the cost. The small family norm has to become a way of life due to development particularly women development. For this purpose, organisation of population education in the schools and colleges and adult education programmes would be most vital.
- vi) **Immunisation against major infectious diseases:** Immunisation of children has been referred to earlier. In some endemic areas, immunisation against cholera and typhoid has also to be considered. For the organisation of appropriate education activities as well as for providing services and follow-up support and care, help and cooperation of other sectors such as education, social and women's welfare, *panchayat* and voluntary organisations would be very valuable.

- vii) Prevention and control of locally endemic diseases:** Although the prevalence of endemic diseases will vary from one region to another, some of the important ones are: tuberculosis, malaria, leprosy, filarial, scabies, guinea worm infestation, rabies, iodine deficiency, goitre, etc. People are to be educated for their early diagnosis and health treatment functionaries are to be trained for early detection and the services and follow up care are to be organised. For the success of these activities, cooperation of different sectors such as education, social and women's welfare, animal husbandry, *panchayat* and voluntary organisations, industry, and business houses should be ensured.
- viii) Appropriate treatment of common diseases and injuries:** Treatment of minor ailments and first aid may be given at village level. Treatments for common diseases and injuries are to be provided at the sub-centre and PHC, and appropriate referral services are to be organised. People need to be educated about the availability of local remedies and other facilities to meet these needs. Other sectors such as education, social and women's welfare, *panchayat*, voluntary organisations can play an important role in educating the people and school teachers, etc., and in organising of resources.
- ix) Provision of essential drugs:** For local health care and treatment of common diseases and disorders, at least 20 drugs should be available, within one hour's walk. Utilising locally available remedies and using indigenous systems of medicine should be considered. Considering the financial constraints from Government sources, community funding may be explored.

9.6 SUGGESTIONS FOR DEVELOPMENT OF PRIMARY HEALTH CARE

A number of supportive activities essential for successful implementation of primary health Care were identified community involvement and participation; intra- and inter-sectoral co-ordination; development of effective referral support; development and mobilisation of resources; involvement of managerial processes; medical and health services research including innovative approaches; development and application of appropriate technology; health manpower development. These are described in detail below.

- i) Community involvement and participation:** For the success of primary health Care, community involvements and participation is vital. So far, meaningful community participation in various programmes has been largely lacking. The initial passive involvement has to be gradually and progressively turned into more active participation. Recent developments would be conducive to increasingly greater participation of the community in the health care programme. The Health Guides and the trained *dais* are local people. With the activation of the village health committees, *mahila mandals*, youth clubs, etc., it should be possible to get greater active participation of the community. The community should be able to mobilise resources and, gradually, try to become self-reliant in matters of health and family welfare in a spirit of self-development. Health and family welfare personnel working within the community have to develop credibility among the people and act as catalytic agents. The primary health care approach lays emphasis on preventive and promotive aspects of health care, which is possible only

when curative services which are the felt-need of the community are provided satisfactorily. This should serve as an entry point for establishing credibility of health personnel. The chapter on Panchayati Raj Institutions (PRIs) describes this dimension in detail.

ii) Inter-sectoral co-ordination: Health, family planning, and socio-economic developments are closely inter-related and inter-dependent. Success in the field of health and family welfare will largely depend on successful implementation of various programmes of social and economic change, particularly rural health, adult education, women's education, rural water supply and sanitation, nutrition programme, rural development programme, etc. Therefore, close inter-sectoral linkages and proper coordination of programmes and activities of different sectors such as education, social welfare, agriculture, animal husbandry, food, industry, work and housing, communication, etc., would be very important. This is described in detail in a separate unit on Inter-sectoral Action in Health.

iii) Development of referral services: For the success of primary health Care, one of the essential requisites will be a systematic development of proper referral support at secondary and tertiary levels. The following problems need to be solved:

- people and the community are often not satisfied with the services being provided at the primary and secondary levels;
- they are bypassing the local facilities, causing overcrowding at referral centres/ urban centres, as a result of which the quality of care at referral hospitals is suffering;
- there is lack of physical facilities, back-up support and supervision;
- lack of mobility of health personnel; lack of communication and transport for emergency cases;
- lack of effective logistic and supply system, lack of flexibility etc.;
- low priority is given to the referred cases by the consultants of the urban/referral centres; lack of proper resources in terms of health manpower, finances and equipment;
- for developing an effective system for referral care, the following issues need careful attention;
- establishing network of institutions;
- developing appropriate record system;
- identification of referred cases; transportation of patients;
- building teams and movement of specialists; and
- providing support of services; involvement of private practitioners and voluntary agencies.

iv) Managerial processes: It include strategies and steps as given below.

- Situational analysis; Policy formulation; Setting goals/objectives/targets;
- Framing of strategy; Making Plan of Action;
- Broad Programming; Budgeting; Detailed Programming;

- Implementation organisation of resources and initiation of activities;
- Monitoring and control, Evaluation and feedback; and
- Reprogramming.

In the organisation and development of national health care delivery system, application of the above mentioned managerial processes will vary with different 'categories of personnel working at different levels. Functioning at different levels would also require blending of varying degrees of managerial and technical skills. The higher the level in the organisation, greater is the need for managerial functions and lesser the need for technical skill. Conversely, the lower the level in the organisation, the lesser is the need for managerial function and higher the need for application of technical skill. However, development of well-coordinated and systematic style of functioning, even at the grass roots level, is important for proper management of the programme.

- v) **Appropriate manpower development:** This has two aspects: pre-service and in-service training of the newly recruited and existing health and family welfare personnel for continuing education; and professional training of potential medical, nursing and other paramedical personnel in future. Continuing education provides the means for equipping workers with knowledge to perform competently in their current and future jobs with the objective of increasing the efficiency of the individual as well as the organisation. It is the planned provision for systematic learning in the job, and is an essential element for personal and organisational development. An important aspect is the ability of the individual and the organisation to recognise and respond to changes in advancing technology for health maintenance and promotion, new pattern of disease, disability, etc., new social policies, expectations and programmes for better health services.
- vi) **New competencies with changing context:** New competencies need to be developed at different levels to be able to observe, analyse, interpret realistically and react intelligently to human behaviour, event and environments, and to effectively perform as a member of the team, to address to priority community problems and concern and to develop proper attitude for continuous learning. The concept of life long education is being accepted as an indispensable supplement to basic education, and in nearly all countries there exist some programmes, which, however, are piece meal, ineffective, and sometimes inappropriate. For maintaining high level of competence and performance, development of adequate systems for continuing education and to integrate it with supervision at all levels would be most vital for proper health manpower development. Such educational systems should be based on identified real community problems and needs; the task to be performed; the methods, techniques and equipment to be used; and should be provided to all health workers and their supervisors. The responsibility of providing competency-based continuing education should be shared by the individuals, the health care system, the educational institutions/system and the professional bodies.

After going through this section on primary health care delivery system, before we sum up this unit, you should attempt the following questions given in Check Your Progress-2.

Check Your Progress 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

- 1) How do safe drinking water and sanitation play a significant role in primary health care services?

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- 2) Give some suggestions for the development of primary health care services in India.

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9.7 LET US SUM UP

The health care services organisations in the country extend from the national level to village level. From the organisation structure, we can slice the basic structure of health care system at national, State, district, community, PHC, subcentre, and village levels. Each level has its own roles and contribution to the whole organisation. The primary health centre has been defined as the essential health Care which is close to the people, where most of their health problems can be dealt and resolved. As we discussed earlier that the eight essential components of primary health care (PHC) was played a significant changes in basic health care needs with community driven approach for diverse role of health. It has major role towards control of fertility rate, maternal mortality, infant mortality; while enhance life expectancy, prevention of diseases, better treatment and overall improvement in health facilities. There are also supportive activities required for the success of primary health care. They are (a) active community involvement and participation; (b) inter-sectoral coordination; (c) development of referral services; (d) managerial processes; and (e) sufficient workforce and appropriate manpower development.

9.8 KEYWORDS

Primary Health Centres (PHCs): This is the basic structural and functional unit of the public health services in developing countries. PHCs were established to provide accessible, affordable, and available primary health care to people, in accordance with the Alma-Ata Declaration (1978).

Community Participation: community participation refers to the involvement of the community to solve their own problems. Any social problem can be resolved only through collective people's participation. This is essential for the success of health and well-being programmes by analysing public health programmes in different developing countries around the world, and drawing out successes and limitations.

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9.10 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

Check Your Progress 1

- 1) What do you mean by primary health care?

Answer. According to the Declaration of Alma-Ata, Primary Health Care is broadly defined as 'essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participations and at cost that the community and country can afford to maintain at every level of their development in the spirit of self-reliance and self-determination'.

- 2) Describe the important functions of primary health care delivery system.

Answer. The important functions of primary health care delivery system are: (a) provision of curative medical care, referral and laboratory services; (b) control of communicable and non-communicable diseases; (c) provision of reproductive and child health care services; (d) environmental sanitation and safe drinking water; (e) school health services; (f) collection of vital statistics; (g) carrying out national health programme; and (h) training of personnel.

Check Your Progress 2

- 1) How do safe water and sanitation play a significant role in primary health care services?

Answer. According to UNICEF, almost 2.5 billion people have lack of improved sanitation facilities; and over 884 million people still use unsafe drinking water sources. Inadequate access to safe water and sanitation

services, coupled with poor hygiene practices kills and sickens thousands of children every day; and impoverishment affects the health of thousands more. Water-borne diseases are widely prevalent in the country; these may be preventable if the use of pure and safe water as well as personal hygiene is properly appreciated.

- 2) Give some suggestions for development of primary health care services in India.

Answer. Primary health care is needed to strengthen implementation in the following areas: a) community involvement and participation; b) intra- and inter-sectoral co-ordination; c) development of effective referral support; d) development and mobilisation of resources; e) involvement of managerial processes; f) medical and health services research including innovative approaches; g) development and application of appropriate technology; and h) health manpower development.



UNIT 10 CIVIL SOCIETY AND HEALTH CARE

Structure

- 10.1 Introduction
- 10.2 Concept and Role of Civil Society
- 10.3 Civil Society and Health in India
- 10.4 Civil Society Organisations and Health Care
- 10.5 Scope of CSOs in Health Care
- 10.6 Let Us Sum Up
- 10.7 Keywords
- 10.8 References and Selected Readings
- 10.9 Check Your Progress: Possible Answers

10.1 INTRODUCTION

Civil society, today, has come to occupy a very significant place in the process of development. It is widely recognised as third sector of development after the state and the market. It refers to the totality of civic and social organisations or institutions such as non-government organisations (NGOs), voluntary organisations, philanthropic institutions, including the local self-governments which play critical roles in a functioning democracy. It has been frequently observed that civil society groups advocate and take action primarily for social development and public interest. They also play important roles in providing civic and social infrastructure essential for a minimum quality of life for the masses. In fact, in recent years, civil society organisations (CSOs) have become increasingly more prominent, more visible and more diverse all over the world. In this unit, various aspects of civil society, and particularly its role in the area of primary health care will be discussed.

After studying this unit you should be able to:

- a) understand the concept and importance of civil society,
- b) describe different roles played by CSOs, particularly in the primary health care system,
- c) analyse the need for decentralisation of primary health care and the role of Panchayati Raj Institutions (PRIs),
- d) discuss the scope for promotion of CSOs in primary health care.

10.2 CONCEPT AND ROLE OF CIVIL SOCIETY

The concept of 'civil society' is very old and its roots can be found even in ancient Greece, but its meaning has been changing with time and it has been defined differently in different contexts. Even today, it is defined in many ways. The UN considers civil society as the third sector comprising various institutions of society, including family. At times, it is said to be a system parallel to the state. Recently there has been a renewed interest in civil society as the trend towards democracy created open space for the different civil society actors like, NGOs, interest groups, associations, co-operatives, etc. With the emergence of

non-government organisations as a third sector (after state and corporate sector) has become a key terrain of strategic action to construct ‘an alternative social and world order’.

According to the London School of Economics Centre for Civil Society’s working definition, ‘Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family, and market, though in practice, the boundaries between state, civil society, family, and market are often complex, blurred, and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organisations such as registered charities, development non-government organisations, community groups, women’s organisations, faith-based organisations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions, and advocacy groups.’ The Food and Agriculture Organisation (FAO), considers civil society organisations as groups that are not part of any government.

The United Nations Development Programme (UNDP) defines civil society organisations (CSOs) as non-state actors whose aims are neither to generate profits nor to seek governing power. CSOs unite people to advance shared goals and interests. They have a presence in public life, expressing the interests and values of their members or others, and are based on ethical, cultural, scientific, religious, or philanthropic considerations. There is yet another way to understand this concept. According to Aisha Ghaus-Pasha “civil society should not be equated to non-government organisations (NGOs). NGOs are a part of civil society though they play an important and sometimes leading role in activating citizen participation in socio-economic development and politics and in shaping or influencing policy. Civil society is a broader concept, encompassing all organisations and associations that exist outside the state and the market.” Therefore, civil society is made up of ordinary citizens who organise themselves outside of government and the public service to deal with specific issues and concerns.

10.2.1 Role of Civil Society

The 7th Global Conference on Health Promotion held at Nairobi has recognised that civil society is an expression of community empowerment, where groups of people sharing common interest, concerns, or identities, come together for social and political change. It is the central element in the successful implementation of international and national policy-making.

Table 10.1: Distribution of Workforce of Civil Society by Fields

Sector	Workforce by field
Education	64
Social Services	20
Health	14
Development/ Housing	7
Expressive Function	32
Culture/ Recreation	19

Professional/ Unions	7
Civil/ Advocacy	4
Environment	2
Others	
Foundations	1
International	1
Not classified	2

In recent years, because of its dynamism, the civil society has been increasingly considered as an important agent for promoting good governance, particularly focussing on elements like transparency, effectiveness, openness, responsiveness, and accountability. According to Ghaus-Pasha (2004), civil society can further good governance, first, by policy analysis and advocacy; second, by regulation and monitoring of state performance and the action and behaviour of public officials; third, by building social capital and enabling citizens to identify and articulate their values, beliefs, civic norms and democratic practices; fourth, by mobilising particular constituencies, particularly the vulnerable and marginalised sections of masses, to participate more fully in politics and public affairs; and fifth, by development work to improve the well-being of their own and other communities.

Some experts increasingly view civil society organisations as critical contributors to economic growth. They also play an increasingly important role in providing civic and social infrastructure essential for a minimum quality of life of the common masses. According to one of the discussion papers published by WHO, “Strategic Alliances: The Role of Civil Society in Health”, the CSOs play a vital role of participation, legitimacy and watchdogs of policy formulation as well as collaborators in national development. Civil society organisations play an important role in social development, particularly in the development of health and education. A study conducted by Salaman, Solokolowski and Associates (2003) shows that out of the total workforce of CSOs, 64 per cent of the workforce are engaged in delivering services such as education, social services, health, development, and housing.

10.3 CIVIL SOCIETY AND HEALTH IN INDIA

India has deep rooted of civil society in the form of various associations, social movement and other social formations. Many religious organisations existed during ancient and medieval period. Modern history is also witness to the emergence of socio-religious reform groupings like *satyabrahma samaj*, *sodhak samaj*, *prarthna samaj* and other groupings. Along with this there are numerous instances of charity and philanthropy related activities has illustrated in text. All these traditional efforts of civil society are strongly motivated by religious and moral values. Unlike these traditional voluntary actions, modern voluntarism is based on social justice, human right and other democratic notion. Thus modern voluntarism has a shift from traditional voluntarism. In 2000, Johns Hopkins University with Participatory Research in Asia observed that there are 1.2 million civil societies working in India. Planning Commission established a ‘voluntary

action cell' (later on renamed NGO Darpan) and also made provision to strengthen welfare schemes and programmes with NGOs' support.

Mahajan (1999) described five types of civil society roles in terms of functions. First, as a public contractor, who engaged in service delivery; secondly, as a collaborator who works with government to generate a desired development outcome; third role is that of social innovator which incubates new ideas, models and practices for specific developmental problems, such as Help Age India for problems of the elderly, Sulabh International for sanitation, Mahila Udyog for women's empowerment.. Fourth role is the policy advocates and social critics who focus on providing an analysis of emerging social, political, economic and environmental issues as well as the policies and practices of government and international agencies. The fifth role is the building of civil society institutions in order to provide access, voice and representation to the hitherto excluded and marginalised citizens.

Gurpreet Mahajan's classification closely relates to the roles attributed to non-profit organisations that are used in the impact assessment component of the Johns Hopkins University Comparative Non-profit Sector Project (Salamon, Hems and Chinnock, 2000). Rajesh Tandon (1998) has also presented another classification of voluntary non-profit development sector, first as field programme-based including welfare, empowerment and innovation, secondly as support services like, capacity building, awareness and information based, thirdly, umbrella or network as federations and associations such as Pradan, VANI, fourth category as research, and advocacy including philanthropic.

Indian civil society organisations are regulated by four different legal categories under which these CSOs operate. First is the Societies Registration Act (1860) which allows a group of people to initiate non-profit welfare activities with certain conditions. Second is under Section 25, Indian Companies Act (1956) any group of seven or more people initiates with registration at registrar of companies. This type of CSOs as sister companies mostly operated by private companies like, Observer Foundation by Reliance company, Ford Foundation by Ford company and many others. Now Indian government made a law for corporate sector that 2 percent of their profit must be spent for Corporate Social Responsibility (CSR). Third is Trusts Act which has enacted by various states of India like, Bombay Public Trusts (1950). The fourth type of association is called 'interest group' which is a group of people who join on one platform to save their interest and are registered under Co-operative Societies Act (1904). These laws have seen many improvements after Independence, including the National Policy on Co-operative Societies (2002). Some CSOs' activities are motivated by religious and moral values rather than law, thus more than half non-profit organisations are not legally registered and are funded by external sources.

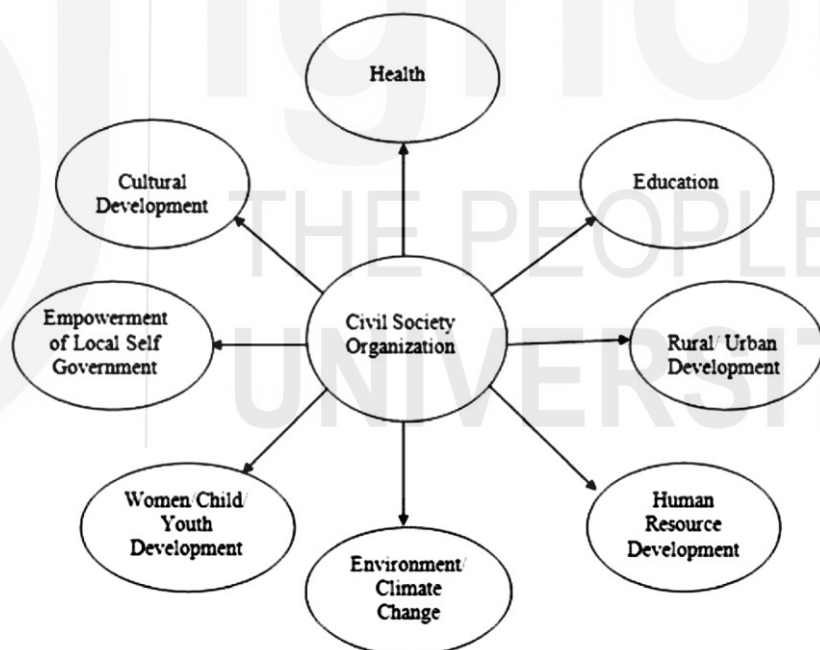
As far as the involvement of NGOs in various sectors in India is concerned, the National Planning Commission data shows that around 90 per cent of NGOs are involved in social sector activities. Out of the total, 91 percent are engaged in rural development; 11 percent in human resource development; 10.15 percent in social justice and empowerment; 6.2 percent in health and family welfare and 4.8 percent in youth affairs and sports.

Civil society organisations also play a vital role in political development. Civil society organisations in many countries are involved in strengthening democracy

and democratic institutions. In India, many of them are found to be associated also with the strengthening of Panchayati Raj Institutions. Liberal political theory regards civil society as indispensable to democratic governance. Civil society is necessary for overseeing public administration and public officials and promoting official accountability and transparency. Civil society is an equally crucial agency in generating public support for building public ownership and, therefore, for fostering the sustainability and consolidation of the democratisation of programmes and processes.

CSOs are playing important role in various sectors; some of these sectors are given below.

- i) promotion of literacy and education programmes
- ii) welfare of women, children and youth development activities
- iii) implementation of various rural and urban development programmes
- iv) capacity building programmes at various levels
- v) promotion of health status of the population in general and disadvantaged sections in particular
- vi) environmental protection and climate change
- vii) cultural development activities
- viii) empowerment of local self-governance



Graph I: Activities Linkages of CSOs

In this section you studied the meaning and role of CSOs in development, now answer the questions given in Check Your Progress-1.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

- 1) What do you mean by CSOs?

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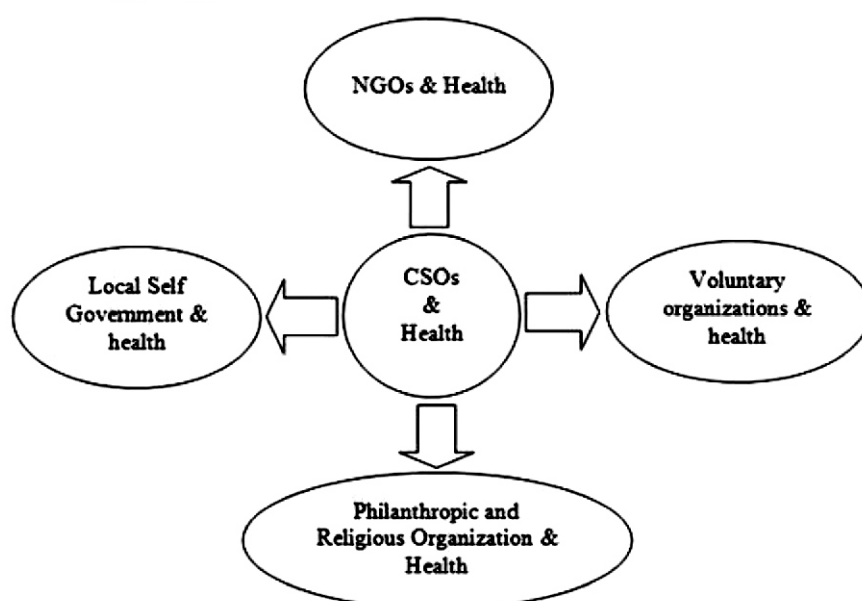
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10.4 CIVIL SOCIETY ORGANISATIONS AND HEALTH CARE

Civil Society Organisations (CSOs) are playing important role for health care development at the national, state and local level. Primary Health Centres (PHCs) in particular are the cornerstone of the rural health care system. These facilities are part of a tiered health care system situated at various levels in terms of population. Primary Health Centres and sub-centres rely on trained health and health related personnel to meet most of their needs. However, the main problems affecting the success of Primary Health Centres are the predominance of clinical and curative concerns over the intended emphasis on preventive work and the reluctance of staff to work in rural areas. In addition, the integration of health services with family planning programmes often causes the local population to perceive the Primary Health Centres as hostile to their traditional preference for large families. In view of the above factors adversely affecting the primary health care system, the CSOs have a vast space to play a critical role, more particularly in the promotion of preventive and promotive health care.

The role of CSOs in primary health care can be broadly categorised as:

- non-government organisations and primary health care
- voluntary organisations and primary health care
- voluntary health agencies and primary health care
- philanthropic and religious organisations and primary health care
- decentralisation and primary health care.



Graph II: Forms of Civil Society Organisations

10.4.1 Non-Government Organisations and Health Care

The World Health Organisation (WHO) has noted that the involvement of civil society has profoundly affected not only the concepts underpinning public health, but the formulation and implementation of public health programmes and policies as well. Civil society organisations play an important role in a range of health systems function. Important roles played by CSOs in the health system are described below.

- i) In different parts of the world, national and international NGOs have gained considerable experience in health care and health development. NGOs have certain advantages as compared to government because (i) they are less bound by red-tapism and bureaucratic procedure; and (ii) they are usually staffed by local people who are well acquainted with the local language and culture. NGOs facilitate community interaction with the health services providers. They motivate people to take maximum advantage of the health care infrastructure and service providers. They promote safe motherhood through ante-natal, prenatal and post-natal care; and child survival through immunisation and also distribution of condoms, oral pills and other contraceptive practices for control of fertility.
- ii) NGOs play an important role in health promotion through health information, education and communication. They build informed public choice on health and play an important role in the prevention and treatment of RTIs and STDs. They provide general information on health, sexuality, and other topics to adolescents and adults.
- iii) According to WHO, the contribution of CSOs towards setting of health policy are significant as given below:
 - a) Representing public and community interests in policy
 - b) Promoting equity and pro-poor policy
 - c) Negotiating public health standards and approaches
 - d) Building policy consensus and disseminating policy positions
 - e) Enhancing public support for policy
- iv) Today, CSOs play an important role in resource mobilisation. Since CSOs are closer to the people, they can better motivate them for their contribution to health care service. A non-profit project on reproductive health, implemented with the help of Bill and Melinda Gates Foundation in Punjab, the resource mobilisation, from public and business community, was directed for the purchase and distribution of medicine in the mobile clinics, satellite clinics and health camps. It is only community contribution that can make health care services sustainable.
- v) CSOs provide help to the public sector in monitoring the quality of care and responsiveness. They work in giving voice to marginalised groups and work for equity in health care services and delivery system. They communicate patients' complaints and claims to the medical authorities.

10.4.2 Voluntary Organisations/Associations and Health Care

Voluntary organisations contribute towards health development at the national, state and local levels. Some of the activities in which the voluntary organisations

are involved are as follows: (i) to raise fund for the implementation of various primary health care programmes; (ii) provide education on primary health care to professionals and to the public; (iii) provide services to those individual and families that are afflicted with disease, or health problems; (iv) contribute to policies, laws and regulations that affect the work of the agency.

In India, Voluntary Health Association of India (VHAI) is one of such agencies which have a presence at the national, state, and local levels. It advocates people-centred policies for dynamic health planning and its management in India. The goal of the VHAI is: (i) to ensure social justice, equity and human rights in the provision and distribution of health services to all, with emphasis on the less privileged millions; (ii) to promote and strengthen a medically rational, culturally acceptable and economically sustainable health care system in the country; (iii) it also follows the path of health policy research and policy interventions for a cost-effective promotive and preventive health care system.

10.4.3 Philanthropic and Religious Organisations and Health Care

The contribution of religious groups to community health care has been substantial. The types of involvement in community health by religious groups include: (i) the donation of space for voluntary health programmes; (ii) organisation of camps such as blood donations camps, eye camps, blood pressure, and sugar check-up camps. RCH (reproductive and child health) camps, and; other support services to the public health care programmes; (ii) sponsoring food banks and shelters for the hungry, poor and homeless; (iii) sharing of the doctrine of good personal health behaviour, counselling and motivation; and allowing community health professionals to deliver their programmes through the congregations; (iv) organising school health programmes; (v) organising satellite clinics and health camps.

10.4.4 Decentralisation and Primary Health Care

In recent years, decentralisation is being seen an important tool for development. An exponent of decentralisation said that decentralisation is not only important for health development, it is also recognised as a vital factor in stimulating all local development. WHO has recognised that it ensures flow of information, resources, decisions and action between the national government at the centre and the localities; it encourages inter-sectoral co-ordination in the localities, reduces excessive reliance on the central government and promotes local initiative and responsibility.

In India, although the local self-government institutions in the urban and rural areas were in existence for a long time, the 73rd constitutional amendment has entrusted to the Panchayati Raj Institutions 29 duties under the 11th Schedule of the Indian Constitution. The health and family welfare related duties assigned to PRIs in the 11th Scheduled are: (i) health, sanitation including hospital, primary health centres and dispensaries; (ii) family welfare, and (iii) drinking water. In 1994, the M.S. Swaminathan expert group categorically said that the present, vertically structured family welfare programmes must be replaced by municipalities because they provide a new window of opportunity for promoting decentralised action. In the same vein, the 10th Five Year Plan document also reiterates the importance of achieving population stabilisation by involving the

Panchayat in planning, monitoring, and mid-course corrections of the programme at the local level. The plan also envisages the appropriate delegation of power to the Panchayati Raj Institutions (PRIs) so that there is local accountability of the public health care providers and problems relating to poor performance and those can be sorted out locally. In equal terms, but in a different context, the National Population Policy 2000 urged that since 33 per cent of elected Panchayats seats are reserved for women, therefore, representative committees of the Panchayats (headed by an elected woman Panchayat member) should be formed to promote a gender sensitive, multi-sectoral agenda for population stabilisation.

In the last decade, and particularly after the PRIs Act, many states have taken important steps towards the involvement of Panchayati Raj Institutions in the effective implementation of various rural development programmes including health and family welfare programmes. Different committees have been formed for the effective implementation of the developmental programmes of different sectors, as an example of one of such steps. The Kerala Panchayati Raj Act envisages the formulation of three standing committees having provision of the sub committees. The Madhya Pradesh government, in its Panchayati Raj Act, made a provision for the formulation of eight standing committees, including health committees, entrusted with functions relating to health and family welfare activities. Besides Kerala and Madhya Pradesh, other states are also involving *panchayats* in the implementation of health and family welfare programmes. Moreover, many NGOs have undertaken capacity building programmes in the states of West Bengal, Punjab, Tamil Nadu, etc., for the representatives of PRIs in order to effectively involve them in the implementation of health and family programmes.

The involvement of PRIs in reproductive and child health (RCH) programme through Local Initiative Programme (LIP) in Punjab and Himachal Pradesh implemented by Centre for Research and Industrial Development (CRRID) during 1999-2002 had fetched rich dividend. The mid-term evaluation report remarked 'CRRID-Local Initiative Programme, Panchayat Reproductive and Child Health (PRCH) committees are vibrant, empowered and mobilised. Building upon the cohesive Sikh community structure, the Panchayat RCH committees has effectively mobilised local resources to hold information dissemination, *melas* (fairs), establish regular satellite and mobile clinics, and, with the help of CRRID, procured drugs, and staff these clinics with government doctors' (Pattanaik 2004).

The formation of Panchayat Health and Sanitation Committees (PHSCs) is critical to raise the health status of the village. The functions of the PHSCs are outlined, below.

- i) Oversee the cleanliness of health sub-centre.
- ii) Monitor and even provide help to health workers in the matter of provision of electricity, water supply, and furniture in the sub-centre.
- iii) Motivate ante-natal women for the early registration of pregnancy and regular health care check-ups in health sub-centre.
- iv) Motivate pregnant women and their family members to opt for institutional delivery and post-natal care.
- v) For complete immunisation, families with children in the 0-5 years age-group must be motivated to take advantage of the immunisation programme..

- vi) Arrange vehicles for referral cases.
- vii) Monitor the availability of common medicines in health sub-centres and if possible to make arrangement through community contribution.
- viii) Motivate families for small family norms by adopting various family planning methods.
- ix) Organise health and health awareness camps in the village from time to time with the help of health personnel.
- x) Organise school health programmes in the village with help of health workers and medical officers.
- xi) Organise health check-up camps for adolescents in secondary and senior secondary schools.
- xii) Oversee the households' access to safe drinking water and sanitation.
- xiii) Organise drives for the prevention of drug abuse in the village among people in general and adolescents in particular.
- xiv) Provide necessary help and cooperation to health department personnel for the management of epidemic and other national level health programmes, such as Pulse Polio Immunisation, AIDS awareness campaign, etc.

In this section, you have studied the role of CSOs in primary health care. You can now answer the questions given in Check Your Progress-2.

Check Your Progress 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

- 1) Explain the role of NGOs in primary health care.

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- 2) Explain the role of Panchayati Raj Institutions in health care development.

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10.5 SCOPE OF CSOS IN HEALTH CARE

There is abundant scope of civil society organisations in primary health care services. In this regard, some of the suggestions for the involvement of CSOs in the promotion of primary health care are given below.

- i) The government of the country must create an enabling environment of the civil society organisations so that CSOs and NGOs can express their role effectively and play an important role in empowering people at the grassroots

level, as well as health and health related personnel, and the people at large in primary health care.

- ii) Civil society is an essential element in both national and international decision making. Therefore, it must be recognised as an indispensable force for the promotion of primary health care.
- iii) The national, international, and regional government must provide trouble free resources to the CSOs project on primary health care programmes. It is said that the CSOs are responsible to the people; therefore, they are more transparent than the others. Many CSOs are, today, working for strengthening the social audit system at the grassroots level.
- iv) CSOs are known for promoting innovative projects. They must be encouraged to do so.
- v) A national data base of the CSOs is required which will enable the government, as well as private agencies, interested in funding the CSOs for implementing health and health related projects in different states and regions.
- vi) The government health functionaries are also required to develop a positive attitude towards the role played by the CSOs in the development of primary health care in their respective areas.
- vii) The government and international agencies must build up the capacities of the CSOs from time to time in various health related programmes, so that they can effectively launch those programmes at the grassroots.
- viii) Moreover, the CSOs are also required to be honest and dedicated to conduct their interventional activities for the promotion of primary health care status.

10.6 LET US SUM UP

The civil society organisations play an important role in overall development in various sectors like health, education, awareness campaign, women and child welfare, etc. The increasing number CSOs indicates its increasing role particularly their involved in the promotion of primary health care and immunisation are witnessed the eradication of polio and other diseases. Taking CSOs significance even government collaborated their presence in many health programmes. In this unit we studied CSOs concept, their role and typologies of NGOs, private voluntary organisations and associations. Primary health care centres playing significant role with the help of Panchayati Raj Institutions (PRIs). The CSOs support primary health care through the organisation of various health programmes with the help of government health functionaries at the grassroots, creating awareness programmes, providing space and finances, and organising satellite clinics and health fairs. The role of CSOs in the promotion of health care cannot be over emphasised and these are needed to be strengthened.

10.7 KEYWORDS

Third Sector: There are three important sectors for development- state, market and civil society. The two sectors state and corporate always played a dominant role and were called first and second sector. The late twentieth and twenty-first century experienced an 'association' revolution to balance the earlier two sectors and the new sector was called 'third sector'.

NGOs: Non-Government Organisations, also called NGOs, refer to those organisations which emerge from society to keep watch on state and market organisations, for people's interest. These are known by many other names, i.e. third sector, CSOs, grassroots organisations, co-operative societies, non-government development organisations, associations.

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10.9 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

Check Your Progress 1

- 1) What do you mean by CSOs?

Answer: Civil Society Organisations are non-state actors whose aims are neither to generate profits nor to acquire power. They unite people for common causes by expressing the interests and values of their members or others and are based on ethical, cultural, scientific, religious or philanthropic considerations. The CSOs include NGOs, voluntary organisations, religious and philanthropic organisations, Panchayati Raj Institutions and other such institutions are working for the development of the society at various levels.

- 2) What are the various activities that CSOs perform in the development sectors?

Answer: Some of the activities and sectors in which CSOs are playing important role are as follows:

- Promotion of literacy and education programmes
- Welfare of women, children and youth development activities
- Implementation of various rural and urban development programmes
- Capacity building programmes at various levels
- Promotion of health status of the population in general and disadvantaged sections in particular

- Environmental protection and climate change
- Cultural development activities
- Empowerment of local self-governance

Check Your Progress-2

- 1) Explain the role of NGOs in health care?

Answer: In different parts of the world NGOs have gained considerable experience in health care and health development. They facilitate community interaction with the health services provider and also motivate people to take maximum advantage of these services from available health care infrastructure. They motivate and promote safe motherhood through ante-natal, prenatal and post-natal care; and child survival through immunisation distribution of condoms, oral pills and other contraceptive practices for control of fertility.

- 2) Explain the role of Panchayati Raj Institutions (PRIs) in health care development.

Answer: The Panchayati Raj Institutions (PRIs) are playing an important role in the primary health care development at the grassroots levels. Some of these important roles are ensuring that cleanliness is maintained; monitoring electricity and water supply, providing health workers and fulfilling the needs of the sub-centre; ante-natal care and regular health check-ups; institutional delivery and post-natal care; immunisation; providing vehicles for referral cases; ensuring availability of common medicines in the health sub-centre; motivate people to have small families.

UNIT 11 BEHAVIOURAL CHANGE COMMUNICATION IN HEALTH CARE

Structure

- 11.1 Introduction
- 11.2 Behavioural Change Communication in Health Care: Meaning and Benefits
- 11.3 Channels of Behavioural Change Communication
- 11.4 Strategies of Behavioural Change Communication
- 11.5 Guidelines for Successful Behavioural Change Communication
- 11.6 Barriers to Behaviour Change of Communication in Health Care
- 11.7 Let Us Sum Up
- 11.8 References and Selected Readings
- 11.9 Check Your Progress- Possible Answers

11.1 INTRODUCTION

Nowadays many health care programmes in most countries, particularly in developing countries, are using behavioural change communication (BCC) to improve the health status and well-being of its people. Generally speaking BCC is a process that motivates people to adopt and sustain healthy behaviours and lifestyle. A comprehensive BCC strategy would be helpful to effectively implement BCC activities in order to improve health status of the population. It is pertinent to mention here that BCC is one of the health care education strategies outlined in the Uttar Pradesh National Rural Health Mission (NRHM) to achieve the goals of reduction in mortality, fertility and morbidity.

After reading this unit you should be able to:

- a) explain the meaning and benefits of BCC in family health care,
- b) discuss various channels of BCC,
- c) how to formulate a BCC strategy,
- d) describe and follow guidelines for successful BCC.

11.2 BEHAVIOURAL CHANGE COMMUNICATION IN HEALTH CARE: MEANING AND BENEFITS

National Health Policy (1982) emphasised on appropriate communication strategies to provide health information in easily understandable form and to motivate formation of an attitude for healthy living. Communication is derived from a Latin word “*Communis*” which means common. When we communicate we are trying to establish commonness with someone. It is the way which provides a link between two individuals or an individual and the world outside himself / herself.

11.2.1 Meaning of BCC in Health Care

Some of the definitions of BCC are narrated below.

- BCC in health aims at to improve people's health and well-being including education about maternal and child health care, health care of adolescents and the elderly, family planning and communicable and non-communicable diseases.
- The BCC in health care is customarily a process that motivates people to adopt and sustain healthy behaviours and lifestyle. A sustained BCC programme
- leads to improvement in the health status of people. Behavioural Change Communication strategy in health refers to systematic attempts to modify and influence behaviour or practices; and environmental factors related to that behaviour which directly or indirectly promotes use of healthy practices.
- Behavioural Change Communication (BCC) is the strategic use of communication to promote positive health outcomes based on proven theories and models of behaviour change.
- According to Bertrand and Becker-Benton, the main difference between IEC (Information, Communication and Education) and BCC is that while IEC stresses one-way communication focussed on "Messages", BCC is more "Outcome" oriented and also includes the role of participatory methods and motivation in the behavioural changes process.
- Behavioural change communication is part of an integrated, multi-level, interactive process with communities, aimed at developing tailored messages and approaches using a variety of communication channels.
- Behavioural Change Communication uses behavioural and communication theories and research to develop interventions that influences individual behaviours and the social contexts in which they occur.

What is Behaviour Change Communication?

BCC is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

Neill McKee

What is Behaviour Change Communication?

BCC is about changing specific behaviours – "well defined actions at the household, community and health service levels". BCC approaches recognize that behaviour change is more about identifying the causes and barriers to behaviour change and overcoming the barriers. It is about understanding the communities, contexts and environments in which behaviours occur. BCC is also about using persuasive techniques to demand health rights and to make public sector health services available and accessible to the neediest. BCC is about integrating new practices into long standing social, cultural and communication systems.

Nandita Kapadia-Kundu

11.2.2 Benefits of BCC

Behaviour change communication (BCC) is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. BCC employs a systematic process beginning with formative research and behaviour analysis, followed by communication planning, implementation, and monitoring, evaluation and follow-up activities. Audiences are carefully segmented; messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives.

BCC aims to foster positive behaviour; promote and sustain individual, community and societal behaviour change and maintain appropriate behaviour.

Some of the important benefits of BCC are as follows:

- Increases knowledge, attitude and skill
- Stimulates community dialogue
- Promotes essential attitude change
- Creates demand for information and services
- Advocates for appropriate family health care policies
- Enhances use of promotive, preventive and curative health care services
- Is more appropriate for the illiterate and less literate group of audiences

In this section you read about the meaning and benefits of BCC, now answer the questions given in Check Your Progress-1.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) What do you mean by BCC?

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2) What are the benefits of BCC?

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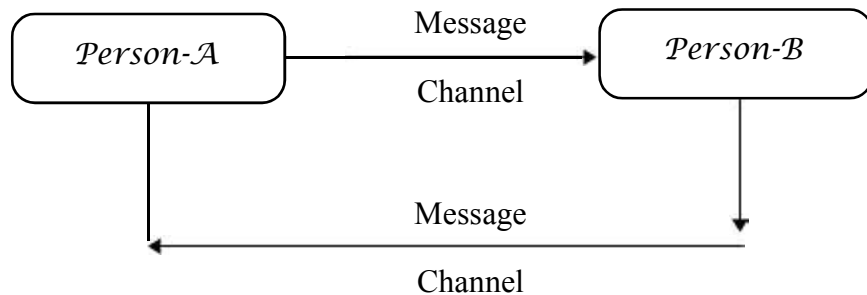
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11.3 CHANNELS OF BEHAVIOURAL CHANGE COMMUNICATION

Various channels are used in the process of communication. All these channels intend, either directly or indirectly, to pass on information from one source to the other. The simplest model of communication is represented in Diagram-I.

Diagram I



Sometimes the message can be transmitted through mass media i.e. radio, television etc. In Diagram-I, person-B who is listening to that message was broadcast by information source-A. The communication processes are concerned with the flow of information from one source to that of the other. The Diagram-I is the face-to-face communication or two-way communication process, while Diagram-II describes the mediated communication, where a variety of means of communication are used.

Diagram-II

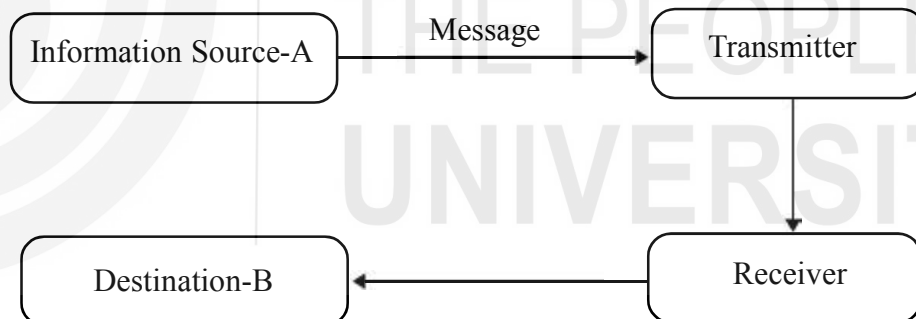
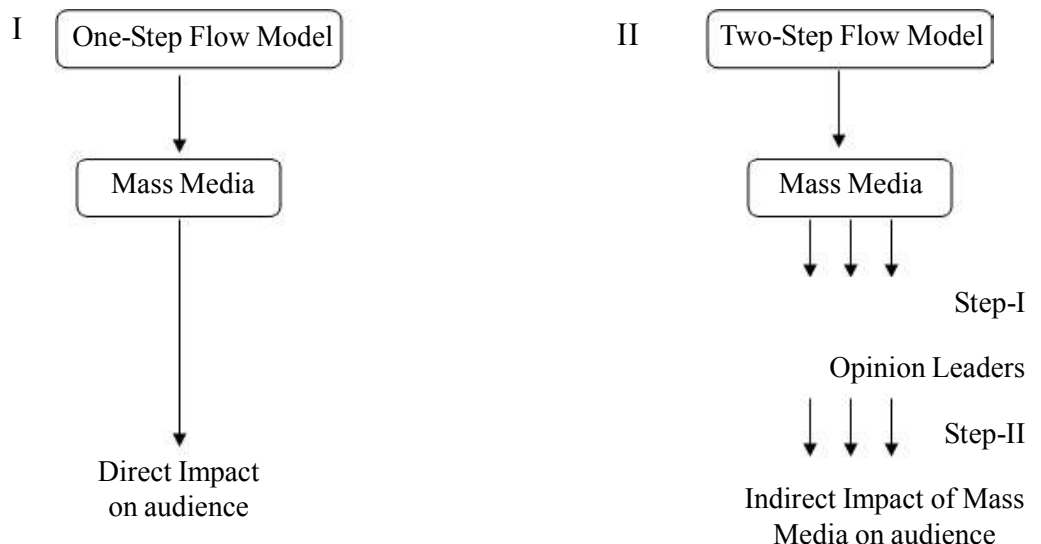


Diagram-III



Mass communication denotes message transfer via such mass media as newspapers, magazines, films, radio and television—which enables a message to reach an audience of many. Early researchers in mass communication thought the mass media were powerful tools in influencing an individual's attitudes and behaviours. The two-step flow of communication (Diagram-III) is probably the most exciting idea of communication research. It is postulated on the principle that ideas often flow from mass media to opinion leaders and from them to the less active sections of the population.

Rogers (1962) found that mass media communication is more important in changing cognition, whereas interpersonal communication is more likely to cause attitude change. While Chacko (1980) in his study concluded that the effect of mass media like cinema, drama and folk arts is more pronounced among the respondents. The channels of communication and their characteristics are represented in Table-3.1 and 3.2. The channels of interpersonal communication to be used for BCC by the health personnel for the propagation of health and family welfare messages in the countryside are through neighbours, youth club members, Panchayat members, Mahila Mandal members etc., while for interpersonal communication, the functionaries of the line departments can be used for BCC.

Table 11.1: Point of Origin

Nature of Channel	Local	Non-local
Interpersonal	i) Neighbour ii) Relative iii) Village Panchayat members iv) Youth organisation members v) Women's organisation members vi) Opinion leaders vii) Shopkeepers viii) Co-operative members	i) Extension Agents ii) Wandering story-tellers iii) Salesman iv) Health Workers v) Village Development Officers
Mass Media	i) Village newspaper ii) Wall posters	i) Radio ii) Television iii) Cinema iv) City newspaper

However, the effectiveness of both interpersonal and mass media channels depends on the characteristics of communication which are explained in Table-3.2. The pace of flow of information through interpersonal and mass media depends on these characteristics.

Table 11.2: Characteristics of Communication

Communication Characteristics		Interpersonal Channel	Mass Media Channel
1.	Direction of message flow	Two-way	One-way
2.	Speed to a large audience	Slow	Rapid

3.	Message accuracy to large audience	Low	High
4.	Ability to select receiver	High	Low
5.	Ability to overcome selectivity processes	High	Low
6.	Amount of feedback	High	Low
7.	Possible effect	Attitude change	Increased Knowledge

In this section you read about the various channels of BCC, now answer the questions given in Check Your Progress-2.

Check Your Progress 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) Draw a diagram for a two-way channel of communication.

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2) What are the various channels of interpersonal and mass communication of local origin?

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3.3.1 Tips for Effective Interpersonal Communication

- Introduce yourself
- Explain the purpose of visit
- Establish mutual understanding
- Allow the audience to speak more than you do and facilitate the discussion
- Win the confidence of the audience
- Understand their problems
- Analyse whether your interest and his/ or her problems are the same or different
- Do not make false promises / pose as someone else

11.3.2 Tips for effective Mass Communication

- Use real or fictional stories that illustrate real situations, actions and consequences
- Use credible characters and make use of people in the campaign message, who care for, and are liked and respected by the masses
- Address the most immediate health and family welfare problem
- Expose the audience to multiple messages and multi channels. Messages that work together and build on each other through different media; print, news, radio, television, posters, have more influence than any one media method only.

Be realistic and remember that campaign messages are only one source of influence. Do not expect revolutionary changes.

Skill Required for Interpersonal Communication

Listening Skill

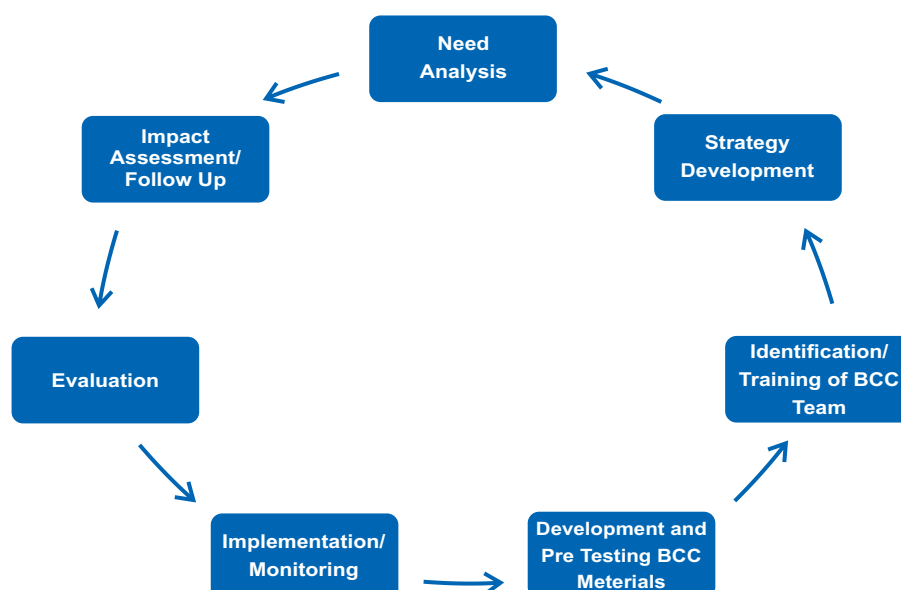
- ⇒ Keep your mind open
- ⇒ Be flexible
- ⇒ Find area of interest
- ⇒ Listen to ideas
- ⇒ Judge content not delivery
- ⇒ Resist distractions
- ⇒ Hold your tire
- ⇒ Work at listening
- ⇒ Capitalize on thought speed

Speaking Skill

- ⇒ Face the audience
- ⇒ Maintain eye contact
- ⇒ Use appropriate aids if required
- ⇒ Use appropriate language
- ⇒ Focus on the needs of the audience
- ⇒ Be brief, to the point, without ambiguous
- ⇒ Give chance other to speak
- ⇒ Communicate with clarity
- ⇒ Speak in local language

11.4 STRATEGIES OF BEHAVIOURAL CHANGE COMMUNICATION

The successful implementation of BCC programme depends on an effective BCC strategy. The BCC strategy uses BCC programme cycle for the systemic implementation of BCC programme.



Step-1: Need Analysis

Step-2: Strategy Development

Step-3: Identification and Training of BCC team

Step-4: Development and Pre-testing of BCC materials

Step-5: Implementation and Monitoring of BCC programme

Step-6: Evaluation

Step-7: Impact Assessment / Follow-Up

Step-1: Need Analysis- During the process of need analysis, the BCC experts have to find out:

- i) Firstly, identification of various needs and issues in the area. For example, in some areas the need may be control of communicable diseases, while in other areas it may be promotion of MCH care.
- ii) Secondly, the characteristics of population i.e. gender, caste, ethnicity, etc. It is true that the health care needs vary from community to community. The health care needs of tribal communities may differ from those of non-tribal communities.
- iii) Lastly, which aspects of family health care issues can be addressed through communication?

It is important to study the primary and secondary audiences carefully. Primary audiences are those who are suffering from health problems; while secondary audiences are those who influence health problems of the primary audience. For example, in case of ante-natal care of rural women, the primary audience is the ante-natal mother and the secondary audiences are the TBA (Traditional Birth Attendant) and other local health care providers.

Collect in-depth information about the knowledge, attitudes and beliefs about health and health care practices, information seeking habits and their (audience's) access to various channels of BCC.

Another important dimension of need analysis is the categorisation of behaviour of the clientele. The behaviour in BCC can be "Priority Behaviours" and "Specific Behaviours". A priority behaviour is the main outcome or expected behavioural change. While, the specific behaviour is the set of ancillary behaviours may be required for priority behaviour. For example, in antenatal care, the "Early Registration" is the outcome or priority behaviour. However, to reach this "Early Registration" outcome behaviour, the early detection of pregnancy at the community level through identification of symptoms and testing of urine, etc. are the specific or ancillary behaviour.

Step-2: Strategy Development- It is the most important stage and in this stage the following points are largely taken care of:

- i) The goal and objectives of BCC programme is clearly identified. While doing so, it has to be ensured that the objectives are SMART-Specific, Measurable, Appropriate, Realistic and Time-bound.
- ii) Develop a framework and show how the BCC programme activities would be helpful in achieving programme goals and objectives of health and family welfare.

- iii) Prioritising the various channels of BCC. Here the co-operation of community and community leaders must be resorted. A few questions needed to be put to the strategy formulators here are:
- Are messages accurate and meaningful?
 - Whether messages are clear, concise, relevant and appealing to the audience?

Step-3: Identification and Training of BCC Team– The third step is to choose a media team. People with experience in health communication must be given preference. The composition of the team must be in such a way that it will comprise both technical and generalist. The individual having knowledge with development of BCC materials would be of great help. To be precise, the team needs to comprise health, nursing and health related and media personnel.

Step-4: Development and Pre-Testing of BCC Materials- Once the BCC team is selected, the duty of the team is to prepare BCC materials and pre-test it over a sample before finally go to larger audience. The good quality BCC materials must have following characteristics.

- Should be accurate
- Should be clear and consistent
- Should be relevant and based on the needs of the audience
- Should be appealing
- Should be sensitive to gender differences

Step-5: Implementation and Monitoring- After the development of BCC materials, the implementation process starts. It is pertinent that the BCC team should mobilise a large number of stakeholders who want to provide help to implement activities and develop a broad sense of ownership. Involve the stakeholders and a few active audiences. These audiences also may be involved in the monitoring and assessment of BCC materials for making recommendations, and further improvement of BCC activities and materials. An example of priority areas of BCC campaign in NRHM in Uttar Pradesh is given below (Box-3.1).

Box 11.1: Priority for BCC Campaigns- 14 Core Trigger Behaviours

1.	Delay first pregnancy before 21 years for girls
2.	Eat three times a day (women and adolescent girls); eat 3-4 times a day (pregnant women)
3.	Early registration before 12 weeks; 3 ANC check ups
4.	Institutional delivery; Stay in the hospital for 24 hours after delivery
5.	Immediate health seeking behaviour on recognition of danger signs in mother and newborn
6.	Immediate and exclusive breast feeding within one hour of birth and continue exclusive breast feeding up to six months
7.	Keep the newborn warm with mother lap (skin to skin)
8.	Complete immunisation / Booster / Vitamin A
9.	Complementary feeding from six months 4-5 times a day in addition to breast feeding

10	Wash hands with soap after defecation and prior to feeding child
11.	Increase birth interval to three years
12	Adopt any limiting method after first two children even if both are girls
13.	Early detection of tuberculosis (TB)
14.	Empty and dry the water containers once a week

Source: Behavioural Change Communication (BCC) strategy for NRHM in Uttar Pradesh, Government of Uttar Pradesh, November, 2008.

Step-6: Evaluation- In this stage following three activities are to be conducted:

- i) Measure outcomes and assess impact
- ii) Disseminate results to partners, key stake holders, the news media and funding agencies.
- iii) Record lesson learned and archive research finding for use in future programs.

Step-7: Follow up: The last step in the BCC strategy is follow up. If it is an action research programme, then the BCC Team has to follow up it usually after six month and collect the gaps in activities and materials from the clientele. Then revise or redesign programme based on both evaluation and follow up.

11.5 GUIDELINES FOR SUCCESSFUL BEHAVIOURAL CHANGE COMMUNICATION

Guidelines for Successful Communication

A successful communication strategy depends on some factors which must be adhered to before initiating the communication process. These are as follows:

- i) **Avoid Communication Under the Influence of Emotions:** Emotional state influences the effectiveness of communication. If either party is in a heightened emotional state because of some incident, good communication is going to be very difficult. It is better not to even try to communicate if someone is extremely upset, as they need a cooling-off period before trying to work out the issues. A little deep breathing with eyes closed can do wonders. Postponing the communication for the time being or it is better to avoid communication if someone is not in good mood.
- ii) **Controlling Assumptions:** It is good to check your assumptions before communicating. A discussion has a greater chance of success if someone assumes that the other has good intentions. Most of the time, even someone says something hurtful to you, it may not have been their intention to hurt you. Give the other the benefit of the doubt and try not to make assumptions about their intentions. Generally in the family and or in an organisation people assume that they know the intentions of others, and it makes them biased. Assumptions can be avoided by simply sticking with “I” messages. It is very difficult to resolve a dispute or calm hurt feelings if we begin by accusing. When we say that we are angry because of what you did or what you said, we are automatically putting the other on the defensive. A successful

communication may not be possible when accusations are flying. When you use the word “I,” you are not talking about what the other did or what the other said. You are not accusing or condemning. You are simply sharing your feelings. You are reflecting to the other how their words and/or actions impacted you. You say, “I feel upset when you...” or “I feel hurt when you...” and so on. You are still letting them know that you are hurt and upset but you are talking about your feelings, the impact on you, and not simply blaming or accusing. (Bob Trowbridge)

- iii) **Quality Listening/Listening with Full Concentration:** One of the most effective communication tools is not a form of communication at all. It is listening. Many problems in communication are worsened because we do not listen to what the other is saying. If we are thinking about how we are going to reply to them while they are still talking, we are not really listening to what they are saying. We are simply trying to give them a befitting reply. Quality listening is missing, important information's are lost. Communication link is distorted. Listening means mentally present with the other person. Really listening is a sign of respect. You can show this kind of respect even if you are angry at the other. Respectful listening can calm a situation down on both sides.

By being present, you are saying that the relationship is important and you want to stay and work it out. We must listen very carefully. It is called “active listening.” In active listening, one may interrupt an individual for two different reasons. One is to get clarification. If one doesn't want to be misinterpreted, one can respectfully ask for clarification. The other reason for interrupting has the same goal. One may repeat something back to the person to make sure that he understood clearly, or communicate with a brief note. If you feel that you are not good at verbal communication when you are upset, you might agree with the other person that you will try to gather your thoughts and explain your feelings about the situation in writing. The other person may be willing to do the same. Then you come together and read what the other has written and use that as a springboard for your ongoing communication. The words carry power to hurt and heal. Practising use of good words with proper context can improve communication skill.

- iv) **Use evidence-based communication:** This guiding principle believes in communication supported by true facts, figures and data. It never encourages speculation and guesswork. People, particularly the rural and urban slum dwellers having little knowledge, believe in individuals and other communication media which give true facts and figures and lucidly analyse the facts.
- v) **Prioritising behaviours:** The health and family welfare activists and the communicators who want to propagate health and family welfare messages have to prioritise the communication themes on the basis of their importance. For example, immunisation of children and women has more priority than the family education aspects. In other words prioritisation of essential service delivery is more important.
- vi) **Utilising technology for message dissemination:** A large number of information technology platforms such as the Internet, mobile apps, etc. are being used now a day for the dissemination of health and family welfare

messages. The health communicators and education have to use the technology based on the age-group of clientele and areas in which the messages are to be delivered. For example mobile apps and Facebook can be popularly used in transmitting messages on adolescent education than immunisation and family planning services.

11.6 BARRIERS TO BEHAVIOUR CHANGE IN COMMUNICATION IN HEALTH CARE

Some of the barriers of behavioural change communication are described below. They are broadly categorised into four types.

11.6.1 Socio-Cultural Barriers

- Gender discrimination/ preference for sons
- Norm of early child bearing / early marriage
- Traditional child feeding practices
- Stereotyped dietary pattern
- Prevalence of religious believes and values

11.6.2 Health Services

- Lack of regular outreach services at the village level
- Health provider attitude and low motivation
- There are no personnel for BCC at sub-centre level
- Poor budgetary allocation for BCC in health and family welfare
- Lack of trust in public sector services
- Lack of professionalism among NGOs delivering services at the grassroots

11.6.3 Socio-economic Conditions and Infrastructure Facilities

- Transport constraints
- Illiteracy and low literacy
- Lack of electricity
- Poverty
- Lack of women empowerment

11.6.4 Lacunas in Behavioural Change Communication Methods and Channels

- Too much focus on awareness creation
- Limited reach of mass media in rural areas
- Weak system of BCC supervision
- Lack of trained BCC personnel
- Community based BCC such as folk media, group meeting, etc. require lot of time and effort
- Some BCC methods suitable for rural areas like wall painting is more costly

In this session you need about the BCC strategies, now answer the questions given in Check your Progress-3.

Check Your Progress 3

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) What are the important steps of need analysis for any intervention in BCC?

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2) Describe the socio-cultural barriers of behavioural change communication

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11.7 LET US SUM UP

Behavioural Change Communication (BCC) plays an important role in creating awareness and developing attitude and skill of both, health service providers and beneficiaries. In this unit you read about the meaning and benefits of BCC. It has delineated various channels of BCC and BCC strategies. The successful carrying out of BCC requires certain guidelines. This unit has also described guidelines for successful conduction of BCC, particularly of inter-personal communication and mass communication.

11.8 REFERENCES AND SELECTED READINGS

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11.9 CHECK YOUR PROGRESS- POSSIBLE ANSWERS

Check Your Progress-1

- 1) What do you mean by BCC?

Ans. Behaviour change communication (BCC) is the strategic use of communication to promote development, based on proven theories and models of behaviour change. According to Neill Mackee, BCC is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analysing, and segmenting audiences and participants in programmes and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

- 2) What are the benefits of BCC?

Ans. BCC aims to foster positive behaviour; promote and sustain individual, community and societal behaviour change and maintain appropriate behaviour. Some of the important benefits of BCC are: (a) Increases knowledge, improves attitude and skill (b) Stimulate community dialogue (c) Promote essential attitude change (d) Creates demand for information and services (e) Advocate for appropriate family health care policies (f) Enhances use of promotive, preventive and curative health care services (g) It is more appropriate for the illiterate and less literate group of audiences.

Check Your Progress-2

- 1) Draw a diagram for a two-way channel of communication.

Ans. See diagram- III of this unit.

- 2) What are the various channels of interpersonal and mass communication of local origin?

Ans. Various channels of interpersonal and mass communication of local origin are: (i) neighbour, (ii) relative (iii) village Panchayat members (iv) youth organisation members (v) women organisation members (vi) opinion leaders (vii) shop-keepers (viii) co-operative members.

Check Your Progress-3

- 1) What are the important steps of need analysis for any intervention in BCC?

Ans. The process of need analysis is a very important strategy for any intervention. The BCC experts usually follow these steps for need analysis. Firstly, identification of various needs and issues in the area. For example, in some areas the need may be control of communicable diseases, while in other areas it may be promotion of MCH care. Secondly, studying the characteristics of population i.e. gender, caste, ethnicity, etc. It is true that health care needs vary from community to community. The health care needs of tribal communities may differ from those of non-tribal communities.

Lastly, find out which aspects of family health care issues can be addressed through communication?

- 2) Describe the socio-cultural barriers of behavioural change communication.

Ans. Broadly, there are four types of barriers of behavioural change communication -- socio-cultural barriers, health services, socio-economic conditions and lacunas in BCC methods and channels. Socio-cultural barriers include gender discrimination, norm of early child-bearing / early marriage, traditional child feeding practices, stereotyped dietary patterns, prevalence of religious believes and values.



UNIT 12 INTER-SECTORAL CO-ORDINATION IN HEALTH CARE

Structure

- 12.1 Introduction
- 12.2 Co-ordination- Meaning and Related Concepts
- 12.3 Intra- and Inter-Sectoral Co-ordination in Health
- 12.4 Guiding Principles for Inter-Sectoral Co-ordination
- 12.5 Historical Perspective of ISC under Primary Health Care Model
- 12.6 Areas of Inter-Sectoral Co-ordination in Health
- 12.7 Co-ordination Mechanism and Benefits of ISC
- 12.8 Requisites for Effective Inter-Sectoral Co-ordination
- 12.9 Let Us Sum Up
- 12.10 References and Suggested Readings
- 12.11 Check Your Progress: Possible Answers

12.1 INTRODUCTION

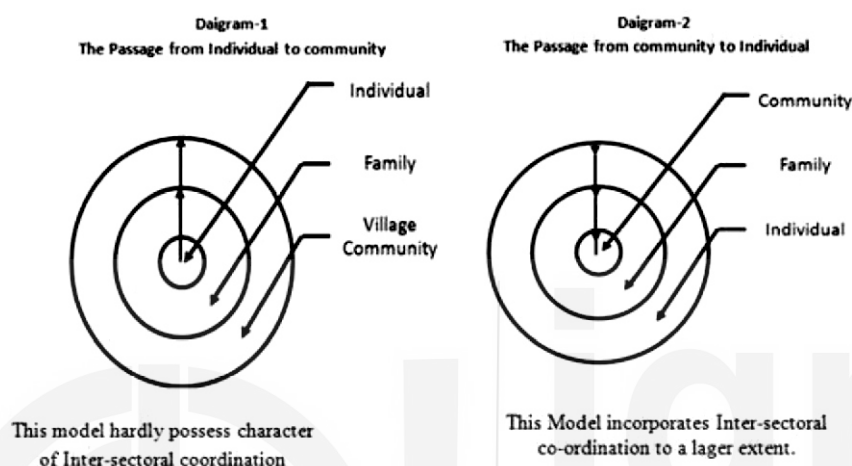
A mechanism to reinforce the concept of inter-sectoral co-ordination is most essential to changing a development concept into reality. But the major reason for its absence lies in the mindset of personnel engaged in developmental departments, government departments/ directorates/ ministries. All the developmental sectors possess their own administrative structures, and mechanisms to carry out their programmes/schemes. The department operates at district level, directorate operates at state level and the Ministry operates at Central Government level.

Most of the health schemes flows through a single channel i.e. Health Ministry to Directorate to Department. These are not integrated without developmental schemes. It may be an administrative compulsion/mechanism. But when it comes to the district and downward up to the village level, the need for inter-sectoral co-ordination is utmost important to translate health schemes objectives into reality. This is possible if the Ministry of Human Resource Development (HRD) develops holistic perspectives and co-ordinates with other related departments. For example, if Block Development Officers are not sensitised about the health education, food and nutrition through the HRD, they cannot extend their full participation in the health schemes. Similarly, personnel from other departments need sensitisation about the health of people and the health schemes in order to run various health programmes at the village and block level.

The second feature of inter-sectoral co-ordination should be seen in terms of integrated strategies in the implementation of all the developmental schemes. For building up community participation, inter-sectoral co-ordination can play a significant role. The focus should be to build effective awareness of all the schemes, their benefits to the people through community –to the family-to the beneficiaries rather through individual beneficiary-to the family-to the community reflected in the diagram.

After going through this unit you will be able to:

- explain the concept of Inter-Sectoral Coordination (ISC), its importance for development,
- how interrelated departments are contributing to the community health, and learn the strategies to mobilizing people and the personnel working,
- describe the mechanism of coordination within and outside the health sector,
- discuss the role of ISC for health promotion and increased community participation.



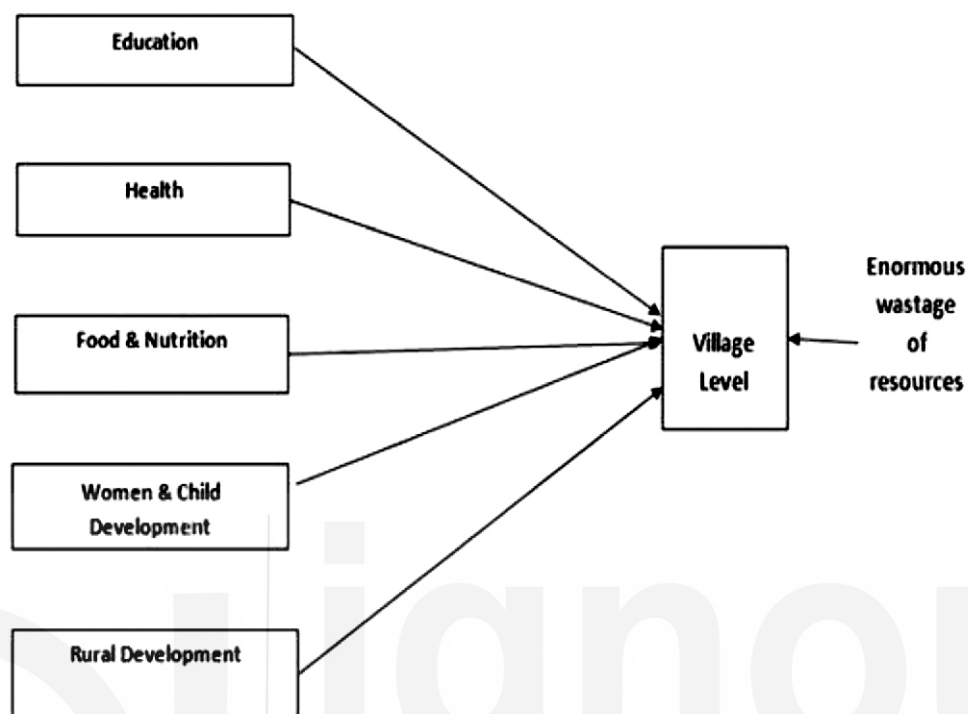
The capacity development programmes of each department need inter-departmental sensitisation about purpose, goals of schemes and their relevance to people. It would not be possible without inter-sectoral co-ordination. DDOs, BDOs other grassroots personnel need effective sensitisation about the health and health schemes. Similarly if the medical officers are not sensitised about food and nutrition and other developmental schemes under education, agriculture rural development, water and sanitation schemes, they can not make sincere efforts for the participation of community at large and other related developmental departments.

Different Levels of Inter-sectoral Co-ordination

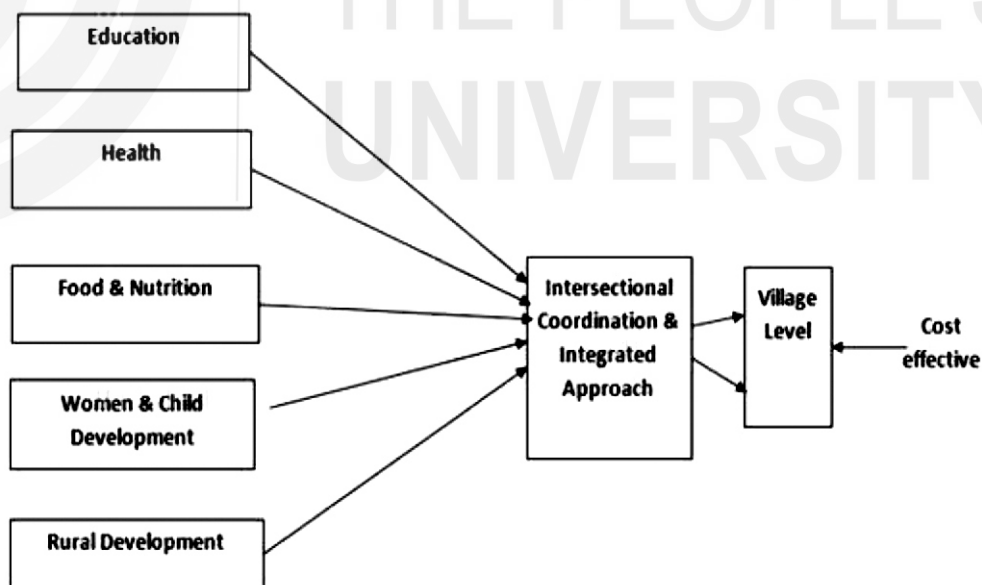
District Level	Service Provider	DDO	CMO	Director Education
Block Level	Service Provider	BDO	Medical Officer	Education Officer
Village Level	Service Provider	Mukhya Sevika	ANM	Educator

Unless the entire community internalise the values inbuilt in the schemes, it would not be possible to achieve the expected goals under the any developmental programme. The real and most effective approach of working in co-ordinated manner is to make the entry to the beneficiary through community and family rather than individual directly. Many of the developmental schemes, which have a direct bearing on the health of people, need co-ordinated executed. And it needs intersectional co-ordination and integrated approach to translate the health schemes into reality. Given below are diagrams that refer to two models which are generally used in the community:

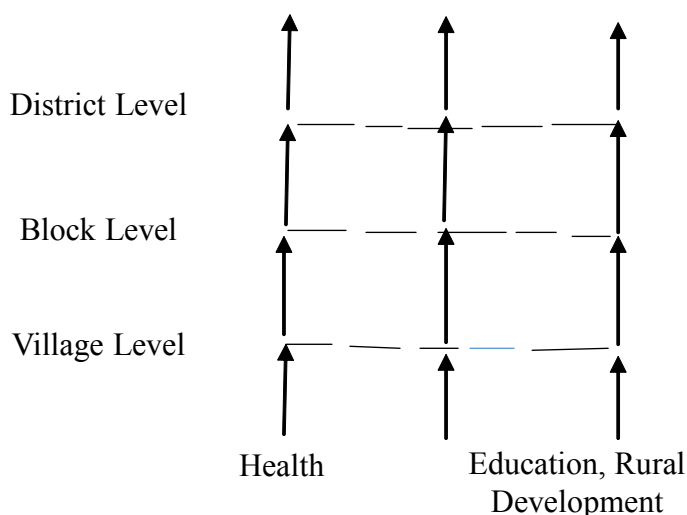
Model -A



Model-B



Model A is integrated and lack intersectoral coordination, while Model B is integrated and encompass intersectoral coordination. It can be cost effective. Many Schemes just address the beneficiaries like women, mother, and child, adolescent and focus remain only on them and not the entire family and community.



As evident from the diagram; the link amongst all the departments are missing at every level. The flow of development schemes is vertical in nature. So the existence of inter-sectoral co-ordination is lacking.

The focus of the schemes remains the individual without addressing the barriers operating at family and community level. For example- son preference is rooted in community culture and family values attached to son. It is normative behaviour. It means a person performs all those duties that are approved by the majority of the people in the society. Individuals or couples just carry out their duties as normative behaviour. The success of “*Beti Bachao Beti Padhao*” depends on the normative forces that prevail in the village/community.

Health is intrinsically related to development. However, the inter-linkages between health and development were brought to the limelight at the Alma Ata conference on Primary Health Care (PHC) in 1978. The Alma Ata conference not only gave a new impetus to the inter-linkages between health and development but also restated the fact that ‘Health for All’ could not be achieved without inter-sectoral co-ordination. This restatement gave a new direction not only to those involved in promoting health but also to those participating in the process of community development. The scholars, the policy makers and the development functionaries promoting an inter-sectoral approach to health, tend to consider seriously three major sectors that are crucial for health and development. While in this unit we attempt to discuss how closely health is related to various health related sectors, and we shall focus our attention on some of the key factors that are to be considered for promoting health through inter-sectoral approach.

12.2 CO-ORDINATION- MEANING AND RELATED CONCEPTS

The co-ordination and some related concepts such as cooperation, collaboration briefly mentioned here for the understanding of students and convergence are discussed below.

- **Co-ordination** means integration, synchronisation or orderly patterning of group efforts towards the accomplishment of common goals. Co-ordination implies that all governmental and non-governmental agencies understand each other’s roles, speak the same language, avoid overlap and add value to each other’s work. Co-ordination can be differentiated from ‘co-operation’ and ‘collaboration’ in a number of ways. The ultimate aim of co-ordination is convergence of health care services in the community. Willing co-operation

and agreement to collaborate leads to effective co-ordination. It has certain advantages as the process of working together and sharing of ideas leads to value addition and the cumulative effect of each functionary's work when they co-ordinate becomes more than the sum total of their work altogether. There can be two types of co-ordination; within the Department i.e. intra-sectoral and between the Departments i.e. inter-sectorial co-ordination.

- **Co-operation:** It implies collective effort put in by a group willingly or voluntarily for accomplishing some task. The effort does not have any directional framework. It depends on people's willingness to help each other.
- **Collaboration:** It refers to sharing similar responsibility by a group of people or agencies based on certain agreement to carry out a project or programme. Co-ordination as distinguished from co-operation and collaboration is more participative, implies commitment, economises effort, improves quality of work, avoid duplication and wastage, and optimises output.
- **Convergence:** It is a process that facilitates different functionaries and communities to work together for efficient service delivery. Convergence leads to time saving, helps in building rapport with others, reduces workload, and increases efficiency. Involvement and participation of community is a necessary pre-requisite for convergence.

12.3 INTRA AND INTER SECTORAL CO-ORDINATION IN HEALTH

12.3.1 Intra-Sectoral Co-ordination

Vertical Health care system has been under criticism on account of several reasons. The health sector as a strategy of intra-sectoral co-ordination has to co-ordinate with the family welfare, AYUSH, homeopathy and nursing. The health department can achieve the goods of HFA (Health for All) without the intra-sectoral co-ordination. Under NRHM it has been realised that unless all the systems of health care are integrated and delivered from single window, the outcome of NRHM will not be achieved. All alternative and traditional health system are integrated under AYUSH in India. The Health Department at the district level implements a number of programmes such as malaria control, leprosy control, family welfare, RCH, etc. At the middle level a number of officials are implementing them and District Health Officer co-ordinates these programmes and frequent meetings, sharing of experience and success stories etc., are part of intra-sectoral co-ordination. The programmes which need to be co-ordinated are: Immunisation, RCH, nutrition, Malaria, Filariasis, Kalazar control, control of diarrhoeal diseases, home visit and follow-up of family planning acceptors, TB (tuberculosis) etc. and other programme implementation related activities such as maintenance of health records, programme planning, monitoring, evaluation and implementation strategies. Conceptually, it is ideal, but in reality, ISC cannot be visualising only in terms of physical presence of officials from different departments. They are guided mostly by their departmental identity. Therefore, ISC need to be understood in terms of willingness (Commitment) to change their departmental identity and acquire new identity. Because as a member of ISC (Intersectional Co-ordination) they are supposed to adjust into new roles, which is a great challenge because this requires handling of different types of conflicts and therefore to make ISC as a success there is a tremendous need to create situation of understanding co-

ordination and co-operation. An example of intra-sectoral co-ordination is given in below (Figure-12.1).

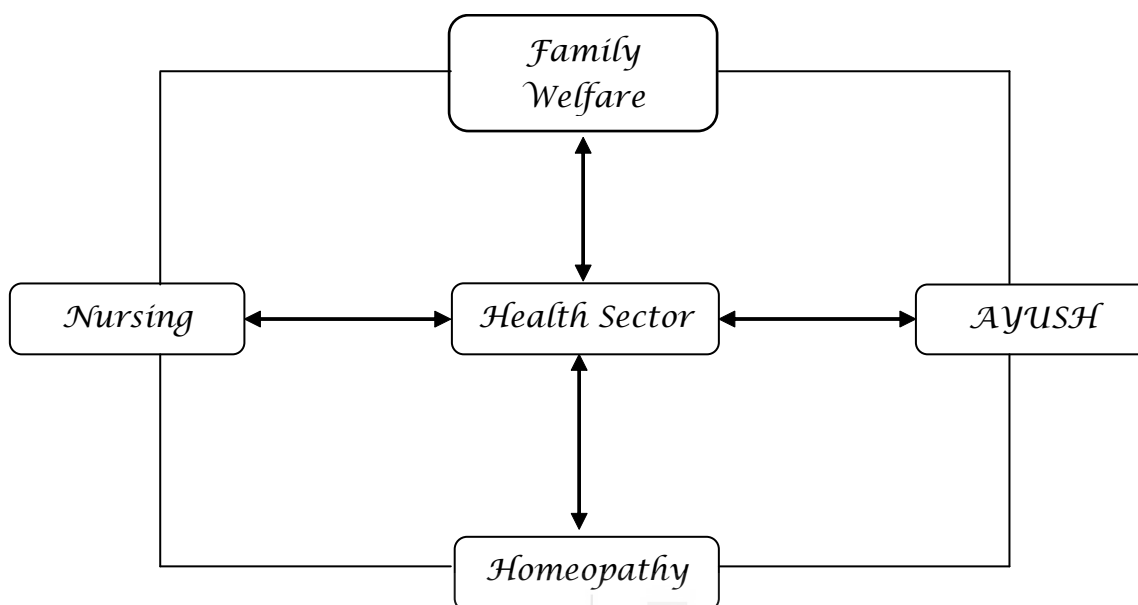


Fig.12.1: Intra-sectoral Co-ordination

12.3.2 Inter-Sectoral Co-ordination (ISC)

Alma-Ata declaration has also suggested multi-sectoral approach as one of the basic principles underlying primary health care. The approach is based on the assumption that health is intrinsically linked with other development issues in a synergic manner. Some of the departments for inter-sectoral co-ordination are Women and Child Development, Department of Education, Rural Development, Rural Water Supply and Sanitation, Panchayati Raj Institutions, NGOs, Department of Agriculture, Department of Social and Tribal Welfare, Department of Forest, Department of Road and Transport, etc. The changes in other sectors affect health and similarly health affects the development in other sectors also. Therefore, a better understanding of the relationship between health and other development sectors is needed for best results. As a matter of structural reality, development programmes are being implemented by various ministries without successful co-ordination at the level of planning. So much so even officials are not fully aware of it. All development programmes need to achieve some tangible indicators related to the quality of life of the people. The success of development should be viewed from the angle of those tangible indicators.

This approach would automatically bring all development agencies at one platform and this would strengthen the concept of inter-sectoral co-ordination. There is a need to develop capacity development strategy in an integrated manner. Officials of the entire department should have knowledge and understanding of the schemes, which are interrelated. For example, concept of good hygiene is linked with facility of toilet and water. The health department cannot promote the culture of good hygiene without full support of other departments looking after schemes related to rural/urban toilet and water supply and therefore with public health department. Similarly, there could be several other examples. The statistics of birth and death, early marriage, early pregnancy which are vital for achieving the desirable health indices, are provided by different departments. Without the support of the education and other departments directly addressing issues of birth and death registration, and child marriage practices is impossible.

The concept of ISC demands the working of departments in synergy. The issue is how to create sensitivity of the personnel from different departments towards achieving the health of the people unless this issue is taken seriously and the managers of other departments from ministers to the block level officials are given realisation about the health and life of the people. The ISC should not become a 'number game' as the mere physical presence of an official in different meetings may not be sufficient to ensure co-ordination and co-operation in the real sense. There is a need for evolving integrated training packages of different nature through which the personnel at all the levels are sensitised about the issues like IMR and MMR and related factors and their contribution is must to manage these issues. Otherwise, mere presence in the meeting and administrative compulsion and threat would not provide true colour to ISC. Figure- 12.2 gives an idea about the sectors with which health sector has to co-ordinate in order to achieve better health status.

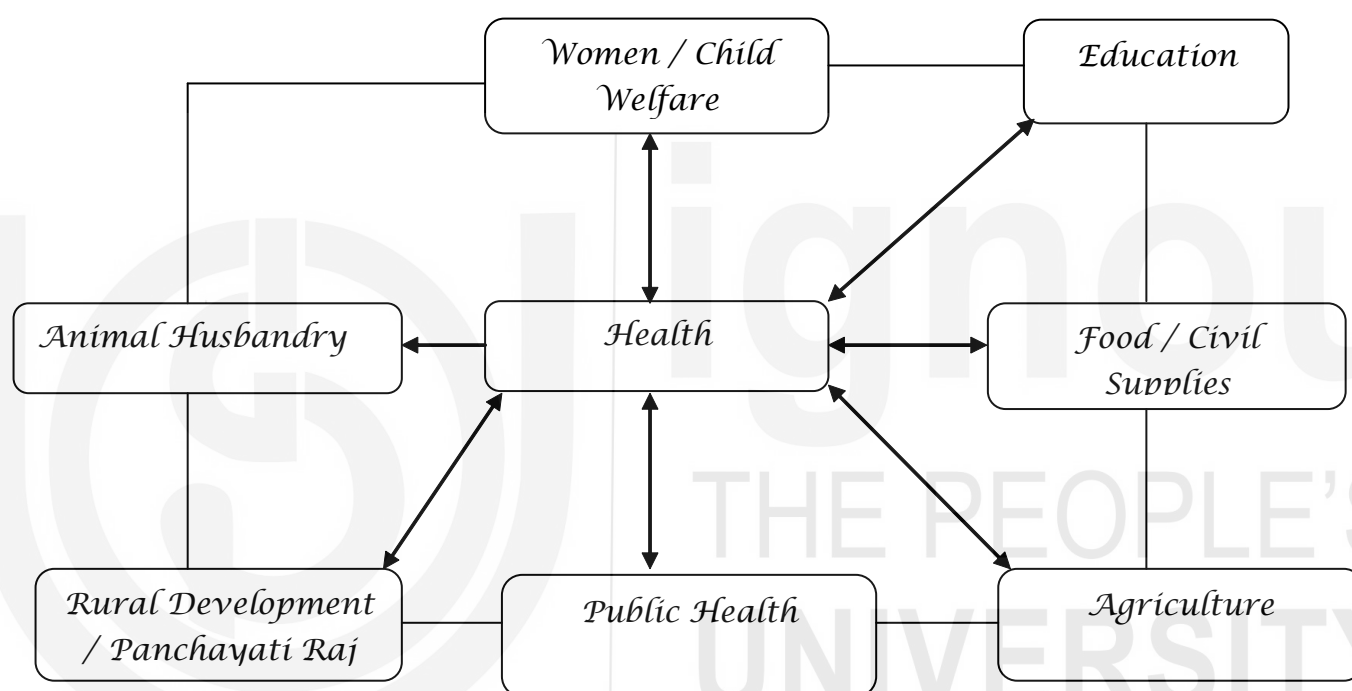


Fig. 12.2: Inter-Sectoral Co-ordination

12.4 GUIDING PRINCIPLES FOR INTER-SECTORAL CO-ORDINATION (ISC)

Within the health sector a number of programmes are being implemented. Most of the times, these programmes pursue to achieve their specific objectives in a vertical manner losing sight of the ultimate goal of primary health care. Diverse specific activities for each programme are pursued to an extent that they may clash with other programmes and prove to be counter-productive. Personalised, egoistical ventures come in the way of operationalisation of various programmes, to help people and community. Co-ordination among various programmes and services is therefore very important for effective delivery of services in a convergent manner and also to avoid duplication of efforts, minimise wastage and to encourage them to work for maximum output. It is to sustain the psychology of multi/purpose work and create a more amiable and acceptable work climate.

It is to ensure unity of purpose and direction and to encourage teamwork to deliver primary health care at various levels. Under NRHM most of the observations mentioned in the paragraph above have been taken into account and commendable efforts have been made to strengthen operational convergence. However, personality clash dimension will remain active till a new identity for integrated services in co-ordination with the entire developmental programme is fully formulated. Development personnel who have worked for a long period on the vertical model would remain convinced of some of those things, which do not suit the conversion.

12.4.1 Guiding Principles

Before we begin to understand the inter-linkages between health and other sectors, we must know some of the guiding principles, which are important to the understanding of inter-sectoral co-ordination. These principles are (i) development is basic to health development, (ii) equity and (iii) promoting economic capacity of the poor people. These three principles are not independent of each other and therefore they form the guiding principle of Inter-Sectoral Co-ordination (ISC). A brief description of these follows.

- i) **Development is basic to health:** Health is closely related to development. Therefore, any action taken to promote health must be necessarily linked to the process of development which includes growth, production and distribution. Health care by and large is considered as a part or degree of distribution of benefit of the growth or production.
- ii) **Equity:** The most common understanding of equity in terms of health is that “every man, woman and child, no matter where he or she lives, has the right to enjoy good health and deserves to have access to health care services.” This definition then implies the following. Firstly, there must be enough health care services - availability. Secondly, whatever is available must be accessible to the poor, forgotten and the marginalised. However, the meaning of ‘accessibility’ assumes greater importance because there are many factors that determine access. Help rendered by an organisation to the community to use the existing health care services is one factor. For example providing transport facilities to the referral patients of the poor to reach the clinic or the hospital.
- iii) **Promoting Economic Capacity of the Poor People:** Economy plays an important role in the health status of the people. It not only enables the people to undertake preventive and curative health care measures, but it also promotes sustainability of their health status. There are many countries or community specific strategies or programmes involved to build people’s economic capacity. Some of the key strategies are enabling the poor to have: (i) asset creation and development, (ii) capital formation, (iii) employment opportunities in the private or public sector, and (iv) access to market avenues.

The above described three principles have been tested under comprehensive rural health project Jamkhed in Maharashtra. In this project it was found that these principles are not independent.

12.5 HISTORICAL PERSPECTIVE OF ISC UNDER PRIMARY HEALTH CARE MODEL

The Primary Health Care model as articulated at Alma-Ata explicitly stated the need for a comprehensive health strategy that not only provides health service but also address the underlying social, economic and political causes of poor health. In addition to the health sector, all related sectors of community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communication, demand the co-ordinated effort of all these sectors (Irwin, 2007). During the 1980s, as the drive for Health for All unfolded, the concept of inter-sectoral action for health took an increasing prominence. In 1986, WHO and the Rockefeller Foundation co-sponsored major consultation on International Association of Health at the latter's Bellagio conference. From the mid-1980s, Social Determinants of Health were also given prominence in the emerging health promotion movement. The first International Conference on Health Promotion – co-sponsored by the Canadian Public Health Association, Canada's Health and Welfare Department and WHO-was held in Ottawa in November 1986. The conference adopted the Ottawa Charter on Health Promotion, which identified eight key determinants of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. It was understood that this broad range of fundamental enabling factors could not be addressed by the health sector alone, but would require co-ordinated action among different government departments, as well as among non-governmental and voluntary organisations, the private sector and the media.

In 1992, Dahlgren and Whitehead formulated their rainbow model of health determinants in which the living and working conditions such as agriculture and food production, education, work environment, water and sanitation, health care services, and housing were accepted as contributors to health. The term 'social determinants of health' also appeared in Tarlov's 1996 analysis of how inequalities in the quality of housing, education, social acceptance, employment, and income were translated into disease-related processes. Tarlov saw both material conditions and the cognitive appraisal of these living conditions relative to others as influencing factors of health. The Canadian Institute of Advanced Research outlined various determinants of health, such as, income and social status, social support network, education, employment and working conditions, physical and social environments, biology and genetic endowments, personal health practices and coping skills, healthy child development, and health services. A British working group charged with the specific task of identifying social determinants of health named the social (class health) gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport. The US Centre for Disease Control highlighted socio-economic status, transportation, housing, access to services, discrimination against social groups (e.g., race, gender, or class) and social or environmental stressors as influencing factors of health.

The global development agenda is increasingly shaped by the Millennium Development Goals, adopted by 189 countries. The eight MDGs were linked to quantitative targets and indicators in poverty and hunger reduction; education; women empowerment; child health; maternal health; control of epidemic disease; environmental protection; and the development of a fair global trading system. Three of the eight MDGs are directly focussed on health, and several of

the other goals have important health components, confirming that, overall, health in the 2000s stands higher on the international development agenda than ever before (WHO, 2005).

After studying this section on meaning and related concepts on co-ordination, intra and inter-sectoral co-ordination (ISC), its guiding principles and historical sketch of ISC dynamics, now attempt questions given below in Check Your Progress.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

- 1) Discuss the need for co-ordination in the delivery of primary health care.

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- 2) List three major constraints in the way of effective co-ordination.

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12.6 AREAS OF INTER-SECTORAL CO-ORDINATION IN HEALTH

Areas of great concern for Inter-Sectoral Co-ordination are as follows: Promotion of Nutrition, Supply of Safe Water, Excreta Disposal and Refuse Disposal, Waste Water disposal, Maternal & Child Health, Family Welfare, Immunisation against major Infectious Diseases, Prevention and Control of locally Endemic Diseases, Health Education on Prevailing Health Problems etc. The inter-sectoral co-ordination of health sector with other sectors for the promotion of the above mentioned aspects are discussed below.

- i) **Promotion of Nutrition:** The Health Department organises activities related to educating pregnant mothers and lactating mothers, regarding quantity and quality of food, supplementary nutrition, semi-solid and solid food for child, educating adolescent girls and boys on food habits, food hygiene, balanced diet, malnutrition among children, osteoporosis among females, food for geriatrics, adulteration of food and subsequent diseases, role of kitchen garden, mid-day meals in schools; organising nutrition education and preventing problems of malnutrition and anaemia in the community.

The activities of the other departments where co-ordination shows better results are listed below:

Agriculture	Promote growing of cereals, pulses, oil seeds, vegetables and local fruits to change eating habits and distribution through Fair Price Shops or Co-operatives.
Education	Organise sessions on food, food hygiene, nutrition and demonstrate to develop kitchen gardens and preparation of balanced diet and special diet supplements.
Social Welfare, Women and Child Development	Organising women to give nutritional supplement and monitor children's growth. To utilise services of primary health centres for protecting children aged 0-6 years from communicable diseases and severe malnutrition problems and mothers for check-up and follow-up, in the Integrated Child Development Services Scheme (ICDS).
Panchayats	Encouragement and support to grow kitchen gardens and reward the best garden and healthy mother and baby and help health personnel in the organisation of immunisation and health camp.
Animal Husbandry	Help in monitoring health of milch animals, such as cows, goats, buffaloes etc. and poultry farming, fish tanks and sale of milk, eggs and fish through village co-operatives.
Co-operative	To store agricultural produce and organize sale of the same through village co-operatives.
Banks	Financial assistance to villages for promotion of dairy, fishery and poultry at the village level.

- ii) **Supply of Safe Water:** Health department needs to co-ordinate with the public health department for supply of safe drinking water. Public health department is involved in site selection and survey for water sources; water analysis; and educating the community how to get safe water. The other departments can co-ordinate with the public health and health department in following ways.

Agriculture	Co-ordinating and co-operating with public health and health sector in identifying water sources and utilisation of water for drinking purposes.
Education	School health education on safe water and its importance.
Panchayati Raj	Providing finance for maintenance of water sources.
Social Welfare/ Women and Child Development	Organising women's groups on maintenance of water sources and use of safe water.

- iii) **Excreta and Refuse Disposal:** Health Department conducts education at household level for use of sanitary latrine and safe garbage disposal. The activities of other departments can be co-ordinated in the following ways.

Agriculture	Organising educational programmes on proper composting
Co-operative	Evolving co-operative community composting
Education	Conducting school health education on proper disposal of excreta and composting. Construction of school toilets
Panchayati Raj	Providing financial support for sanitary community latrine and community composting; and organising education on proper collection and disposal of excreta
Rural Development	Manufacturing latrine sets; manufacturing equipment for latrine construction and composting.
Social Welfare/ Women and Child Development	Organising women's groups on safe excreta disposal and composting.

- iv) **Waste Water Disposal:** Health Department organises health education camps on methods of safe disposal of wastewater and, its advantages to the community. Other sectors/departments need to co-ordinate with the health department in activities with similar objective.

Education	Educating the children on safe wastewater disposal and its advantages; adult education on safe disposal methods and its advantages.
Agriculture	Providing drainage for household kitchen garden and community kitchen garden.
Co-operative	Financing preparation of kitchen garden; financing for soak pit construction.
Panchayati Raj	Providing finance for community kitchen gardens and soak pits construction.
Rural Development	Encourage and provide fund for manufacturing equipment for laying kitchen gardens, and digging of soak pit and soak wells.
Social Welfare/ Women and Child Development	Educating the women on maintenance of kitchen garden and its advantages and use of wastewater.

- v) **Maternal and Child Health:** Health Department is responsible for health education on ante-natal, natal, and post-natal care; infant and child care; immunisation to children, mothers and others related maternal and child health care services. The similar activities of other departments/sectors can be converged.

Co-operatives	Organising co-operative insurance scheme for MCH care
Education	Health education on baby care and personal hygiene
Panchayati Raj	Provision of sub-centre buildings, crèche buildings and support for MCH Programme
Social Welfare/ Women and Child Development	Organising and educating women on maternal and child care

- vi) Family Health Care Education:** The Health and Family Welfare Department conducts health family welfare education through various communication methods at the grassroots. The similar activities organised by other departments/sectors are illustrated below:

Education	Organising population education in schools and adult education centres. Integrating population education in the school curricula.
Panchayati Raj	Provide help in the organisation of camps, motivation and community involvement in the family health care education.
Social Welfare/ Women and Child Development	Organising and conducting educational sessions for women at the grassroots level, particularly women belonging to weaker and socio-economically backward sections of the society.

- vii) Immunisation against Major Infectious Diseases:** Health Department organises and conduct educational programmes and provide service facilities on immunisation through the health centre personnel at various levels. The related activities of other departments are as following.

Education	Health education on various immunisations like cholera, typhoid, TB, tetanus etc. Helping in organising school immunisation programme. One of the examples is school teachers providing support to health department in the smooth conduction of Pulse Polio Programme.
Panchayati Raj	Propagation of health messages through posters and group discussions.
Women and Child Development	Education of mothers through Mahila Mandal and Anganwadis and women's groups.
NGOs/Community Leaders	The NGOs and community leaders provide support to the health department in immunisation and control of infectious diseases programme.

- viii) Prevention and Control of Locally Endemic Diseases:** Education on diagnosis, treatment and follow-up of cases of TB (tuberculosis), leprosy, malaria, scabies, etc. is being organised by Health Department. The related activities of other Departments are:

Animal husbandry	Immunisation of cattle and domestic animals against rabies etc.
Education	Education in early diagnosis and prevention of TB, leprosy, malaria, scabies, etc. and provide help in organising health camps.
Panchayati Raj	Propagation of health messages through wall painting, posters and folk media.
Social Welfare/ Women and Child Development	Education on prevention of communicable diseases, through self-help groups, mothers' committees, etc.

- ix) Health Education on Prevailing Health Problems/ Epidemics:** Health Department is supposed to organise and conduct health education on health

epidemics for community through individual, family social group and mass approach and mass media. Similar activities are being organised by several departments.

Agriculture	Education through village extension workers to create awareness among the public in identifying health problems.
Animal husbandry	Imparting health education to the community through its grassroots level workers.
Education	Providing health education at schools and adult education classes on various health problems.
Panchayati Raj	Propagation of health messages through wall painting, posters/ hoardings, and folk media.
Social Welfare and Women and Child Development	Organising and conducting health education sessions for Mahila Mandal members, and SHGs members.

- x) **Improvement of overall Environment in Primary Health Centre premises:** It includes plantation, gardening, water supply, sanitation, supply of materials and electricity.

Forest	Provision of trees and plants
Public Health	Provision of waste and sanitation facility
Panchayati Raj	Overall support including finance
NGOs	Community education and community mobilisation
Community Based Organisations	Community education and community mobilisation

12.7 CO-ORDINATION MECHANISM AND BENEFITS OF ISC

In order to co-ordinate the different units the health sector needs to evolve various mechanisms of co-ordination at intra and inter organisation level. These are:

- Listing out the programmes which need joint efforts
- Identifying the areas where co-ordination is required
- Knowing the categories of health personnel whose activities should be integrated
- Locating the levels of health systems where joint efforts are needed
- Forming co-ordination committees of members of district health teams which includes all the middle level supervisors and specialised functionaries working at district level
- Forming of operation teams at field level
- List out names of different sectors like Social Welfare, Women & Child Development, Public Health, Rural Development, Municipalities and Municipal Corporations etc. and the head of those sectoral units which are directly or indirectly related with health and family welfare programmes

- Identify the non-governmental and voluntary health organisations, which are working in the area of health and family welfare
- Constitute co-ordination committees with the representatives from district, block and village level
- Formulate specific task-forces
- Jointly decide the objectives and areas for co-ordination to achieve desired goals
- Decide the role and responsibility of each department and mechanism of reporting and feedback sharing
- Develop a plan of action with focus on independent tasks, joint tasks, sharing of resources and field work in team
- Jointly decide HRD for the personnel operating at different level

12.7.1 Benefits of Inter-Sectoral Co-ordination (ISC)

The benefits expected from inter-sectoral co-ordination are:

- i) to achieve goals which cannot be achieved alone,
- ii) to increase the chance that those policy alternatives are chosen which are most likely to result in the highest overall welfare gains
- iii) to help to prevent overall welfare losses because of policies that entail positive welfare effects for individual actors, but disadvantages from an overall point of view
- iv) to provide legitimacy and acceptance to public policy.
- v) Reduce the cost of implementation of schemes.
- vi) Timely achievement of target goals.
- vii) Confidence building in the community.
- viii) Inbuilt monitoring and quality assurance measures.

To sum up, inter-sectoral co-ordination (ISC) is likely to lead to more effective public policies due to enhanced governance knowledge, mutual learning, reduced risk of deadlock in decision making, avoidance of unintended side-effects and the prevention of implementation resistance.

12.8 REQUISITES FOR EFFECTIVE INTER-SECTORAL CO-ORDINATION

Some of the pre-requisites for the effective inter-sectoral co-ordination are:

- i) **Establishing an overall inter-sectoral strategy-** This step is added for the sake of completeness, but is unlikely to be attainable in practice.
- ii) **Establishing commonly agreed or binding priorities-** Inter-sectoral agreement to common priorities and/or central agencies lays down the main lines of policy and establishes cross-sector priorities.
- iii) **Defining common limits by setting parameters for sectoral activities-** A central organisation of an inter-sectoral decision-making body may play a

more active role by constraining the admissible range of sectoral activity. The parameters define what sectoral actors must not do, rather than prescribing what they should do.

- iv) **Arbitration of inter-sectoral differences-** Where inter-sectoral differences cannot be resolved by the horizontal co-ordination processes defined in steps two to four, a central mechanism of an *ex ante* commonly agreed procedure for arbitration is applied (e.g. state hierarchy, voting).
- v) **Avoiding policy divergences among sectors and seeking consensus-** Beyond negative co-ordination to find out differences and prevent mutual negative effects, the actors / organisations should work together by forming joint committees and project teams, because they recognise their interdependence and their mutual interest in resolving policy differences.
- vi) **Consultation with others-** As a two-way process, sectors/actors need to inform others about what they are doing; they consult others in the process of formulating their own policies, or positions.
- vii) **Information exchange among sectors-** Sectors/actors keep each other up to date about recent issues and problems and how they propose to act in their own areas and also in co-ordination of one another. Reliable and accepted channels of regular communication must exist.

Steps required for effective Inter-sectoral Co-ordination (ISC)

Effective co-ordination depends on leadership style and willingness to collaborate with other sectors. So, it is essential to make others know the health policies and priorities. Some of the necessary actions required to be taken for ISC are:

- 1) Proper orientation of policies and programmes of each developmental department at all levels.
- 2) Formation of joint co-ordination committee at each level i.e. village/block/district.
- 3) Defining roles and responsibilities of participatory agencies and classifying them in relation to each other.
- 4) Participatory decision-making.
- 5) Developing formal system of interaction, discussion and debate.
- 6) Sharing of the problems faced in implementation of health programmes and seeking co-operation from each partner.
- 7) Spelling out strategies and procedures.
- 8) Joint monitoring and evaluation.
- 9) Remedial measures in solving problems related to co-ordination/resource mobilisation.

After studying this unit on Inter-sectoral co-ordination (ISC), particularly areas of ISC in health, its mechanism and benefits as well as necessary requisites for effective outcome, now attempt questions given in Check your Progress-2.

Check Your Progress 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) Identify the areas of great concern for linkages with PHC.

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2) Detail the steps required for effective inter-sectoral co-ordination.

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12.9 LET US SUM UP

The goal of all the developmental activities is a comprehensive, overall socio-economic development of the community in which other sectors contribute to health and vice versa. The co-ordinated health care activities involve working with people, people's elected representatives (PRI), local groups, youth clubs, mahila mandals (women's groups), self-help groups, NGOs, etc. The ultimate aim of co-ordination is convergence of health care services in the community. Convergence is a process that facilitates different functionaries and community to work together for efficient service delivery. Convergence leads to time saving, helps in building rapport with others, reduces workload, and increases efficiency. Involvement and participation of community is a necessary pre-requisite for convergence. It has certain advantages as the process of working together and sharing of ideas leads to value addition and the cumulative effect of each functionary's work when they co-ordinate becomes more than the sum total of their work altogether. There can be two types of co-ordination; within the Department i.e. intra-sectoral and between the Departments i.e. inter-sectoral co-ordination. To co-ordinate the different sectors and non-governmental organisations, there are needs to create task-forces and committees of heads of different institutions and organisations operating in the district.

List out names of different sectors like Social Welfare, Women & Child Development, Public Health, Rural Development, Municipal and District Boards etc. and the head of those sectoral units which are directly or indirectly related with health and family welfare programmes. It is desirable to design and plan programmes based on a multi-sectoral and convergence approach. Some such experiments have already being carried out in the country to provide valuable insight in the process of co-ordination. For example, Integrated Child Development Services Scheme (ICDS), the biggest programme of child

development in the country envisages the delivery of a package of services including health, nutrition, pre-school education and community participation in an integrated manner. The inter-sectoral co-ordination would result in effective implementation of health sector programmes.

12.10 REFERECES AND SUGGESTED READINGS

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12.11 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

Check Your Progress 1

- 1) Discuss the need for co-ordination in the delivery of primary health care.
Ans. Since the Alma Ata conference (1978), Primary Health Care has given most important strategies for effective solution of health problems and development. It also stressed the missing concern of inter-linkages among various sectors related to health and restated the fact that 'Health for All' could not be achieved without inter-sectoral co-ordination.
- 2) List three major constraints in the way of effective co-ordination.
Ans. The real constraint in effective co-ordination is rigid departmental identity and indifference of personnel at different level towards health of the people. They possibly believe it is the responsibility of health department to look after the health of the people. It is also possible that the notion of health is not clear to other development agencies as conceptualised under health and family welfare department. The three major constraints are: 1) perspective on health, 2) knowledge, attitude and practices 3) the need for all three to be dealt with using different strategies.

Check Your Progress 2

- 1) Identify the areas of great concern for linkages with PHC.
Ans. Areas of great concern for PHC and inter-sectoral co-ordination are following: 1) Promotion of Nutrition, 2) Supply of Safe Water, 3) Excreta

Disposal and Refuse Disposal, 4)Waste Water disposal, 5) Maternal & Child Health, 6) Family Welfare, 7) Immunisation against major Infectious Diseases, 8) Prevention and Control of locally Endemic Diseases, 9) Health Education for Prevailing Health Problems.

- 2) Detail the steps required for effective inter-sectoral co-ordination.

Ans. Effective co-ordination depends on leadership style and willingness to collaborate with other sectors. Some of the necessary steps for ISC are given in section- 4.8 of this unit.

