

Community Participation and Primary Health Care in India

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ABBREVIATIONS

ACMOH	Assistant Chief Medical Officer Health
ADHO	Assistant District Health Officer
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
AYUSH	Dept. of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BAIF	Bharatiya Agro Industries Foundation
BHPWB	Basic Health Programme West Bengal
BMOH	Block Medical Officer Health
BPHC	Block Primary Health Centre
BPHN	Block Public Health Nurse
CBR	Crude Birth Rate
CDR	Crude Death Rate
CEHAT	Centre for Enquiry Into Health and Allied Themes
CHC	Community Health Centre
CHV	Community Health Volunteer
CHW	Community Health Worker
CINI	Child in Need Institute
CMOH	Chief Medical Officer Health
CNAA	Community Needs Assessment Approach
COPD	Chronic Obstructive Pulmonary Disease
CP	Community Participation
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DHO	District Health Officer
DHS	Director Health Service
FCRA	Foreign Contribution Regulation Act
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit/ German Technical Assistance
HIV	Human Immunodeficiency Virus
HPVHA	Himachal Pradesh Voluntary Health Association
ICDS	Integrated Child Development Service
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPD	Inpatient Department
ISM	Indian System of Medicine
K.E.M.	King Edward Memorial
LPG	Liquefied Petroleum Gas
MM	Mahila Mandal

MMR	Maternal Mortality Rate
MPW	Multipurpose Worker
MNGO	Mother Non-Governmental Organization
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MSS	Mahila Swasthya Sangh
NACO	National Aids Control Organization
NGO	Non-Governmental Organization
NHP	National Health Policy
OPD	Outpatient Department
PARIKAS	Parivar Kalyan Salahkar Samiti
PHC	Primary Health Centre
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PRIA	Society for Participatory Research in Asia
PWD	Public Works Department
RCH	Reproductive Child Health
Rs.	Indian Rupees
SC	Sub-Centre
SC	Scheduled Caste
SHG	Self-Help Group
SMO	Senior Medical Officer
SNGO	Service Non-Governmental Organization
ST	Scheduled Tribe
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UIP	Universal Immunization Programme
UNFPA	United Nations Fund on Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHW	Voluntary Health Worker
WBVHA	West Bengal Voluntary Health Association
WHO	World Health Organization

GLOSSARY OF INDIAN TERMS

Anganwadi	Childcare centre under ICDS scheme at village level
Anganwadi Worker	Female worker under ICDS scheme, responsible for supplementary nutrition, immunization, health check-ups, referral, nutrition and health education to women and children aged 0-6 at the village level
Jajmani system	Jajmani = patron; customary payments are received in return for the performance of regular services for a patron
Mahila Mandal	Women group
Mahila Swasthya Sangh	Women group active in family welfare and health
Panchayati Raj Institutions	Local self-government following a three tier system of Gram Panchayat (village level), Panchayat Samiti (block/ sub-district level), and Zilla Parishad (District level)
Parivar Kalyan Salahkar Samiti (PARIKAS)	Health and Family Welfare Advisory Committee
Taluka	Administrative unit below district level, size is equivalent to block

1 HEALTH CARE REFORM IN INDIA

Health is an important commodity not only at the individual level but also in terms of the micro- and macroeconomic scale of a country. Improvement of health status is therefore on the political agenda of every government. In India health has been a major policy issue since independence. The development of rural health infrastructure, immunization programmes and the extension of water supply and sanitation led to health gains. Major achievements include the rise of life expectancy, decline of infant mortality and crude birth rate as well as eradication of smallpox. Nevertheless, the health situation in the country is not satisfying for several reasons. First of all targets set in the five-year plans and in the National Health Policy 1983 have not been met. Although India has established national health programmes for special diseases like tuberculosis or malaria, the responsibility for the health system lies in the hands of the federal states themselves. Therefore, economical performance of the respective state and the priority level health has within the state government are the decisive factors for health care spending. It is not surprising that huge differences in health system performance and quality exist between the states. Within the states the health system is often characterized by an urban-rural dichotomy. Concentrations of public and private health care facilities in the urban areas and missing facilities in remote rural areas have thus become a common feature of the Indian health system. Furthermore, the burden of disease is disproportionately placed on the poor. Mortality rates, fertility rates and undernourishment are double as high in the poorest quintile of the population (Misra et al. 2003: 1). They receive fewer subsidies and have to spend a higher share of their household incomes for health services. While successes in communicable disease control are noticeable and mortality rates declined, inequality in access to and in quality of health care has not decreased. On the contrary, the gap between rural and urban areas and between the richer and the poorer part of society has widened (Peters et al. 2002). Even the Ministry of Health acknowledges that the public health system showed only limited success “in meeting the preventive and curative requirements of the general population” (Ministry of Health and Family Welfare (MoHFW) 2002b: 3).

In view of this situation India introduced a health care reform in 2002. The new National Health Policy focuses on decentralization and community participation as measures to improve the quality of health care and to achieve comprehensive primary health care (see MoHFW 2002b). Community participation and decentralization are the leading principles of health care reforms in developing countries since the 1970ies. Heavily promoted by the World Health Organization and later the World Bank they are perceived as the solution for low health system performance and thought to improve equity in the health care system. Even though decentralization and community participation are the leading strategies for health care reforms, studies about their impact on quality of health care and health status do hardly exist.¹ Decentralization is perceived as inherently good by policy makers, therefore, its goals are neither questioned nor is the process as such sufficiently

¹ - However, few studies are an exception. For the impact of decentralization on health care see Jeppson/ Okuonzi 2000; Mosquera et al. 2001; Ramiro et al. 2001; Tang/ Bloom 2000.

researched (Eckardt 1998: 7). Community participation is not only an influential concept for health care reforms but also the byword of today in development cooperation. Contrary to former development policies implementing programmes in a “top-down” manner, community participation puts emphasis on “bottom-up” planning. Thus, development cooperation tries to model its projects close to community needs. India has collected experiences with community participation since the 1970ies. None of programmes was able to improve the quality of health care to the desired extent. Nevertheless, it seems that community participation could gain ground again. The success of India’s health care reform now largely depends on the implementation of this concept.

Given the importance of these principles, it is surprising how little is known about their real bearing on health systems. The reason could be that it is not only difficult to establish causal relationships between decentralization or community participation and health status, but also to quantify the two processes. The amount of theoretical literature on the two concepts is large. To fill the gap between the theoretical concepts and the implementation outcomes, research into the ground realities of decentralization and participation is needed. This research requires a holistic view into economical, cultural, social and political processes on different spatial scales (see Rifkin 1988). Modern geography with its emphasis on spatial dimensions and its manifold intersections with other scientific fields delivers the required tools for it (see Werlen 2000). Linking national policy to local places in order to analyse community participation uses the geographical concept of space as a social construct. Local places are thus shaped by socio-economic processes at the micro and macro level. Furthermore, it is at the scale of locales at which social processes are realized (see Massey 1994). Hence, success or failure of India’s National Health Policy will be decided at this scale.

The implementation process of the new health policy has already started. Similar decentralization measures and attempts to introduce community participation have been fostered in the different states. The stage of implementation varies among them. Information about the realization of the National Health Policy differs. While at central levels the process seems to proceed in a fast and efficient manner, new policies and guidelines have been introduced, the situation at the local level presents a different picture. Here decentralization and community participation strategies seem to meet obstacles which were not envisioned by the policy makers. Furthermore, information from secondary sources about policy implementation at the local levels is difficult to get and tends to be biased. Information is the key to successful reforms. Therefore, information from primary sources needs to be collected to assess the status of decentralization and community participation at the local levels. Comparison of states and regions within the states are further helpful to monitor differences and detect similarities. The impact of policy processes on the quality of the health care system is likely to manifest in the long term only. Hence, impact assessment would not make sense at the current stage. Rather, process monitoring is needed to assess health care reform (Rifkin 1988: 933). Analysis of the prerequisites for successful participation can give an insight into existing mechanisms and power structures shaping the implementation process. Furthermore, it is necessary to determine the problems of the public health sector to identify areas where quality

improvement is needed. Last but not least it is the social, political, and economical reality at the basis which determines the success of health care reforms. While the direct impact of decentralization and community participation on quality of health care system is not part of this research, a general discussion about possible outcomes of India's health care reform will take place based on the process monitoring.

Research questions:

- 1) What is the current status of decentralization in India's public health sector?
- 2) What is the current status of participation in India's public health sector?
- 3) Are the prerequisites for successful participation in India's public health sector fulfilled?
- 4) Can decentralization and participation in India help to improve the quality of public health services in rural areas?

As mentioned above the theoretical framework for decentralization and community participation is large. While community participation is embedded in the philosophy of the Primary Health Care Approach, it is also part of decentralization theories. In the Primary Health Care Approach community participation is a basic principle for the achievement of comprehensive primary health care and therewith health for all (see 2.2.1.2.). On the other hand community participation is perceived as one result of decentralization and one of its benefits (see 2.3.2.1.). As a global concept for health care system reforms the Primary Health Care Approach was introduced in 1978 (see 2.2.). Equity, community participation, multisectoral cooperation for health, appropriate technology as well as health promotion and prevention are its basic principles (see 2.2.1.). The Primary Health Care Approach is a holistic concept which requires far-reaching political reforms. Policy makers soon realized that the approach is difficult to implement. Selective primary health care thus became a parallel strategy (see 2.2.2.). The Primary Health Care Approach had an enormous influence on India's health policy. All later health policies refer to it. Health reforms are evaluated using its principles till today (see 2.2.3.).

Decentralization is a process to improve public sector performance. It is widely discussed in political science and economics. The leading concepts like the public administration approach, local fiscal choice or the principal agent approach are the evidence (see 2.3.1.1./ 2.3.1.2./ 2.3.1.4.). However, theory has also been influenced by the social sciences as can be seen in the social capital approach and the decision space approach (see 2.3.1.3./ 2.3.1.5.). Even though decentralization is perceived as a positive reform (see 2.3.2.), it can also have negative effects (see 2.3.3.). Earlier decentralization attempts in India's health care sector took place to implement comprehensive primary health care. The outcomes differ from state to state, as does the impact on quality of health care. A positive conclusion is not possible (see 2.3.4.).

Research in decentralization and community participation needs background information about the status of health care in rural India. Rural characteristics like the burden of disease or geographical, social, cultural and gender disparities influence health outcomes and shape the political realities under which the health system is functioning (see 3.1.).

Rural society in India undergoes economic and political transformation processes which affect traditional systems and social relations. While this change can bring positive improvements for agriculture like new technologies and for society like opening of the caste system, it can also create new dependencies (see 3.1./ 3.1.3./ 3.1.4.). Although mortality and morbidity rates in rural India declined and life expectancy grew, health transition has not reached the rural areas. High child and maternal mortality rates persist. Furthermore, huge differences in health care indicators like immunization rates exist between the states (see 3.1.1.). At a local scale social, cultural, and gender disparities determine the health status. Low social status for example being a member of scheduled caste or tribe can be associated with less access to immunization services and higher mortality rates (see 3.1.3.). Complex local power structures influence decentralization policies and decisions who can participate from the community (see 3.1.4.).

The examination of structure and quality of India's public health system reveals its major problem areas. Policies are influenced by agencies. The hierarchical structure of health agencies in India comprises the Ministry of Health at the central level, sub-national agencies like the Ministries of Health at the state level and agencies at the district level and below. The Central Ministry of Health develops health policies and offers technical support to its sub-national agencies (see 3.2.1.1.). Ministries of Health in the states are dependent on central funding and programmes, although they are the responsible agencies for their respective health care systems. The rural public health care system has a three-tier system. Community Health Centres, Primary Health Centres and Sub-Centres provide health services for the population and carry out the National Health Programmes. Staffing and infrastructure are planned according to size of population (see 3.2.1.3.). However, expansion of health centres could not keep pace with population growth. Lack of facilities and staff are the consequence and hamper the quality of health services (see 3.2.2.). Utilization of and access to public health facilities depend not only on the availability of service provision (see 3.2.2.5.) but also on social, economical and cultural variables as well as on distance, cost, quality of care and trust (see 3.2.2.3./ 3.2.2.4.).

National Health Policy issues are strongly reflected in the National Health Programmes (see 3.2.3.). On the one hand the importance of family planning becomes visible as one of the major issues the health system has to cope with, while at the other communicable and non-communicable diseases play an essential role (see 3.2.3.1.-3.2.3.4.). Emphasis on community participation through non-governmental organizations (NGOs) is evident in most if not all of the programmes. The National Health Programmes receive large funds from international funding agencies. Hence, the influence of these agencies on the programmes can not be neglected.

The private sector plays an influential role in India's health care scenario reflected in the enormous growth rates in the last decades. Nonetheless, it is hardly addressed in health policies. The majority of India's population uses private health services rather than public health services, expecting better services (see 3.3.1/ 3.3.1.2./ 3.3.1.3.). However, these expectations are not always met. Higher prices and prescription of unnecessary treatment and drugs seem to be common in the private-for-profit sector (see 3.3.1.4.). India has a long history of traditional medicine. Indian Systems of Medicine are still practised today

and pose a large potential for rural health care provision, but its quality varies (see 3.3.2.). Furthermore, it is private-not-for-profit organizations which offer health services. The emphasis placed on these organizations by public policy makers is visible in the National Health Policy 2002 and in the National Health Programmes. Therefore, they deserve special attention (see 3.3.3.).

The theoretical explanations of decentralization and community participation (see 2.) as well as the extensive background information about India's rural society and the functioning of the public and the private health system (see 3.) compose the required framework for the case studies. The selection of study areas followed the framework of Miles and Huberman (Miles/ Huberman 1994) as recommended by other medical geographers (see Curtis et al. 2000). The states of Maharashtra, Himachal Pradesh and West Bengal were identified through a study about public performance where each of the states achieved a different performance level (see Paul et al. 2004; see 3.1.2.). Furthermore, the three states have already implemented decentralization and community participation policies in the health sector (see 4.1.1.2.-4.1.1.3/ 4.2.1.2.-4.2.1.3./ 4.3.1.2.-4.3.1.3.). Thus, rich information can be collected which is one of the criteria for sample selection (Curtis et al. 2000: 1003). Districts and blocks within these states were chosen according to their health status, status of community participation and feasibility in terms of costs (money and time) and accessibility (see 4.1.1.5./ 4.2.1.5/ 4.3.1.5.). The research design combines qualitative and quantitative research methods to assess the complexities of decentralization and community participation (see 2.1./ 4.1.1.4./ 4.1.2.). The results are analysed using approaches from existing theories (see 2.2.-2.3.) and also with a newly developed tool to identify prerequisites for successful community participation (see 2.3.2.2./ 4.1.2.). The descriptive character of the study is the consequence of interpretative methods used which are characteristic for qualitative research (Mason 1997: 4) and "well suited to studying such complex situations and offer much to the study of public health." (Baum 1995: 459).

Decentralization and community participation are part of India's new National Health Policy. The intention is to improve quality of public health services and to create more equity in health care provision. The study uses three case studies to assess the status of health care reform and the prerequisites for its success (see 4./ 5.). In doing so, tools for policy makers to monitor the policy process are developed and/or tested. As a result recommendations for effective process monitoring for health care managers are given.

2 FRAMEWORK FOR HEALTH CARE REFORMS

2.1. HEALTH SYSTEM RESEARCH AND GEOGRAPHY

Health System Research in developing countries focuses on quality outcomes of different health care interventions like decentralization and the Primary Health Care Approach (see 2.2./2.3.). In Geography the research in health care has been reestablished in the 18th century (see Barrett 1991, 1993, 1996, 2002; Burnett 2004). From the historical development of medical geography the following issues become clear. Medical geographers research the links between health indicators and place characteristics in order to understand the features shaping the health of people. Describing ecological, cultural, religious or political circumstances of the research area is an important part of the research methodology. Comparison of regions or localities in view of their health systems or disease patterns as well as studies on spread and migration of infections can be seen as the geographical basis of the subject. In modern medical geography or 'post-medical' geography the emphasis has slightly changed. The development of 'post-medical' geography of health was advocated by Kearns (Kearns 1993). The emphasis of 'post-medical' geography is to take up a broader social geographic perspective in research. Social environment, socio-economic status and the perception of a place has gained importance in his view and calls for refocusing the "attention on the social context of health and disease" (~: 141). Rather than concentrating on spatial distribution of health care, medical geography should focus on inequalities in health status (see Hayes 1999). 'Post-medical' geography in his opinion has come into existence through a new understanding of place which incorporates both the subjective and the objective meaning of a place. In his call for reforms Kearns criticises the geographical approach to analyse spatial relationships without questioning the characteristics of places themselves.

Medical geography has not been very influential outside its own discipline due to its "technocratic perception" (Bennett 1991: 340). However, the discipline has much more to offer than the technologies of spatial analysis only (Mohan 1998: 113). Socio-demographic, economic, and political factors are interrelated with health. Medical geography delivers not only the instruments for multidisciplinary research but also offers a theoretical basis upon which researchers can operate. Besides logical positivism and the scientific method, medical geography can and should also use phenomenology, realism, structuralism and others to understand the underlying processes and methods which shape the health system (Mayer 1993: 587). Research on participation and decentralization in health care is a relatively new field of medical geography which looks into the interactions between politics and health (Verhasselt 1993: 121). It is part of the geography of health care delivery. Geography of health care delivery engages with health system analysis, spatial distribution of health services, planning and optimizing health care resources, study of accessibility and utilization of health services and traditional medicine (Ibid.). Since research on participation and decentralization deals with the social and political context of health it follows Kearns call for a 'post-medical' geography. At the same time it uses the strengths of other sub-disciplines of geography, like cultural or

social geography (see Gesler 1992, Verhasselt 1993). Medical geography cannot be seen as detached from geography as such. Therefore, the strengths of geography in spatial analysis are incorporated in this discipline. "Medical geography uses the concepts and techniques of the discipline of geography to investigate health-related topics. Subjects are viewed in holistic terms within a variety of cultural systems and a diverse biosphere." (Meade/ Earickson 2000: 1). The issues of medical geography explained above culminate in this definition which includes all important aspects of the discipline.

The following study will analyse the process of health policy implementation of the new National Health Policy 2002 in India. The Primary Health Care Approach and decentralization are the theoretical background for health care reform in India. Both approaches incorporate participation as an important measure to enhance equity in health care and, thus, to improve the quality of the health services. Several attempts to employ community participation in past reforms have not shown the desired outcomes. The focus of this study will be especially on the involvement of non-governmental organizations, since the government policy places high hopes in them. Non-governmental organizations are defined here as voluntary, not-for-profit organizations. The framework chosen for research is not logical positivism, which is the prevailing philosophy for empirical sciences, because its "hypothetico-deductive" method is not useful for this study (see Mayer 1993; Baer 2002; Bennett 1991). Logical positivism requires that observable and replicable objects are studied from which law-like statements can be formulated (Mayer 1993: 580). Thus, logical statements are verified with empirical methods. While this framework is suited for studies of disease patterns, where causal relationships can be formed, it is insufficient for the complexity of policy analysis. The study will rather use a postmodernist framework, which is better suited for this purpose. The postmodernist framework is sceptical of overarching principles and against the overvaluation of causality and rationality as determinants of social processes (Wessel 1996: 30). Although elements of critical rationalism, structuralism or rationalism prove also useful for this research and are partly incorporated in postmodernism, none of them is sufficient on its own. Theory-building and falsification or verification processes, central to a critical rationalist framework, are acclaimed methods in empirical research in geography. Therefore, they will be used in this study to a certain extent. However, it is anticipated that in the analysis of participation in a diverse country like India, it might not be possible and desirable to formulate universal theories. In the search for truth as it is the case in every scientific study and also in this policy analysis, a complex answer might be more appreciated than a simple answer (see Bear 2002). This leads us to the question of validity.

Scarpaci distinguishes between apparent and instrumental validity (Scarpaci 1993). While "apparent validity is the definition of a particular variable", "instrumental validity refers to subsequent measures in research design which aim to confirm or contradict the meaning of key variables" (Ibid.: 720). Data for variables can be nominal, ordinal (e.g. Likert-scale), interval or ratio (absolute numbers). The study will rely more on nominal and ordinal data, which is less precise than ratio data. However, ratio data from secondary sources will also be used. Apparent validity measures the obvious, for example waiting time in a health care facility to assess accessibility of this facility. The answer, waiting time in hours and

minutes, does not imply how the patients perceived this waiting time and in turn rates accessibility for himself/herself. Therefore, it is important for medical geographers to use instrumental validity to check the validity of apparent variables (Ibid.). Questioning perceptions and asking 'why' affords the researcher with deeper insights. Establishing clear meanings of key terms through definitions benefits validity and prevents variable misspecifications.

Scarpaci's discussion of validity already points towards the debate about quantitative and qualitative methods within the discipline. He proposes to go beyond the discussion of quantitative versus qualitative methods, rather asking how to conceptualize and operationalize ideas. His view is shared by Baum, who argues that both methods are not incompatible but rather "enriching partners in a common enterprise" (Baum 1995: 460). Both methods have their advantages and disadvantages which need not be repeated here (see Wessel 1996: 40-46; Litva/ Eyles 1995; McKinlay 1993). Qualitative research is employed in different disciplines and by researchers from various traditions, therefore, it can not be reduced to a simple set of principles (Mason 1997: 4). However, few characteristics are common to qualitative research. Openness and flexibility are central features (Flick et al. 1991: 150; Wessel 1996: 40-42; Mason 1997: 4). The researcher should be open to the research subject in the sense that he/she does neither pre-structure the subject nor formulate hypotheses (Flick et al. 1991: 150; Wessel 1996: 40). Flexibility in methods of data generation like participant observation or non-standardized interviews facilitate interaction and communication between the researcher and the researched (Wessel 1996: 42; Mason 1997: 4-6). The results are social explanations which help the researcher to understand and interpret social reality (Ibid.). Development of hypotheses and formulation of theories are the first steps in quantitative research (Wessel 1996: 43). Distance to the research subject, explanations of facts and generalization of individual behaviour are characteristic for it (Ibid.: 42-44). Even though quantitative and qualitative research are polarised in theory, the distinction between them is less clear in practise (Wessel 1996: 44; Mason 1997: 6).

Since research of participation is a new field for medical geography, it is interesting to see how other disciplines have approached it. Most of the research uses case studies to analyse participation (Brown/ Ashman 1996; Blair 2000; Kumar 2002; Mosquera et al. 2001; Murthy/ Klugman 2004; Ramiro et al. 2001; Tang/ Bloom 2000). Case studies are a useful tool for the assessment of complex policy issues. In the geographical tradition case studies were predominantly used for country analysis in regional geography. Three case studies from different Indian states have been selected for the purpose of this study. The states of Maharashtra, Himachal Pradesh and West Bengal each stand for a different performance level of public services (see 3.1.2.). At the same time they are comparable in their status of health transition (see 3.1.1.) and the implementation stage of decentralization and community participation policies (see 4.1.1.2.-4.1.1.3/ 4.2.1.2.-4.2.1.3./ 4.3.1.2-4.3.1.3.). The three states reflect the cultural diversity among and within Indian states. Rather than a comparison of two states or regions, three examples were chosen to fulfil one requirement of qualitative research that it "should produce social explanations which are generalizable in some way" (Mason 1997: 6).

The spatial dimension of the examples from literature reaches from local scale, where small counties or communities as such are the focus (Ramiro et al. 2001; Tang/ Bloom 2000), to inter-country comparisons i.e. a global scale (Blair 2000). Not all studies focus on health care, but conclusions from other disciplines can also be helpful since decentralization takes place in other sectors too. Since the focus of comprehensive primary health care has shifted to the district level with the WHO policy of healthy districts (see Külker 2001), the scale chosen for this analysis is the district as well. The district is the smallest administrative unit where health system management takes place. The different administrative units are compared to distinguish external and internal influences on the health system. Although districts offer only small main units, since the number of interview partners is limited, they nevertheless allow a detailed insight into mechanisms and power structures influencing community participation and decentralization. Power structures and relationships are established at a personal level. They manifest themselves in everyday routines. Their specific characteristics, however, affect health policy implementation on a national scale.

After examining the extent and form of decentralization in the Indian health sector, participation in health care will be assessed. One method to assess the degree of participation is the stakeholder analysis. Characteristics of stakeholders influence decision-making processes. Stakeholder analysis, therefore, can generate knowledge about behaviour, intentions, interrelations, agendas and interests of the relevant actors, which is essential for the understanding of the policy context and the assessment of the feasibility of future policy directions (Brugha/ Varvasovszky 2000: 239). Interests and intentions are subject to change as is the political context, hence, the time frame needs to be short. Cultural contexts, where respondents are not used to give their opinions, can further limit its usefulness. For the interpretation of responses it is important to consider the position of the respondent within an organization, that his/her views are individual and other external or internal influences on him/her (Varvasovszky/ Brugha 2000: 339). The analyst also needs to reflect his/her own bias through values which he/she brings into the analysis. Stakeholder analysis alone is insufficient for predicting or managing the future, other policy analysis approaches should complement it (Brugha/ Varvasovszky 2000: 239). However, in studies of health care policies and issues, stakeholder analysis plays an important role.

In examples from literature quantitative and qualitative methods were often both used in the same study depending on the context of the research question. As mentioned above it can be useful to complementary employ qualitative and quantitative methods (Wessel 1996: 45). The following study uses expert interviews and participant observation as qualitative methods and a standardized questionnaire as quantitative method, even though the overall study outline is rather qualitative in nature. In view of the complexity of issues concerning decentralization and community participation in India's public health system and the absence of a pre-structured research field a qualitative approach is preferable (see *Ibid.*).

Figure 2.1 shows the study design for stakeholder analysis. Quantitative and qualitative research methods were aimed at different hierarchical levels of the government and the

non-governmental health sector. The selected interview partners are stakeholders in the sense that they are affected by decentralization and community participation policies on the one hand or/and make decisions which have an impact on these processes. Their interests in decentralization and community participation differ and can even be opposing. Expert interviews were employed at the beginning of the research process to collect information to identify interrelationships. This method was chosen because it is useful for structuring new research fields (Wessel 1996: 134). Interview partners included health professionals from the state health ministries from the government sector and from international funding agencies and NGOs from the non-governmental sector. The results from these interviews were incorporated in the research framework. Preliminary field visits to the proposed research areas for the study took place in April and May 2003. Sample interviews with stakeholders (Medical Officers and NGOs) were conducted and later used to shape the study outline. Results from expert interviews and field visits were taken to develop standardized questionnaires for the public health sector and the NGO sector. Data about the status of health services and community participation from secondary sources was hardly available and controversial. Therefore, it was necessary to create primary data. Information from the questionnaires was then coded and analysed in Excel.

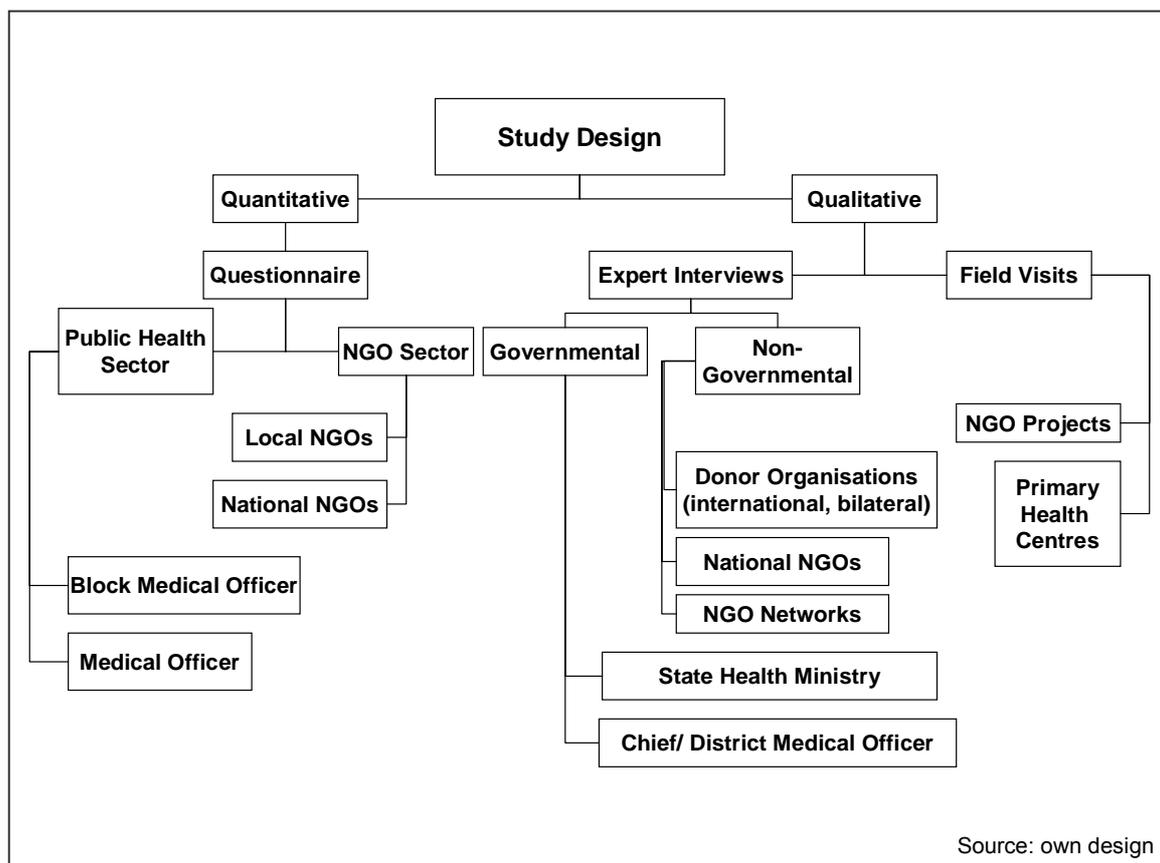


Figure 2.1: Study Design for Stakeholder Analysis

Standardized questionnaires are practical for the research of relatively homogenous groups especially if it is a written interview (Wessel 1996: 104). Although all interviews were planned as oral interviews, part of the interviews with the Medical Officers could only

be conducted in a written form. The same questionnaire was used. Large size of the focus group, time constraints at the meetings of Medical Officers (availability), and spread of their facilities in large areas (accessibility) are the reasons. Written and oral interviews with the same standardized questionnaire were analysed together. Even though the interview situations were different, written interviews in a group on the one hand and individual oral interviews on the other, the closed-ended questions warrant comparability. Freedom of expression and especially critic on superiors are not common in India's society, because relationships are determined by strong hierarchies and interdependencies. Anonymity through standardized questionnaires was therefore guaranteed to obtain unbiased information.

Interviews with and without questionnaire were undertaken in English, an interpreter was only used in rare cases. However, cultural misunderstandings due to language and beliefs have to be taken into account. Since the research was supported through the infrastructure of a bilateral agency (Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)/ German Technical Assistance), bias towards the researcher cannot be ruled out.

Stakeholders selected for this study include health professionals from various levels of the government sector- state, district, block, Primary Health Centre and Sub-Centre level (see Figure 2.1). On the other side non-governmental organizations involved in health projects were interviewed for their views. To generate basic information about the work of health centres and NGOs the standardized questionnaires were used.

The questionnaire for Medical Officers (MOs) engages in general information about MOs, health facilities (location, infrastructure, maintenance, management), organization of work, handling of staff, information transfer, patient information, coordination and cooperation with other health personnel, community, and NGOs, knowledge of patient behaviour, work satisfaction, and recommendations for change (see Annex I and III)². The information is essential for understanding the functioning of the health facilities. Health facilities are the platform where processes of decentralization and community participation take place. Management and organization of health facilities not only point out power structures but also reveal local day to day practise.

The questionnaire for NGOs deals with general information about the organization (registration, working areas, size, funding, issues in health), its target population (knowledge about diseases, health service use and satisfaction), its own work organization, cooperation with community, its relationships with community and health personnel as well as with tasks and potentials of the respective organization (see Annex II and IV). Since it was not feasible to include communities as such in the survey, NGOs were chosen to represent them. "Community are groups of people living in the same defined area sharing the same basic values and organization."(Rifkin 1988: 933). Social fragmentation and heterogeneous power structures in the villages make selection of stakeholders from the community problematic for reasons of involvement and exclusion. Thus, identification of homogenous groups is difficult, if not impossible, and poses ethical

² - Questionnaires were slightly altered after the first case study to generate more detailed information (see 4.2.1.4.)

questions on the researcher. Because selection of stakeholders influences study outcomes and research results, the researcher has to be conscious who he/she does involve or exclude. NGOs are organizations formed by community members and partly reflect local interests. Decentralization and community participation processes in India's public health sector rely on these organizations as intermediaries between the public health sector and the communities. Although NGOs cannot solely be seen as 'voice of the community' since they have own interests, they play an important role in voicing community demands (see 3.3.3.). Furthermore, it was size of research area, time constraints and limited accessibility to village communities which led to the choice of NGOs.

Additionally expert interviews with policy makers and funding agencies were used to acquire more information about experiences and perceptions regarding decentralization and community participation. While some interviews took place at the workplace/office of the interviewed, others were taken at headquarters and official meetings. The influence of the occasion on the interview, i.e. the influence of space, cannot be neglected.

Field visits to Primary Health Centres (PHC) and NGO projects top the survey off. These visits were used for participant observation. Patient-doctor, community-public health system, and community-NGO interactions were the focus of observation. The character of these observations was direct, open, unstructured and participant (Werlen 1996: 138). Results from the observations were used to validate answers from the questionnaires and to evaluate relationships between the different actors.

The chosen methods are relevant to the conceptual framework and can generate rich information about decentralization and community participation in rural India. The sources of information come from the governmental and the non-governmental sector and are able to produce believable explanations (see Curtis et al. 2000: 1003). Reliability of data is further generated through cross comparisons. Thus, bias can be identified and ruled out. Quantitative and qualitative methods are both valuable for this research. The study could not do without either of them because the strengths of each method are employed to answer the research question. While standardized questionnaires generate the basic primary data to structure the research field, non-standardized interviews and participant observation deliver the required information to understand and interpret decentralization and community participation processes at local scale. They also allow the researcher the flexibility to adapt to new challenges in a difficult cultural setting.

The main field work was done from September 2003 till April 2004. The study was carried out to enhance the knowledge of policy makers about participation processes in the health care system. The linkage between NGOs and the primary health care system was of special interest. The findings of this study will be used for the improvement of further decentralization policies in health care.

Participation is essential for equity in health care. Equity research in turn is an important and new field in medical geography. In the social sciences and also in social geography research in inequalities has long been established. The interest of the public health sciences in inequalities, however, has only recently emerged. The strength of geography to address spatial dimensions in social processes will be employed here for the selection

of the spatial level of analysis - the district - and for an inter-area comparison. Hence, this study is soundly embedded in the tradition of geographical research, while at the same time using an interdisciplinary approach – which is another advantage of geography.

2.2. PRIMARY HEALTH CARE APPROACH

Health care systems throughout the world are shaped by the historical patterns of their countries as well as by political, economical and geographical conditions. After their independence from colonial rule many developing countries³ inherited a health system which focused on curative care. Furthermore, it was built to care for a selected proportion of the population only, leaving out the rural poor. Although some achievements in health were reached in the 1950ies and 1960ies, infectious diseases were still widespread. By the 1970ies it became clear that the health systems in the respective countries were not able to achieve the health outcomes desired by the World Health Organization (WHO). The high prevalence of infectious diseases, high infant and maternal mortality rates in the countries of Asia, Africa and Latin America made it clear, that the inherited health infrastructure was not fit to cater for the needs of the population (Hall/ Taylor 2003: 17). It became apparent that low health status was also linked to underdevelopment, low productivity, high unemployment rates, malnutrition, and environmental degradation (Diesfeld 2001b: 46). Poverty was identified as one root cause of diseases (Greinacher 1989).

Not only the United Nations Organizations were concerned with the lack of health care in the Southern countries, but also religious institutions like the World Council of Churches and other governmental and non-governmental organizations (Diesfeld 2001a: 28). UNICEF and WHO called for a global conference to address these issues. In 1978 the conference was held in Alma Ata. The Primary Health Care Approach was established there and became a globally accepted policy instrument. The approach emerged out of the previous experiences of China, Tanzania, Sudan, Papua New Guinea and Venezuela (Hall/ Taylor 2003: 17). Basic health care for poor rural populations was the main concept successfully tried there. The experiences of those countries and the realisation that health care systems needed to change fundamentally in order to address the immense amount of health problems in the world led to the major 7 principles, which were laid out to promote equity in health care (see Box 1). Adaptation of the health systems to sociocultural and political conditions, a turn towards more preventive and promotive care, focus on health education and development of other health related sectors like agriculture and housing were the main points. Community participation and self-reliance at the local level were highly emphasized.

Box 1: The 7 Principles of Primary Health Care

“Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

³ - The author is aware that the term „developing countries“ has been criticised from various sides for its notion of 'backwardness'. Other terms like “countries of the South” or “Southern countries” which are more objective and less burdened with values are preferred. In this work both terminologies will be used as it is done in the development literature.

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.”

Source: Alma Ata Declaration 1978

(http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

In sum the Primary Health Care Approach was a paradigm change from curative, urban based care to preventive, rural based care. This change also required a new definition of health contrary to the medical definition of health. The WHO had formulated in its constitution that health “is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.” (WHO 1946). The Alma Ata Declaration adopted this definition of health. Although the definition had existed for some years, it was only after Alma Ata that its contents were translated into policy guidelines (Magnussen/ Ehiri/ Jolly 2004). All WHO member countries signed the declaration and were, therefore, requested to implement primary health care.

The Primary Health Care Approach can be interpreted in different ways (see for example Diesfeld 2001b, Green 1992, Greinacher 1989, Kölling 1994). Taking a broader view of primary health care, Green points towards the concepts of equity, community participation, a multisectoral approach to health, appropriate technology and a health-promotive and preventive approach (Green 1992). In his view, these are the basic pillars of primary health care, which need to be operationalized for research (see Figure 2.2).

Other authors especially focus on the third principle of the Primary Health Care Approach, which defines the minimum requirements – the so called eight elements of primary health care (Kölling 1994: 21-22). The implementation of these eight elements will take place together with the seven superior principles as mentioned in Box 1. However, whether there are eight or five underlying ideas, the tenor is the same. Definitions are needed to translate theories into actions. In the following sections the focus will be on the five concepts mentioned by Green, since they already incorporate all major points for health care reform.

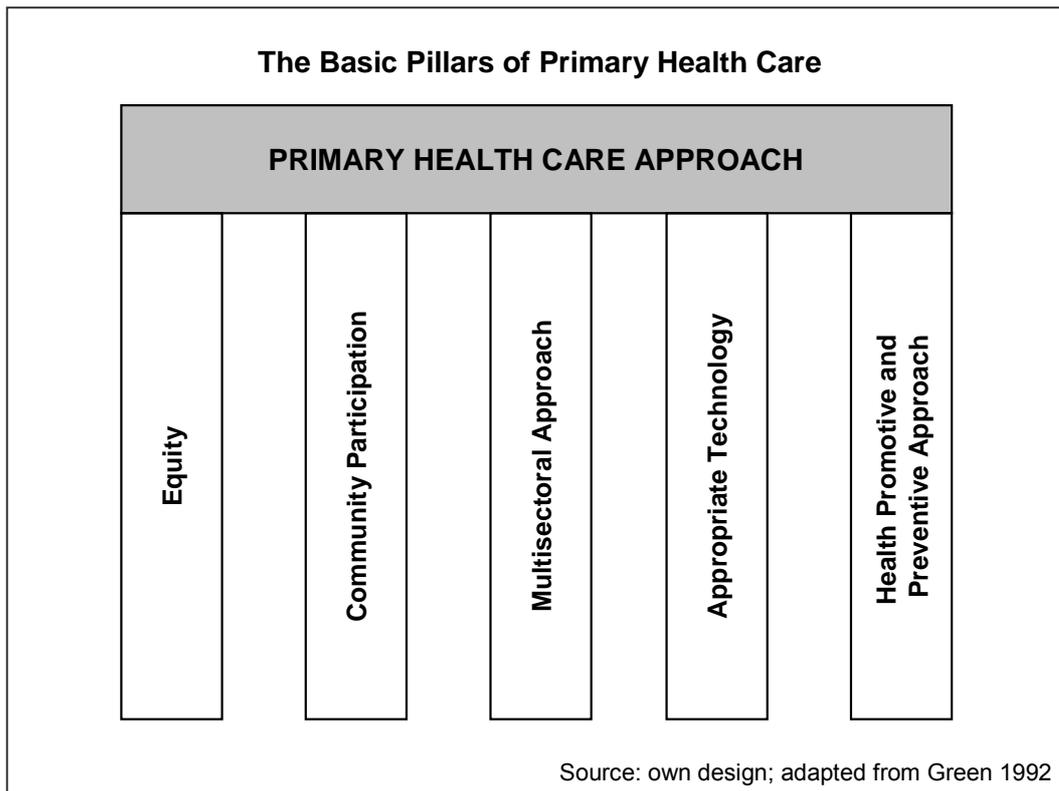


Figure 2.2: The 5 Basic Pillars of Primary Health Care

2.2.1. Basic Principles of Comprehensive Primary Health Care

2.2.1.1. Equity

Equity is addressed in principles 6 and 7 of the Primary Health Care approach (Box 1). In health care research it is often used to highlight the idea of social justice in service delivery, although it is not clear what equity stands for (Waters 2000: 599).⁴ There are two forms of equity. Horizontal equity is reached if equal need receives equal treatment, this would be the case if all poor citizens or all pregnant women with complication are provided

⁴ - Since the equity discussion in health care research is a broad field in both developed and developing nations, it is beyond this study to repeat all of it. See for examples of the discussion the International Journal for Equity in Health.

with the same quantity and quality of care (Green 1992: 57; Meade/ Earickson 2000: 345). Vertical equity suggests different provision of care for different needs or “unequal treatment of unequal need” (Green 1992: 57). Most studies focus on horizontal equity, since it is easier to assess (Waters 2000: 600). For the measurement of equity in the health sector the variables can be health status, distribution of resources, expenditure, utilization, and access (Ibid.; Meade/ Earickson 2000; Navarro/ Shi 2001; Starfield 2001; Whitehead et al. 2001). Often health inequality is assessed in order to determine the level of equity (Gakidou/ King 2002; Houweling et al. 2003). It is important to note that inequality is not the same as inequity, because there can be “inequality without inequity” (Musgrove 2004: 117). Looking at the hierarchy of the terms, inequality is always a part of inequity while inequity also incorporates the legal dimension - the right to health care.

Equity in health status is not only difficult to achieve, since every individual has other health characteristics, but also hard to measure. Even more, it might not be efficient and cost-effective to use resources to equalize health status. However, health variables like infant mortality rate (IMR), crude birth rate (CBR), or crude death rate (CDR) are often used for comparisons between administrative units. They are insufficient to measure the full extent of equity but can show first tendencies of health status in the population. Equal health care resources for each individual are another factor. If a physician or a hospital is available when the need for health care arises, could be the indicator here. However, the availability of resources alone is insufficient. If one person can use the services more than another, there is again inequity in society (Meade/ Erickson 2000: 345). Distribution of resources can be spatial, e.g. location of doctors, or non-spatial, e.g. special health services for disease groups or income groups. Percentage of income used for health services is often applied as indicator for equity. How much a client has to spend for health services depends on the kind of service he/she wants to use, the available insurance scheme, and the economic status of the client. Expenditure for health care can differ enormously among income groups, often with the low income groups spending a much higher proportion of their wages than higher income groups - a clear sign for inequity (Peters et al. 2002). Affordability of health services is also a prerequisite for access. The relationship between health care affordability and utilization rates has been thoroughly researched in the United States (Guagliardo 2004).

Utilization and access to health care have received great attention in equity research. Access is the product of “the availability of services, the possession of the means of access, the non-discriminatory attitudes of health care providers, and the failure of the ill themselves to cope with their situation” (Meade/ Earickson 2000: 381). The factors influencing utilization depend on the approach one chooses. Structure of the health system is the indicator for the organizational approach. Factors such as age, gender, and ethnicity are part of sociodemographic studies. The sociocultural approach looks into variables like religion, health beliefs, and family structures. All of these indicators are useful to assess utilization. Meade and Earickson, therefore, recommend taking a social systems approach to fuse all approaches (Meade/ Earickson 2000: 392). Access and utilization also depend on spatial factors such as distance, which can be map or road distance, time distance, patient mobility, perceived distance, social or economic distance.

Studies have shown that physical access has an impact on service utilization (Hotchkiss 2001: 39). Non-spatial factors include continuum of coverage, socioeconomic barriers (e.g. age, sex, social class, ethnicity), economic constraints, and cultural barriers (e.g. ability to communicate) (Meade/ Earickson 2000: 385-389). Five dimensions of barriers to access have been identified by Penchansky and Thomas in 1981 (Guagliardo 2004). All the above mentioned barriers can be grouped into these dimensions: availability, accessibility, affordability, acceptability and accommodation (Ibid.).

Green suggests that “equal access according to need; and equal utilization of health care according to need” are the closest indicators for equity as it is used in the Primary Health Care Approach (Green 1992: 55). Need is often translated as self-reported morbidity in the past year (Waters 2000). In fact, the formulation of principle six and seven - health for all according to their needs – supports Greens definition. Low et al. distinguishes five health equity goals (Low et al. 2003). Goals three and four, namely “equal access for equal met need” and “equal utilization for equal need” are corresponding to Greens indicators. However, Low et al. perceives these goals as insufficient because equal access means that “less mobile and less educated populations use services less” and equal utilization leaves “determinants of poor health of socio-economically deprived groups” unaddressed (Ibid.). “Equality of health status” is instead the goal where all sufficiency criteria are met (Ibid.). Funding allocation in the National Health Service of the United Kingdom which is based on inequalities of health status is the example used for the fulfilment of the fifth goal. Although one can agree with Low et al. insofar as the highest goal of health care is the wellbeing of the people, hence, a good health status. It has already been argued above that equity in health status is as good as impossible to achieve and very difficult to assess. The 7th principle of Alma Ata concludes with the notion that the health system should “respond to expressed health needs of the community” (Box 1: 7). Therefore, equity in the context of the Primary Health Care Approach can be translated as suggested by Green into the indicators equal access and equal utilization according to need.

2.2.1.2. Community Participation

Community participation is the second principle. In the Alma Ata Declaration community participation contains involvement in all phases of primary health care (see Box 1: 5.). The WHO’s promotion of community participation was greatly influenced by the China example of ‘barefoot’ doctors. This programme consisted of part time health workers which provided basic health services in rural areas. It was very successful in China. For the transfer of this experience it is important to notice, that mobilisation for health in China was part of a much wider socio-economic and political upheaval (Chatterjee 1988: 102). For the understanding of community participation it is essential to find out what community participation is and what its goals are, since the term can be interpreted in different ways. In the Primary Health Care Approach community participation is one goal of health care reform and also a means to reach the other objectives like equity. The expected outcomes of community participation in the health sector include more health consciousness and

knowledge, further pushing up the demand, more access to health care through community-level workers, and improvements of community level health infrastructure (Ibid.: 106-107). The major theoretical framework for community participation has been done by the Cornell University (Uphoff et al. 1979).

The Cornell study is based on questions about the kind of participation, who participates and how participation occurs. Participation may take place in decision-making, in implementation, in benefits, and in evaluation. The participating individuals or groups may be local residents, local leaders, government personnel, and foreign personnel. Heterogeneity in these groups should be considered by looking at age, sex, family status, education, occupation, income, and residence. For the qualitative assessment of participation the 'how' dimension is needed. It asks where the initiative for participation comes from (administrators or local communities), and whether the inducements are voluntary or coercive. Structure and channels of participation are evaluated by considering the basis for participation, which can be individual or collective. Furthermore, it looks if formal or informal organizations are involved and if participation is direct or through indirect representations. The duration and scope of participation and the empowerment are useful indicators too. Empowerment measures if community participation leads to the desired results by the involved people (Uphoff et al. 1979: 5-7). Westergaard criticises the "lack of a theoretical and political framework in which to analyse popular participation" in this study (Westergaard 1986: 22). She considers power to be an important aspect of popular participation. Therefore, a theoretical framework of the causes of poverty, where poverty is "the outcome of a process of increased concentration of power and resources", is needed for studying participation (Ibid.: 24). Since the Cornell study only delivers a vague definition, Westergaard develops a definition out of several studies which includes control as an element of power. Thus, popular participation in her view can be understood as "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from such control." (Ibid.: 25). Other studies also agree with Westergaard that participation is influenced by the political, social, economic and cultural environment (Kapiriri et al. 2003: 206).

While on the one hand community participation is highlighted in financing of health systems under the heading of "use of local resources" (World Bank 1993), other interpretations include the individual's responsibility for her/his own health or the involvement in decisions about health care (Green 1992: 59). For individual responsibility and decision-making knowledge is required. Hence, education and empowerment on an individual and community scale are prerequisites for community participation. Mobilization of additional resources is in turn needed for community participation in the form of community financing. This category leaves it open to which extent individuals or the community can take part in decision-making (Ibid.: 61). Community participation is thought to enhance accountability on the one hand. On the other hand, it also needs the two elements of accountability namely 'answerability' and 'enforceability' to expand (Murthy/Klugman 2004: i78-i79). The degree of community participation as well as the degree of accountability can rank from low to high, depending on issues like who represents

community, depth of community participation or how accountability is operationalized (see Table 2.1, Ibid.: i79-i80).

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents community	Powerful clients	Powerful groups in population; NGOs who represent community	Marginalized groups in population; NGOs who represent their interests
Rationale for CP in health	CP as a means to - expand outreach - raise resources - support infrastructure	CP as a means to - improve management of local health services (efficiency)	CP as a means to - increase effectiveness - improve accountability CP as a right by itself
Depth of CP	Manipulation Informing	Advice/ Consultation	Collective or community decision-making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals Through invitation by government	As members of small collectives Often through invitation by government	As members of mass-based organizations and small collectives Both through invitations and demands from below

Table 2.1: Community Participation (CP): lower to higher degrees of participation (Murthy/ Klugman 2004: i79)

Table 2.1 shows six indicators to assess the degree of community participation. The definition of community is the first criteria. Community can be defined as clients or users, as relatively easy to reach people living in an area or as marginalized groups of the population. The highest degree of community participation is reached if community is defined as marginalized groups of the population who were hitherto excluded following Westergaard's definition (see above). Representation of the community has a similar structure ranging from powerful clients indicating a lower degree of community participation over powerful groups to marginalized groups of the population having the highest degree of community participation. All six indicators show the highest degree of community participation the more people are involved and the higher the level of the

decision-making process is. The classification is very useful to assess the current status of community participation⁵.

Besides the rating of the extent of participation and the selection of indicators for operationalization, it is also important to look at the overall methodology. Rifkin distinguishes between the “top-down” and “bottom-up” approach (Rifkin 1996). In the “top-down” approach planners decide the objectives and then try to convince people to accept them. This approach corresponds with Murthy and Klugman’s classification of lower degree of community participation (see Table 2.1). In this so called “target-oriented frame” the aim of community participation is defined to improve the health status of people (Ibid.: 81). The “bottom-up” approach understands “community participation as the result of community people, essentially the poor, gaining information, access to resources and eventually control over their lives rather being dominated by the authorities (elites) by whom they have been exploited.” (Ibid.: 82). The second approach is also called “empowerment frame”. It corresponds with Murthy and Klugman’s classification of higher degree of community participation (see Table 2.1). Furthermore, it highlights that poverty and poor health is caused by inequities in resource distribution and can only be overcome with a change in the existing power system. For this change information is the key to control and influence.⁶ Rifkin’s definition of participation shows many similarities to Westergaard. Both see control as the end goal of participation. The logical course or hierarchy of participation, namely first gaining information, then access and lastly control, is best explained by Rifkin’s definition. The “bottom-up” approach described by her reflects community participation as it is emphasised by the Primary Health Care Approach.

2.2.1.3. The Multisectoral Approach

The multisectoral approach to health as promoted in the Alma Ata Declaration recognises that many health problems are caused by other factors (see Figure 2.3). Figure 2.3 shows that the patient is influenced by four factors: the state, the professional discourse, the organization of work and social networks. The influence of other sociocultural, economic or political variables on health is now a widely accepted reality within the scientific community (Marmot 2001). Especially the notion of “diseases of poverty” plays an important role for the Primary Health Care Approach (Greinacher 1989). The interrelatedness of poverty and health status was acknowledged in Alma Ata. The influences of poverty on health whether it is through lack of information/education about health, lack of hygiene and sanitation, lack of food etc. are manifold.⁷ In development theories it was long thought that economical development of a country would also benefit the poor. Reality proved this theory wrong. Health policy needs to address the root causes of disease. It is insufficient to start at the curative end.

⁵ - Another important study to assess the progress of community participation has been done by Rifkin, who develops process indicators (Rifkin et al. 1988). Her study is especially useful for programme monitoring.

⁶ - This approach was brought into practice in the health field by Paolo Freire, a Brazilian educator. See Freire, P. (1972): *Pedagogy of the oppressed*. Sheed and Ward: London.

⁷ - for poverty see the vulnerability discussion e.g. Bohle, H.-G. (2002): *Vulnerability*. Special Issue of *Geographica Helvetica*, (57).

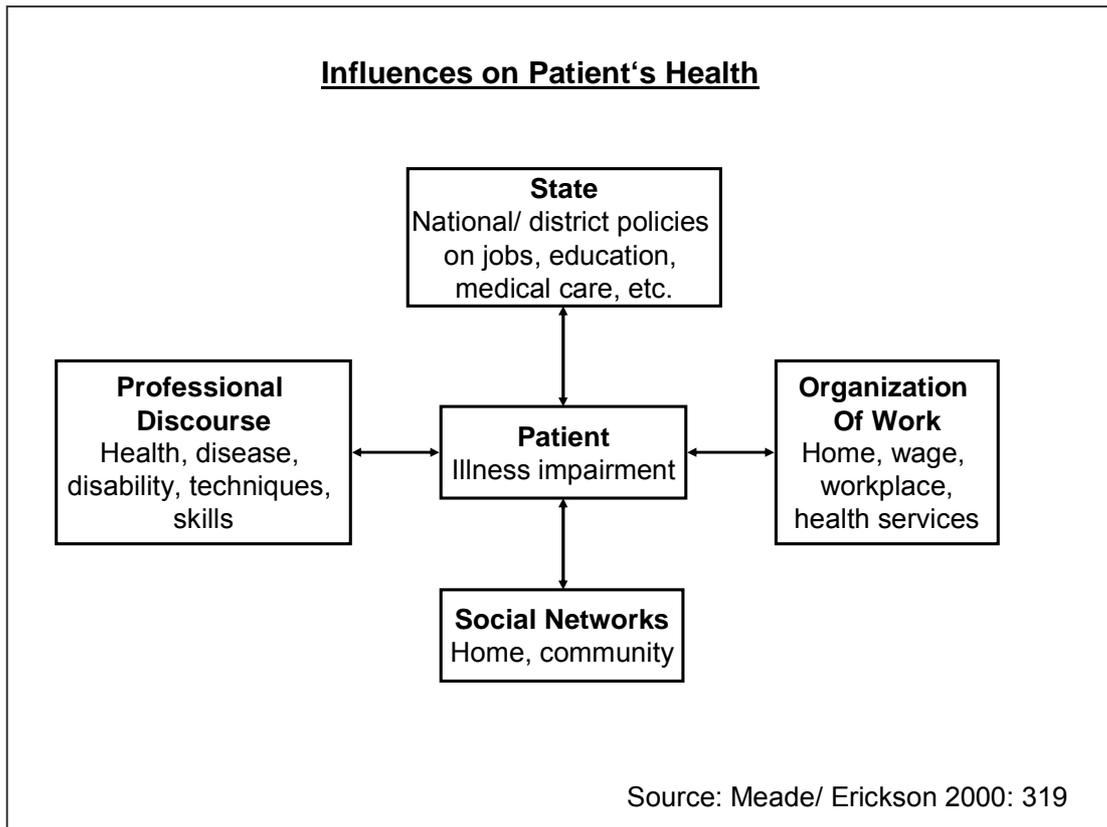


Figure 2.3: Influences on Patient's Health

Therefore, other sectors also have to contribute to achieve 'health for all' as proposed in Alma Ata, either through direct interventions (e.g. safe water) or through indirect interventions. Other sectors have other priorities than the Health Ministry. Together they compete for limited resources from the central budget. Hence, conflicts of interests and power struggles belong to the daily political life on the local or on the central level. Equity in distribution of other resources, be it economical resources, education, or access to water has benefits for health. From the experience of European countries it is legitimate to say that more equity in resource allocation will enhance equity in health and produce a higher health status. This approach chooses a long-term perspective by trying to eliminate the causes of disease.

2.2.1.4. Appropriate Technology

Appropriate technology is the fourth principle of primary health care as emphasized by Green, meaning the employment of personnel and resources according to health-care needs and the socio-economic context of a country (Green 1992: 63). Indicators to be considered are besides the costs, efficacy, effectiveness and acceptability of the health intervention as well as sustainability. One criticism on health care in developing countries brought up by the Primary Health Care Approach was the use of capital intensive Western medicine without adjustment to the specific characteristics of a country (Greinacher 1989). Thus, appropriate technology means to get the best possible health service for the lowest

available costs, which is comprehensive for its users and shows good health results (see also McKinlay 1993: 113).

2.2.1.5. Health-promotive and Preventive Approach

A health-promotive and preventive approach is the fifth principle of primary health care. Preventive measures are often more successful and less expensive and, therefore, the appropriate technology to tackle a certain health problem. However, this is not to condemn curative care as unnecessary but rather to uncover the potential of health promotion and prevention. Knowledge about health is no guarantee for healthy behaviour but it clearly influences individual choices. A better understanding of health has also benefits for the patient-doctor relationship and fosters accountability. Among the 8 elements of primary health care education comes first (see Box 1: 3.), since it is a prerequisite for successful community participation and prevention measures. Especially in the areas of hygiene, sanitation, nutrition for children and babies, prenatal services, family planning etc. can knowledge enhance the health status (Görge 2001: 133). Health promotion for the prevention of diseases is one major goal of the World Health Organization.

2.2.2. Selective Primary Health Care

The Primary Health Care Approach was established in a time when provision of services by the governments was taken for granted in developing countries (Hall/ Taylor 2003: 17). Health services free of charge, centralised health planning and vertical programmes to fight certain diseases were common features of these countries. At the same time Western medicine in its advanced professional state was seen as the means to solve all health problems (Diesfeld 2001b: 48). Traditional medicine in turn was still perceived as backward and unfit to meet the prevailing problems. The dispute between technical advanced but expensive medical care versus less scientifically proven but easily accessible and less expensive care was a typical sign for the wider dialogue about professional dominance of the developed countries and their post-colonial influence in the politics of the developing countries (Kölling 1994). The Primary Health Care Approach opened up new possibilities for traditional medicine with its emphasis on health by the people as it is defined in the 5th principle (see Box 1). However, as mentioned earlier health systems in developing countries were shaped through their history of colonialism, missionary efforts and post-colonial aid. The Primary Health Care Approach meant for those countries to restructure their systems. In a way, this policy requirement incorporated also the hidden idea of democratisation. Participation of population in health system design and planning at the lowest possible level clearly is an element of democracy. Acknowledging that not all developing countries were democracies, this new approach, therefore, did not only call for the restructuring of health systems but also for the creation of new political realities (Green 1992).

Critics on the Primary Health Care Approach came up shortly after Alma Ata. The approach would be too idealistic and too expensive were the main points (Magnussen et al. 2004: 167). Only one year after the conference the concept of “selective primary health care” was introduced by Walsh and Warren (Walsh/ Warren 1979). Cost-effective medical interventions to fight target diseases on a target population are the quintessence of their approach. Since selective primary health care was easier to accomplish, ensured better control over used resources and was more affordable, it quickly became a parallel strategy to comprehensive primary health care as promoted in Alma Ata (Külker 2001: 315). The focus shifted to four vertical programmes: growth monitoring, oral rehydration therapy, breastfeeding, and immunization (GOBI). Later family planning, female education and food supplementation (FFF) were also added. GOBI-FFF was a UNICEF programme. However, selective primary health care was also promoted by WHO and Worldbank. The renunciation of international funding agencies from the Primary Health Care Approach meant also to abandon its principles. The vertical structure of selective primary health care, its values of effectiveness, efficiency and cost benefit and its definition of health as absence of disease make it ignorant towards the broader context of development (Magnussen et al. 2004: 170).

The critiques on comprehensive primary health care already hint at its major problem: the implementation of its principles in the national health care systems. Commercial interest in market shares as well as political resistance to change existing power structures were the major obstacles (Green 1992: 67-68).

2.2.3. Primary Health Care in India

2.2.3.1. Primary Health Care in India before Alma Ata

The guidelines of Alma Ata were wide-ranging. The implementation depended on the political will and the means in the respective countries. India signed the Alma Ata Declaration. Building a health care system after independence was one of the major tasks the new nation had to fulfil. The health care system of the British was highly centralized and racially segregated. The influence of indigenous medicine declined during the colonial times, which was a result of the internal division of its practitioners and the loss of social status as consequence of the promotion of Western medicine through the British (Jeffrey 1988: 57-58). In India the primary health care idea was under discussion long before 1978. The Bhore Committee in 1946 already recommended promoting health and using the health system for preventive as well as for curative care (Duggal 2001). It was this report which provided the framework for later health policies (Jeffrey 1988: 112).

The establishment of primary health units at the village level to bring the service as close to the people as possible, cooperation of the people in the health programme, and adequate medical care for all individuals, irrespective of their ability to pay for it, were included in the Bhore Report (Ranga Rao 1993: 20-21). The report acknowledged that rural provision is the cornerstone for the economic development of the country. The

existing rural-urban disparities were recognised. Therefore, the committee had planned a 3-tier district health scheme with primary units covering a population of 20,000, secondary units for supervision of primary units and extended services covering 600,000 population and the headquarter at the district level (Ibid., Duggal 2001).

Within the scope of the Community Development Programme launched in 1952, the setting up of one Primary Health Centre (PHC) per Block was accepted by the Central Council of Health in 1953 (Ranga Rao 1993: 70). The ratio of PHC to population was thus much lower than Bhore's recommendation. It meant one primary unit for 70,000 people, covering 100 villages (Duggal 2001). Gradually the number of PHCs rose from 725 in the 1st five-year plan to 22,842 in the 9th five-year plan 2001 (MoHFW 2003: 167). For each PHC several Sub-Centres (SC) were created which serve as first contact point.

The above mentioned concepts include elements of the later Primary Health Care Approach. Equal distribution of resources according to population ratio, more access for rural communities, participation of the people, and the removal of disparities are some of them.

2.2.3.1.1. The Health Committees

In a time when India struggled to establish a solid democracy despite widespread poverty, social unrest, famine and epidemics, several committees were established to assess the progress of and recommend health care reforms which promoted basic health services for all. The committees were named after their chairpersons Mudaliar (1959), Chadah (1963), Mukerji (1965), Mukherjee (1966), Mungalwala (1967), Katar Singh (1973), and Shrivastava (1975) (Ranga Rao 1993: 22-26).

The report of the Mudaliar Committee stated that not much improvement in health infrastructure and health outcomes had taken place (Duggal 2001). Funds were committed to urban areas and personnel were reluctant to go to rural areas. The recommendations included the demand for qualitative improvement of primary health care e.g. consolidation of PHCs (Ranga Rao 1993: 23). Integration of health and family planning and the introduction of one male and one female multi-purpose worker per 10,000 population to deliver the services was proposed by the Chaddah Committee in 1963 (Duggal 2001). Home visits and collection of vital statistics were included into their work schedule (Ranga Rao 1993: 23). The Mukherjee Committee in 1966 was mainly concerned with the Family Planning Programme. It suggested a vertical structure for the programme. The next committee in turn favoured the integration of all levels in health organization and personnel (Mungalwala Committee). Instead of segmentation into different programmes it called for a unified approach for all problems (Ibid.: 24). The Katar Singh Committee in 1973 had been asked to recommend a structure of integrated services, assess the feasibility of appointing multi-purpose workers and examine the mobile family planning unit for integrated medical and public health work (Ibid.). Accordingly the conversion of uni-purpose workers into multi-purpose male and female workers was planned (Duggal 2001). Medical education and manpower were on the agenda of the Shrivastava Committee. The employment of paraprofessional or semi-professional workers from the community itself as a link between the Sub-Centres and the

community to provide simple services was one proposal (Ibid.; Ranga Rao 1993: 25). Solving the lack of doctors for rural areas through the opening of more medical colleges was marked insufficient. Therefore, they opted for the Community Health Worker scheme. The recommendations of the different committees already incorporate the major concepts of the Primary Health Care Approach as described above. Equity in health care through equal distribution of financial and human resources to rural areas is apparent in all reports. Direct access to the health services through health workers was proposed in 1963, which picked up Bhore's recommendations. Community participation in the Community Health Worker scheme, appropriate technology and promotive and preventive interventions are highlighted. However, the multisectoral approach apparently did not receive much emphasis in the committee's recommendations. Although principles of primary health care are included in the different recommendations, it becomes clear from the repetitions in these reports that the implementation either did not take place or that it was not successful. To obtain a holistic picture of the health care system in India before Alma Ata, it is important to look at another influential commission.

2.2.3.1.2. The Planning Commission

The health system was more influenced by the decisions of the Planning Commission (Ranga Rao 1993: 22-26). The Planning Commission is the most influential political body in India. All budget allocations for the five-year plans are decided there. The budget distributed by this commission was not always in line with the committee's recommendations. Examining the allocation of resources for health care gives an insight into political priorities of the Indian government. The Planning Commission does allocate the budget to all sectors. While India focussed very much on economic growth and agricultural development, the social sector including health and education had a low priority (Duggal 2001). Economic uplift and secure food supply for the ever growing population were the burning issues at hand. Agricultural programmes like the "Green Revolution" received highest attention.

Jeffrey did a detailed study on plan and non-plan expenditure in health care till the 6th five-year plan (1980-85) (Jeffrey 1988: 146-166). He found that the Planning Commission had favoured preventive health care and had directed expenditures towards primary care. Furthermore, the influence of foreign assistance on the commission had created pressure for preventive, single-disease control programmes (selective primary health care), which were dominant in the 1960ies. Finally he states that the share for family planning measures has increased, while the overall government budget for health and health related issues declined in absolute terms if measured in percentage of GDP. Contrary to Jeffrey, Duggal says that three-fourth of medical care resources were still directed to urban areas during the first two five-year plans (1951-56; 1956-61), while the Community Development Programme aimed at rural areas failed (Duggal 2001). The difference in opinion can be linked to the different viewpoints. While Duggal puts more emphasis on basic health facilities and, therefore, highlights infrastructural aspects of primary health care, Jeffrey also includes the individual communicable disease programmes into his considerations. Jeffrey relates the variations in expenditure not only to the kind of party in

power but also to macro-economic events like the rise of oil prices during the 5th five-year plan (1974-79) which led to drastic revisions (Jeffrey 1988: 153). The influence of foreign assistance on special programmes has already been mentioned above. Although the Planning Commission is influential in allocating the budget for the sectors, it has no control over the actual expenditure of states. Jeffrey finds that actual expenditure is 0.3 to 0.6 % lower than the plan outlays (Ibid.: 158).

The health care system in India before Alma Ata was not able to adequately serve the population of the country. Family planning and management of epidemics were more important in the five-year plans than the extension of primary health care in rural areas. The programmes started as early as 1951 and 1953 respectively. From the 5th five-year plan onwards family planning received the single largest share in the health sector outlay (Duggal 2001). Reforms undertaken were not successful in improving equity in health care or the quality of the service. The health system, which still lacked infrastructure and resources, was not open for participation.

2.2.3.2. Primary Health Care in India after Alma Ata

2.2.3.2.1. The National Health Policy 1983

India's first National Health Policy was formulated in 1983 following a time of political and economic uncertainty in the country. The state of National Emergency under Congress rule from 1975 to 1977 with its forcible campaign to control population growth was shortly replaced by community-oriented approaches of the Bharatiya Janata Party (BJP) government. A severe drought in 1977-78 led to rising food prices and unsettled India's economy. The Congress party, who was not in power when the Alma Ata Declaration was signed by India, was reelected in 1980. While the National Health Policy pays its tribute to Alma Ata in promoting comprehensive primary health care, it also shows some resemblance to the Bhore committee recommendations of 1946 (Ranga Rao 1993: 28-33). In the 1980ies slow progress towards better health was made through expansion of the rural health care infrastructure, the Universal Immunization Programme (UIP), and the Integrated Child Development Service (ICDS) Scheme (Chatterjee 1993: 345). Although the number of Primary Health Centres and Sub-Centres grew, it could not keep pace with population growth. Instead of staying ahead of development, the health system stayed behind. Meeting numerical targets was on the forefront of the agenda, putting quality issues behind. Opening up new Primary Health Centres sometimes only meant to put up a new sign board in front of a Sub-Centre (Ranga Rao 1993: 72). The population was not involved in the establishment of Primary Health Centres. The location of these centres often did not follow practical considerations but was rather a result of the struggle of economic and political influence between villages (Ibid.: 77-81). Furthermore, having a Primary Health Centre on paper does not essentially imply that there are personnel or equipment available. Doctors were in short supply, despite the large number of students graduating in medicine each year. To attract more doctors to the rural areas, their administrative tasks were lessened through the introduction of Community Health Officers at the Primary Health Centres in the 1980ies (Chatterjee 1993: 348). The officers were to

manage health centres, so that the doctor could concentrate on his medical tasks. However, the training of Community Health Officers was slow and only introduced in a few states. Having a manager and a doctor at the centre at the same time led to power struggles since the hierarchy was not clear. The National Health Policy also envisioned to retrain medical and paramedical staff in community health needs. The refresher courses given could not achieve manpower reorientation. Solutions to improve the inadequacy of the system were sought. Management courses, motivational training, introduction of management information systems and 'information, education and communication' (IEC) programmes were the steps taken. All these programmes tried to create awareness at the health personnel and to generate quality in health care. The IEC programme was planned to generate accountability, following the Primary Health Care Approach in educating the people and thereby creating demand for services. Since the same people who delivered the services were in charge of IEC, they gave little priority to the programme (Ibid.: 349). Unfortunately, the programmes were not successful, because they were not able to remove the lack of understanding of preventive health care. The failure of these programmes results from several factors. First, the large size of the health system made it difficult for the administration to handle training programmes for the whole workforce. Second, the paucity of good training institutions and trainers constrained the upgrading of skills. Third, the limited financial resources prevented the opening of new institutions. The expansion of rural health infrastructure in numbers, thus, has to be read with care, since it does not include quality issues or functioning of the centres.

2.2.3.2.2. The Community Health Volunteer Scheme

After briefly examining the recommendations of the National Health Policy 1983, it is important to look into the implementation of programme components which can be linked to the Primary Health Care approach in their outline. The main focus will be on the Community Health Volunteer (CHV) Scheme of 1977 and other efforts to increase community participation. Using community health workers was already a part of the recommendations of the National Planning Committee 1946. It was planned to train young men from the villages for 9 months in simple curative care and hygiene for primary health service at the village level. However, the government put the programme aside in 1951, stating that it did not want to give less qualitative care to villagers than to urban dwellers (Jeffrey 1988: 228). It was voluntary agencies which picked up the idea in the 1960ies and 1970ies, and used auxiliary personnel for the delivery of primary health care. Successes from the voluntary sector in India received international recognition and together with the China example of "barefoot" doctors served as role models for the Indian government (Ibid., see above Srivastava committee). When the Bharatiya Janata Party (BJP) government came to power in 1977, it adopted the approach but changed the length of training to 3 months. Additionally, it was planned to add one doctor per Primary Health Centre for training purposes. The implementation progress was slow and further delayed by the reelection of Congress in 1980. By then India had signed the Alma Ata Declaration. The new government renamed the programme in Community Health Volunteers (CHV)

Scheme. Completion of training of all CHVs was planned for 1984. All states except Kashmir, Kerala and Tamil Nadu implemented the scheme.

In this programme community participation followed a “top-down” approach. Although, the selection of one person per village for training lay in the hand of the community itself, the community was neither involved in the planning phase, nor had any other influence on the programme. Given the huge financial commitment necessary for this programme, Jeffrey finds it surprising that it was implemented despite the lack of demand for it (Jeffrey 1988: 230). Demand here means the articulation of wishes by the rural people themselves. The programme was thought to enhance access to health care, assuming that there is neither a spatial nor a social or cultural barrier to address a local person. Furthermore, the volunteers were to increase the health knowledge in the villages and promote preventive measures, thereby bringing primary health care in every village. First problems arose with the selection process. Local elites used their influence to choose their favourite candidates (Greinacher 1989: 49). In turn they expected the candidates to influence the decisions of villagers in other matters. The training focused mostly on curative aspects, while social aspects were not taught (Chatterjee 1993: 360). Therefore, community health volunteers lacked a clear role definition. While they were intended to be accountable to the community, the communities viewed them as government workers. The misconception of their role was nurtured by three aspects. One was their orientation away from primary health care, secondly they got paid a small fee of Rs. 50 by the government, and lastly they were used by the Primary Health Centre staff in their family planning and malaria programmes (Greinacher 1989: 50). The scheme was further criticised by the Indian Medical Association to produce quacks since some people used the training to start up their own private health practice. After the government reduced its support by 50 % in 1981, several states backed out of the programme not willing to bear the remaining costs. The emphasis on community participation was to improve the health of people rather than empowerment, thus following Rifkin’s “top-down” approach. Although the outlay of the Community Health Volunteer scheme incorporated primary health care issues, the implementation was not successful.

2.2.3.2.3. The Integrated Child Development Service Scheme

The Integrated Child Development Service (ICDS) Scheme was launched in 1975 and includes a package of services like supplementary nutrition, immunization, health check-up, referral services, treatment of minor illnesses, nutrition and health education for women, preschool education of children in the age group of 3-6 years, and convergence of other supportive services like water supply, sanitation etc. Target groups are children below 6 years, pregnant and lactating women, women in the age group of 15-44 years and adolescent girls in selected blocks (Kishore 2002: 156). The programme is community-based. A local woman is selected and trained for three months to become the Anganwadi worker. She then works in the village covering a population of 1000. In the Anganwadi centre (childcare centre) she prepares and distributes food, maintains growth charts, weighs children and gives non-formal education to the beneficiaries. The Anganwadi also cooperates with the Primary Health Centre staff for health check up,

immunization and referral. The programme started in 33 experimental blocks and expanded to 2996 projects by 1993 (Kishore 2002: 155).

The programme encountered several problems. Communication with the health staff of Primary Health Centres was weak. The programme was more perceived as a feeding scheme by the communities and demand for health services did not increase (Chatterjee 1993: 356). Further, the food was thought as a supplement, but often poor families redistributed their food accordingly, leaving the beneficiary child with the food from the Anganwadi only. The educational efforts fell short to increase health knowledge of mothers, thus, prevention of malnourishment was not achieved. At the begin of the programme participation mechanisms were included, asking the villagers to provide accommodation and to ensure participation of the children. They also were to select the Anganwadi worker. With the rapid expansion of the programme, community participation was cut short. The selection process showed the same mechanisms as in the CHV Scheme. Women with higher educational qualifications and the right connections were preferred. Although the programme was a success in terms of immunization and nutrition coverage, the impact on nutrition status was low. It was found that “children in ICDS areas have similar nutritional status to those in non-ICDS areas” (Chatterjee 1993: 357). Nevertheless, the ICDS Scheme continues till today.

2.2.3.2.4. The Universal Immunization Programme

The Universal Immunization Programme (UIP) was introduced in 1985 for the immunization of infants and pregnant women. With the support of UNICEF an extensive cold chain was established, which was an enormous effort given the prevailing infrastructure. The public health campaign started was huge and involved also non-governmental organizations. Posters, slogans, radio and television messages were used to inform the villagers about the programme. By 1989 the programme covered all districts of India. Special officers at the district level were appointed for supervising the delivery of the programme through the already existing workers. The programme was a success in its outreach. In 1990 between 70 to 80 % of the target children were immunized (Chatterjee 1993: 352). On the one hand the programme showed that it is possible to provide health services even in remote villages. On the other it also highlighted differences in implementation and outcome between states, districts or blocks even though it is a centrally sponsored programme. Chatterjee finds that “in UIP, the worst performance occurred in the States with the worst health situations and, thereby, greatest preventive health needs.” (Chatterjee 1993: 353).

2.2.3.2.5. Non-governmental Organizations

Another effort to increase community participation was the attempt of the government to involve non-governmental organizations (NGOs). The successes of voluntary organizations in their own health programmes lead to the question what and how these organizations could contribute. NGOs involvement ranges from conducting research over training of government workers to running and managing government health facilities. However successful these NGO endeavours have been, for example in community

participation, the government was slow to adopt these new ideas. Only few NGOs decided to take over Primary Health Centres, with mixed successes. Bureaucratic constraints, resistance of private practitioners and government staff at the centre, payment delays and lack of support from the district authorities hindered the smooth running of the Primary Health Centres (Vishnu/ Sudarshan 2003: 56). Furthermore, the outreach of NGOs is limited to a small amount of people and areas.

2.2.3.2.6. Conclusion

Despite several attempts India was not able to realise comprehensive primary health care as it was promoted in Alma Ata. Partial success has been achieved with some of the programmes implemented like UIP, ICDS or CHV (see above). In all these programmes communities could only participate in the benefits but were not involved in the planning or implementation. The outline of programmes was determined by the central policy makers. The influence of local government employees was limited. Their lack of training and, therefore, lack of knowledge regarding the basic principles of primary health care made it difficult to strengthen health prevention and promotion. The curative focus of care prevailed. The influence of stakeholders like local party members or other powerful people affected the location of health centres. Hence, the distribution of resources was not even. Equal access according to need and equal utilization according to need is, thus, not possible. The highest rating for equity was achieved with UIP, when a universal coverage in immunization services was reached for all beneficiaries. However, UIP as a vertical programme was not linked to other health issues even within the health sector. The multisectoral approach was missing in all these programmes. If multisectoral programmes were tried out like in the Community Development Programme or the Minimum Needs Programme either health did only play a minor role or the focus was solely on health issues. In a way the development in India described above also reflects progress in other developing countries. Successes in immunization programmes and oral rehydration therapy in the 1980ies and failures to control communicable and non-communicable diseases, in particular HIV/AIDS, tuberculosis and malaria, indicate the problems with the implementation of the Primary Health Care Approach (Sanders 2003: 16).

2.3. DECENTRALIZATION OF HEALTH CARE

The failure to implement comprehensive primary health care became increasingly linked to the centralistic features of states. Central control mechanisms were criticised for their inefficiency and unawareness of population needs. Thus, the centralistic features of states were seen as the reason for the failure of the Primary Health Care Approach. The spatial distance to beneficiaries of health programmes was held responsible for the lack of knowledge about health care needs of the population. Therefore, decentralization became important for the health sector in developing countries in the 1980ies (Omar 2002). The first move towards decentralization was the introduction of health districts by WHO in 1987. Health districts incorporate comprehensive primary health care but are a smaller administrative unit for its implementation. The concept requests the transfer of decision-making power from the central to the district level. A fully functioning district unit needs its own budget, access to essential medicaments, and authority in personnel matters (Külker 2001: 318-319). The World Bank report "Investing in Health" 1993 marks another clear turn towards selective primary health care and decentralization (World Bank 1993).

Promoted by money transfers through development aid and supported by international organizations such as the World Bank (Eckardt 1998), decentralization was soon seen as an end in itself. It was perceived as an administrative reform which could improve the quality of health care. Although decentralization has been the driving force behind health sector reforms in many African, Asian and Latin American countries, few empirical studies on the actual impact exist (Ibid.). Bossert especially criticises the lack of a "common analytical framework to examine the relationship between processes and types of decentralization and actual performances in the health sector." (Bossert 1998: 1513). Bossert's critique draws on the fact that the term decentralization is used in many different disciplines and with different definitions. Furthermore, as a reform process decentralization comprises a complex set of factors. It is not one single process but rather many.

2.3.1. Frameworks for Decentralization

Bossert distinguishes four frameworks for the analysis of decentralization: the public administration approach, local fiscal choice, the social capital approach, and the principal agent approach (see Figure 2.4; Bossert 1998). It is useful to distinguish between these approaches since the literature on decentralization presents a mixture of definitions, goals, and specifications for the term and often does not place it within a special framework. Additionally to the four frameworks Bossert introduces the decision space approach.

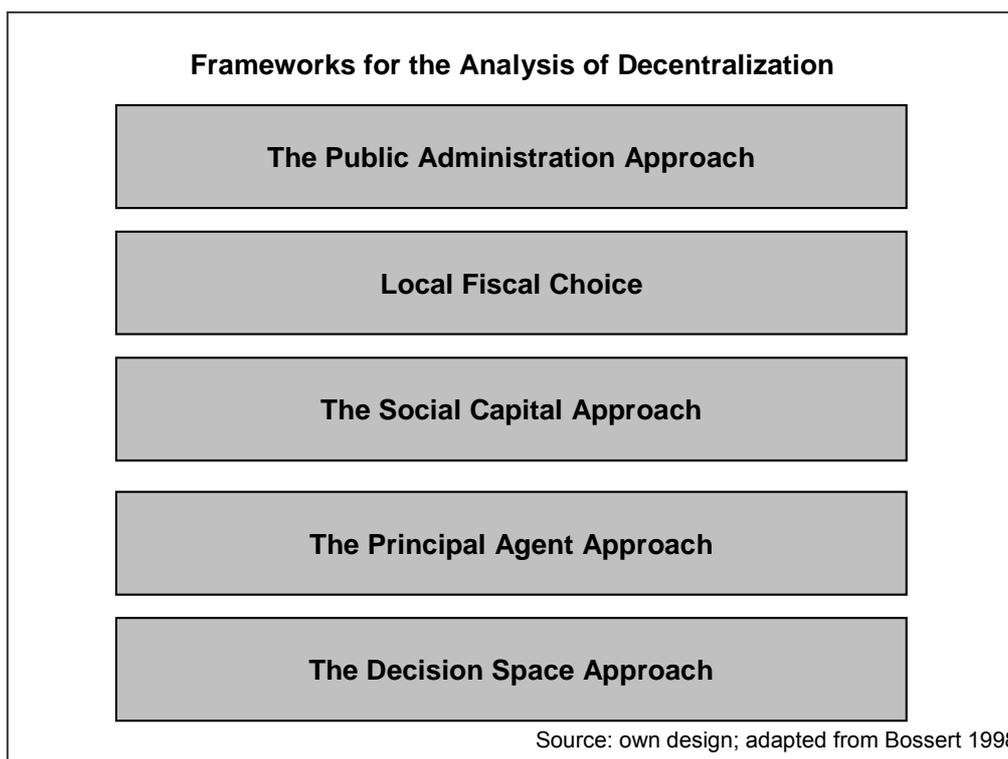


Figure 2.4: Frameworks for the Analysis of Decentralization

2.3.1.1. The Public Administration Approach

The public administration approach is widely used and was developed by Cheema and Rondinelli. They distinguish between four forms of decentralization on the basis of objectives: political, spatial, market, and administrative decentralization (Cheema/ Rondinelli 1983). Among the four forms it is administrative decentralization on which most of the literature is focussed. Administrative decentralization is used to “describe or reform hierarchical and functional distribution of powers and functions between central and non-central governmental units” (Cohen/ Peterson 1996: 10). “Deconcentration”, “devolution”, “delegation” and “privatisation” are the four types of administrative decentralization which are used in most of the literature on decentralization (Omar 2002; Metzger 2001; Bossert 1998; Cheema/ Rondinelli 1983).

Following Cohen and Peterson’s definition of the four types from Cheema and Rondinelli, “deconcentration” is the transfer of authority over specified decision-making, financial and management functions by administrative means to different levels under the jurisdictional authority of the central government. “Devolution” is the transfer of authority from the central government to local-level governmental units holding corporate status under state legislation. “Delegation” is the transfer of government decision-making and administrative authority and/or responsibility to institutions or organizations that are either under its indirect control or independent. (Cohen/ Peterson 1996: 10-11). While deconcentration is the least extensive form of decentralization, it is also the most common form of the three (Ibid., Metzger 2001: 72). Devolution in turn is the most extensive form of decentralization.

Although the forms and types of decentralization described above bring some clarity into the discussion of decentralization, they are not without critique. Eckardt quotes several authors criticizing the lack of aspects of allocation, pointing out that the definition is too wide, that the political dimension of democracy is not sufficiently incorporated, and that the concept can be misused by authoritarian regimes (Eckhardt 1998: 7). In her opinion it is the analysis of the goals of decentralization in relation to the used measures which is missing in the definitions and also in most of the studies. Furthermore, the literature also puts little emphasis on the analysis of effects of decentralization (Ibid.: 8). Although the definition identifies the process as such, it is indeed not clear what goals political decision-makers follow when they employ deconcentration, devolution and delegation.

2.3.1.2. Local Fiscal Choice

The local fiscal choice approach comes as the name already implies from the economic sciences to analyse local government choices of resource spending and intergovernmental transfers. It is not a market form of decentralization, since market forms deal with the production of goods and their distribution according to individual preferences (Cohen/ Peterson 1996: 10). Metzger introduces fiscal decentralization as a fifth form⁸. He uses the term to describe fiscal federalism and national cash flows which complement the fields of political and administrative decentralization (Metzger 2001: 78). Local fiscal choice can be seen as a fiscal form of decentralization. In this approach competition for mobile voters are the basis for local government decisions about resource mobilization and allocation (Bossert 1998: 1513). The presumption that local voters and therefore tax payers are mobile enough to choose the local government offering them the best conditions is overly optimistic. In most developing countries taxation is centralized and local resources are small, therefore, it is less realistic to assume a competitive scenario among local authorities for voters (Ibid.). Other political factors which also influence decision-making like clientalism, patronage, or local elites further limit the response of local authorities to the median voter. However, the approach focuses on local decision making, accountability of local authorities, and the use of local resources. Its strength lies in the concentration on the local scale.

2.3.1.3. The Social Capital Approach

The social capital approach was introduced in decentralization studies by Putnam (Putnam 1993). He links better institutional performance of decentralized governments to the density of civic institutions. For Putnam the density and tradition of civic institutions in an area create expectations, experiences and trust among the local population which form the social capital. Social capital, thus, generates more participation of the local population and, therefore, fosters accountability. Bossert adopts his approach to health care,

⁸ - see above: the other forms of decentralization are political, spatial, market, and administrative as developed by Cheema/Rondinelli 1983 and Rondinelli/ Nellis/ Cheema 1984 and described in Cohen/Peterson 1996

suggesting that “localities with long and deep histories of strongly established civic organizations will have better performing decentralized governments than localities which lack these networks of associations.” (Bossert 1998: 1516). But he also criticises Putnam’s approach for the lack of policy relevant conclusions. The social capital approach does not allow assumptions about areas with no civic institutions, despite the insight that decentralization will not work there. Since developing countries rarely have a history of strong civic institutions, this theory is not politically viable. However, Atkinson proposes to use Putnam’s findings for researching the influence of local social organizations and political culture (Atkinson 2000: 620).

2.3.1.4. The Principal Agent Approach

The principal agent approach comes from the economic sciences. In research it is often used to analyze intergovernmental transfers, the bargaining between local and central levels of government, and in the field of health care also for the research of provider-patient relationships (Bossert 1998: 1516). Silverman distinguishes between “top-down” and “bottom-up” principal agency (Silverman 1992: 2). In the context of “top-down” principal agency, local governments exercise responsibility on behalf of central governments or parastatals. In the “bottom-up” principal agency model, various levels of government or government parastatals act as agents of lower level of governments or directly as agents of beneficiaries/ users/ clients (Ibid.). Most of the literature only reflects the “top-down” principal agency, where the principal is “an administrative agency at the centre, which delegates, through legislation or contract, to a local-level governmental or private sector institution or organization (the agent) the authority to deliver health care to the citizen beneficiaries (client).” (Cohen/ Peterson 1997: 13). Thus, the principal uses the agent for the implementation of its objectives. Agents usually have other interests and more information than the principal. The principal has to generate incentives for the agent in order to ensure its cooperation and the delivery of information. Control of information and improved monitoring are central issues in this approach. In health care the Ministry of Health or the district health authority could be the principals who use local authorities or medical officers as agents. The approach sees these relationships as dynamic and assesses how performance is monitored and incentives and punishments are shaped (Bossert 1998: 1516-1517). The “bottom-up” principal agency incorporates the idea of community participation. Although actual examples of this approach are rare, some attempts to use this approach in primary health care have been encouraging (Silverman 1992: 2).

2.3.1.5. The Decision Space Approach

However, for Bosserts research all these approaches have shortcomings. Thus, he introduces the decision space approach as a modification of the principal agent approach. He defines decision space “as the range of effective choice that is allowed by the central authorities (the principal) to be utilized by local authorities (the agents).” (Ibid.: 1518).

Decision space can be divided in formal and informal space. While laws and regulations define the formal side of decision space, their absence or lack of enforcement shape the informal side. Bossert examines the range of choice for different functions of local governments in finance, service organization, human resources, access rules and government rules (see Table 2.2). The range of choice and how this decision space is used by the agents affects the performance of health care reforms. The different functions help to understand decentralization not as a single transfer of power but rather as incorporating many processes. For each function an indicator is defined. The range of choice shows the degree of influence of central control through the principal on the agent. The more control is exercised by the central level, the narrower is the decision space for the local agent. The decision space approach can therefore help to advise governments on how to decentralize functions to local governments and what extent of decentralization is useful to achieve the desired levels of performance. It is also an useful approach to assess the current status of decentralization.

Function	Indicator	Range of Choice		
		narrow	moderate	wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total health spending	High %	Mid %	Low %
Allocation of expenditure	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Insurance plans	Choice of how to design insurance plans	Defined by law or higher authority	Several models for local choice	No limits
Payment mechanisms	Choice of how providers will be paid (incentives and non-salaried)	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms
Human resources				
Salaries	Choice of salary range	Defined by law or higher authority	Moderate salary range defined	No limits
Contract	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service

Access rules				
Targeting	Defining priority populations	Law or defined by higher authority	Several models for local choice	No limits
Governance rules				
Facility boards	Size and composition of boards	Law or defined by higher authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by higher authority	Several models for local choice	No limits
Community participation	Size, number, composition, and role of community participation	Law or defined by higher authority	Several models for local choice	No limits

Table 2.2: Map of Decision Space
(Bossert 1998: 1519)

2.3.2. Benefits of Decentralization

For the research of decentralization it is essential to look into the relationships between actors, as it is the case in the principal agent approach and in the decision space approach, and also into the socio-economic and political environment. The importance of social organizations and political culture in the assessment of decentralization of health care has been highlighted by Atkinson and others (Atkinson et al. 2000). While the frameworks explained by Bossert look into the internal processes of decentralization, it is still unclear what decentralization seeks to achieve in the health care sector.

Among the goals of decentralization greater involvement of communities is a central issue (Mills et al. 1990: 31). Other benefits emphasised by WHO include more rational organization of health services, containment of costs, less inequalities through selective reallocation of resources, closer integration of services, better implementation, greater community financing, more intersectoral coordination and less delays through long distances (Ibid.: 142). Financial aspects are obviously more dominant now. The influence of the World Bank also affected WHO policies. The World Bank emphasised economical losses for states through disease with its concept of DALYs (Disability Adjusted Life Years) (World Bank 1993). It recommended that investments should be made in order to maximise gains in DALYs (Duggal 2001). However, Atkinson states that the key feature of decentralization is “that increased local autonomy over decision-making combined with inputs of voice from the population to be served will increase the responsiveness of health care to local needs, accountability of the actions of the health system to its client population in terms both of the quality of care offered and the use of health system resources and also to social development goals of popular empowerment.” (Atkinson et al. 2000: 621). Figure 2.5 summarises her definition. Her approach incorporates decentralization and participation and links their functions to quality of health care. It can therefore help to understand the influence of decentralization and participation on the health care system and to estimate possible improvements through these reforms.

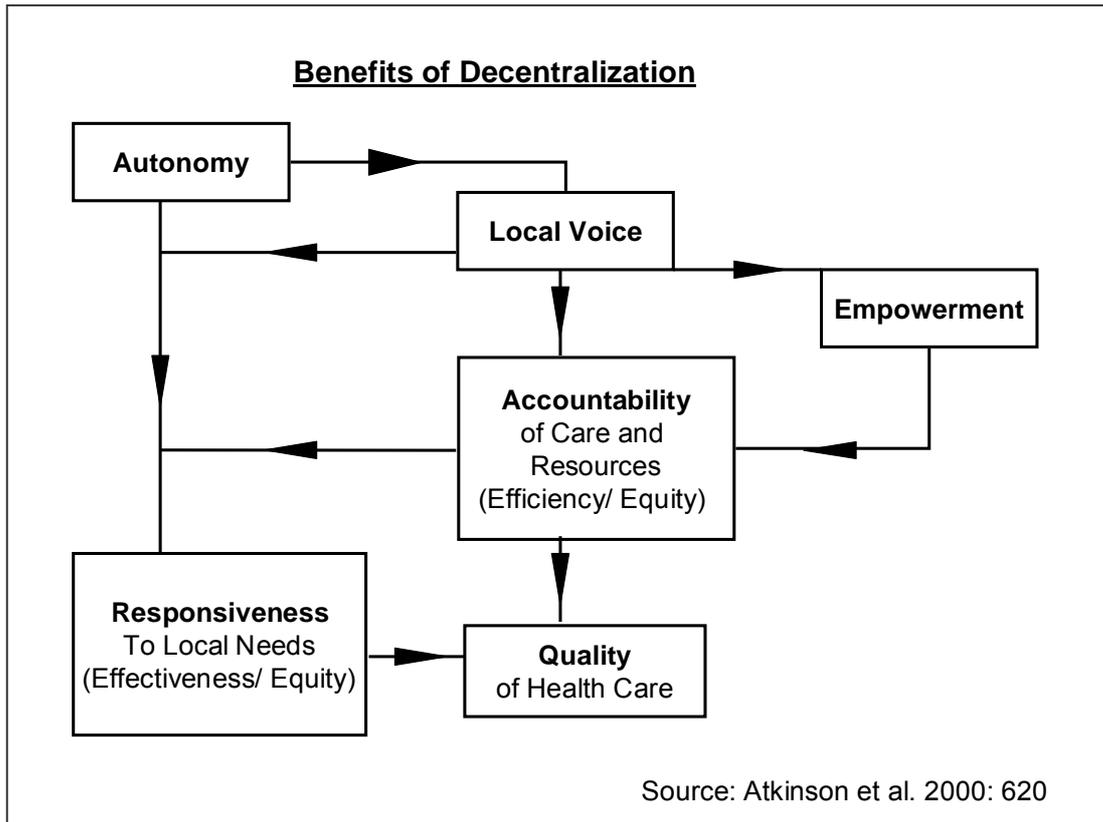


Figure 2.5: Benefits of Decentralized Management of Health Care

2.3.2.1. Community Participation

The benefits of decentralization include primary health care goals. “Local Voice” can be translated as community participation, which is also one of the central demands of the Primary Health Care Approach (see above). The aim of community participation is eminent in most of the decentralization literature (Metzger 2001; Eckardt 1998), even if it is hidden under the heading of accountability (Cohen/ Peterson 1997). Metzger defines participation as the active involvement of population in one area in assemblies, data generation activities and transmission of information to local administration (Metzger 2001: 80). He further uses the Cornell framework for the analysis of participation (see above, Uphoff et al. 1979). In his opinion, participation is needed for the functioning of decentralization, because it facilitates accountability. To forecast the extent of participation researchers have to ask four questions: (1) to what extent is the population interested in participation; (2) how much participation is possible with the actual educational status of the population; (3) which possibilities for communication and information transfer for the implementation of participation exist; and (4) how can motivation for participation be made sustainable (Metzger 2001: 83). The questions already stress the importance of interest, knowledge, communication channels and motivation. Metzger uses the rational choice theory for the interpretation of interest in participation. Following this theory he concludes that participation takes place in anticipation of the benefits of social recognition, new communication channels, and to take pleasure in tasks associated with participation (Ibid.:

84). It is crucial to distinguish between extrinsic motivation (expected benefits at the end) and intrinsic motivation (benefits through action as such). Therefore, participation can only take place in association with motivation. Eckhardt sees participation not only positive since the legitimation of participating individuals and groups is often diffuse (Eckhardt 1998: 39). However, she also acknowledges that more participation is positive if it generates more information. Hence, participation cannot replace political delegation but as an additional tool can enhance efficiency and rationality of planning for local provisions.

2.3.2.2. Prerequisites for Successful Participation

The large amount of theory on community participation as discussed in 2.2.1.2. and 2.3.2.1. points out several indicators which could be useful for the analysis of prerequisites for successful community participation. Indicators for this analysis have to be different from indicators like those measuring the degree of participation, because they assess conditions and not status (see 2.2.1.2.; Murthy/Klugman 2004; Table 2.1). Metzger identified interest in participation, actual educational standard, communication and information transfer, motivation, and sustainability as the guiding principles (see above; Metzger 2001). Individual responsibility and education was also linked by Green, whereas information as the key to community participation was highlighted by Rifkin as well (Green 1992; Rifkin 1996; 2.2.1.2.). Further indicators include control over resources (Westergaard 1986; Rifkin 1996), accountability (Murthy/ Klugman 2004), and responsiveness (Atkinson et al. 2000).

While educational standard is important for questioning the extent of participation in communities; it is less essential for the analysis of predefined groups⁹. Interest in participation and motivation are connected (see above). Additionally it is experience of participation which affects motivation and interest, because experiences influence actions. All indicators mentioned above are prerequisites for successful participation and have been discussed in detail in previous sections. Even though their value is clear, the question of measurability remains.

Table 2.3 defines a range for each indicator from low to high according to Rifkin's approach of "top-down" and "bottom-up" community participation (Rifkin 1996; 2.2.1.2.). Low on the one hand stands for a low chance for successful participation. No interest in participation, "top-down" communication within an organization and no information transfer between organizations, no responsiveness to community needs, no incentives or benefits for motivation, accountability only to higher government authorities, a "top-down" approach in sustainability, control over resources as defined by law as well as no or bad experience of participation indicate that the prerequisites for successful community participation are not fulfilled. High on the other hand means a high chance for successful participation and is determined through the "bottom-up" approach. Interest in "bottom-up" participation, "bottom-up" communication and information transfer, open responsiveness to all community needs, extrinsic and intrinsic motivation through incentives and benefits,

⁹ - Predefined groups for this analysis are NGOs and public health personnel. It can be rightly assumed that they have the required education, because their position requests it.

accountability to the community, sustainability which is determined through the “bottom-up” approach and community involvement, free control over resources and good experiences with participation signify that the prerequisites for successful community participation are satisfied. The moderate range of indicators describes a situation inbetween; first steps towards “bottom-up” community participation have taken place but the “top-down” approach is still influential. The practical usefulness of these indicators will be tested in chapter 4.

Table 2.3: Map of Participation
(adapted from Atkinson 2002; Murthy/ Klugman 2004; Metzger 2001; Rifkin 1996; Westergaard 1986)

Indicator for successful participation	Range of indicators		
	low	moderate	high
Interest in participation	No interest	Interested in top-down participation	Interested in bottom-up participation
Communication and Information Transfer			
within an organization	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
between organizations	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
Responsiveness	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
Motivation for participation	No incentives/ benefits	Incentives/ benefits by government (extrinsic)	Incentives/ benefits by government and community (extrinsic and intrinsic)
Accountability	To higher government authorities	To local government authorities	To community
Sustainability	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
Control over resources	Defined by law or higher authorities	Several models for control over resources	Free control over resources
Experience of participation	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful

2.3.2.3. Accountability

Participation also empowers people to demand better services and, thus, increases accountability through monitoring of services through the clients themselves. Cohen and Peterson state that political and legal oversight, institutional competition, and administrative mechanisms are needed to promote accountability (Cohen/ Peterson 1997: 12). Administrative mechanisms include monitoring systems (Ibid.). Monitoring can be done by a superior agency (the principal) or by the clients. All monitoring mechanisms need a sound information and knowledge basis. Accountability in turn “promotes the efficient and effective mobilization and management of resources.” (Cohen/ Peterson 1997: 5). While “effectiveness examines the benefits of healthcare measured by improvement in health; efficiency relates these health improvements to the resources required to produce them.” (Aday et al. 1998: 1). In the economical sciences efficiency is analysed through administrative costs. Administrative costs can be divided into coordination costs, organizational costs and information costs (Eckhardt 1998: 20). Coordination costs arise when different administrative units have to work together. They incorporate costs between resorts within a political subdivision or local authority and costs between different authority levels. The more authority levels participate in decision making, the higher are the coordination costs (Ibid.). Organizational costs are expenses for establishment and maintenance of political and bureaucratic institutions. Therefore, administrative units need a minimum size to be viable. Information costs are the costs for investigation of demand for public services. The higher the degree of decentralization, i.e. the closer the contact between the decision making levels of administration and the end users of services, the lower are the information costs (Ibid.).

2.3.2.4. Responsiveness

Responsiveness to local needs (effectiveness) and quality of health care are the two remaining indicators from Atkinson’s framework (see Figure 2.5). In health care research effectiveness has a clinical perspective where the emphasis is on “contribution of medical care to improving the health of individuals” and a population perspective where “the contribution of medical and non-medical (e.g. environmental and behavioural) factors to the health of communities” is assessed as a whole (Aday et al. 1998: 2). However, Atkinson attaches more importance to responsiveness of the health care system, therefore highlighting demand. This demand-orientated approach reminds of the Primary Health Care Approach which calls for primary health care “to respond to the expressed health needs of community” (see Box 1: 7). It is also in line with the equity goals of primary health care, namely equal access and equal utilization according to need (see above). Quality of health care incorporates the concepts of effectiveness, efficiency, and equity which have been described above. Hence, it is the extent of effectiveness and efficiency and of equity in health care which determine the quality of health care services.

2.3.3. Problems of Decentralization

Although the framework explained above shows decentralization and its benefits in a positive light, it can also have negative impacts. Collins and Green point towards several hurdles for successful decentralization in the health care sector (Collins/ Green 1994). First of all training for the lower-level management is needed, so that adequate human resources are available to take on the decentralized functions. Another stumbling block can be local governments which are often vulnerable to locally dominant groups. Thus, local planning might be controlled by class interests, capital demands or political clientele networks which will resist change that benefits marginal groups. Decentralization can also have negative effects on the primary health care goal of equity. Since decentralization includes local revenue generation, differences in income between places affect the available expenditures for those areas and can deepen inequities. Central resource allocation according to need is problematic, if the necessary data is not available. Indicators for need such as mortality rates are further subject of political debates and cannot be easily selected since they might support bad performance. If the decisions for finance rest with the local authorities, different health outcomes in each administrative unit can be expected due to different emphasis on health care spending. Decentralization can even hinder political access, although it is meant to increase it. The dispersion of conflicts to local areas constrains horizontal linkages and makes protest more difficult. All these examples from Collins and Green show that decentralization is an ambiguous term and has to be used with care (Ibid.).

Studies on the impact of decentralization on health care have not shown the desired outcomes. Jeppson and Okuonzi find a deterioration of health services and a decline in immunization coverage in Uganda and Zambia after decentralization of the health sector (Jeppson/ Okuonzi 2000). Similarly, Tang and Bloom discover that decentralization of basic health services to townships in a poor rural county in China “led to neither increased local government health finance, nor improvements in equity, efficiency and effectiveness.” (Tang/ Bloom 2000). Attempts to strengthen community participation in health care have not been successful either. Mosquera et al. who researched institutionalised social representation in the Colombian health sector, states that despite the introduction of user associations and customer service offices, “health care users do not yet have a meaningful seat around the table of decision-making bodies.” (Mosquera et al. 2001: 52). In the Philippines community participation in local health boards varies. Low awareness of potential roles in health decision-making hinders empowerment of community members and leads to a negative attitude towards the devolution of health services (Ramiro et al. 2001).

2.3.4. Decentralization in India

The economic crisis of 1991, when India was unable to pay its debt, led to forced economic reforms including the opening of markets, liberalization and privatization policies. Therefore, the 1990ies are characterised by privatisation and private sector expansion in the health sector (Duggal 2001). Two forms of decentralization took place. With the 73rd Amendment to the Constitution 1992 the path was laid out for devolution of functions to local bodies. The local self-government institutions called Panchayati Raj Institutions (PRI) are elected village bodies. The three-tier structure of panchayats at village, intermediate and district levels covers 96 % of India's villages (Rai et al. 2001: 11). The extent to which powers and authority are transferred to PRIs is in the hand of the states, but they are requested by the Constitution to endow them with enough powers to enable them to function as institutions of self-government. Some states have handed over control of health institutions to panchayats. In Kerala panchayats were given 37 % of the states development budget as untied funds for economic and social development (Misra et al. 2003: 129). The focus of these panchayats was mostly on preventive measures like sanitation or mosquito control. The decentralization initiative was relatively successful in Kerala due to extensive capacity building programmes for local bodies over a period of one and a half years (Ibid.: 128). Other states have also launched decentralization activities be it in the form of registered societies (Andhra Pradesh), devolution of administrative and financial powers at the primary level to local bodies (Maharashtra, Madhya Pradesh, Uttar Pradesh) or district health societies (Orissa, West Bengal). The outcome of these decentralization attempts for health care cannot be anticipated yet. The fears that dominant elites, lack of interest in health, lack of knowledge about primary health care, and inadequate control in PRIs can detain the positive efforts for community participation are strong (Chatterjee 1993).

Devolution of powers to private bodies took place in the form of involvement of NGOs in programme implementation. Since NGOs are thought to be closer to the beneficiaries of health interventions, they are used for service delivery in several health programmes like Family Planning, Reproductive and Child Health, AIDS Control and Integrated Child Development Services (see 3.2.3.). The government established a three-tier system of Small NGOs at the village level, which are assisted by Mother NGOs (MNGOs), which have substantial resources and are located at the district, state or national level. Four National NGOs in turn assess the performance of Mother NGOs (Kishore 2002: 24). Implementation of programmes, training and service delivery lies in the hands of the Small NGOs. The lack of systematic documentation of NGO contributions makes it difficult to evaluate their achievements. Higher immunization rates of 11-12 % in areas where NGOs are present were revealed in an empirical analysis and could be one indicator for their influence on quality of health care (Misra et al. 2003: 106).

The second form of decentralization in India is delegation of administrative and financial powers to facility levels. Some states like Kerala, Madhya Pradesh, Andhra Pradesh, and Rajasthan have introduced hospital societies to facilitate autonomy and a sense of ownership (Misra et al. 2003: 129). The society members come from local stakeholder

groups or are representatives of political parties. The hospital society is authorised to collect fees for e.g. parking, diagnostics or visitors and save the amount for the development of the facility. This community participation in hospital management was successful in some states, since they were able to generate own revenue and improve the facilities infrastructure (Ibid.: 129-130).

The experiences of decentralization in India show mixed results and do not allow a generalization about the improvement of quality in health care through decentralization measures. It remains open which form of decentralization contains the best strategies to implement comprehensive primary health care.

3 STATUS OF HEALTH CARE IN RURAL INDIA

3.1. RURAL CHARACTERISTICS

Health care in rural India is shaped by social structures, socio-economic, cultural and political realities, as well as through demographic and epidemiological features. The Primary Health Care Approach requests health system planning to take all these factors into account (see Box 1: 1). The majority of India's one billion plus population lives in rural areas (72,2 %, MoHFW 2002a: 6). Although rapid urbanization and megacity development are characteristic for the country, rural areas are crucial for India's development potential. Despite the large growth of the service sector, the agricultural sector has the largest share in the workforce (66 %). Villages are heterogeneous entities. Caste system, economic assets, and religious and political affiliation determine social status in the villages. Social status in turn influences health needs and health care seeking behaviour. However, the full extent of the health care situation in rural areas can only be understood after first looking at the general characteristics of rural India.

Nowadays India has good economic growth rates worldwide only topped by China. Software exports make up more than 10 % of all exports. Internet connections and mobile phones are on the rise. India successfully presents itself as a modern nation. At the same time the World Development Report states that 34.7 % of India's population is below poverty line and has less than 1 US Dollar per day available for living, the number rises even to 79.9 % of population living from less than 2 US Dollars a day (UNDP 2004: 10). The report also assesses other country averages for health, education and infrastructure, where India shows an equally bad performance. High mortality and morbidity rates and low health care spending are further characteristic for the country. While modern industries grow in selected urban centres, development of rural areas is slow. Given that the majority of India's population lives and works in rural areas, rural development is of utter importance. Since India's independence all governments have focused on rural development strategies. The Intensive Agricultural District Programme (IADP), later known as "Green Revolution", was a major policy in the 1960ies and 1970ies which provided subsidised inputs, introduced high yielding varieties of seeds and promoted chemical fertilizers (Mitra 1992: 24). Although agricultural productivity and output grew, small farmers hardly benefited from these capital intensive methods, thus, social inequality increased (Ranga Rao 1993: 38). In the 1970ies the Congress government introduced programmes with a 'target group approach' aimed at small farmers. Community development was considered essential for rural development. Participation became a substantial part of rural poverty alleviation programmes influenced by the politics of international funding agencies. However, historically India has no tradition of popular participation (Ibid.: 55). The programmes were not able to balance the disequilibrium which had emerged through the economic changes. As a social

consequence of rapid economic transformation the traditional Jajmani¹⁰ system of social, economic and political relations (bound labour) was replaced by specialised contractual relations (capitalism) (Mitra 1992: 27). While the new production relations imply less debt and more freedom of choice for landless agricultural labourers, they also mean increasing competition for decreasing jobs without the cushion of traditional networks (Ibid.). Besides capital intensive production, it is rapid population growth which puts further pressure on land and water resources in rural areas. It is widely believed that agrarian reform leads to accumulation of farmland in the hands of a few and increases landlessness. Polarization in landholding indeed increased (Mitra 1992:27). Nevertheless, studies on trends in landlessness do not support this thesis. There is no unified trend for increasing landlessness traceable (Jayaraman/ Lanjouw 1998: 7). However, wage labour employment in agriculture increased and employment outside the agricultural sector has gained importance for rural people as well. Labour migration to urban areas is common. The change from self-employment to wage labour can be interpreted in a positive sense (pull-factors) and in a negative sense (push-factors). "The fact that proletarianization often takes place against a background of rising real agricultural wages suggests that the influence of "pull" factors might in general be more pronounced than the "push" factors." (Ibid.: 22). Even though poverty in rural areas decreased and living standards increased through economic reforms and pro-poor rural policies, they could not keep pace with the development in urban areas.

3.1.1. Burden of Disease

India is currently undergoing a health transition. Health transition is a combination of the demographic transition and the epidemiological transition caused by social, economic and ecological change (see Figure 3.1; Martens 2002: 639). While the demographic transition is the shift from high fertility and mortality rates to low fertility and mortality rates, the epidemiological transition indicates the move from infectious to chronic diseases. Despite considerable population growth, India registers a decline in crude birth rate and crude death rate. Although it is a slow process (see Figure 3.2), it shows the onset of the demographic transition. Incidence of infectious diseases is still high, nevertheless, mortality through infectious diseases ranks only second after diseases of the circulatory system pointing towards epidemiological transition (see Figure 3.3). Age and gender are important for the distribution of disease. In rural areas people above 60 years have the highest mortality rates (MoHFW 2003: 296).

¹⁰ - Hindu jajmani system: customary payments are received in return for the performance of regular services for a patron (Jayaraman/ Lanjouw 1998: 14); see Wisner, W.H. (1988): *The Hindu Jajmani System*. New Delhi; Caldwell, B. (1991): *The Jajmani system: an investigation*. New Delhi.

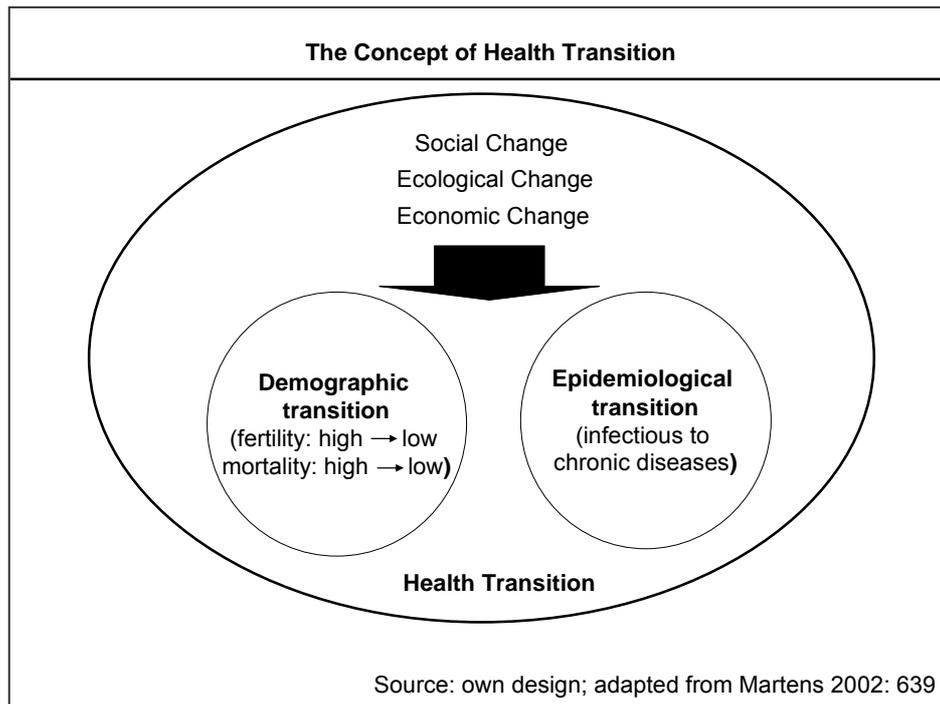


Figure 3.1: The Concept of Health Transition

There is no significant difference between men and women at this age group. Even though overall mortality for men is higher (see Figure 3.3), women have higher mortality rates than men in younger age and in specific diseases. Women below the age of 34 years have higher mortality rates in respiratory diseases, infectious and parasitic diseases, diseases of the circulatory system and diseases of the digestive system. In the age group below 24 years they dominate mortality from external causes of accidental injuries and below 14 years external causes of mortality (MoHFW 2003: 296). Causes of death also vary from urban to rural areas, according to economical and environmental conditions.

Nonetheless, country averages do not reflect the spectrum one indicator can have within a country as diverse as India. Heterogeneity leads to geographical, social, cultural, and gender disparities. The following sections will examine the extent of these disparities in India and their influence on the health system.

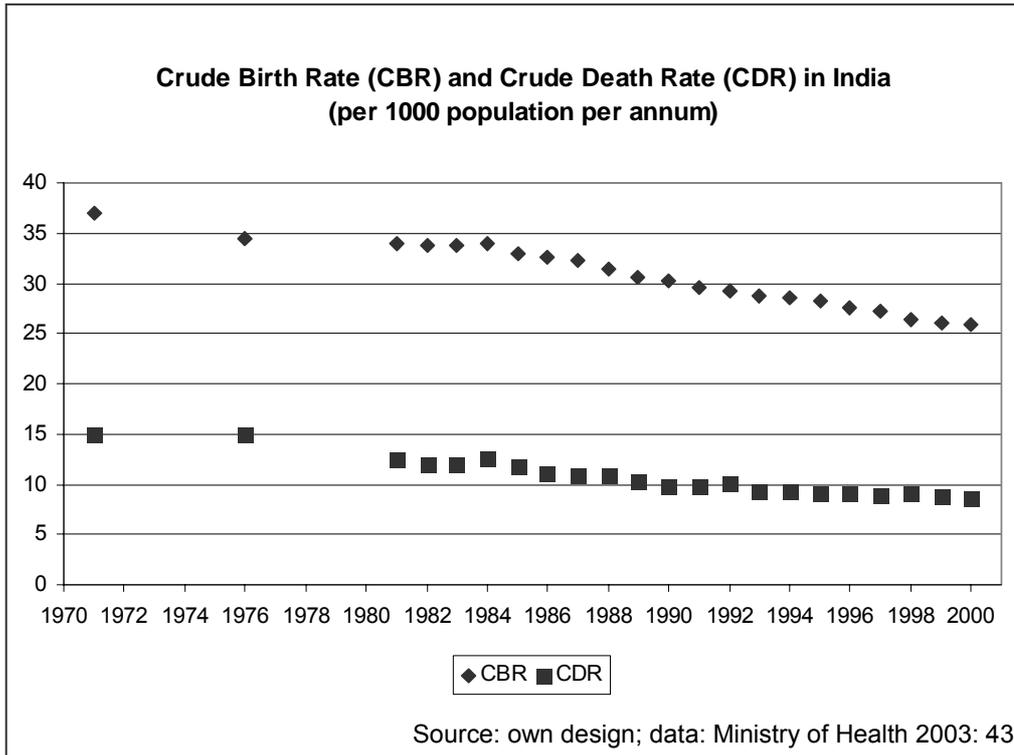


Figure 3.2: Demographic Transition in India - Decline of Crude Birth Rate and Crude Death Rate

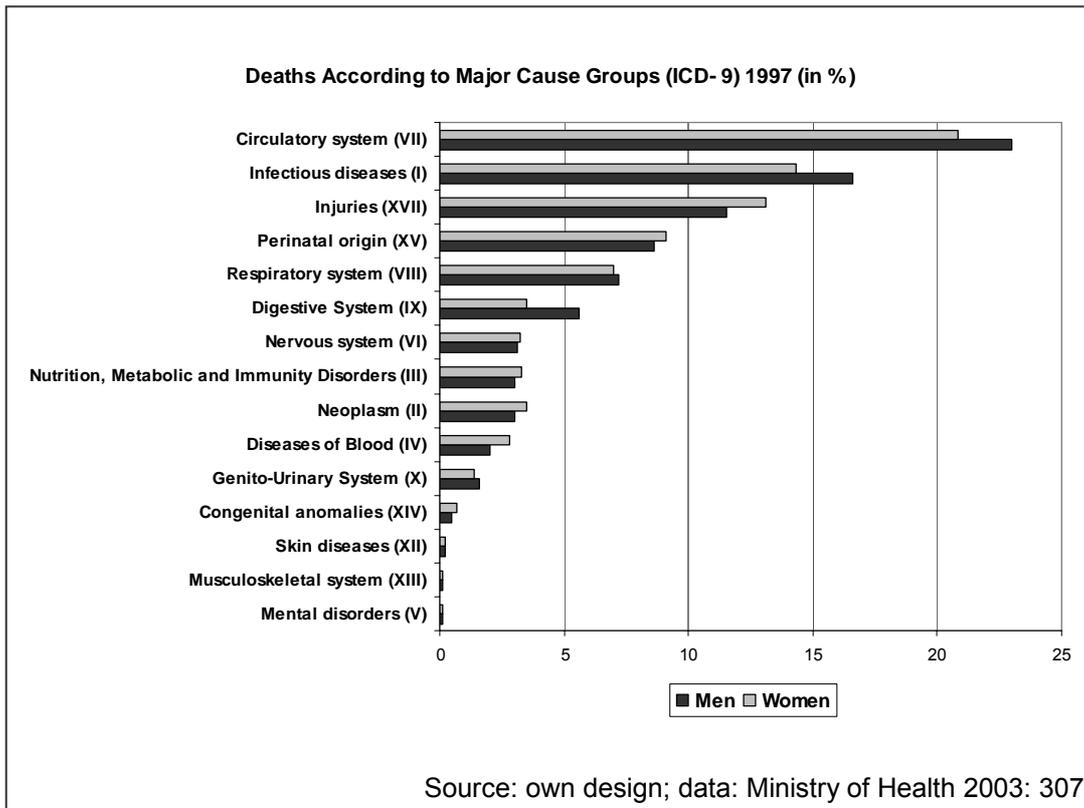


Figure 3.3: Epidemiological Transition in India- Causes of Death

3.1.2. Geographical Disparities

The per capita net state domestic product varies from Rs. 6,015 in Bihar to Rs. 52,795 in Chandigarh (see Figure 3.4; Ministry of Finance 2005: 12). The huge differences are reflected in poverty indices also (see Figure 3.5). The percentage of population below the poverty line ranges from 3.48 in Jammu and Kashmir up to 47.15 in Orissa. Figure 3.5 also shows the differences between rural and urban population falling under the poverty line. Some states, especially those from the North-East, have a much higher proportion of poor population in rural areas than in urban areas. In other states with better economic performance and lower overall poverty, the percentage of urban poor exceeds the one for rural poor. In very few states is the percentage of urban and rural poor equally distributed. Between poverty and health status exists a strong link as Figure 3.6 indicates. The richest quintile of India's population enjoys a much better health status than the poorest quintile. The assumption from these figures is that the higher the percentage of population below the poverty line in one state, the lower is the expected health status in this state. The figures already highlight inter-state differences and rural-urban disparities. The performance of states in health, education and transport is equally diverse.

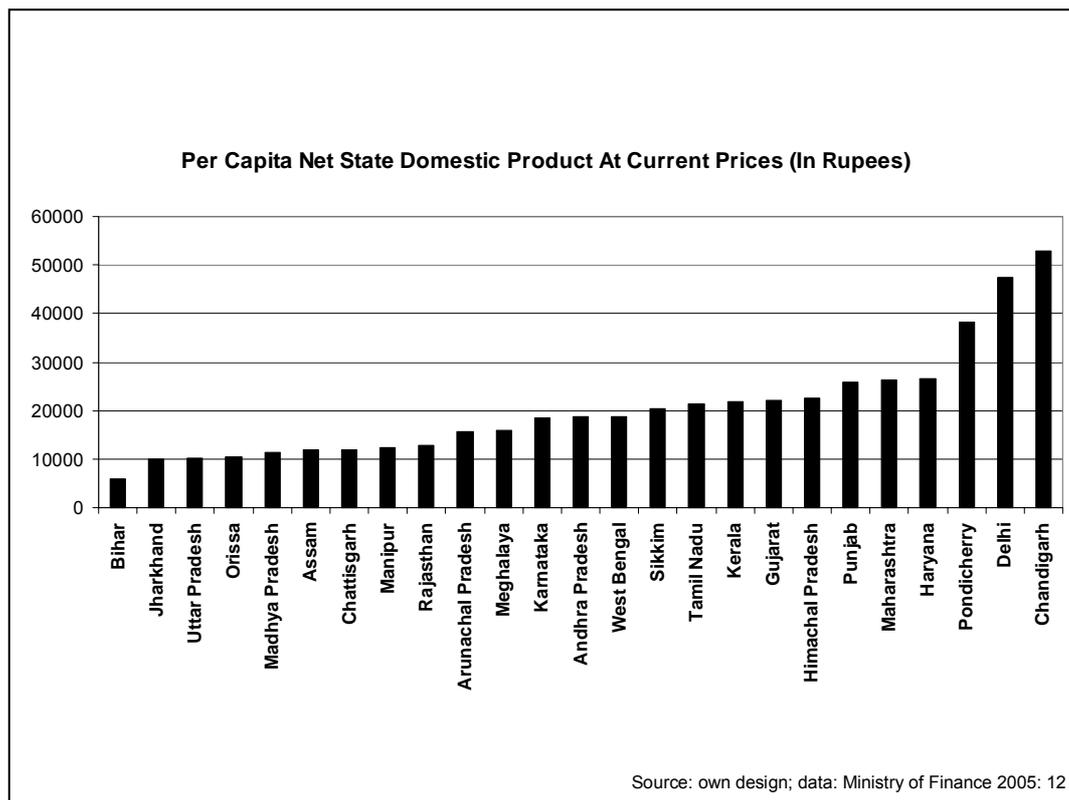


Figure 3.4: Per Capita Net State Domestic Product At Current Prices

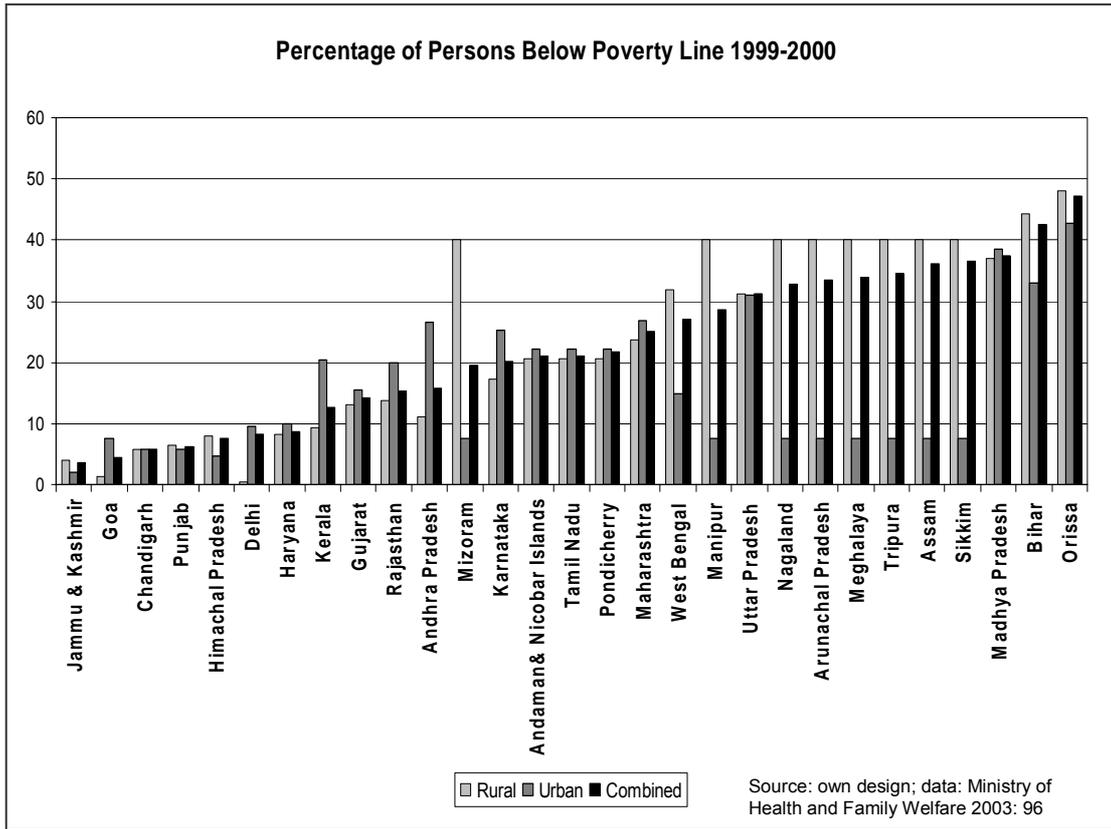


Figure 3.5: Percentage of Persons Below Poverty Line 1999-2000

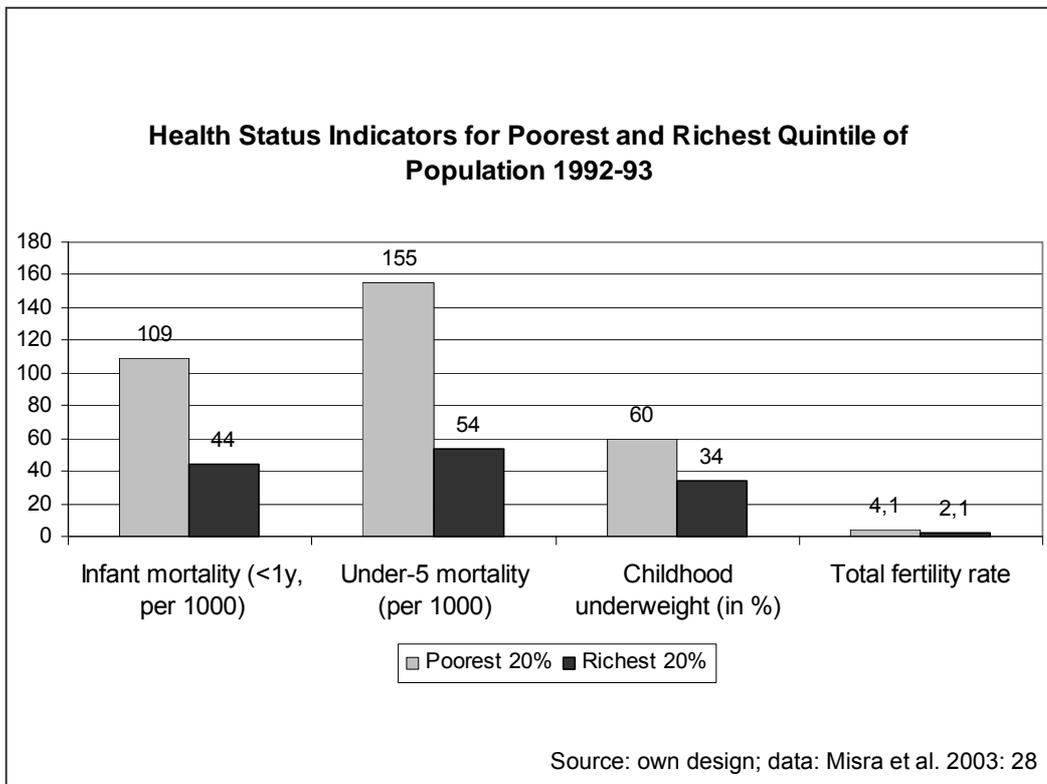


Figure 3.6: Health Status Indicators for Poorest and Richest Quintile of Population

An extensive survey of India's public services covering access, utilization, quality, reliability and satisfaction for drinking water, health care, road transport, public distribution system and primary schools covered 36,542 households in all over India (Paul et al. 2004). As a result of the study the states were sorted into three groups according to their performance in all sectors (see Table 3.1).

From each performance category one state was selected for this study. In terms of health care Maharashtra showed the second best performance, Himachal Pradesh ranked 5th and West Bengal showed the second worst performance (see Table 3.1). The three states also differ in their economic performance and in their poverty rates (see Figure 3.4 and 3.5). Access to drinking water, health care, public transport, public transportation and primary schools of the first level states, Andhra Pradesh, Karnataka, Kerala, Tamil Nadu, Gujarat, and Maharashtra, by far exceeded the access rates of the third level states, Assam, West Bengal, Orissa, Rajasthan, and Bihar (Ibid.: 931). Public transport shows the most significant differences in access rates. In the first level states 84 % of the population have access to it, compared to only 26 % of the third level states. For health care the figures are lower with 48 % in the well performing states and 32 % in the less performing states. The states ranked second level for their performance are Haryana, Himachal Pradesh, Punjab, Madhya Pradesh, and Uttar Pradesh. Utilization and reliability of health are surprisingly the same in third level states compared to first level states (see Figure 3.7). Satisfaction with health care reflects the mismatch between demand and access, hence, it is very low with 21 % for the first level states and only 7 % for the third level states.

	DW	Health	Transport	PDS	Education	Overall
<i>First level</i>						
Andhra Pradesh	7	16	4	2	4	5
Karnataka	2	6	3	3	3	3
Kerala	13	7	7	5	8	6
Tamil Nadu	1	4	2	1	1	1
Gujarat	3	1	1	6	2	2
Maharashtra	5	2	5	4	4	4
<i>Second level</i>						
Haryana	11	9	8	11	13	10
Himachal Pradesh	4	5	6	13	15	7
Punjab	14	3	10	10	16	11
Madhya Pradesh	6	10	13	8	6	8
Uttar Pradesh	9	7	9	14	7	9
<i>Third level</i>						
Assam	15	10	14	7	11	14
West Bengal	7	15	11	15	13	13
Orissa	10	13	15	9	10	12
Rajasthan	12	12	12	16	9	15
Bihar	16	14	16	12	12	16

Table 3.1: Ranking of Relative Performance of States in Public Services
(Paul et al. 2004: 930; DW= Drinking Water; PDS= Public Distribution Services)

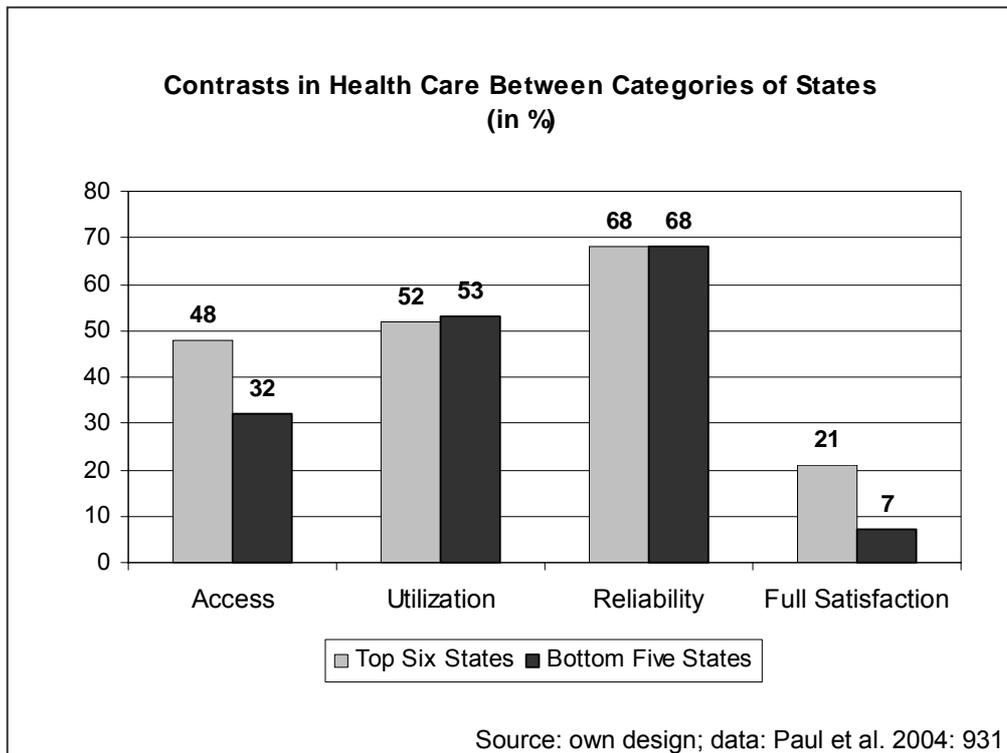


Figure 3.7: Contrasts in Health Care Performance Between Categories of States

Primary schools have the highest utilization rates, followed by public distribution, with health care coming last (1st level: 52 %/ 3rd level: 53 %). While the difference for utilization of public transport is again very high (75 %/ 8 %), the other services show similar figures for first and third level states. Drinking water has the highest reliability (76 %/ 72 %), followed by health care (68 %/ 68 %), public transport (22 %/ 10 %) and primary schools (24 %/ 12 %) coming last. Satisfaction with public services is low for all categories ranging from 10 % for public distribution to 30 % for drinking water in the first level states and from 3 % to 14 % for the same categories in the third level states. It is further interesting to notice that there are no significant differences between poor and non-poor households for access to most public services in the top six states, although access to health care is a bit lower (Ibid.).

However, access to health care, public transport and public distribution decreases further for poor households from the five second-level to the five third-level states, showing that states which have a low overall performance also have more inequality in public services. Hence, poor households benefit less from public services than non-poor households. The access data for antenatal care and immunization services from another study support these findings (see Figure 3.8 and 3.9). Low standard of living has negative effects on utilization rates of these services. Andhra Pradesh and Tamil Nadu are an exception. They show a pro-poor bias for antenatal care. Women with higher living standards, in turn, have better access to the services in nearly all states. Access to drinking water and primary schools shows no pro non-poor bias in either of the categories. These services

seem to reach all groups equally. From this data it can be assumed that there will be a large difference between decentralization and community participation in the public health sector in Maharashtra, Himachal Pradesh and West Bengal, reflecting their different performance levels.

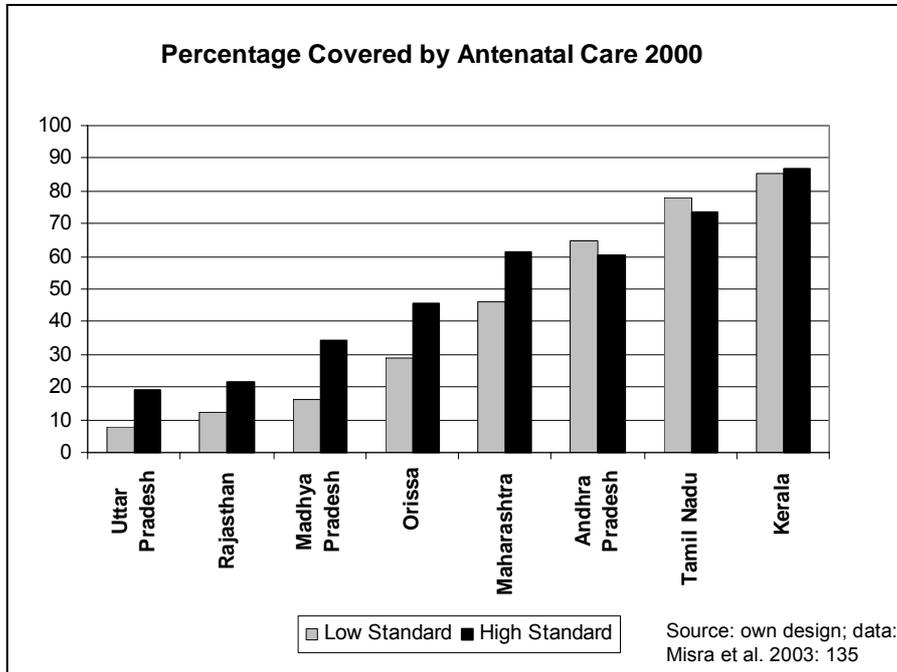


Figure 3.8: Percentage of Women Covered by Antenatal Care by Standard of Living¹¹

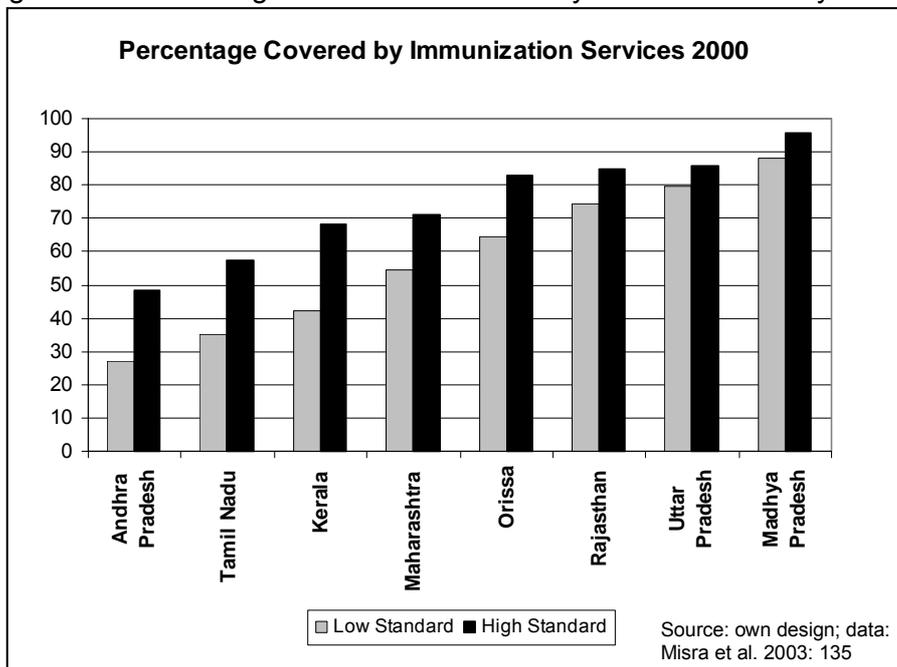


Figure 3.9: Percentage of Women Covered by Immunization Services by Standard of Living

¹¹ - Low standard of living refers to kutch house - a house structure made of unburnt bricks, bamboo, mud, grass, leaves, reeds, or/ and thatch. High standard of living refers to pucca house - a house structure made of cement, concrete, oven-burnt bricks, stones, stone blocks, jackboard, tiles, timber, galvanized tar, corrugated iron sheets, or/ and asbestos sheets (Misra et al. 2003: 139).

However, the benchmarks for public services in the above mentioned states do not necessarily correspond with their ratings for economic performance (see Figure 3.4). States having similar per capita net domestic products like Andhra Pradesh and West Bengal, took the 5th and the 13th rank in public service performance (see Table 3.1). The same holds true for the amount of poverty in the states, Rajasthan (15th rank) comes just behind Gujarat (2nd rank) (see Figure 3.5, Table 3.1). Maharashtra and West Bengal do have equally high poverty rates (see Figure 3.5), but are worlds apart in their performance ranking (see Table 3.1). Only for Assam, Orissa and Bihar are performance of public services, economic performance and people below poverty line consistently bad. From this comparison two things become clear. First, states with low economic performance like Madhya Pradesh and Uttar Pradesh can still have good performance in public services (8th and 9th rank). While, states with high per capita net state domestic product like Haryana might not perform well in public services (7th rank). Second, high poverty rates do not automatically imply lack of public services or inequality in access to it (see Madhya Pradesh, Uttar Pradesh). Therefore, assumptions concerning linkages between indicators in Maharashtra, West Bengal and Himachal Pradesh have to be made with care and need to be confirmed through local research.

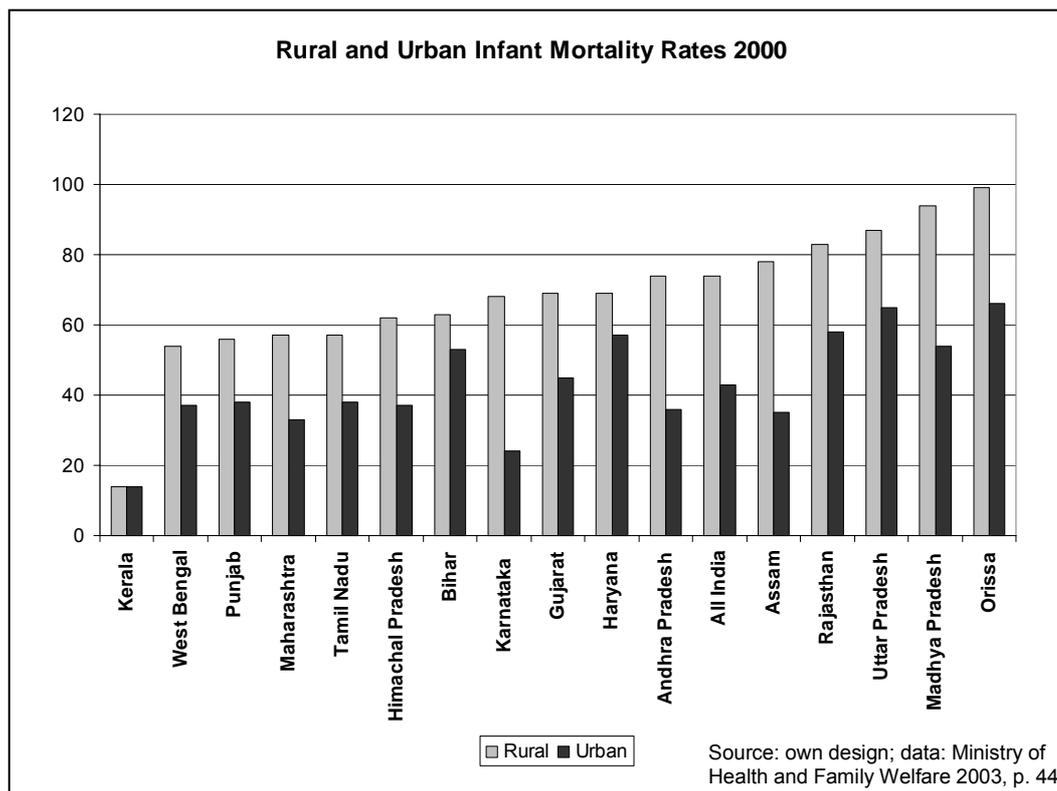


Figure 3.10: Rural and Urban Infant Mortality Rates 2000

Economic status, poverty and performance of public services differ among the states and between urban and rural areas. Although the study of Paul et al. does not make a distinction between urban and rural areas, health indicators reflect the disparities existing there (see Figure 3.10). Infant mortality rates (IMR) are much higher in rural areas of states (except Kerala) than in urban areas, indicating a lower health status. IMR in

Himachal Pradesh and Maharashtra are higher than in West Bengal, although their performance in the public health sector is better. Hence, poor households in rural areas are deprived in double respect. First, a higher percentage of poor people live in rural areas. Second, a higher percentage of poor have a low health status compared to non-poor. Access to public health services, in turn, is lower in rural areas and also lower for the poor (see above). Thus, the higher demand of poor rural population is not met.

Besides the grouping of states after their economic, poverty or access indicators, they can also be grouped according to their status of health transition (see Table 3.2). While the Southern states of Kerala and Tamil Nadu are already in a middle to late transition and have a high institutional capacity, the majority of states including West Bengal and Maharashtra are in an early to middle transition and have only low to moderate institutional capacity. Orissa, Rajasthan, Madhya Pradesh and Uttar Pradesh are in a very early transition phase with very low to low institutional capacity, whereas Assam and Bihar show no signs of health transition (Peters et al. 2002: 8).

Major Indian States, by State of Health Transition and Institutional Capacity		
Stage of Transition, Degree of Capacity	States	India's Population (%)
Middle to late transition, Moderate to high capacity	Kerala, Tamil Nadu	9.1
Early to middle transition, Low to moderate capacity	Maharashtra, Karnataka, Punjab, West Bengal, Andhra Pradesh, Gujarat, Haryana	39.1
Very early transition, Very low to low capacity	Orissa, Rajasthan, Madhya Pradesh, Uttar Pradesh	33.1
Special cases: instability, high to very high mortality, civil conflict, poor governance	Assam, Bihar	13.3

Source: Peters et al. 2002: 8

Table 3.2: Health Transition in Major Indian States

3.1.3. Social, Cultural and Gender Disparities

Going down to the local scale, disparities in health become even more complex. Power structures and social relations are spatial relations which are influenced by caste, class and kinship (Das 2001: 347). The majority of Indians are Hindus (82 %); the biggest religious minority are Muslims (12 %) followed by Christians, Buddhists and tribal religions. In literature there exists a large debate whether India's rural society is more determined through caste or class. India's caste system is highly fragmented and

localised in its appearance. For the production of social structures “jati” (subcaste) is of greater relevance than “varna” (see Mukherjee 2000). Caste is a concept deeply embedded in Hinduism. Members of other religions are placed outside the caste system. While the classification through “jati” is established through birth and more dependent on religion, occupation, cultural tradition and ethnicity, class is rather defined through economic assets like ownership of land. Both systems have strong hierarchies with “jati” being endogamous. In literature rural Indian society is divided in six classes: “landlords and rentiers, capitalist farmers, rich peasants, middle peasants, poor peasants, and landless labourers” (Das 2001: 350). Membership to class, thus, follows Marx’s theory of capitalism.

Poverty has an important impact on health as shown above (see Figure 3.6). Therefore, distribution of poverty among groups of rural society is essential for examining health. Research studies on rural India show that poverty is more concentrated in scheduled castes and tribes which are at the bottom of the caste hierarchy (Gang et al. 2005). Krishna reveals similar results in his detailed household level study (Krishna 2004). The probability of being poor or of falling into poverty is much higher among scheduled castes and scheduled tribes than for upper castes. On the other hand the percentage of these lower castes escaping from poverty is also higher. The reasons for falling into poverty are the same among all caste groups, in most cases “a combination of health and health-related expenses, high-interest private debt, and social and customary expenses” such as death feasts and marriages (Ibid.: 128). One factor that also emerges from his study is information. High-quality information is crucial for escaping poverty, at the same time as lack of information may lead to poverty. Hence, wrong choices in seeking health care are linked to a decline into poverty. Kinship networks and connections to influential people therefore become more important as survival strategies. Although these two studies show general tendencies for lower castes to be in lower class, thus combining caste and class, they do not deny that upper castes may also be poor.

In their study on the allocation of publicly-provided goods Betancourt and Gleason find a significant variability in districts (Betancourt/ Gleason 2000). They explain this variability by the influence of caste and religion. Rural areas of districts with higher proportions of scheduled castes or Muslims acquire lower public input (Ibid.: 2177). Jeffrey on the contrary assessed the influence of social status on access to state bureaucrats, police or judiciary in rural India (Jeffrey 2002). His study shows similar results on an individual basis, dominant classes are more successful in influencing decisions of local police or politicians than scheduled castes and Muslims. Hence, he uses social status as determinant, which is composed by class and caste membership. While researching inequalities in immunization rates for children within states, Pande and Yazbeck found that gender, wealth and place of residence influenced immunization rates (Pande/ Yazbeck 2003). Girls from poor households in rural areas were least likely to receive full immunization, whereas boys from rich households in urban areas were most likely to receive full immunization. Hence, female gender, poverty and rural residence are further discriminating factors and reasons for inequality in health care. The Primary Health Care Approach highlights education as a means to achieve better health status. The link

between educational status of women and infant mortality can be seen in Figure 3.11. The higher educated the mother, the lesser the plausibility of death for her infant. Therefore, health status is not only influenced by caste, class and poverty, but also by education. Literacy rates are significantly lower in rural than in urban areas and for women than for men (Ministry of Home Affairs 2002). Thus, lack of education poses another threat for the health status of rural people, especially for women. Besides other factors it is religious affiliation which also influences contraceptive use in rural areas, therefore, supporting the thesis that elements of social status affect health behaviour and health needs (Chacko 2001).

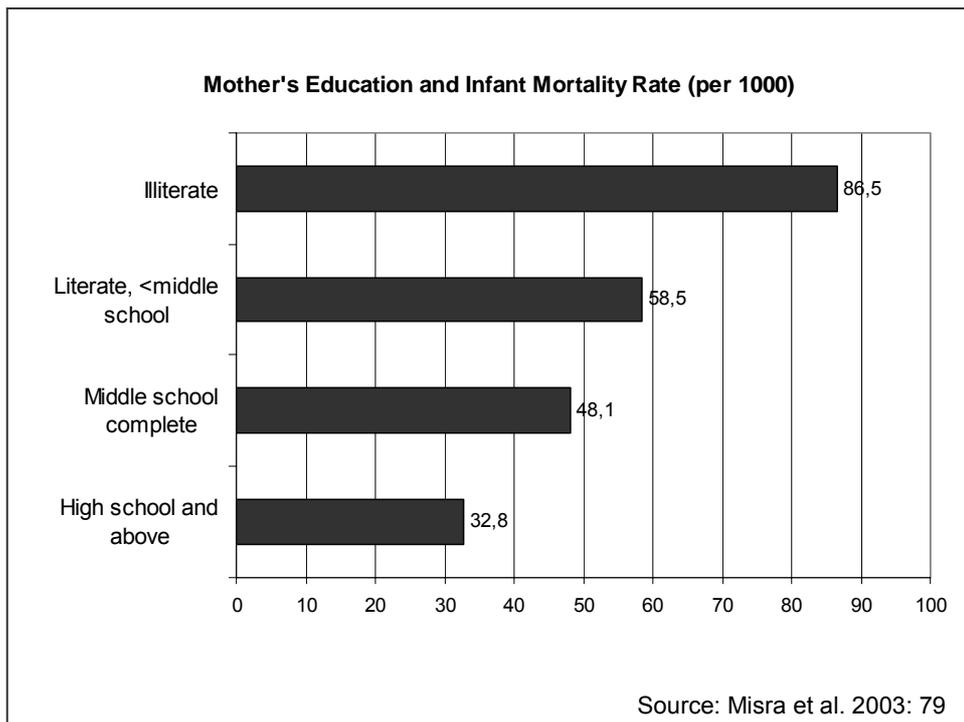


Figure 3.11: Mother's Education and Infant Mortality Rate

All the above mentioned studies show that researchers have focused on class or caste relations as well as on social status. The distinctions they make between the categories are not always clear. Using scheduled tribe and scheduled caste as well as religious affiliation as indicators is supported by the data generated by the government. However, social relations and power structures in the villages are established through all characteristics of social status including caste and class. The studies prove that members of scheduled castes and scheduled tribes as well as Muslims in rural areas are more likely to have lower social status, reflected in poverty rates and access data. At the same time lower social status is linked to less service provision in health care and other sectors. Figure 3.12 and 3.13 correspond with these findings and also show that scheduled tribes and scheduled caste have higher mortality rates and less access to immunization services than other castes (Misra et al. 2003: 47,135). Therefore, it can be concluded that the driving factors for vulnerability in health are low class and caste, female gender, illiteracy or low educational status and Muslim religion. Members of these vulnerable groups have the highest mortality and morbidity risks.

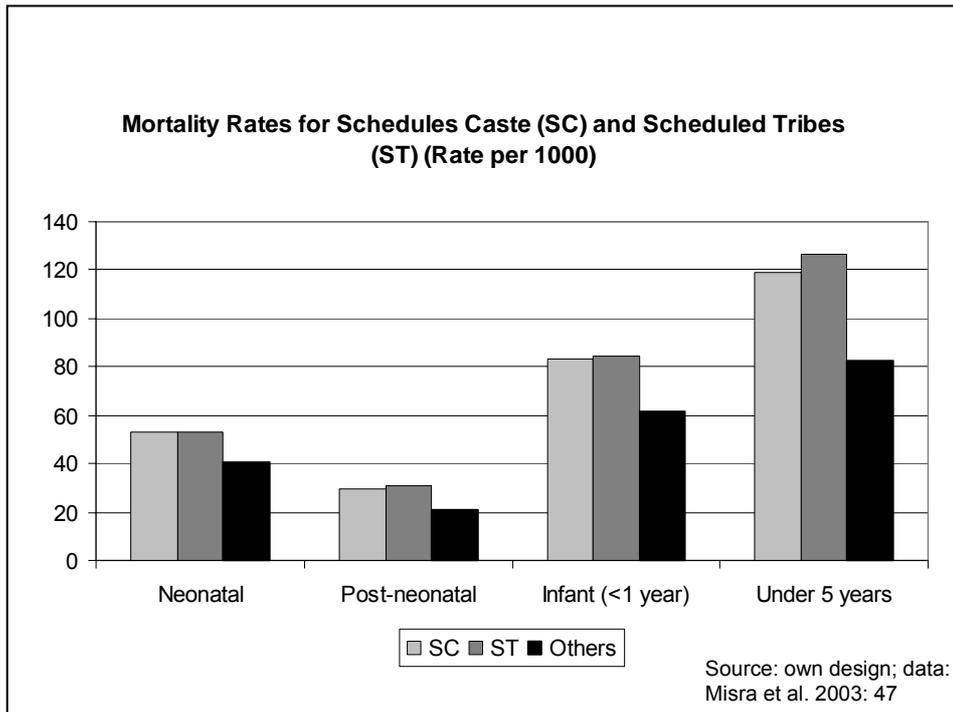


Figure 3.12: Mortality Rates for Scheduled Caste/ Scheduled Tribe and Others

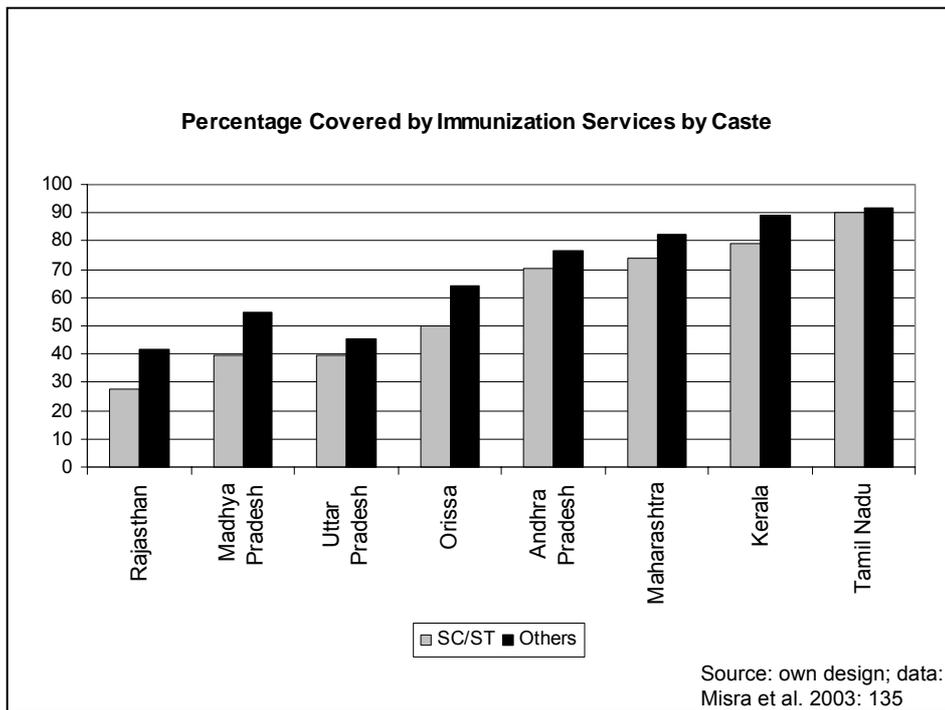


Figure 3.13: Percentage Covered by Immunization Services by Caste

3.1.4. Local Elites

Another often discussed fact in research on social relations and power structures is the influence of local elites on rural development. While there is no study denying the existence of local elites, the interpretations of their roles and influences are diverse. The concentration of resources in the hands of few individuals or a group is common in rural India (Das 2001; Mitra 1992; Jeffrey 2002). On the one hand this unequal allocation is a sign for inequality if not inequity. On the other hand it places a special role in the hands of these elites. The picture of local elites in India corresponds with Marx's class theory, where land and capital goods are placed in the hands of a few. His theory is often applied in Indian studies, hence, marking local elites as suppressive class (see Das 2001). In development studies local elites are blamed for withholding the benefits of rural programmes targeted at poverty reduction. They are perceived as one major reason why development does not reach the poor (see Jeffrey 2002). If this presumption holds true, local elites could also be responsible for the failure of health programmes targeted at the poor. The power of local elites leads to the establishment of patron-client relationships or clientelism networks. Local elites are the only ones which can reach out to state officials and bureaucrats since they have the means (time, money, bribes, political affiliation) to do so. They can use these links to ensure benefits of development programmes for themselves but they can also function as intermediaries between village population and the state. The positive role of elites is highlighted by Mitra (Mitra 1992). He sees them as a bridge between society and state, where they have an important role to play in the transfer of political agendas. Local elites are used by political parties as recruiter of votes at the time of elections. They also serve as first contact point for all kinds of development programmes. As villagers cannot easily establish contact to state bureaucrats, judiciary or police, they use local elites as spokespersons. While this patron-client relationship creates new dependencies, it also serves as channel for the villagers. It comprises benefits for both parties. However, poor villagers can also influence politicians directly through bribes or other initiatives, but they are less successful than elites (Jeffrey 2002). Community participation through intermediaries, in this case local elites, points towards a lower degree of community participation (see Table 2.1; Murthy/ Klugman 2004).

Clientelism in turn does not only work through mutual economic dependencies but also through kinship. Family ties are very important in rural India, people rely on their relatives for support before consulting other groups. Krishna's study supports this. It showed that one major reason for escaping poverty is help of relatives and friends (Krishna 2004: 130). From the discussion above, one conclusion emerges. Apparently, low social status is not only linked to poverty and less access to public services but also to less power in decision making. Local elites are an important player in rural power relations, but it is not possible to generalize their role into negative or positive. Their influence has to be kept in mind when discussing participation in health policy making.

3.1.5. Conclusion

After looking into social structures of rural India and examining the existing power relations, we can identify the marginal groups of society. Since the main question will centre on participation in health care, a conclusion can be drawn from the already existing power structures. Rural India is characterised through strong inter- and intra-household hierarchies¹², unequal distribution of resources, huge percentage of poor people, small group of elite, and widespread corruption. The mutual disadvantages for people who are in lower castes or belong to the religious minority, poor, female and less educated emerged from the local studies. Individuals in each of the groups or as members of several groups face higher health risks and less access to public services. Marginal groups of society have been recognised by the government which introduced reserved seats for scheduled caste, scheduled tribe and women in panchayats. To some extent it empowered these marginalized groups, but it is not sufficient to fully overcome strong local dependencies.

It has been proved that geographical, social, cultural, and gender disparities influence health status in India. The Indian health system is divided into the public and the private health system. It further has a long history of traditional medicine. The next sections will show the organization of these health sectors and the amount of equity in the different systems.

¹² - The huge amount of literature on the status of women in Indian society cannot be repeated here. See Bala, R. (1999): *The legal and political status of women in India*. New Delhi; Kumar, H. (2002): *Status of Muslim Women in India*. New Delhi; Majumdar, M. (2004): *Social status of women in India*. New Delhi; Panda, P./ Agarwal, B. (2005): *Marital violence, human development and women's property status in India*. *World Development*, Vol. 33, No. 5, p. 823-850.

3.2. PUBLIC HEALTH SYSTEM

India's public health system was established after independence. Following the recommendations of the Bhole committee 1946 and later the Primary Health Care Approach an extensive network of health facilities was built (see 2.2.3). The specific socio-economic and geographical conditions of the country (see 3.1.) require the public health system to fulfil a variety of tasks. The eradication of certain communicable diseases like polio and leprosy, the reduction of mortality through tuberculosis, malaria and other vector and water-borne diseases, the reduction of infant and maternal mortality rates to 30/1000 and 100/100,000 cases, the increase of utilization rates of public facilities from less than 20 % to more than 75 %, the integration of a surveillance system and the increase of health expenditure by central and state governments are declared policy goals (MoHFW 2002b: 22). These goals already highlight major problem areas: the prevalence of communicable diseases despite 50 years of national health programmes, high IMR and MMR, underutilization of public health facilities and lack of financial resources for health care. Therefore, the following section will outline the general structure of the public health system, look into financial and human resources and examine achievements. Special emphasis will be placed on decentralization and community participation in rural public health care and in the national health programmes.

Since India has a federal system, the responsibility for health care lies in the hands of the states. Although the central government develops the policies and the National Health Programmes (centralized planning), implementation of these policies is solely state business (decentralized implementation). In theory, states can also develop own policies in certain areas, but due to the tradition of centralized planning and the financial strength of the centre, independent state level planning rarely takes place (Das Gupta/ Rani 2004: 3). Consequently, state sector health spending is 5.5 % of GDP, while the central government spends only 0.9 % of GDP on health (Ibid.). Overall health expenditure, thus, is very low and places India among the bottom 20 % of countries worldwide (Peters et al. 2002: 3). The expenditure even decreased since 1980 (see Figure 3.14). Revenues from general taxation are used as finance source. The small percentage of GDP spend on health also indicates the low priority of health in national policies. The average spending for health in the states per capita was only Rs. 33.91 in 1998-99 (Misra et al. 2003: 145). Since this amount is not sufficient to cater for the health care needs, it is not surprising that private out-of-pocket spending makes up 84.6 % of all health care spending (Ibid.). Compulsory or voluntary health insurance are virtually absent (2 %). Thus, the burden of financing health care is placed at the individual households further adding to existing inequalities.

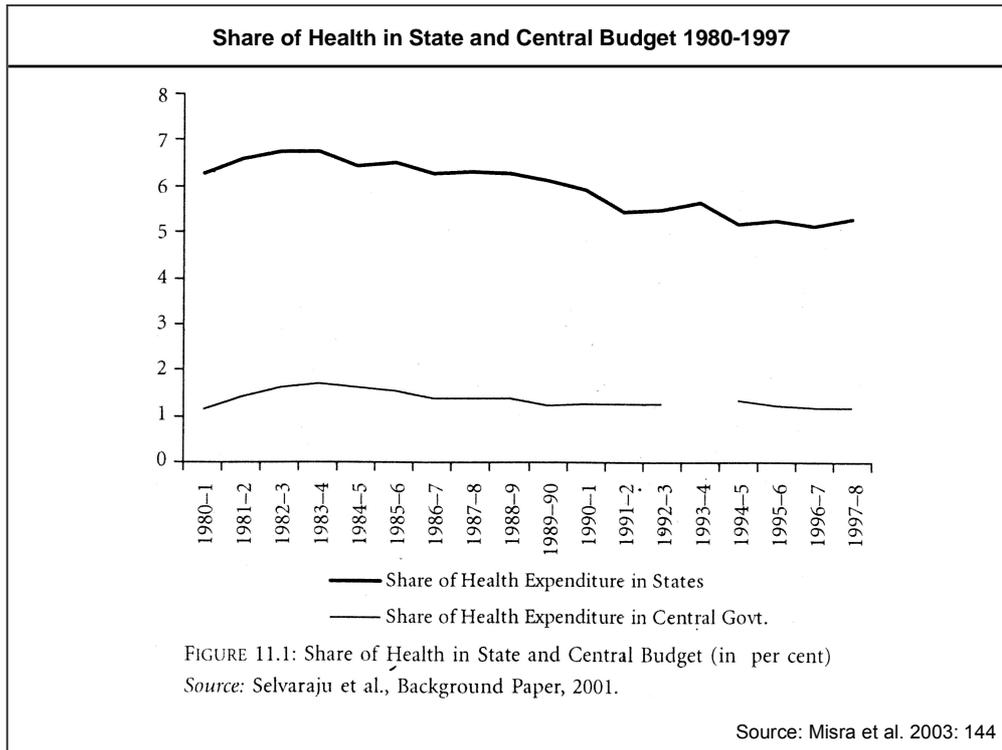


Figure 3.14: Health Expenditure of State and Central Government

3.2.1. Structure of the Public Health System

3.2.1.1. Central Ministry of Health

The Ministry of Health at the central level consists of the Department of Health, the Department of Family Welfare, and the Department of Ayurveda, Yoga-Naturopathy, Unani, Siddha & Homoeopathy (AYUSH). The Director General of Health Services is attached to the Department of Health and renders advice to all medical and public health matters. Public health, medical services, medical education, food and drug standards, professional councils, and international aid and health research are the working spectrum of the Department of Health. The Department of Family Welfare, as the name implies, looks after all family welfare programmes which are implemented through the Primary Health Care System. Therefore, it also deals with rural health infrastructure. The Department of AYUSH is concerned with upgradation of educational standards, standardization of drugs and quality control of all health issues related to Indian Systems of Medicine (MoHFW 2005: 209). The Ministry of Health is hardly involved with direct service provision, its tasks are more of an administrative nature. States and local health authorities are advised, supported and monitored by the Ministry to facilitate effective and efficient administration at these levels (Das Gupta/ Rani 2004: 2). In short, the Central Ministry provides the technical support for the sub-national levels. The Ministry of Health further controls and monitors a vast network of autonomous research and training institutions which are under its administrative control.

The essential public health functions of the Ministry of Health and its agencies were assessed by a World Bank study (Das Gupta/ Rani 2004). The results present the perceptions of officials from within the Ministry and show very low scores for the functions: social participation and empowerment (0.19)¹³, public health laws and their enforcement (0.26) and ensuring the quality of health services (0.32) (Ibid.: 9). The highest score was reached by the function “reducing impact of emergencies and disasters” (0.65). This evaluation from within highlights that performance of public health functions by the Ministry and its agencies is generally weak. Community information for the evaluation of quality of health services is rarely collected. User satisfaction is not evaluated for the development of policies. Evaluation results are, further, not communicated back. Thus, the influence of community level information on health policy is very low. Although guidelines for the enforcement of policies exist, mechanisms to encourage honest and correct enforcement of public health procedures are not in place. The partnerships with sub-national levels for the effective implementation of public health laws and regulations are weak. Weak linkages to sub-national levels are also reflected in quality warranty. Sub-national levels and non-governmental organizations are hardly asked to participate in the development of standards. Das Gupta and Rani thus conclude that the strengths of the Ministry of Health are the assessment of epidemiological needs and the response with planning and evaluation of actions as well as the development of written guidelines, standards and protocols. Its weaknesses, besides management flaws and poor feedback, are represented by the facts that fundamental public health functions are overlooked and that the Ministry functions too much in isolation (Ibid.: 19-21).

3.2.1.2. Sub-national Agencies

At the state level the Minister is in charge of the Secretariat, which is the policy-making body, and of the Directorate, which is the implementing body (see Figure 3.15). The Secretariat deals with all legislative measures including the making of rules and regulations on matters of health administration (Ranga Rao 1993: 58-59). It exercises authority over financial and personnel matters and further controls, supervises and regulates the departments at the various levels. Proposals of the Directorate are first reviewed in the Secretariat before they are handed up to the Minister. This practice is criticised by the more technical-oriented staff of the Directorate, who feel that the administrative staff of the Secretariat is not conducive to technical efficiency (Ibid.).

Under the Directorate are four Directors for Medical Education, Homeopathy/ Ayurveda, Health Services and Drug Control. The bifurcation of directorates took place in the 1970ies and is not universal in all states. It did not follow scientific or administrative considerations. Rather it was influenced by political concerns (Ibid.: 60). The Director Health Service (DHS) has the highest responsibilities; he/she looks after the district health system and the implementation of all health programmes. Hence, he/she is also accountable for the functioning of the primary health care system.

¹³ - scores on a scale of 0-1, based on the average proportion of positive responses to the questions

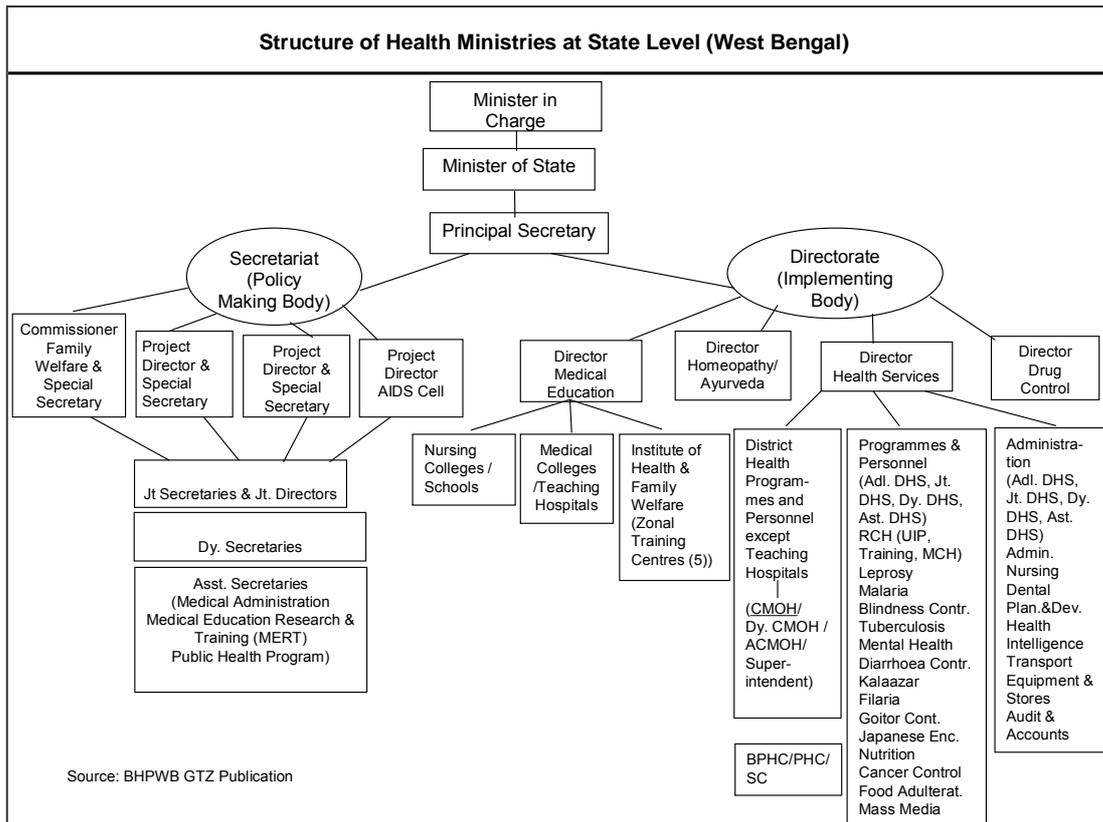


Figure 3.15: Structure of Health Ministries at State Level (West Bengal)

At the district level the Chief Medical Officer Health (CMOH) supervises the public health system, except for the teaching hospitals, with the help of the Deputy CMOH, the Assistant Chief Medical Officer Health (ACMOH) and the Superintendent. The Joint, Deputy and Assistant DHS advice and monitor the implementation of the health programmes through CMOH. Thus, CMOH is the bridgehead at the district level for the operation of all state and central health policies. He/she looks after the whole primary health care structure at district level including Community Health Centres (CHC), Block Primary Health Centres (BPHC) if present, Primary Health Centres (PHC) and Sub-Centres (SC). All primary health care staff down to the lowest level i.e. Anganwadi worker and Multi-Purpose Worker (MPW) male and female, are under his/her supervision.

3.2.1.3. Rural Public Health Care

Rural public health care has a three-tier system (see Figure 3.16). At the bottom of the hierarchy is the Sub-Centre (SC) catering for a population of 3,000 to 5,000. Next tier is the Primary Health Centre (PHC) supervising the work of 5 to 6 SCs, catering for a population of 18,000 to 30,000 and having 4 to 6 beds. First referral unit of curative care is the CHC or Community Hospital which is planned for a population of 100,000 and has 30 beds (see MoHFW 2002a).

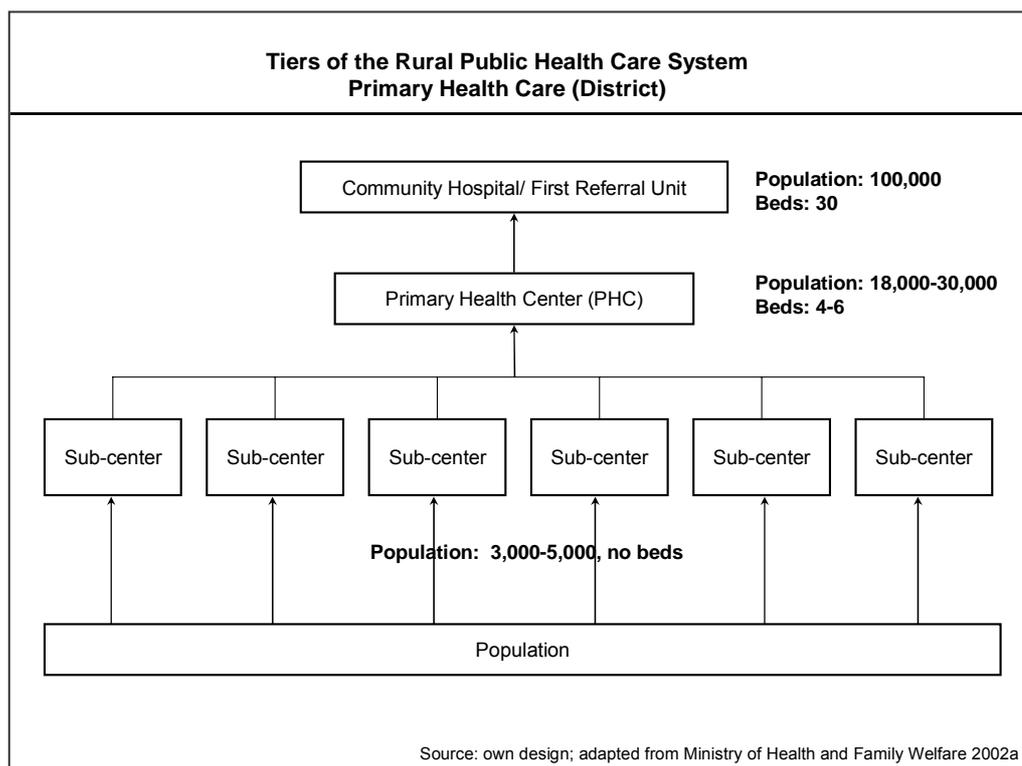


Figure 3.16: Tiers of the Rural Public Health Care System

SCs are staffed with one MPW female also sometimes called Auxiliary Nurse Midwife (ANM) and one MPW male. They serve as the first contact point between primary health care system and community and take care of preventive aspects. Before the MPWs were established, health workers were separately appointed for each health programme, coordination between them was rare. Now all health programmes are implemented through one agency with the MPW at the bottom of the hierarchy. While the female MPW is paid by the central government, her male counterpart receives his salary from the state (MoHFW 2002a: 74). SCs are otherwise fully funded by the central government, PHCs on the other hand are established and maintained by the state governments under the Minimum Needs Programme (MNP)/ Basi Minimum Service Programme (Ibid.: 75). MPWs are supposed to spend half of their time with household visits, where they collect the basic information for the health programmes (population statistics) and inform villagers about the purpose and schedules of the health programmes (e.g. vaccinations, sterilizations etc.). In case of health clinics or other activities under the National Health Programmes, they are also supposed to assist the Medical Officers (MOs) at the PHC. MPWs are monitored by a supervisor, who looks after five to six SCs. All MPWs under the jurisdiction of one PHC meet monthly with the MO to submit reports about their achievements in the National Health Programmes.

The PHC is manned with one Medical Officer (MO) and 14 subordinate paramedical staff (MoHFW 2002a). The main emphasis is on preventive care, family planning and other programme activities. Simple curative care is also available (see Ibid.). MOs manage the PHC and have to make regular tours to inspect and supervise the Sub-Centres under their

jurisdiction. They have to study the major health problems in their areas and send monthly reports to the CMOH or Block Medical Officer Health (BMOH). Medical tasks and administrative tasks are equal parts of their responsibilities. However, the administrative functions they have to perform are very time-consuming. They have to maintain the registers, write reports every month, attend meetings and trainings, coordinate their employees and do the daily correspondence. Ranga Rao found that in Tamil Nadu the number of registers was 40, monthly reports 52 and correspondence 6 letters a day (Ranga Rao 1993: 85-88). The monthly reports are mostly handed in personally at the monthly district level meetings (own observation). Relations between MOs, who are mostly outsiders, and employees, often local residents, can be problematic. The local influence of paramedical staff and the existence of powerful unions lead to difficulties in maintenance of discipline.

The CHC has specialised services, it is staffed with 4 MOs (Surgeon, Obstetrician, Physician and/or Pediatrician), 7 nurses and other paramedical staff leading to a total number of 25 (MoHFW 2002a). Family planning operations and other small curative services are offered here. However, the figures provided here are only policy requirements and do not correspond with the actual situation of rural primary health care.

3.2.2. Quality of Public Health Care

3.2.2.1. Rural Health Facilities

The provision with PHC, SC and CHC according to service population is much lower than envisioned by the plan. The shortfall of CHCs is the most prominent among the health facilities (54 %) (MoHFW 2002a: 28). The number of PHCs should be 19 % and for SCs 16 % higher than the current number to serve the whole population (Ibid.). However, the absolute number of health facilities does not automatically imply that their spatial distribution is even. Placement of health facilities is more often a political decision rather than a geographical. Hence, PHCs are sometimes not based in the centre of their service areas but on the border (Ranga Rao 1993: 76-82). The spatial distribution of PHCs has not been researched as such, but some studies about access to PHCs in India from a geographical perspective exist (see Kumar 2004). Kumar for example shows that lack of locational efficiency prevails despite the increase of PHCs, while geographic access improves (Kumar 2004: 2063). The average radial distance, the distance between the health facility and the border of its service area, for SC is 2.73 km, for PHC it is 6.69 km, and for CHC it is 18.32 km (MoHFW 2002a: 59). Depending on landscape features like mountains or rivers, infrastructural conditions (type of road), mode of transport (bus, walking), and seasonal conditions (monsoon season, harvest season etc.) access to the facilities varies.

3.2.2.2. Public Health Personnel

However severe the shortfall of health care facilities is, the lack of doctors and paramedical staff in the existing rural facilities hampers quality of public health care even more. Despite the high output of doctors from medical colleges, nearly 6 % of PHCs have no doctor, 9% lack a pharmacist, and 23 % have no lab technician (MoHFW 2002a: 38). In all of India the ratio of public sector physicians to population is as low as 0.2 per 1000 persons (Peters et al. 2002: 41). Most of the urban educated doctors are not willing to serve in rural areas, where infrastructure and payment are poor. The private sector in turn offers high technology and good payments, most often in an urban location, where living standards are much higher than in rural areas. Incentives to bring more doctors to rural areas include housing allowances and obligatory two years of rural services for students who want to continue their education with Post Graduate courses (Misra et al. 2003: 125). All the attempts have not been fruitful so far. The state's dilemma is high spending on education of doctors which will not be working in public services later on. The kind of education medical students receive is also blamed for their lack of enthusiasm for rural areas. While social and preventive medicine is only a side subject, Western medical care models and technologies are the major part of teaching. Therefore, it is not surprising that a large number of doctors also emigrate to the United States of America, Great Britain and Arabian countries (4,000-5,000 each year; Duggal 2000: 11).

The National Health Policy summarises the inadequacy of public health facilities as a combination of insufficient funding, lack of staff and consumables, obsolescent and unusable equipment, deteriorated buildings, lack of essential drugs, and inadequate capacities (MoHFW 2002b: 9). The quality of public health services can be further evaluated looking into utilization, access and equity of health care.

3.2.2.3. Utilization of Public Health Services

Overall utilization of public health services is very low. The utilization rate for outpatient care is less than 20 % (MoHFW 2002b: 22; Peters et al. 2002: 7). Figure 3.17 shows the shares of the public sector in the delivery of immunization, prenatal care, institutional deliveries, hospitalization and outpatient care for patients above and below the poverty line (Peters et al. 2002: 7). While the share of the public sector in immunization is more than 80 %, it declines for the other services. The figures indicate that the public sector plays an important role in immunization, prenatal care and institutional deliveries, where its share is around or above 50 %. The public sector distribution to hospitalization and outpatient care is less significant. The figures also indicate that patients below the poverty line use public sector facilities more in all categories than patients above the poverty line.

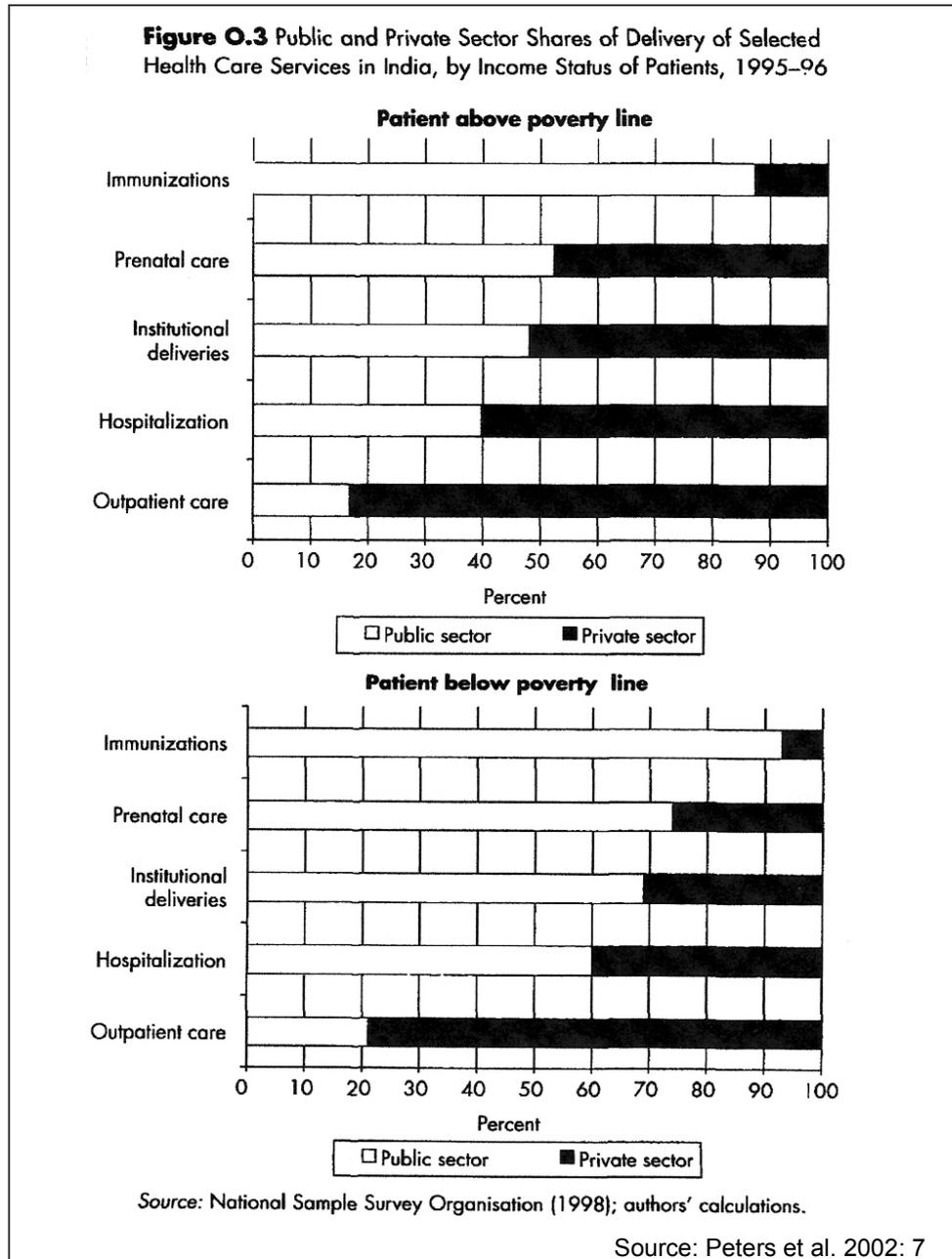


Figure 3.17: Utilization of Public and Private Services by Income Status

The estimates for all of India are partly corresponding with but also contradicting village level studies. Banerjee et al. found in their study on health care delivery in Rajasthan that public services are more used by the richer third of the population (Banerjee et al. 2004: 945). Higher income in this study was also associated with a higher frequency of visits and higher monthly absolute expenditure on health. However, according to household budget all income groups spend the same amount for health care (7 %). The study also reflects that private health services were the most important source for health care delivery for all income groups, followed by public health services and traditional healer¹⁴. The poor and the middle income group were more likely to use the traditional healer than

¹⁴ - Traditional healer (ojha) is a person with no medical degree, who practises faith healing (ojha-tona). "The idea of ojha-tona is to get rid of any possible evil spirit causing illness." (Ray/ Bhaduri 2001: 15).

the public system. Ranga Rao in turn discovered that villagers in Andhra Pradesh, Tamil Nadu and Karnataka preferred the PHC doctors (72.2 %) to the private practitioners (27.8 %; Ranga Rao 1993: 148). Traditional healers were again popular in the poorer sections of population, but most people who decided to use the services of the private doctors preferred doctors with a qualified degree (77.1 %). In Gujarat contacts of women to traditional healers outnumbered all other services (67 %), followed by services from a non-governmental organization (56 %, Aga Khan Health Services), government services (35 %) and private services ranking last (20 %)¹⁵ (Vissandjée et al. 1997: 143).

Income is not the only variable influencing utilization of health services. Education, occupation, age, households assets like tap water, family structure, severity of illness and others also influence the decision to use health services (see Vissandjée et al. 1997; Pallikadavath et al. 2004; Pillai et al. 2003; Chacko 2001). Vissandjée et al. highlights that older age, higher education, access to tap water and membership of higher caste for women is positively associated with private doctor use (Vissandjée et al. 1997: 143-145). Women with an occupation outside the household were also more likely to use private practitioners or non-governmental health services. All these variables were linked to more awareness and more freedom of choice of these women. Their preference for private doctors was associated with more modern and higher quality services offered there. The use of public antenatal care services of women in rural north India was positively related to women's education, use of family planning services, older age at marriage, low parity and access to television (Pallikadavath et al. 2004). Social dynamics, biological factors and community level perceptions were important for utilization here. Out of these studies education emerges as one major determinant for utilization of health services. Pillai et al. shows contradicting results. They found that higher education of the mother was linked to less care-seeking for their children. However, higher education in their study was thought to indicate more available resources in the households of the respective mothers which enables them to obtain care later.

3.2.2.4. Access to Public Health Services

While utilization is influenced by social, economic and cultural variables, distance, cost, quality of care and trust are further important for access to public health services. Distance to health facilities was more important for women in Gujarat than the actual costs of services (Vissandjée et al. 1997: 145). In rural areas walking distance to health facilities is an important factor, because of the lack of transport. Hence, a distance of 5 km, which means one hour walking, is considered to be the maximum radius for PHC (Ranga Rao 1993: 146). Others have defined the distance of 1 km from the village centre as easy access (Paul et al. 2004: 924). The time needed for reaching the facility and going back as well as the time spend within the facility further constrain access since it means a loss of income. Peters et al. confirms for all of India, that costs were a more important reason for not seeking care for all income quintiles than distance (Peters et al. 2002: 292).

¹⁵ - Sum of percentage exceeds 100, because categories were not mutually exclusive and women used 0-4 health providers in the reference period (Vissandjée et al. 1997: 143).

Distance and cost are interlinked as shown above. Costs for public health services are an ambiguous subject. Primary health care at SC and PHC is free of charge, except a small registration fee (Rs. 0.25 - 2). Patients below poverty line do not have to pay for public hospital services at CHC or higher facilities either. Even though SC and PHC offer free services, they are often not adequately stocked with free medicines (Kamat 1995: 95). Patients thus have to buy medicines from private pharmacists or from the doctor (Banerjee et al. 2004: 948; Ray/ Bhaduri 2001: 17). Public health officers might also charge for their services when working outside their official office hours (Banerjee et al. 2004: 949). The dependence of treatment on extra payment has been mentioned in other studies also (Ranga Rao 1993: 148; Misra et al. 2003: 121). Corruption in public offices is widespread in India and largely affects public services (Peters et al. 2002: 194). Therefore, it appears that public services are not as free as they should be. Low-caste, uneducated households feel that their access to public services is limited as these services are biased towards high caste, educated and powerful people (Ray/ Bhaduri 2001: 17). This perception also reflects a lack of trust. Trust is an essential element for household decision-making on health service use (see Kamat 1995; Das/ Das 2003; Pallikadavath et al. 2004). Experiences with public health services affect participation in health programmes and immunization activities (Das/ Das 2003: 111). Hence, bad experiences with the public health provider lead to less utilization of public services.

3.2.2.5. Availability of Care

Quality of care variables like access and utilization have already been mentioned, availability of care is another indicator. Availability of doctors and paramedical staff at public health facilities is a crucial determinant for quality of care and influences utilization of these facilities (see Banerjee et al. 2004; Devarajan/ Shah 2004; Ranga Rao 1993; Kamat 1995). Absence rates¹⁶ in government facilities are high (see Figure 3.18). Absence rates for doctors are higher than absence rates for teachers or health workers, they range from 28 to 67 %. Banerjee et al. findings correspond with these figures. In Rajasthan 45 % of medical personnel at the SC and 36 % of medical personnel at PHC or CHC were found absent (Banerjee et al. 2004: 948). Distance of facility to road has an impact on absence rates, in far-off SCs only 38 % of staff was present compared with the average of 55 % (Ibid.). Hence, availability of doctors is less in remote areas. Asked about their problems with the Primary Health Centres most respondents of a study in Andhra Pradesh, Tamil Nadu and Karnataka named absence of doctors as first criteria (Ranga Rao 1993: 149). Furthermore, facilities which are open more often, show higher utilization rates than facilities where the personnel are present less often (Banerjee et al. 2004: 948). If the public facility is often closed, the poor are more likely to visit traditional healers (Ibid.). The experience of a closed facility obviously affects the service decision for the

¹⁶ - „The absence rate is the percentage of staff who are supposed to be present but are not on the day of an unannounced visit. It includes staff whose absence is 'excused' and 'not-excused'.” (Devarajan/ Shah 2004: 910).

next time. The reason for high absence rates is seen in the lack of accountability of the public personnel (Devarajan/ Shah 2004: 911).

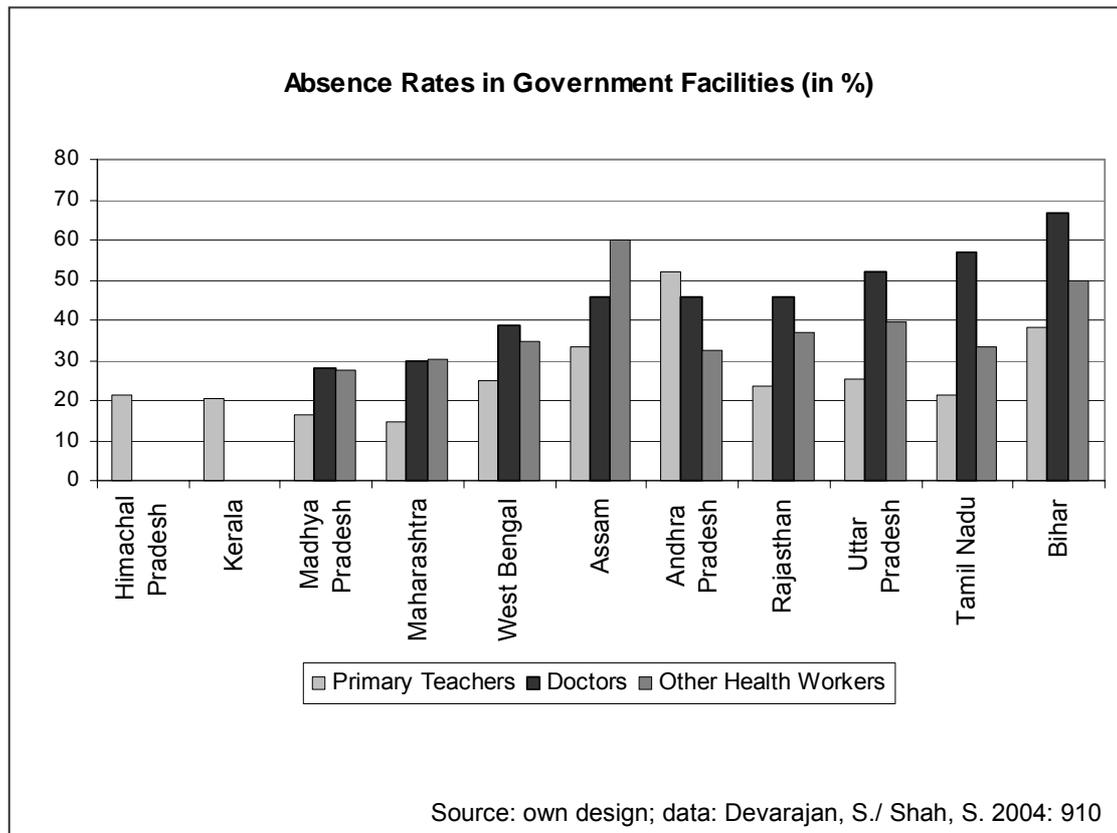


Figure 3.18: Absence Rates in Government Facilities

Lack of medicines and doctors, inadequate quality of service, and individual access and utilization barriers are responsible for the underutilization of public services in rural areas. Public health policies and management have failed to address these issues. Insufficiency at the Ministry of Health (see above) affects all sub-national levels. Sub-national levels also do not appear to work effectively. The next section will look into the management and performance of National Health Programmes and into the status of primary health care in India.

3.2.3. National Health Programmes

India currently undertakes 16 National Health Programmes and various other programmes related to health like Basic Minimum Service Programme, Poverty Alleviation Programme, National Water and Sanitation Programme, and National Programme of Improved Chulha (cook stove) (Kishore 2002). Family planning, communicable and non-communicable diseases are the major working areas. In terms of spending the Family Welfare Programme has the highest priority, the budget for 2003-2004 was Rs. 49.3 billion (MoHFW 2005: 155). Among the other National Programmes the highest amount is spent for HIV/ AIDS, followed by Vector Borne Diseases and Tuberculosis (see Figure 3.19).

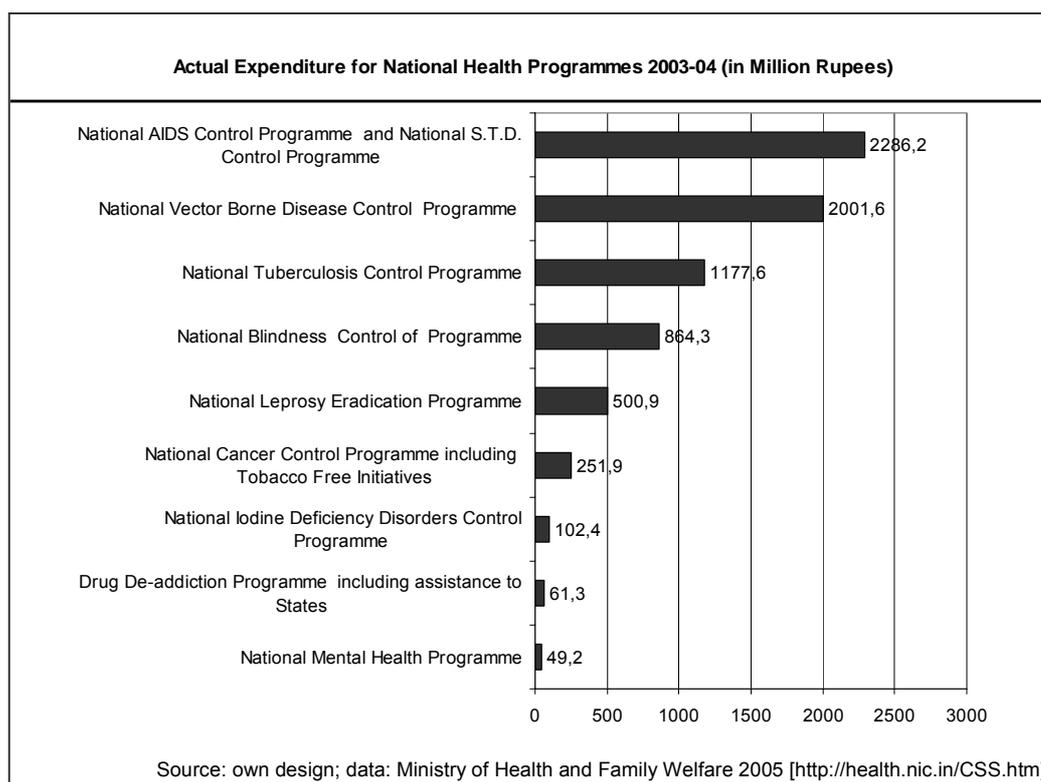


Figure 3.19: Expenditure for National Health Programmes 2003-04

3.2.3.1. Family Welfare Programme

The Family Welfare Programme includes all other programmes concerned with reproductive and child health such as the ICDS Scheme. The Family Welfare Programme was adopted in India as early as 1951 under the name of Family Planning Programme. It was the first population control programme worldwide, introduced in the knowledge that rapid population growth poses a socio-economic problem for the country. The programme was renamed in 1974 and more components were included. Sterilization rates were abolished in 1996 under the target-free approach which became the Community Needs Assessment Approach (CNAA) in 1997 (Kishore 2002: 16). The motivation fee for sterilization was withdrawn. The CNAA envisions that the female MPW prepares an action plan for Sub-Centre which draws on the information collected through her household survey and discussions with other health workers, women groups and the panchayat. The data is compiled at the PHC and later at the CHC, which prepare their action plans accordingly. According to the achievements from the last year, the health staff has to accomplish 5 to 10 % higher rates for mother and child health services, antenatal care visits, and immunization (Ibid.: 20). This decentralized participatory planning strategy tries to involve community and opinion leaders in the formulation of decentralized family welfare and health care plans (MoHFW 2005: 124). The programme is supported through funds from United Nations Fund on Population Activities (UNFPA: Rs. 3.65 billion in 2003-2007), World Health Organization (WHO: US\$ 505,000 in 2004-2005) and United States

Agency for International Development (USAID: US\$ 325 million in 1992-2004) (Ibid.: 156). Special programme components like the Border District Cluster Strategy for child health is sponsored by UNICEF releasing its funds directly to the states (Ibid.: 165). The World Bank has also given large loans through its population projects since 1972. During 1998-2003 US\$ 248.3 million for reproductive and child health care and US\$ 300 million for women and child development were granted (World Bank 1999: 7).

The goal of the Family Welfare Programme is the reduction of Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Crude Birth Rate (CBR). Higher coverage with antenatal and prenatal care services as well as higher immunization coverage, more institutional deliveries, higher female literacy, more services for scheduled castes and slums, and more eligible couples who use permanent or temporary contraceptive methods are the steps towards these goals (see Kishore 2002, MoHFW 2005). Although IMR, MMR and CBR sank throughout the last decades, the rates are still high (see 3.1.1.). Inequalities in antenatal care services and immunization coverage prevail (see above).

3.2.3.2. Participation in the Family Welfare Programme

Non-governmental organizations (NGOs) are involved in several parts of the programme as are village community groups. In the Information, Education and Communication (IEC) Programme NGOs were used to sensitize, mobilise and involve elected representatives and the general public in reproductive and child health through workshops and newsletters (MoHFW 2005: 126, 170). The Mother NGO (MNGO) scheme introduced during the 9th five year plan (1997-2002) is another important component of Public Private Partnership (PPP) within the Family Welfare Programme. Currently, 102 MNGOs receive grants from the government for the promotion of reproductive and child health (Ibid.: 173). The MNGOs in turn issue grants to smaller Field NGOs (800 FNGOs) in 439 districts throughout the country, who exercise the mainly educational tasks according to the goals of the programme. Under the new NGO guidelines they are also supposed to complement and supplement public-private health care infrastructure in un-served and underserved areas (Ibid.: 175). MNGOs control and supervise FNGOs. While FNGOs are accountable to them, MNGOs have to report back to the government.

Another scheme is the Service NGO (SNGO) scheme, which will be implemented in un-served and underserved areas. The SNGOs are supposed to deliver a variety of clinical and non-clinical services as an integrative package of reproductive and child health services (Ibid.: 174). Documentation and training activities are included in the non-clinical services. To carry out these services, SNGOs need appropriate staff (doctors, paramedical staff) and infrastructure (ambulance, hospital, clinic). Tamil Nadu and Karnataka also want NGOs to adopt PHCs.

The changes as envisioned under the revised NGO guidelines are as follows:

- “decentralization of the schemes to the state and district level;
- shift from exclusive IEC and awareness generation to service delivery;
- delivery of RCH services by NGOs in un-served and under served areas;
- clearly defined eligibility criteria for registration, experience, assets and jurisdiction;

- rationalization of the jurisdiction area serviced by the NGO to provide in depth service and optimize resources, mainstreaming gender issues in all intervention areas;
- enhanced male participation and involvement in delivery of all RCH services;
- emphasis on measurable qualitative and quantitative performance indicators;
- selection, approval, funding and monitoring of MNGO/SNGO projects by State and District RCH Committees.
- increased interface of NGOs with local government bodies.” (Ibid.: 173).

Community participation is tried through establishment of Mahila Swasthya Sangh (MSS). The MSS are women groups in the villages, whose members are five grass-root level volunteers, ten prominent women from the community, the MPW female, and field level functionaries from the Education Department. Since 1990 79,512 MSS were established in the country, of which each receives Rs. 1,200 per year for conducting their monthly meetings (Ibid.: 169). Education and motivation of the community to participate in reproductive and child health programmes are the main tasks of MSS.

3.2.3.3. National Programmes for Communicable and Non-Communicable Diseases

The National AIDS Control Programme was initiated in 1999 to reduce the spread of HIV/AIDS and to strengthen the response of the public system to the disease. In India 5.1 million people were infected with HIV in 2004 (NACO 2005). Although this is only 0.9 % of the adult general population, it means that India has an equal number of infected people like in South Africa, where the prevalence is 21.5 % (UNAIDS 2005: 9). Prevention, care and surveillance are the three dimensions of the programme. Treatment of sexually transmitted diseases (STD), awareness raising, voluntary counselling and testing, and condom programming are part of the preventive programme. The Gates Foundation supports the programme with US\$ 200 million (Ibid.: 43). The World Bank group provided an interest free credit of US\$ 191 million in 1999 (World Bank website). Other UN organizations and bilateral development agencies also support the programme. The Programme is carried out by the National Aids Control Organization (NACO) and its sub-national State Aids Control Societies. In the prevention programme 150 NGOs are involved.

Knowledge concerning the prevention of HIV grew. The programme managed to increase the condom use of commercial sex workers. The number of centres for voluntary testing and counselling increased to 628 in 2004 (MoHFW 2005: 43). However, HIV is still on the rise in India and awareness in rural areas is low.

The National Vector Borne Disease Programme encompasses the prevention and control of Malaria, Kala-Azar, Filariasis, Japanese Encephalitis, and Dengue Fever (Kishore 2002: 98). Among them Malaria has the highest prevalence with 1.65 million cases in 2003, followed by Kala-Azar (17,321) and Dengue Fever (12,750) (MoHFW 2005: 23-28). Strategies for Malaria prevention and control are early diagnosis and prompt treatment, integrated vector control through indoor residual spray, promotion of bednets, use of larvivorous fish, IEC and capacity building. The number of Malaria cases has fluctuated

between 2 and 3 million cases per year since 1984, a small decline can be noticed since 1997 (Ibid.: 23). Filaria is endemic in 20 states, “control strategies include vector control through anti larval operations, source reduction, detection and treatment of microfilaria carriers, morbidity management and IEC.” (Ibid.: 25). Indoor residual spray is also one main strategy against Kala-Azar and its vector the sand fly. Its elimination is envisaged for 2010. Reduction of vector density and personal protection against mosquito bites are the prevention measures for Japanese Encephalitis. The measures for Dengue Fever are similar, personal protection, source reduction and IEC are employed. The number of Dengue cases shows a stark increase from 1998 (707) to 2003 (12,750) (Ibid.: 28). Kalar-Azar cases also went up and Japanese Encephalitis did not significantly decline (MoHFW 2003: 189-190). Hence, the measures taken for prevention of vector-borne diseases have not been very successful.

The National Tuberculosis Control Programme does not receive as much funds as the AIDS or Vector Borne Disease Control Programme, although Tuberculosis kills more people in India than HIV, STD, Malaria, Leprosy, and tropical diseases combined (417,000 per year; Ibid.: 33). The programme tries to cure 85 % of all detected cases through Directly Observed Treatment, Short Course (DOTS) as recommended by WHO. The programme is supported by World Bank, UK Department for International Development (DFID), Danish International Development Agency (DANIDA), USAID and Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) (Ibid.). The programme was able to reach nearly 76 % of population and to treat 2.8 million since its start in 1993. However, Tuberculosis remains a serious threat with 2.2 million new cases every year of which 1 million are infectious smear positive pulmonary cases (GFATM website).

The National Blindness Control Programme exists since 1976. Prevalence of blindness was 1.1 % in 2001-2002 (MoHFW 2005: 35). The improvement of eye care services is the major programme component. Cataract surgeries steadily increased up to 3.9 million in 2002-2003. School eye screening was introduced and training and IEC activities implemented. The voluntary sector plays an important role in the establishment of District Blindness Control Societies, furthermore, 45 NGOs receive assistance under this programme. World Bank (US\$ 85 million from 1994 to 2002), DANIDA and WHO assist the programme.

The National Leprosy Control Programme came into existence in 1955 (Kishore 2002: 133). Early detection and regular treatment with Multi-Drug Therapy are as important in the programme as public awareness campaigns to remove the social stigma associated with Leprosy. The prevalence of the disease has come down from 57.6 cases per 10,000 population in 1981 to only 2.3 cases MoHFW 2005: 29). Leprosy is eliminated in 16 states of India. The Leprosy elimination campaign was successful. The programme is supported by the World Bank, the International Federation of Leprosy Elimination, WHO and DANIDA. NGOs are involved in the programme and have helped to reduce the prevalence (Ibid.: 32).

The National Cancer Control Programme was established in 1975. Prevention of cancer through education, early detection and treatment as well as strengthening of institutions to improve therapy are modules of the programme. India currently has 150,000-200,000

cancer cases, 70,000 new cases come up every year (Ibid.: 44). Regional cancer centres and district cancer control programmes have been initiated with central funds. Health education through voluntary organizations is again a major focus of the programme.

The National Iodine Deficiency Disorder Programme assesses the magnitude of Iodine Deficiency, supplies iodated salt, and carries out IEC activities for prevention. The Drug De-addiction Programme and the National Mental Health Programme receive relatively small funds. Both programmes started in the 1980ies. Integration of mental health with primary health care, provision to tertiary care institutions, and eradicating stigmatization of mentally ill patients are steps taken under the National Mental Health Programme. District Mental Health Programmes, with a community based approach to the problem, began 1996 in four districts. The programme will be expanded to cover the entire country.

3.2.3.4. National Programmes Related to Health

The Basis Minimum Service Programme introduced in 1974 mainly focuses on “100 % coverage of provision of safe drinking water in rural and urban areas, elementary education and adult education; 100 % coverage of primary health services facilities in rural and urban areas; universalization of primary education; provision of public housing to all shelterless poor families; extension of midday meal programme in primary schools, to all rural blocks and urban slums and disadvantaged sections; provision of connectivity to all unconnected villages and habitants; and streamlining of the public distribution system with focus upon the poor.” (Kishore 2002: 231). The rural primary health care network has already been described in details above (see 3.2.1.3.). The status of India’s public services in view of access to drinking water, primary schools, health care, public transport and public distribution shows that the programme has not been successful so far (see 3.1.2.; Paul et al. 2004).

The National Water and Sanitation Programme was introduced in 1954 and aims at the protection of environment and health through management of water resources and solid waste. A community-based approach was adopted in 1990, trying to mobilise community and build their capacity as well as to enhance community share in capital investment, ownership and control (Kishore 2002: 237). Since the 73rd Amendment of the Constitution of India (1992) PRIs have been involved in reviewing the implementation and management of drinking water sources. Private bodies and NGOs are engaged in the rural sanitation programme, focussing on low cost sanitation. In 2000 only 14 % of the rural population had access to safe sanitation (World Bank 2000: 2). The demand for sanitation among the rural population is low, it is difficult to convince them to built latrines. The sanitation coverage has not risen significantly till today, it is 23.7 % (Ministry of Rural Development 2005).

The National Programme of Improved Chulha (cook stove) has the purpose to conserve fuelwood and to care for women’s health which is severely affected by indoor air pollution through traditional cooking habits with open fire. Access to electricity in rural India is 44 % (Chaurey et al. 2004: 1693), gas is not easily available and also costly, therefore, the use of fuelwood for cooking is widespread, especially among the poor.

The Integrated Rural Development Programme is one of the Poverty Alleviation Programmes. It can be perceived as an employment scheme, promoting self-employment as an additional income source and offering training programmes to unemployed or underemployed men and women in rural areas (Kishore 2002: 235).

3.2.4. Primary Health Care

The five underlying concepts of the Primary Health Care Approach, namely equal access according to need and equal utilization of health care according to need (equity); community participation in all phases of primary health care; a multisectoral approach to health; appropriate technology; and a health-promotive and preventive approach are all important for India's health policy. Nonetheless, the last chapters showed that India's public health system has a variety of problems to cope with (see 3.2.2. and 3.2.3.). Socio-economic and cultural disparities deepen the conflict over access to and utilization of public facilities. Attempts to improve the health system through the Primary Health Care Approach and decentralization have already been highlighted above (see 2.2.3.2. and 2.3.4.). Although these reforms showed mixed results, they still form the leading ideas. Nowadays several aspects of primary health care are established in India, but external and internal reasons have prohibited the fulfilment of the Alma Ata vision.

India owns a large network of primary health care facilities in rural areas and a huge cadre of health staff. Primary health care already started with India's independence and the recommendations of the Bhore committee. After Alma Ata efforts were doubled to reach health for all. The conflict between comprehensive and selective primary health care is visible in the coexistence of the primary health care system and vertical national health programmes. Even though all programmes are streamlined at present through the primary health care infrastructure and executed by the personnel of PHCs and SCs, they still receive separate funding and are controlled by the Central Government. National programmes to fight certain diseases are heavily supported by international agencies but health outcomes are still below the targets. All the problems mentioned under 3.2.2. and 3.2.3. are known to and acknowledged by the government. Decentralization to enhance community participation in health care through NGOs and panchayats continues improving the health care situation in the country. However, access and utilization studies (see 3.2.2.3.-3.2.2.5.) show that India's public health system is far from reaching the equity goal.

3.3. PRIVATE HEALTH SYSTEM

The majority of India's population uses private health care providers (see Figure 3.17; Peters et al. 2002: 7). The private health sector thus plays an important role in improving and maintaining the health status of the population. There had already been private practitioners in preindependence India, either working as qualified practitioner of allopathy or Indian system of medicine or unqualified practitioner (Duggal 2000: 3). After independence the private sector shows a constant growth in terms of hospitals and hospital beds (see Figure 3.20 and 3.21). The highest growth rates for private hospitals are between 1988 and 1996, when India opened its markets as a result of the economic crisis of 1991.

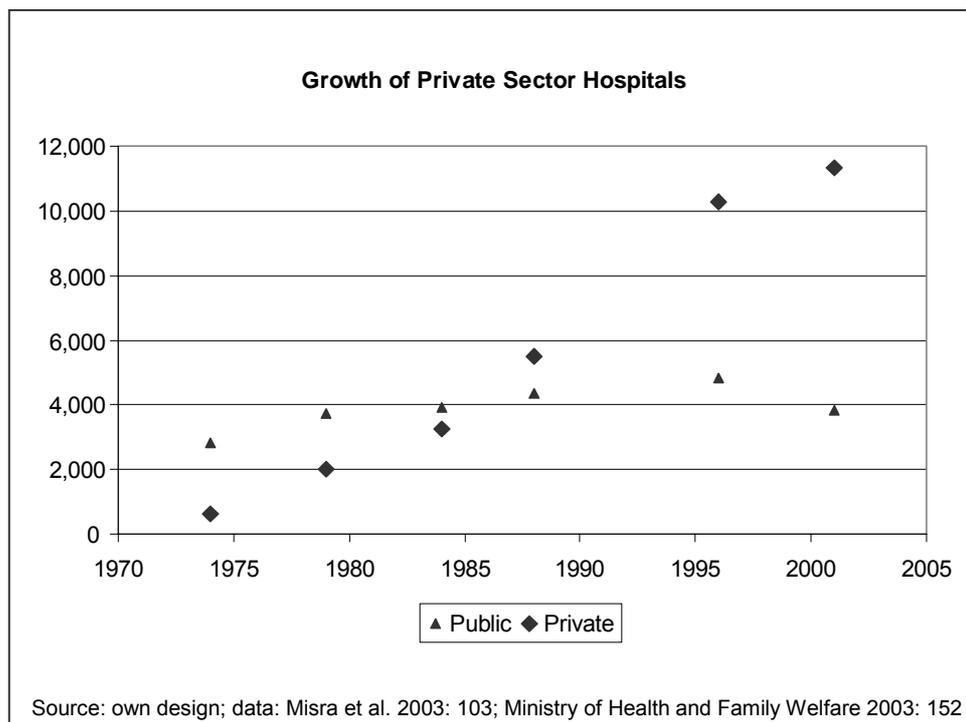


Figure 3.20: Growth of Private Sector Hospitals 1974-2001

More hospitals are run by the private sector than by the public sector, although the public sector still holds a larger number of beds¹⁷. Of the private-sector hospitals 31 % are located in rural areas, compared to 25 % of government hospitals. In terms of beds, the difference is even larger, with 29 % of private hospital beds in rural areas and only 10 % of government hospital beds (Misra et al. 2003: 104). Private health care exists in the form of hospitals, nursing homes¹⁸ and private ambulance. The average size of hospitals and nursing homes is quite small (10 beds; Misra et al. 2003: 103).

¹⁷ - Figures for hospitals and beds might also be underestimated (Duggal 2000: 11).

¹⁸ - Nursing homes are small private hospitals and dispensaries, offering inpatient and outpatient services to patients of all age groups (Bhat 1996: 271).

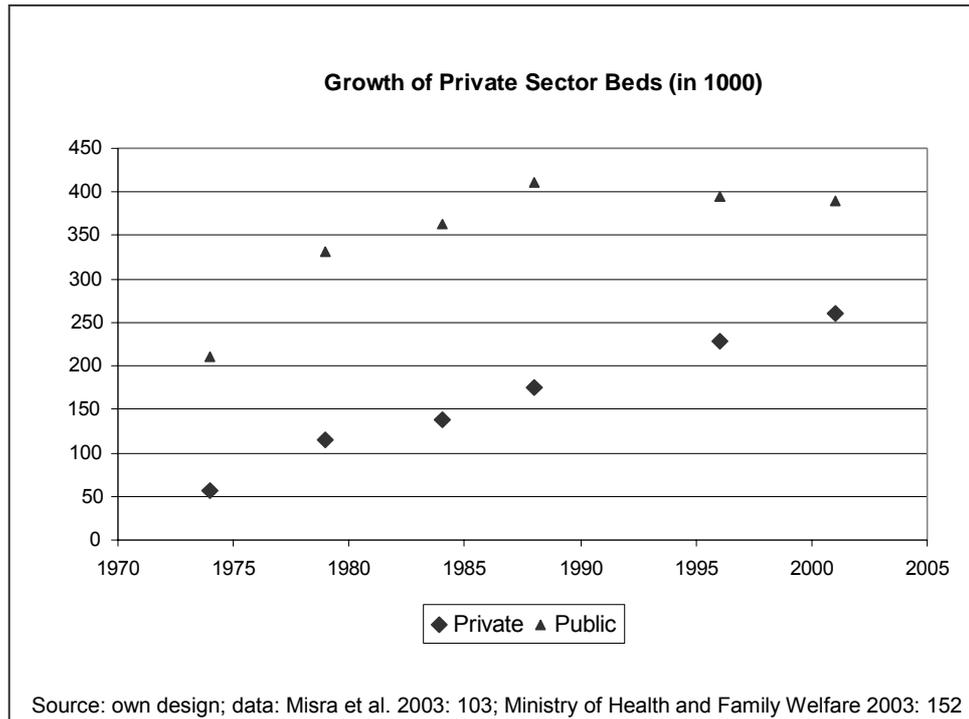


Figure 3.21: Growth of Private Sector Beds 1974-2001

The corporate sector makes up less than 1 % of the private hospital sector (Ibid.). Exact figures on the number of practitioners in the private sector do not exist. Estimates, however, show that private practitioners make up 85 % of all doctors (Duggal 2000: 7). In the private health care system several disciplines exist. Beside allopathy and modern medicine, ayurveda, homeopathy, siddha, unani and others are practised. The private health care sector can be further divided into private-for-profit and private-not-for-profit. While the first category is dominating, voluntary organizations and NGOs also play an important role in health care as depicted above (see 3.2.3.). Although the private sector cares for the majority of the population, data on distribution of private providers or quality of care are rare. Health policy focused on the development of public sector only, trying to create a national health service following the example of the UK National Health Service (Berman 1998: 1465). Hence, integration of the private sector as well as regulation and control policies are less developed.

3.3.1. Private-for-Profit

The lack of statistical data on private-for-profit practitioners only allows estimates about their spatial distribution, qualifications and numbers. Although private providers have a larger share of hospitals and beds in rural areas (see above), hospitals and nursing homes are also more concentrated in urban areas. In rural areas private practitioners who offer ambulatory services are more common than hospitals or nursing homes. While Berman argues that private providers built an extensive health care network in rural areas (Berman 1998), other studies show different concentrations. Kumar found that locational

efficiency of private providers was lower than for public providers. They prefer to stay in villages with better transport facilities and in proximity to a city or town (Kumar 2004: 2060-61). Chakraborty and Frick support these findings, 90 % of doctors in their study were based in rural town centres (Chakraborty/ Frick 2002: 1583).

The distribution pattern of private providers is further influenced by their qualification. In-depth studies on private provider's qualifications showed that a large percentage has no formal medical qualification. In Gujarat 62 % of the private doctors did not hold a medical degree (Bhat 1996: 257). Similar findings come from a study in Madhya Pradesh where 56 % of private providers were untrained (Deshpande et al. 2004: 220). Of the 40 providers studied in rural West Bengal none had received formal medical education (Chakraborty/ Frick 2002: 1583). Nevertheless, patients prefer to use these providers (see 3.2.2.3.). Private providers with limited formal training or no training are more located in rural areas and far away from sealed roads (Deshpande et al. 2004: 220). The villages with least access to public facilities due to large distances are most likely to have untrained private providers or no provider at all (Ibid.).

3.3.1.1. Acts and Regulations

Private providers with no formal education are referred to as "less-than-fully-qualified" practitioners (Berman 1998: 1473), unqualified rural medical practitioners (Misra et al. 2003: 106) or "quacks" (Duggal 2000: 7). Allopathic practice without the qualification and registration required is not legal but was permitted until the mid-1970ies in many states (Berman 1998: 1474). Several acts exist to regulate the private sector, most prominent are the Consumer Protection Act (1986), the Indian Medical Council Act (1956), and the Nursing Home Act (see Kishore 2002: 330-333, 337-338). Although these acts are quite known, implementation and enforcement of rules and regulations have been weak (Bhat 1996: 263). The Indian Medical Council Act provides the constitution for the Medical Council of India which gives recognition to medical qualifications, maintains uniform standards in education, and defines a professional code of conduct and ethics (Ibid.: 269; Kishore 2002: 330). The Medical Council of India and the State Medical Councils are supposed to maintain registers of providers, but a systematic database does not exist. Furthermore, the councils lack punishment for cases of misconduct, hence, their performance as regulators is not sufficient (Bhat 1996: 270). Consumer councils established under the Consumer Protection Act promote and protect the rights of consumers who can apply to these courts free of cost (Kishore 2002: 337). The efficiency of this act received high ratings among the private providers, but lack of infrastructure and staff led to pending cases (Bhat 1996: 263-265). In addition, patients have problems in proving medical negligence as private providers do not make their diagnosis available (Ibid.). The Nursing Home Act requests the registration of all nursing homes with their local supervising authority. However, inspections by these authorities are rare and cancellations are infrequent (Ibid.: 272). No minimum standards are specified in the act. Therefore, the act has so far not proved useful for the regulation of the private sector.

3.3.1.2. Services of the Private-for-Profit Sector

Most private practitioners in rural areas use a mix of allopathy and Indian system of medicine. The overlap between Western and Indian medicine is quite substantial (Berman 1998: 1472). Hence, the strict distinction between the different types of practice is blurred. The services offered are advice, treatment and the prescription of drugs. Most providers use a fee-for-service reimbursement scheme. In Bhat's study on private providers in Ahmedabad, 70 % of the private providers used fee-for-service as payment system and 30 % used a case-based system (Bhat 1999: 29). Charges for health service were mainly based upon the actual costs, but also oriented to market practice (Ibid.). Recommendations by medical associations played only a minor role. Costs are as well affected by the location of the provider, the equipment and technology he/she uses and to a lesser extent by manpower employed, maintenance, and other infrastructure requirements. In the absence of strong regulations or rules over-prescription of drugs and over-use of diagnosis services are common among private practitioners who rely on the income generated by these activities (Ibid.). No institutional framework to review user charges exists (Peters et al. 2002: 242).

3.3.1.3. Utilization of Private Health Services

Private providers are sought after by all rural people, differences by expenditure groups, age and sex are not very significant for determining utilization (Berman 1998: 1467). However, the use of private sector for hospitalization differs among the income quintiles, with the richest quintile using private facilities more (67 %) than the poorest quintile (39 %) (Peters et al. 2002: 214). Other factors which influence utilization have been discussed in detail above (see 3.2.2.3.), therefore, they will not be repeated here. They are as relevant for the public as for the private sector. While people slightly preferred the public system for the treatment of tuberculosis (51.6 %), the private sector was in favour for services related to malaria (81.5 %) and dysentery (81 %) (Berman 1998: 1472). Studies cited in Misra et al. indicate similar results, 60-85 % seek treatment at private providers for tuberculosis, 80 % for childhood diarrhoea, and private providers are also preferred for treatment of sexual transmitted diseases (Misra et al. 2003: 109). Thus, the private sector is largely involved in the treatment of diseases of national concern, but is not integrated into public policies targeting these diseases (see Peters et al. 2002).

3.3.1.4. Problems of the Private Health Sector

The problems of the private sector are its low technical quality and the higher price (Banerjee et al. 2004, Berman 1998, Bhat 1999, Chakraborty et al. 2000, Chakraborty/Frick 2002, Misra et al. 2003: 108-109). The hospital charges of the private health system are much higher than for public hospitals (see Figure 3.22). The average cost per visit to a private provider is also higher than to a public provider as Banerjee et al. study has shown for rural Rajasthan (Banerjee et al. 2004: 945). In addition, another study found that the

mean cost of drugs was Rs. 74 for the private sector and Rs. 34 for the public sector (Bhatia/ Cleland 2004: 402). The per capita out-of-pocket expenditure to private facilities ranges from Rs. 500 per year for higher expenditure groups to Rs. 75 for lower expenditure groups (Misra et al. 2003: 108). Furthermore, the poorest quintile spends a higher percentage of their expenditure for private health care than the richest quintile. The percentage of Indians falling into poverty from medical costs is high, it ranges from 17 to 35 % depending on their state of residence (Peters et al. 2002: 5).

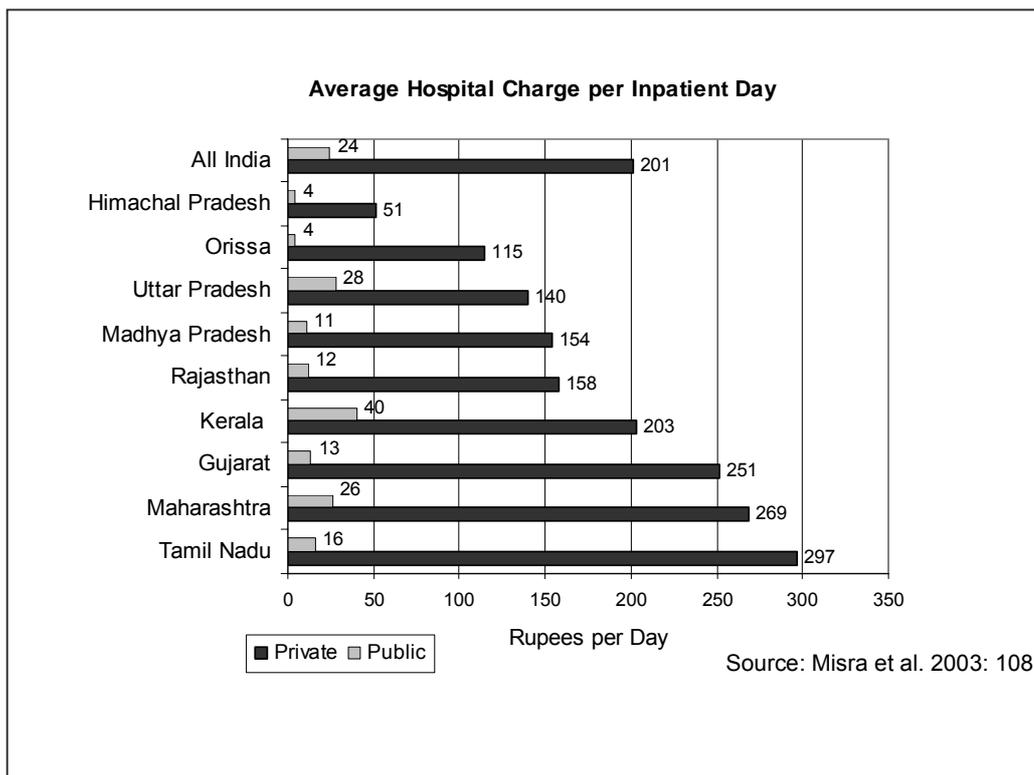


Figure 3.22: Average Hospital Charge per Inpatient Day for Private and Public Hospitals

Despite higher costs, it is the quality of care by private providers which is criticised. The technical quality of care for the treatment of acute respiratory diseases of children was found to be very poor in rural West Bengal, providers obtained only a score of 8 out of 33 (Chakraborty/ Frick 2002: 1583). Lack of knowledge was held responsible for the low performance. Variation in treatment practice is an indicator for low quality, because the same level of health care should be offered for the same need (horizontal equity, see 2.2.1.1.). Significant variations in treatment practices were found in this study. They occur because of different patient load. The more patients are treated per day, the less care is taken per patient. Bhat finds that the majority of private providers in his study exceeded the optimal patient load of 25 patients per day in order to increase their profit (Bhat 1999: 28-29). Incorrect drug regimes and dosages affect the treatment and can harm the patient. Malpractice for the treatment of tuberculosis and malaria was found to be widespread among private practitioners (Misra et al. 2003: 109). Drug resistance and spread of communicable diseases are the results.

3.3.1.5. Conclusion

Although the quality of care is low in the private sector and the prices are much higher than in the public sector, people continue to prefer private services. Studies which directly compare the quality of care in public and private facilities are rare. An exception is Bhatia and Cleland who compared public and private providers in Karnataka (Bhatia/Cleland 2004). They found that thoroughness of diagnosis and doctor-patient communication was better in the private sector, hence, they concluded that quality of care is much higher in the private sector. This view corresponds with the general opinion in India, that private sector is superior to public institutions (Misra et al. 2003: 109). People use private health providers because they can establish long-time relationships and trust, alternative modes of payment are available (credit), the providers are located closer to one's home, and the quality of care seems to be higher (more individualised).

The discussion above shows the following picture for rural India. The rural population, especially in remote areas, relies on less qualified private providers. Qualified private providers tend to concentrate in urban areas, hence, rural population needs to travel to reach them. Higher costs of services are endured for a perceived better quality of care. Lack of knowledge and profit orientation of private providers can jeopardise health outcomes of rural population who are not aware of standard treatment regimes.

3.3.2. Indian System of Medicine

Practitioners of Indian System of Medicine (ISM) mostly work in the private-for-profit health sector and practice ayurveda, siddha, unani, yoga, naturopathy, or homeopathy¹⁹. University education for Indian System of Medicine is recognised by the state. A small percentage of ISM practitioners are also employed in the public sector and few ayurvedic dispensaries exist. The Department of AYUSH controls and monitors the quality of education. ISM practitioners comprise the majority of all registered practitioners in India (54 %; MoHFW 2003: 115). In terms of hospitals and beds, 16 % of all hospitals and 9 % of all beds in the health sector belong to one of the Indian Systems of Medicine (see Figure 3.23). Among the Indian Systems of Medicine ayurveda is the most popular, with the highest number of hospitals, beds and practitioners (see Figure 3.24). The first documentation of ayurveda dates back to the Vedas (ancient Hindu scriptures, 1500 BC-500 BC) (Misra et al. 2003: 179). The concept holds a holistic picture of the human body, it looks into physical, mental, social, and spiritual aspects of human beings. The body is composed of the five elements vata (ether and air), pitta (fire) and kaph (water and earth) (Ministry of Health 2005: 215). In a healthy body these elements are in equilibrium. Morality and religious faith are thought to enhance therapeutic efficacy (Khare 1996: 839).

¹⁹ - The history and development of ISM is an own field of study and cannot be repeated here. See Kakar, S. (1990): *Shamans, mystics, and doctors: a psychological inquiry into India and its healing traditions*. New Delhi; Nichter, M./ Nichter, M. (1996): *Anthropology and international health : Asian case studies*. Amsterdam; Zysk, K.G. (1993): *Religious medicine: the history and evolution of Indian medicine*. New Brunswick; Sharma, P.V. (Ed.)(1992): *History of medicine in India, from antiquity to 1000 A.D.* New Delhi; Gupta, G.R. (Ed.)(1981): *The social and cultural context of medicine in India*. New Delhi.

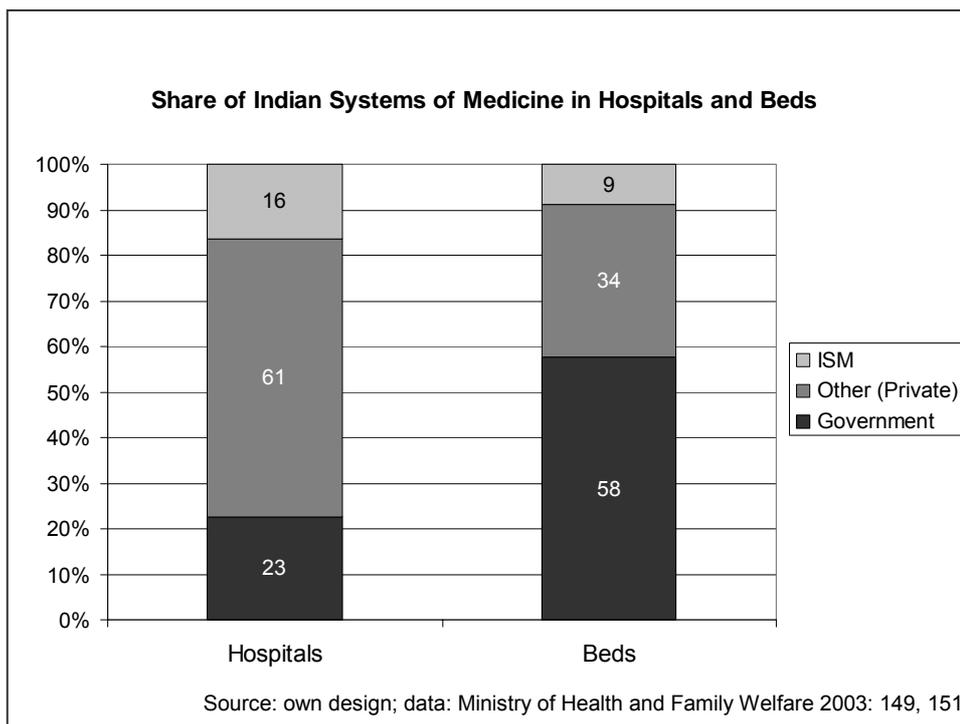


Figure 3.23: Share of Indian Systems of Medicine in Hospitals and Beds

Homeopathy comes second after ayurveda (see Figure 3.24), it came to India in the 19th century through German followers of Hahnemann²⁰. In this system diseases are cured with potentized drugs in high dilutions, which would induce the same symptoms in a healthy human being. Unani and siddha rank far behind ayurveda and homeopathy, but they are still very influential in India. Unani originates from Greece and can be traced back to the ideas of Hippocrates (460 BC- 377 BC) and Galen (Misra et al. 2003: 180). Many Arabic influences can be found in this system since it took its way to India through the Arabic peninsula, where it arrived in the medieval period. The humoral theory, the balance of the four humours, blood, phlegm, yellow bile, and black bile, builds the basis for this system. Unani is widespread among the Muslim community. Siddha is also a very ancient system and comes from South India. It is similar to ayurveda (Ibid.).

Of lesser importance are naturopathy and yoga (see Figure 3.24). Naturopathy is based on the principles of ayurveda but it does not use medicines. Bio-purification and dietary practice form the treatment for diseases. Health can only be accomplished through living by the laws of nature. Although yoga is not really a system of medicine, it promotes general health and well-being through exercise and meditation. Common to all Indian Systems of Medicine is their holistic approach to health, the orientation towards life rather than disease, the emphasis on promotive and preventive aspects and the use of natural substances for treatment (Ibid.).

²⁰ - Hahnemann (1755-1843), a German doctor and scientist, is the inventor of homeopathy.

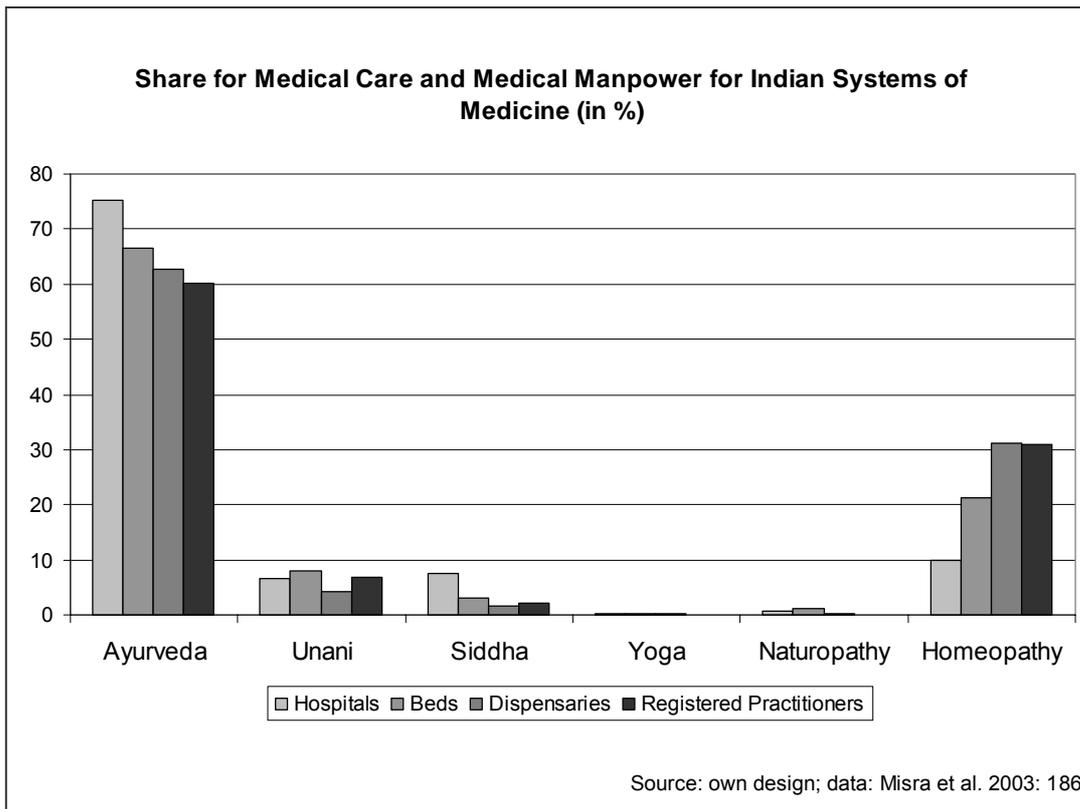


Figure 3.24: Share of Medical Care and Medical Manpower for Different Indian Systems of Medicine

The lack of data about private practitioners especially in rural areas also applies to the practitioners of ISM. The distinction between the practitioners of the different ISM systems is often unclear. Many of them also practice allopathy (see above). Equally blurred are the definitions of traditional healer, ISM practitioners who practice allopathy and quacks. Since many practitioners in rural areas have not received a formal education (see above) and practice a mix of ISM, faith healing and allopathy, it is difficult to define them by their practice. The cultural alienation between modern Western medicine and traditional medicine leads to a constant confusion, but they also influence each other (Khar 1996: 844). Practiced medicine in India is not homogenous. While modern Western medicine gets “Indianized”, ISM adopts concepts of Western medicine (Ibid.: 845). Thus, it becomes more practical to abandon the strict distinction and rather examine practical medicine in India as a whole. Khare states that “Indian patients thus habitually turn to Ayurvedic, Unani, Homeopathic, and Allopathic or modern scientific treatments, in any sequence or combination, to secure “best treatment.” (Khare 1996: 839; see also 3.2.2.3.). Hence, their cultural reasoning in choosing a health care provider or service does not differ from any other culture in its pragmatic approach.

3.3.3. Private-not-for-Profit

India has a long history of voluntarism. Non-profit organizations have been already mentioned in ancient Hindu scriptures (1500 BC; PRIA 2001: 1). Charity as a specificity of religious beliefs and values was widespread in precolonial India and has been existing till today. During the colonial times organizations sprang up as part of the nationalist movement and the freedom struggle. After independence the state took up a dominant role. Although the government recognised the role of private voluntary organizations in the 1st five year plan (1951-56), the space for non-state or voluntary action was restricted (Jesai et al. 1996: 3; PRIA 2001: 15). A new approach focussing on more self-reliance instead of charity came up among the voluntary agencies in the 1960ies. While charity was linked to the establishment of new dependencies and the creation of donor-recipient relationships, under the new approach nothing was given for free, in the sense that community has to participate in the efforts. Instead of only setting up hospitals or dispensaries in rural places, NGOs²¹ in the 1970ies now employed village level workers which were to provide health services at the door step (Jesai et al. 1996: 4-5). This approach was later adopted by the government (see 2.2.3.2.2.). An increasing number of NGOs started to work in the health field. At the same time dissatisfaction with the government grew, because poverty and inequalities increased. After 1980 and the short power period of the Janata government, voluntary organizations experienced a new upsurge. The 6th five year plan (1980-85) established the position of NGOs. They received direct funds from the government and formal representation in government bodies. Cooperation and collaboration with the government in the implementation of many development programmes increased towards the end of the 1980ies (see PRIA 2001: 15-19). Fiscal crisis of the state in India led to the cutback in public programmes and the call for private investment and international assistance in the 1990ies. Thus, NGOs became even more important for the social sector. International assistance was often channelled through NGOs, reflecting the growing importance of NGOs in global politics.

The private-not-for-profit sector in India contains voluntary organizations, charitable trusts, non-governmental organizations (NGOs), welfare organizations, traditional associations, and other community based organizations. The terminology used in India is wide; overlaps between the different categories are not rare. Non-profit organizations in India have to register under the Societies Registration Act (1860), the Indian Trust Act (1882), the Cooperative Societies Act (1904), the Trade Unions Act (1926), or Section 25 of the Indian Companies Act (1956) (PRIA 2000: 7). Registrations as societies or trusts are most common. While the Indian Tax Act 1961 automatically exempts societies and trusts from tax, including professional colleges, hospitals, and professional associations, small, non-formal education programmes, primary health care projects or local sports clubs have to apply every year to secure their non-profit status (Ibid.: 10). Profit-oriented organizations or companies can and have founded trusts. Consultancies or research organizations have been set up as societies and formal organizations like trade unions perform activities for

²¹ - NGO is here used for all non-profit and non-governmental organizations, independent of their background, orientation or working areas.

public good. Even parties sponsor social welfare organizations. The line between non-profit and profit organizations is sometimes difficult to draw. The large study in India of the Society for Participatory Research in Asia (PRIA) in cooperation with John Hopkins University has defined the characteristics for such organizations as non-profit distributing, i.e. "even if surplus is generated, it is ploughed back to the work of the organization." (PRIA 2003a: 3).

Other overlaps can exist in the private or public character of an organization. The government for example has set up District Health Societies, organizations at the district level registered under the Societies Registration Act. Other organizations fully depend on one source of government funding and just act like a department of the government. Collaborative ventures between government departments and non-profit organizations also exist, where nominees of the government have a seat on the board of these organizations. Therefore, it is essential to point out that private-not-for-profit organizations have to be independent of the government apparatus and self-governing to be included under this category (see PRIA 2000, 2003).

Religious organizations also engage in social welfare functions and are a part of the non-profit sector. It has to be kept in mind that they may focus on one particular religious community rather than on the general public but this is no reason to exclude them. To conclude, private-not-for-profit organizations have to have a certain degree of institutional identity and capacity. They have to be institutionally separate from the government (private), non-profit distributing, self-governing and voluntary (PRIA 2003a: 3). Although the non-profit sector in India was traditionally rooted in the major religions, today it comprises 1.2 million heterogeneous NGOs from all kinds of secular and non-secular backgrounds (Ibid.: 5).

The PRIA study shows that the majority of NGOs in the different states work in rural areas (51-96 %), that many are unregistered (26-53 %), and that their size is relatively small, 73.4 % have one or less paid staff (PRIA 2003a: 5-6). NGOs are mainly engaged in religious activities, followed by community and social services, sports and culture and health ranking last (6.6 %). Hence, NGOs working on health issues make up only between 0.1 % and 12.8 % of all NGOs in the states (Ibid.: 7). Health issues are even less dominant in rural areas than in urban areas. The workforce of NGOs is largely made up of volunteers (72-90 %) and amounts to 20 million people working for NGOs on a paid or volunteer basis (Ibid.: 9). The majority of funds for NGOs are self-generated. Government funds contribute to 32.4 % to NGO resources. Only 7.4 % of NGO revenue are foreign funds (Ibid.: 12-13). To receive foreign funds NGOs have to register under the Foreign Contribution Regulation Act (FCRA 1976). Their accounts and registers are controlled by the government who fears the interference of foreign agencies into their politics.

NGOs working in health care in India can be divided into five categories according to their range of activities. Besides organizations implementing government programmes, there are organizations running programmes for basic health care delivery and community development, delivering care for disadvantaged groups, sponsoring health care, and doing research as well as playing an advocacy role (Misra et al. 2003: 104-105). The presence of NGOs differs widely among the states. While 34.4 % of villages in

Maharashtra have some kind of NGO, in only 2.6 % of the villages in Bihar and 1.4 % in Uttar Pradesh NGOs do exist (Ibid.).

Contrary to the small number of NGOs working in the health field (see above) their importance in the delivery of National Health Programmes and the fulfilment of national health goals has increased enormously (see 3.2.3.). The advantage of NGOs is seen in their “flexibility in procedures, rapport with local population and credibility” (NABHI 2003: 381). NGOs are wanted for programme implementation to increase awareness and participation of communities. Nonetheless, NGOs are heterogeneous entities who hold individual values. The involvement of these organizations in all health programmes and especially in IEC activities might not be successful. The influence of NGOs on health outcomes has not been assessed, neither is performance data of NGOs systematically collected. Government funding of NGOs is also a critical issue, since funding creates dependencies.

4 THE PARTICIPATORY APPROACH IN THE NATIONAL HEALTH POLICY 2002

The National Health Policy 2002 (NHP) is the new health reform approach succeeding the National Health Policy 1983. The state of the public and private health system has been examined in the previous chapter. The problem areas have been depicted. The new health policy acknowledges the financial constraints of the states, inequality in access to the public health system for urban and rural areas and for vulnerable sections of society and it admits that public health infrastructure is far from being satisfactory (MoHFW 2002b: 5-9). The recommendations for reform include more decentralization and participation. The government urges the states to decentralize the implementation of public health programmes to local self-government institutions (Panchayati Raj Institutions- PRI) by 2005 (Ibid.: 27). NGOs and other institutions of civil society are wanted for involvement in the public health programmes because of their high motivational skills. More than 10 % of the budget for disease control programmes will be given to them. Detailed plans for their involvement in the National Health Programmes have been described above (see 3.2.3.). Furthermore, the handing over of public health service outlets for management by these institutions is encouraged (Ibid.: 33). In practice, that would mean that they can take over the physical infrastructure (building) and will receive the normative funds earmarked for the institution (Ibid.). PRIs and NGOs will also be included in IEC activities for health issues where interpersonal communication of information is important to bring about behavioural change (Ibid.: 31). They will target on population groups which are normally not reached with mass media and especially focus on community leaders and religious leaders who can impart knowledge to their communities. Annual evaluation of NGOs to monitor their impact is planned. Hence, on the one hand PRIs and NGOs will be used to deliver health services and to participate in the health programmes. On the other hand they will have to motivate and inform the community to participate. The decentralization type of devolution (see 2.3.1.1.) to PRIs will be accompanied by delegation of central functions to the states and deconcentration to the district level within the states. The encouragement of the private sector to take over public functions is an additional measure (privatization).

The critique on the National Health Policy 2002 (NHP) especially points to its silence on certain issues (see Gupta 2002; Nair 2002). "Health for all" is not mentioned in the policy, neither is any reference to Alma Ata made. Community health workers do not play a role in the new policy anymore. In Gupta's view the policy seems to turn away from the Primary Health Care Approach as such (Gupta 2002: 215). He attests the NHP 2002 to be "biased towards urban specialist-based healthcare" and that its rhetoric on community participation "is replete with 'top-down' prescriptions" (Ibid.: 215-216). Hardly any groups outside the Central Health Ministry have been involved in the policy-making process. The 'top-down' approach is also visible in the central governments approach to continue managing all public health programmes, despite acknowledging the failure of vertical programmes (MoHFW 2002b: 8, 23). NHP 2002, furthermore, lacks details about the actual devolution to PRIs. Although, NHP 2002 correctly assesses the failures of NHP 1983 and the problems of the public health sector, its strategies for improving the public

health care systems are weak and vague (see Nair 2002). However, more funds for primary health care and equity are still among the essential goals of NHP 2002. The critiques already highlight that the NHP 2002 is contradictorily in itself. Dandona certifies NHP 2002 the absence of a conceptual basis for reform (Dandona 2002: 226). Stakeholders and beneficiaries have not been taken into account. The contradictory health policy reflects the inner conflict of the government between maintaining control and decentralizing power. While the government realises that it has to give up some of its functions to lower levels within and outside its own hierarchy to improve the performance of the public health system. It is also reluctant to give up too much power out of the fear of losing its influence and position. Even though this is a problem faced by all governments, it can hinder effective policy-making and its implementation.

4.1. CASE STUDY: HIMACHAL PRADESH

4.1.1. Background Information on Case Study Himachal Pradesh

Himachal Pradesh is a small, mountainous state in the North-West of India. The capital of Himachal Pradesh is Shimla. It has a population of over 6 million with the majority residing in rural areas (90.2 %; Ministry of Home Affairs 2005a). Hindus compose the majority of the population (95 %), followed by Muslims (2 %), Sikhs (1 %) and Buddhist (1 %) (Ministry of Home Affairs 2005b). Nearly one fourth of its population belongs to scheduled castes or scheduled tribes (24.7 %; Ministry of Home Affairs 2005a). Himachal Pradesh is one of the states with a relatively low percentage of people living below the poverty line (see Figure 3.5) and a moderate per capita net state domestic product (see Figure 3.4). However, poverty in rural areas is much higher than in urban areas. The deprivation of rural areas is also visible in the lower literacy rate, only 75.1 % are literate compared to 88.9 % in urban areas (Ibid.). Female literacy in rural areas is significantly lower than male literacy (67 % female, 85 % male, Ibid.). Household assets and access to infrastructure also varies between rural and urban areas. Although a high percentage of rural people have access to tap water (82.9 %), it is considerably below the urban access (93.9 %). People without access to tap water rely on wells (5.3 %) and handpumps (4.2 %). While many rural people can use electricity (94.5 %), the availability of drainage facilities and latrines is low. In the rural areas three quarters of the population do neither have any drainage system, nor do they have a latrine of any kind. Furthermore, the houses in rural areas are of lesser quality, with more than one quarter having walls made up of mud or unburnt bricks, which is a sign for low living standard (see 3.1.). There are also more semi-permanent housing structures to be found here (35.3 %) than in urban areas (12 %, Ibid.). The majority of the rural population works in the agricultural sector (73.6 %, Ibid.). According to gender only half of the male workforce and nearly ninety percent of the female workforce are in the agricultural sector (Ibid.). Work migration to the cities is widespread among men.

4.1.1.1. Health Care

As far as health is concerned, Himachal Pradesh is among the better performing states in India. Nevertheless, Infant Mortality Rates (IMR) are twice as high in rural areas than in urban areas (see Figure 3.10). Leading causes of diseases in men are chronic obstructive pulmonary diseases (COPD), lower respiratory infections, diarrhoeal diseases and other unintentional injuries. For women the main burden of disease is from diarrhoeal diseases, lower respiratory infections, iron-deficiency anaemia and COPD (Kumar et al. 2003: 16). Hence, the health status of the population is mainly influenced by water and food-borne diseases as well as by respiratory diseases. Water and food-borne diseases are often a result of poor living conditions and limited household resources. Respiratory diseases may result from a variety of sources such as smoking, outdoor and indoor air pollution and also from poor living conditions. Disease occurrence is also linked to the climate. The year has three climatic seasons: cold dry winters, moderate to hot dry summers and monsoon. Houses usually do not have heating systems or oven. In the cold season fevers and cough are common, while after the monsoon water-borne diseases are on the rise. Mortality from infectious diseases outnumbers all other causes with 31 % for men and 38.3 % for women (MoHFW 2003: 307). The prevalence of these diseases contradicts the generally low poverty figures for Himachal Pradesh. Unhealthy living conditions among non-poor households seem to be widespread.

Himachal Pradesh has a three-tier rural primary health care system as explained in 3.2.1.3. (see Figure 3.16). The 12 districts are organized in community development blocks. Thus, Block Medical Officers Health (BMOH) and Block Primary Health Centres (BPHC) build another hierarchical level between MOs at the PHC and the district health authorities. BPHCs have the same functions as CHCs. The health infrastructure in the state is better than in other states in terms of physical infrastructure, there is a surplus in PHCs, CHCs and SCs according to the population (see Figure 4.1). Nevertheless, the percentage of PHCs having no doctor or lab technician are as high as 13 % (see Figure 4.2), 4 % have no pharmacist (MoHFW 2002a: 38). Absence rates of government workers for the health sector are not available but the absence rate for primary teachers is 21 % (Devarajan/ Shah 2004: 910). Since the absence of doctors from work was higher than for teachers in all states except one (see Figure 3.18), it can be assumed that absence of doctors in Himachal Pradesh is also higher. Access to health facilities is further hampered through bad transport infrastructure. Roads only link major cities and villages and the quality of roads is bad. During monsoon time or in winter many areas become inaccessible. Since the majority of the rural population has no car or other motorized vehicle, walking to the road to get public transport or walking the whole way to reach a health facility are common.

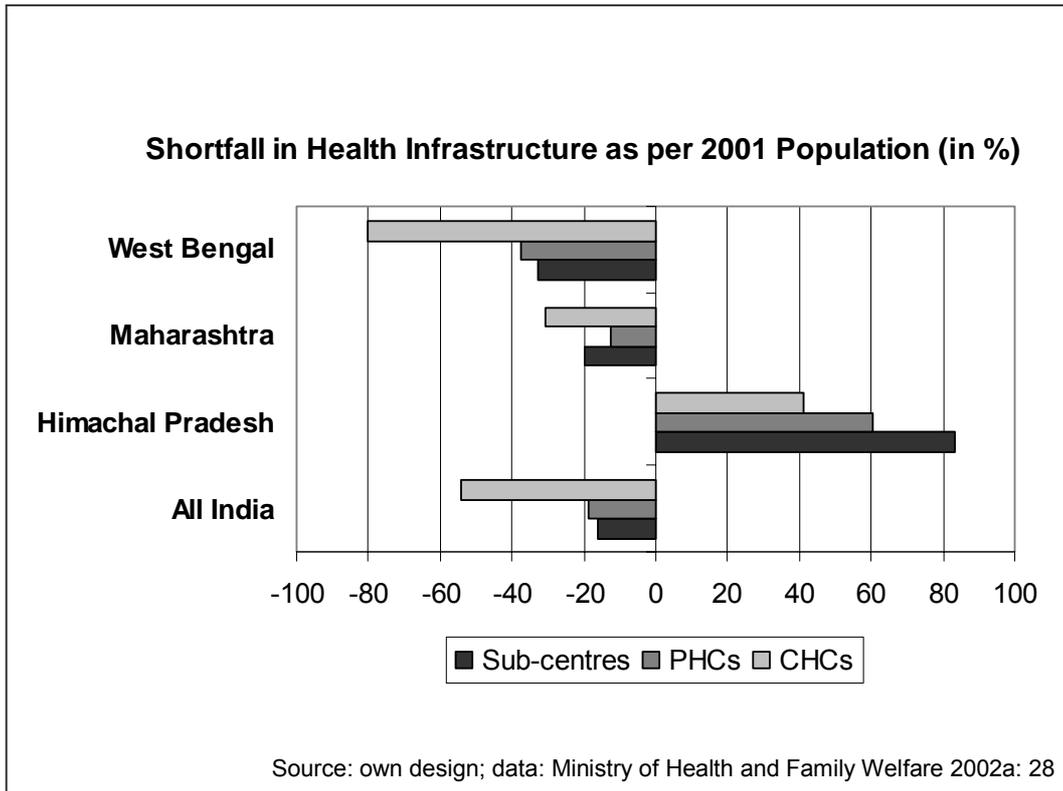


Figure 4.1: Shortfall in Health Infrastructure as per 2001 Population

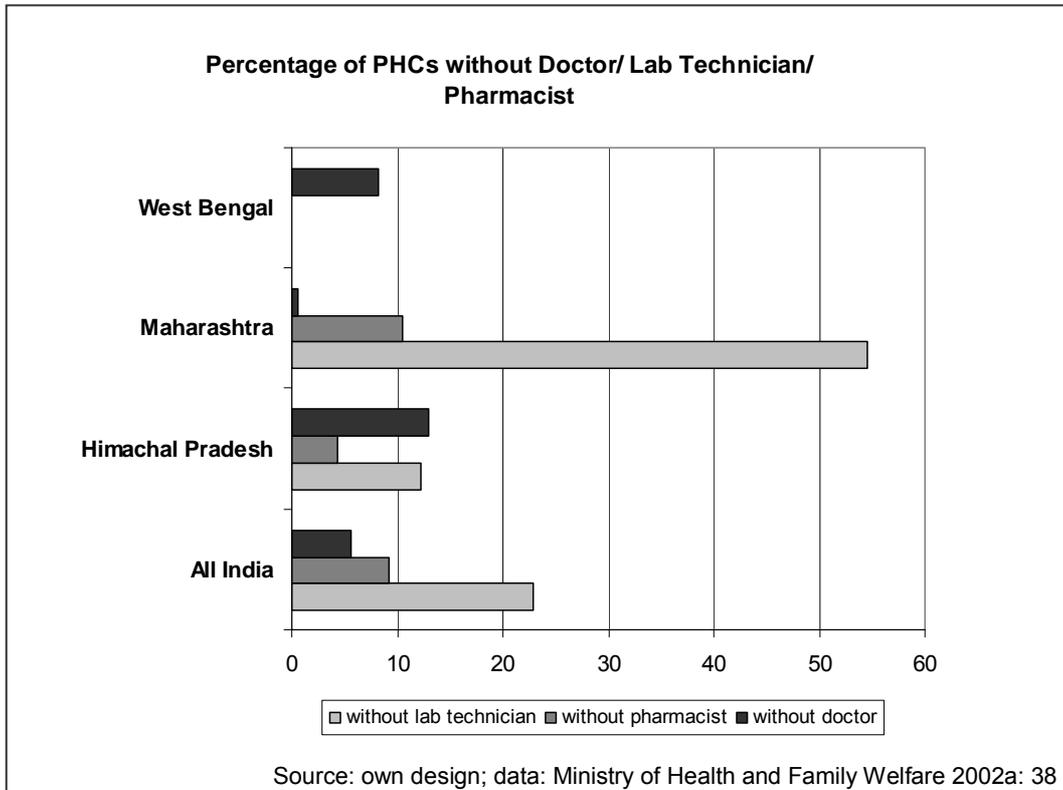


Figure 4.2: Percentage of PHCs without Doctor/ Lab Technician/ Pharmacist

4.1.1.2. Decentralization

Decentralization of the health system has taken place in the form of devolution to PRIs. PRIs were established in Himachal Pradesh in 1994 at village level (Gram Panchayat), block level (Panchayat Samiti) and district level (Zilla Parishad). Health, rural development and welfare functions were devolved to them in 1996 (GTZ 2002: 6). Seats in PRIs are reserved for members of scheduled caste and scheduled tribe according to their percentage in the population, one third of all reserved and unreserved seats are prescribed for women (73rd Amendment to the Constitution). PRIs receive funds from the government to carry out rural development programmes of the government in a “top-down” manner. On the other hand they are also empowered to generate own sources of income through local taxes. Gram Panchayats are supposed to develop micro-plans for the development of their areas according to the local needs. However, bureaucrats do not respond well to this “bottom-up” approach. Thus, acknowledgement and financial support for these micro-plans is rare (GTZ 2002: 8). Further problems include lack of enthusiasm and training of Gram Panchayat members, their unawareness of tasks and responsibilities, and the discrepancy between duties and powers given to them (Ibid.: 8-9). Since the main focus of PRI work was on infrastructure development, they were ordered to form Health and Family Welfare Advisory Committees (PARIKAS) at all three panchayat levels (see above) in 1996 for supporting specific health-related activities. PARIKAS were thus formed following the 73rd Amendment to the Constitution, which had given health in the hands of PRIs. The members of these committees were to come from the respective level of public health institutions (MPW, MO, BMOH or CMOH), from NGOs, women groups, community based organizations and include the head of panchayat as well as officials from other public departments (Education, Social Welfare, Forest, Public Works etc.) (Ibid.: Annex III). Besides their involvement in National Health Programmes Panchayat PARIKAS have to control the functioning of the SC, the cleanliness of the village including water, air and noise pollution, and disseminate information about Reproductive Child Health. Additionally they have to prepare health micro-plans every year. Block and District PARIKAS in turn rather have a leadership and guidance function but inspection of health facilities and IEC activities for the health programmes are also among their tasks. PARIKAS are involved in important decisions for example regarding the location of SCs and PHCs. They are supposed to function as Inter-Departmental Coordination Committees (Ibid.). However, the GTZ study found that in 2002 PARIKAS at the village level were in the process of formation but did not function properly (Ibid.: 12). No PARIKAS existed on the block or district level. The main problems identified as causes of this malfunction are that PARIKAS have no legal or financial powers, that they are supposed to control health facilities of their members, and the general lack of knowledge at the concerned departments, the PRIs and of the health personnel (Ibid.: 13-14). Furthermore, PARIKAS are considered to function under the health hierarchy and not within the PRI context. NGOs are not sufficiently involved although they should be members. The government involved PRIs in health care who

have no prior knowledge of the subject. They were neither trained on the issues they are supposed to perform, nor did they receive detailed information regarding PARIKAS.

4.1.1.3. Participation

NGOs are involved in the National Health Programmes and also in PARIKAS. In Himachal Pradesh 600 NGOs are registered, but only 45 are active in the health field (GTZ 1998: 20). One NGO network in health exists under the guidance of Himachal Pradesh Voluntary Health Association (HPVHA). Small target areas, welfare orientation, and multi-sectoral approach in their work are characteristic for the underdeveloped NGO landscape in the state. International funding for the NGO sector in Himachal Pradesh is low, because of comparably good health indicators and a small and widespread target population. Therefore, NGOs rely more on central government funding and internal sources. In the government schemes these organizations implement “top-down” programmes, advocacy or other activist activities are rare. The NGO sector in the state developed late and only came up in the 1990ies in response to foreign donor agencies (Ibid.). Hence, it is not surprising that they are often criticised as “donor-driven”. NGOs are mainly involved in IEC activities and in the health sector in preventive health. Organizational capacity of these NGOs is low. Problem areas are transparency, leadership, quality of staff, monitoring, and evaluation of own activities.

NGOs mostly work through community organizations like Mahila Mandals (MM; women groups) or Mahila Swasthya Sangh (MSS; women’s health groups). In Himachal Pradesh 6,814 Mahila Mandals are registered (Ibid.: 25). Similarly to the PRIs MMs were initiated by the government, Department of Rural Development, to access government welfare schemes. MMs are mainly passive in character and operate like grassroots NGOs. They neither receive external support, nor training or guidance. MSS were initiated by the State Health Department to help the female MPW at the Sub-Centre in dissemination of information at the villages and in motivating villagers to participate in the health programmes. Although the idea was good in concept, their role is limited to monthly meeting. Members are passive participants of “top-down” government programmes (Ibid.: 26).

4.1.1.4. Method

Starting from this situation the two districts Shimla and Kangra were selected for analysis, because they are typical districts for Himachal Pradesh (see 4.1.1.5.). Within the districts two remote blocks were chosen for field visits. Health situation in the block, existence of NGOs working in the block, and availability of public health staff for interviews were the determinant factors. For Shimla the blocks are Chaupal and Chirgaon. For Kangra the blocks are Shahpur and Thural. Contact to the public health system was established through participation in the monthly district-level meeting of all BMOHs and district health administrators (CMOH, ACOH etc.) at the district headquarters in Shimla and Kangra. The researcher was officially introduced to the participants of these meetings and the

study outline was explained to them. These personal contacts created trust and made it easier to approach the BMOHs and to arrange the field visits later on. The BMOHs were asked to fill in the questionnaire (see Annex I) at these meetings and appointments for field visits were negotiated. Expert interviews were conducted with the Chief Medical Officer Health for the district and his staff at the district level on separate appointments. The CMOH, as the executive power at the district level, has not only the political oversight about all public health projects in the district, but is also the direct point of contact to the Ministry of Health. His/her perceptions about decentralization and community participation processes in the district influence district health management. Hence, they have an impact on all health facilities and health personnel in the area.

Furthermore, the responsible person for rural health care at the Ministry of Health at the state level was asked specific questions related to health policy. Thus, the policy side of the health care reform was highlighted and could be compared with experiences from the executive.

A similar process took place with the NGO sector. All available NGOs working on health were interviewed. Since the overall number of health NGOs in the state is small, the sample is highly representative for the sector in Himachal Pradesh. First NGOs at the district capital, where most NGOs have their headquarters, were interviewed with the aid of a questionnaire (see Annex II). The network of HPVHA was used to interview member NGOs working on health. This procedure used existing relationship to ensure trust and more openness at the interviewees' side. Expert and group interviews were further conducted with leading NGO directors from the health field to obtain insider information. For the field visits NGOs were identified who worked in the respective blocks. The intention was to acquire information from the governmental and non-governmental sector within a defined area. Contacts with the government and the local NGOs were established through GTZ Shimla, who also acquired official authorization for the research from the Ministry of Health at the state level.

Quantitative and qualitative methods were employed for the stakeholder analysis (see 2.1.). On the one hand the attitudes and interests of public health personnel in decentralization and community participation policies were gathered with a standardized questionnaire and expert interviews. Participant observation of outpatient services, health promotion activities, and internal meetings completed the picture and were used for cross comparisons and validation of data. Reliability of data is important to formulate believable explanations (Curtis et al. 2000: 1003). Even though anonymity was guaranteed to all interview partners, no names were collected on the questionnaires, the interviewees were sometimes reluctant to voice their opinions freely. Freedom of expression and especially critic on superiors are not common in India's society, because relationships are determined by strong hierarchies and interdependencies. Therefore, the received information has to be read with care. Valuable data was often received aside from the research situation while having tea or joining an activity not directly related to the study.

On the other viewpoints of NGOs regarding the new National Health Policy and their involvement in community participation and decentralization processes were collected with the same methods. The focus of participant observation here were rural programmes,

activities with the community and internal meetings. Anonymity was no issue in this part of research. Information including self-criticism was given freely. However, experiences with funding agencies shaped the interaction between the organizations and the researcher. Since the contact was established through the German funding agency GTZ or through NGO networks expectations of the interviewees to receive grants if a positive picture of the organization is created cannot be ruled out.

4.1.1.5. General Characteristics of Districts and Blocks



Picture 4.1 (left): Landscape with Settlement in Kangra District

Picture 4.2 (above): Typical House in Chirgaon Block, Shimla District

Shimla and Kangra are typical districts for Himachal Pradesh (see Picture 4.1 and 4.2). Shimla has a population of 700,000 of which 77 % reside in rural areas. Kangra has 1.34 million inhabitants with 95 % living in rural areas (Ministry of Home Affairs 2005a). The share of scheduled castes is very high. They compose 19 to 28 % of the block population (ibid.). The majority of the population works in the agricultural sector, especially women are dominant in this employment sector (see Figure 4.3). The possession of household assets is low (see Figure 4.4). One quarter of all households does not have any household asset. Ownership of motorized vehicles is rare. In Kangra more people have a scooter, motor cycle, moped or bicycle than in Shimla. While the availability of televisions in both districts is higher than of telephones, television is more common in Kangra. Radio in turn is more spread in Shimla. The significant difference in television and radio ownership could be the result of the different landscapes, Kangra has more flat areas, or of different socio-economic factors, more affluent household in Kangra.

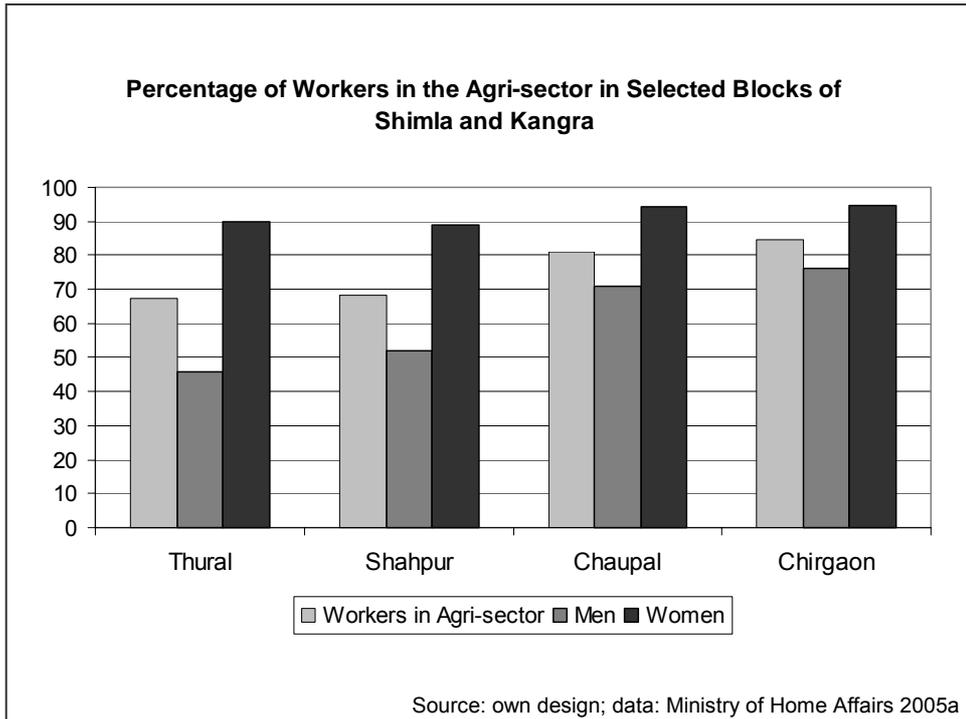


Figure 4.3: Percentage of Workers in the Agri-sector in Shimla and Kangra

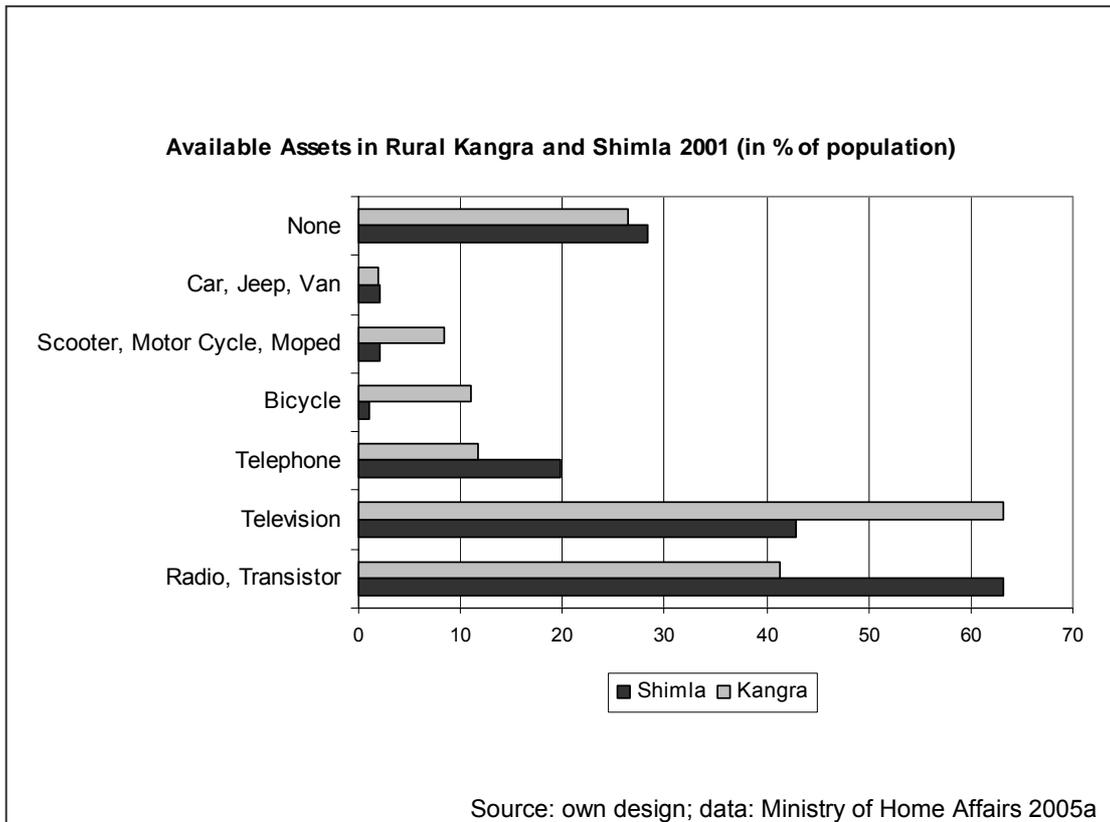


Figure 4.4: Available Assets in Rural Kangra and Shimla

Access to drinking water sources for rural households in both districts is good, more than three quarters of the population have tap water at their disposal (see Figure 4.5). The rest relies on wells and handpumps. Although electricity is used for lighting in most households, fire wood is the dominant fuel for cooking (see Figure 4.6). The second source for cooking is Liquefied Petroleum Gas (LPG) followed by kerosene. Fire wood is not energy-efficient and further causes indoor air pollution. Deforestation is another negative result of fire wood use. It is common for rural households in the two districts to have no latrine and no drainage facilities (see Figure 4.7). Villagers use the fields and surrounding grounds of their houses to get rid of their excrements. Garbage is left outside for decay. The concept of composts or biogas plants has only recently come up, but is not widespread in backward areas. The lack of latrines and drainage facilities leads to pollution of surface water. Although the overall population and the population density in the districts are low, environmental degradation and pollution are serious problems also affecting health. Literacy rates in the four blocks are not sufficient (see Figure 4.8). Female literacy is far below male literacy in all blocks, because girls drop out of school earlier to help with the household chores. The above-mentioned household characteristics show that the majority of people in the selected districts and blocks mainly work in agriculture, seem to be deprived of household assets especially transport facilities, seem to use fire wood for cooking and seem to have no access to sanitation facilities. Positive features are good access to tap water and electricity. These attributes significantly outline that overall living conditions are low in the districts and blocks. The effect of poverty on health has been highlighted several times (see above), health outcomes in the selected blocks will therefore be unsatisfactory as well. Participation and decentralization have to take these conditions into account.

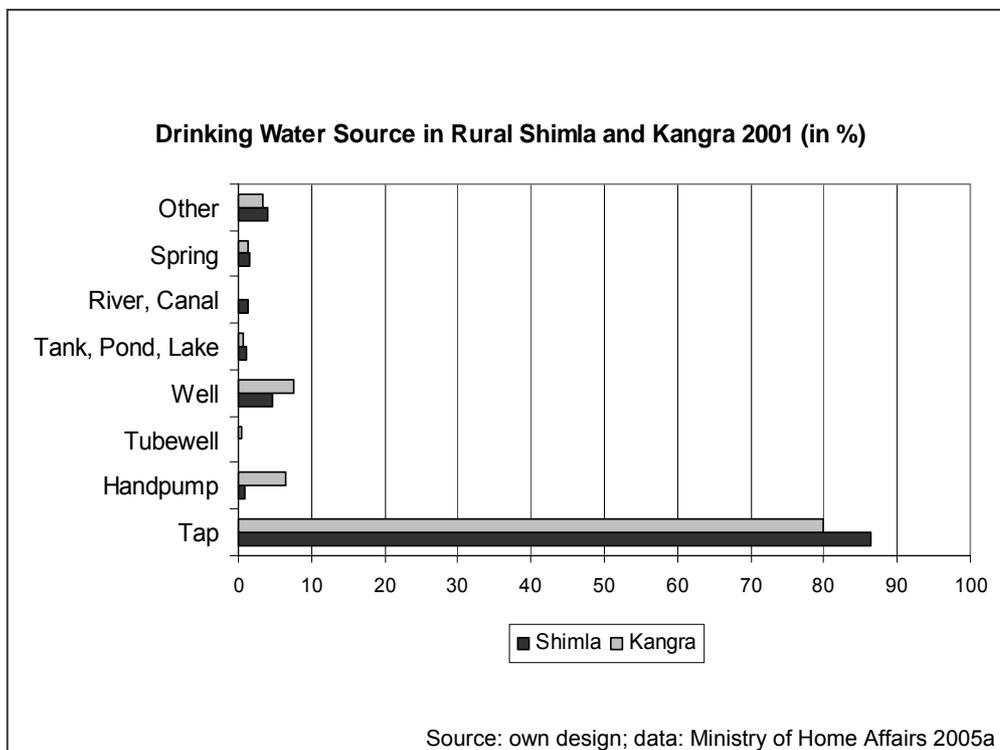


Figure 4.5: Drinking Water Source in Rural Shimla and Kangra

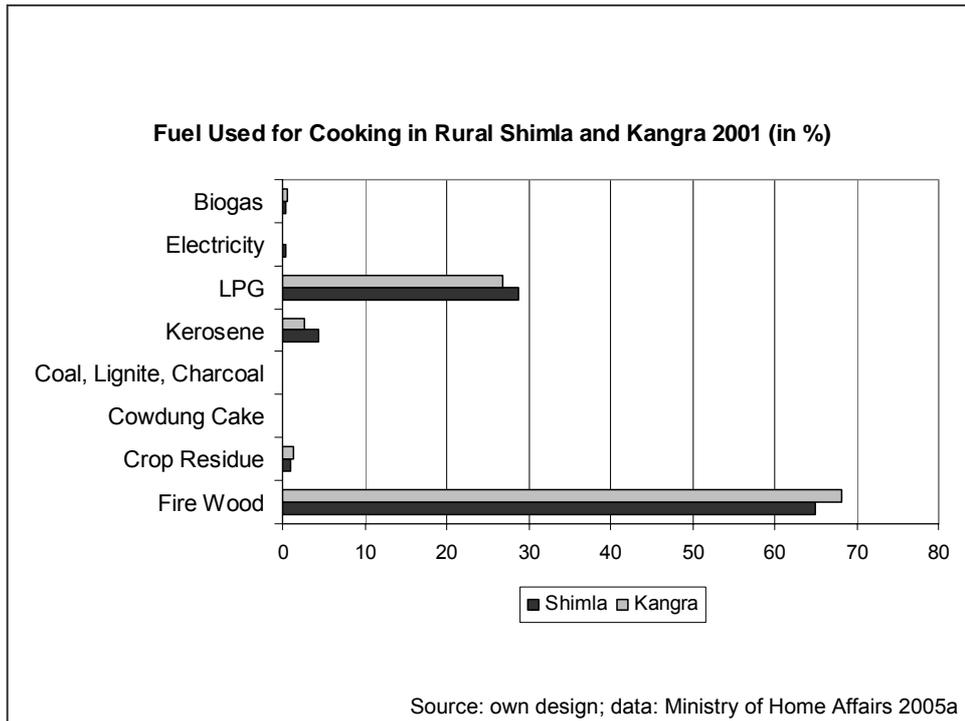


Figure 4.6: Fuel Used for Cooking in Rural Shimla and Kangra

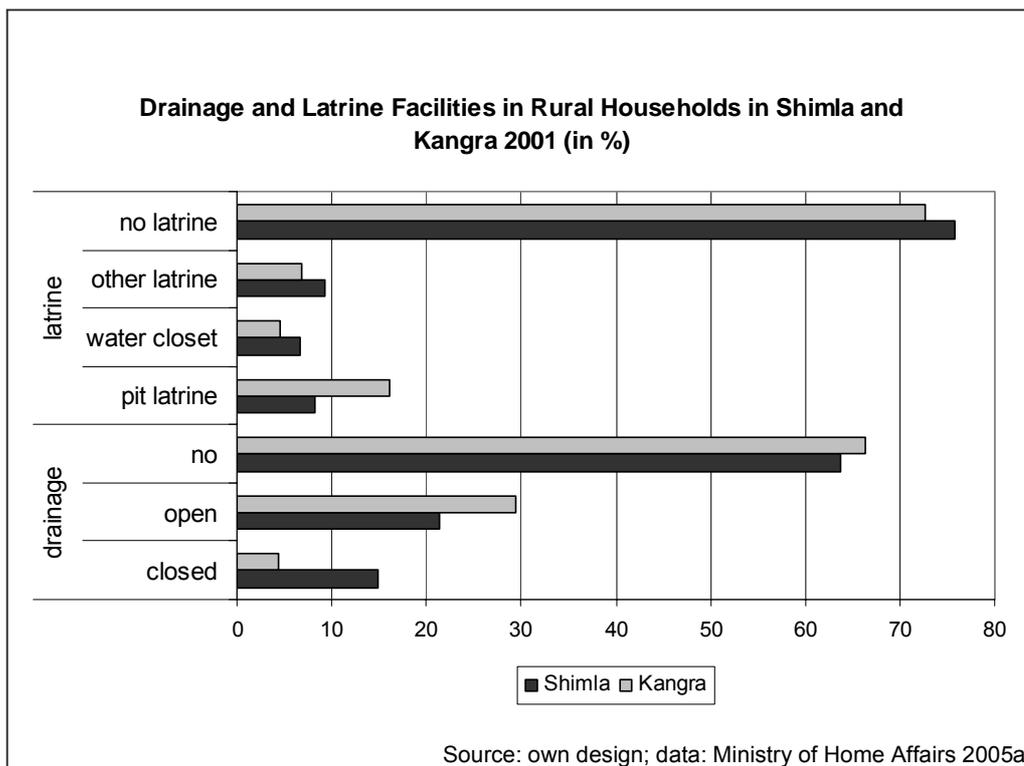


Figure 4.7: Drainage and Latrine Facilities in Rural Households in Shimla and Kangra

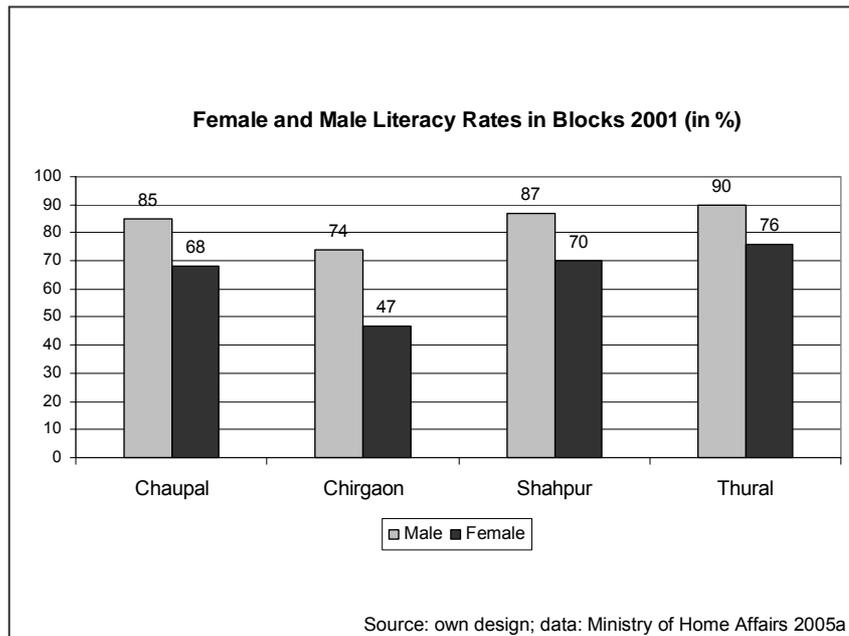


Figure 4.8: Female and Male Literacy Rates in Selected Blocks

4.1.2. Analysis

The analysis of participation and decentralization in the selected districts will follow the theories outlined in 2. First decentralization at the PHC level will be evaluated with Bossert's decision space approach (see Bossert 1998; Table 4.1). Table 4.1 shows the indicators for the functions finance, service organization, human resources, access rules and governance rules and the range of choice which exist for these indicators. The functions "Insurance Plans" and "Payment Mechanisms" were excluded (compare Table 2.2 and 4.1) as they are not relevant for the discussion here. Health insurance is virtually absent and public health services are free of charge (see 3.2.). The decision space grows with the range of choice. The wider the range of choice, the more decision space the individual actors have. Narrow range of choice points towards a centralized health system, while wide range of choice would apply to a decentralized health system. Decentralization within the public health system to lower levels of the hierarchy, district and below, will be at the centre of the analysis.

After that, the degree of community participation will be measured using Murthy and Klugman's framework (see Table 2.1, Murthy/ Klugman 2004: i79). Definition of community, representation of community, rationale for participation in health, depth, scope, and mode of community participation will be rated from lower to higher degrees of community participation. The higher the degree of community participation, the higher are the expected positive influences on the health system and the health status of the population.

Table 4.1: Map of Decision Space for Analysis
(adapted from Bossert 1998: 1519)

Function	Indicator	Range of Choice		
		narrow	moderate	wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total health spending	High %	Mid %	Low %
Allocation of expenditure	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms
Human Resources				
Salaries	Choice of salary range	Defined by law or higher authority	Moderate salary range defined	No limits
Contract	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service
Access rules				
Targeting	Defining priority populations	Law or defined by higher authority	Several models for local choice	No limits
Governance rules				
Facility boards	Size and composition of boards	Law or defined by higher authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by higher authority	Several models for local choice	No limits
Community participation	Size, number, composition, and role of community participation	Law or defined by higher authority	Several models for local choice	No limits

Having assessed the degree of decentralization and participation, the study will look into the chances for success of community participation as it is emphasised in the new National Health Policy 2002. Table 4.2 shows the indicators for successful participation like interest in participation, communication and information transfer, responsiveness, motivation, accountability, sustainability and control over resources. The indicators for this table are derived from the theoretical discussion of participation in the previous chapters (see 2.2.1.2./ 2.3.2.1.-2.3.2.2.; Table 2.3). The two major players at the community level as defined by the government, Medical Officers (MO) and NGOs, were selected for the

analysis. Community participation is dependent on their decisions and behaviour. The ranges for the indicators follow a similar pattern like Bossert's map of decision space. The higher the range for the indicators, the higher is the chance of successful participation. The approach to community participation is essential for many of the indicators. The indicators are ranked using Rifkin's distinction between "bottom-up" and "top-down" approach (Rifkin 1996). The "bottom-up" approach stands for community participation in the tradition of the Primary Health Care Approach, therefore indicating a high chance of successful participation (see 2.2.1.2./ 2.3.2.2.). "Top-down" community participation in turn rather stands for a moderate chance, because it does not include empowerment. However, it is the first step towards community participation. The map of participation is a new tool to evaluate the chances for successful participation. Even though it will be used in these case studies for the local level, it could also be valuable for other scales. The following case studies will prove its usefulness for researchers and policy makers.

Table 4.2: Map of Participation for Analysis
(adapted from Atkinson 2002; Murthy/ Klugman 2004; Metzger 2001; Rifkin 1996; Westergaard 1986)

Indicator for successful participation	Range of indicators		
	low	moderate	high
Interest in participation			
for MO	No interest	Interested in top-down participation	Interested in bottom-up participation
for NGO	No interest	Interested in top-down participation	Interested in bottom-up participation
Communication and Information Transfer			
within public health system	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
within NGOs	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
between public health system and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between NGOs and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between public health system and NGOs	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up

Responsiveness			
MO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
NGO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
Motivation for participation			
MO	No incentives/ benefits	Incentives/ benefits by government (extrinsic)	Incentives/ benefits by government and community (extrinsic and intrinsic)
NGO	No incentives/ benefits	Incentives/ benefits by government and donors (extrinsic)	Incentives/ benefits by government, donors and community (extrinsic and intrinsic)
Accountability			
MO	To higher government authorities	To local government authorities	To community
NGO	To higher government authorities, donors	To local government authorities, local organizations	To community
Sustainability			
MO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
NGO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
Control over resources			
MO	Defined by law or higher authorities	Several models for control over resources	Free control over resources
NGO	Defined by law or higher authorities, donors	Several models for control over resources	Free control over resources
Experience of participation			
MO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful
NGO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful

In the analysis none of the interview partners will be cited by name, because of official discretion. Since most interview partners are either employed by the civil service or in other ways dependent on the government, their statements could lead to inconveniences for them. Therefore, citations are composed of the position of the interviewee and the date of the interview. However, a complete list of all interview partners can be found in Annex V.

4.1.2.1. Decision Space of Medical Officers

In Shimla and Kangra district 27 Medical Officers were interviewed with the aid of a standardized questionnaire (see Annex I) of which 16 were assigned BMOH and two hold the post of Senior Medical Officers (SMO) from Community Hospitals. Pictures 4.3 and 4.4 show the workplace for MOs and BMOHs. Expert interviews were held with seven district officials including the CMOH Shimla. The district officials were met twice or thrice in the monthly meeting with BMOHs and in several visits. At the state level expert interviews took place with the Deputy Director Health and the Deputy Director Management Information Systems.



Picture 4.3: PHC Bhadyara, Chirgaon Block, Shimla District



Picture 4.4: CHC Sandasu, Chirgaon Block, Shimla District

The interviewed MOs, BMOHs and SMOs were all male. The mean for service in the public health system is more than 14 years, at the current location officers were placed for more than 3 years. BMOHs have longer experience in the public health sector (mean 18.4 years) than MOs (mean 6.8 years). The duration of their stay in their current location is also longer (mean 3.4 years).

Medical Officers are supposed to be shifted every 3 years. However, the interviews revealed that shifting practice depends on political connections. Doctors in urban locations or close to cities are not willing to change their service areas to more remote areas. Hence, the longest stay for MO encountered was 7 years and for BMOH more than 10 years. Since the participants were not asked why their stay was prolonged, it is unclear whether they wanted to stay in the location or not. Nevertheless, shifting practice came up often in the discussions and was a major point of critique from the MO side towards government policies. It was not possible to find out from the interviews, who was responsible for replacements and on what grounds the decision was made. Hence, transparency of decision-making in personnel matters is low in the public health system.

Finance is the first function to be looked at in the map of decision space. Since all sources of revenue come from the central and state government the range of choice is narrow. Furthermore, the health officials feel that the financial resources decline (CMOH 07.10.2003). The CMOH does have a free budget of only Rs. 50,000 per year²², which he/she can dispense on needed equipment or others. But the prices for equipment are high, an x-ray machine costs ten times the budget. A contingent revolving fund of Rs. 1,000 is available at the BPHCs and CHCs for emergencies; they can even get funds up to Rs. 5,000 from the district (SMO 08.10.2003). Information on the use of this money was not available. From the district health administrations down to the SCs all receive allotted budgets with little decision space to manoeuvre.

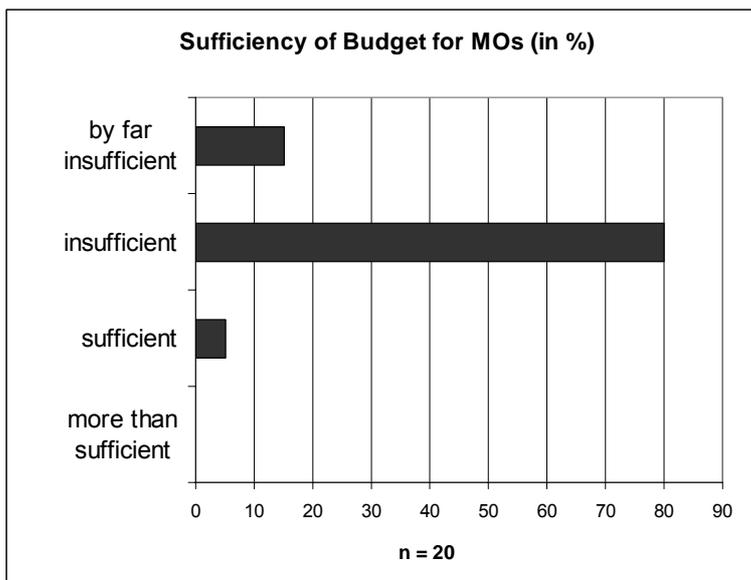


Figure 4.9: Sufficiency of Budget for MOs in Shimla and Kangra

²² - Rs. = Indian Rupees (1 Euro are approximately 50 Rupees)

For each programme and each activity within the programme a certain amount is fixed. The amounts are very low, for example Rs. 25 per school for school AIDS education are given (BMOH meeting 24.09.2003). Most MOs (95 %) find the budget insufficient or by far insufficient for all the tasks they have to carry out (see Figure 4.9).

Service fees are decided at state level. Outpatient services are free of costs at all public health facilities, only a nominal registration fee of Rs. 0.25 is collected. The service fee does not remain in the health facility, but is transferred to the state. No contracts can be given to private organizations due to lack of funds. In cases of repairs this particularly hinders the service. MOs will call up their superiors to report the case. In half of the cases the superior will take all the following actions and in the other fifty percent advises the MO what to do. The Public Works Department (PWD) is responsible for maintenance of health facilities and also for equipment. It is not under the supervision of the health department. The majority of MOs calls the PWD when something is broken. The response of PWD is not satisfactory for the MOs. Repairs may take many weeks or months if they are carried out at all. Most PHCs and BPHCs were in desolate condition. The discussion shows that the range of choice for all financial functions is narrow (see Table 4.3).

The indicators for the function service organization also offer a narrow range only for decision space (see Table 4.3). Autonomy for hospitals is defined by law but it recently opened up and requested the formation of hospital societies (see 2.3.4.). One rural hospital (CHC) was visited during a field trip which had formed a hospital society back in 1979. The MOs at the hospital found the society very useful. They were able to hire a private cleaning service, the society bought equipment when needed and further helped to improve the facility (SMO 30.09.2003). The hospital was remarkably clean and well-organized compared to the BPHCs. The hygiene and sanitation standards in the other BPHCs and CHCs visited also offering inpatient services were very low (see Picture 4.5). The BMOHs have no autonomy to make decisions involving funds or the management of the BPHC, it is all defined by laws and regulations. Furthermore, it was discouraged or even negatively reviewed to be proactive (SMO 08.10.2003). In one case the MO of one CHC run out of outpatient treatment slips. He went to a local copy shop, got them printed and paid it out of his own pocket. For this action he later received negative remarks from his superiors (Ibid.). Local health programmes follow the central norms. The targets for the National Health Programmes are rigid and depend on population numbers. Local demand is not taken into account. One example is the allocation of funds for malaria control but Himachal Pradesh being a mountainous state has malaria only in some districts and could rather use the funds elsewhere (NGO group discussion 22.09.2003).

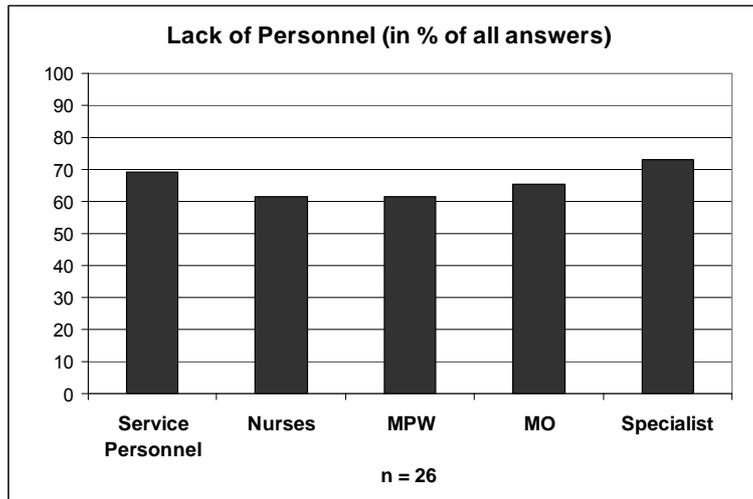


Figure 4.10: Lack of Personnel in Health Facilities in Shimla and Kangra

The human resources function is concerned with salaries, contracts and civil service. The salaries are defined by law and are the same in all states. A Medical Officer starting his service receives Rs. 10,000 per month as a basis salary. In Himachal Pradesh he/she also receives a non-practising allowance of 25 % of the basis salary for not engaging in private practice. The most senior officer met receives a salary of Rs. 25,000 per month after 29 years of public service. However, three quarters of all MOs felt that the salary was sufficient. One reason could be that living costs in rural areas are low. Contracting non-permanent staff is not possible; all jobs at the health facilities are assigned by the state and district authorities. The lack of staff for all designations is a serious problem in the two districts. Nearly 90 % of all facilities do not have the required staff. Most wanted are specialists like gynaecologist, followed by service personnel and MOs (see Figure 4.10). While the lack of specialists in rural areas leads to long travel distances for patients - for one block visited the next available gynaecologist was in Shimla which means 12 hours by bus - the lack of service personnel especially affects the conditions and the maintenance of the health facilities. All facilities visited, except one PHC, were not fit to correspond to any hygienic standards. Operation theatres still containing bloody bandages from three days ago, plaster falling from the wall on sterile instruments, mould on the walls, and dusty indoor departments were recurring aspects (see Picture 4.5 and 4.6). It was not only the lack of sweepers, but also the attitude of the doctors contributing to these situations. Often the BPHC or PHC had a sweeper but he/she was not present or there was no soap available or other excuses were made. Since BMOHs or MOs have no authority to hire or fire staff, they have little influence on their workers. Furthermore, the lower-level staff coming from the local areas may have political connections and influence the doctor might lack. Hence, complaints about subordinate staff hardly occur and are not handed up to the district level either. Responses or actions as follow-ups are rare.



Picture 4.5: Operation Theatre, BPHC Shahpur, Kangra District



Picture 4.6: Inpatient Department (IPD), BPHC Thural, Kangra District

Another problem is the absence of doctors. The district level denies that there is a problem with absent doctors (CMOH 07.10.2003), although it was often mentioned in interviews with NGOs. If doctors are found absent at surprise visits, they have to deliver a sound explanation and an investigation takes place. However, surprise visits are rare because travel plans especially for remote areas are known and good explanations are always found. The suspicion or part knowledge of people that absent doctors bribe their superiors with 10 % of their salary and then take up private practice in the cities were not confirmed from the district health authorities. Job security in the public sector is thus quite high. Working habits and ethics seemed to be negatively affected by this fact.

The definition of priority populations, an indicator for access rules, is done at the central Ministry of Health when the National Health Programmes are developed. Each programme has a specific target population. Special emphasis is placed on women and children in the family welfare programmes and on scheduled castes and scheduled tribes in communicable and non-communicable disease control programmes (see MoHFW 2005). Hence, the decision space for targeting is narrow as well (see Table 4.3). The governance rules concerning the formation of facility boards and district offices are strict. Local choice is not possible. Even the size, number, composition and role of community participation are defined by the state (see above).

The general feeling among the doctors in the public health service is that they cannot influence the health policy (see remarks below).

- “We send our requirements to the Ministry. I don’t know if it is taken into consideration.” (CMOH 07.10.2003)
- “We develop a plan but that does not influence the decisions taken by the government.” (SMO 30.09.2003)
- “MOs send reports to complain about quacks or request repairs to BMOH, who sends them on to the district level. Neither is feedback given, nor is any action taken.” (MO 30.09.2003)

Nonetheless, when asked if all planning is done by the ministry, 80 % answered with no. Only 20 % think that all planning is done by the ministry, 50 % think that it is done at the district level. Hence, planning is a shared task, but MOs are not involved. The districts Shimla and Kangra have a highly hierarchical system which is dominated by “top-down” planning. Upper levels give targets and control lower levels. Lower levels can only respond and try to fulfil targets (own experience BMOH meeting 24.09.2005). They deliver monthly reports indicating their achievements. All receive feedback on these reports from their superiors. The decision space for all indicators was narrow (see Table 4.3). Decentralization has thus not been successful in creating more autonomy. More than 60 % of all MOs wish to have more autonomy and 80 % want more decision-making power over financial issues (see Figure 4.11).

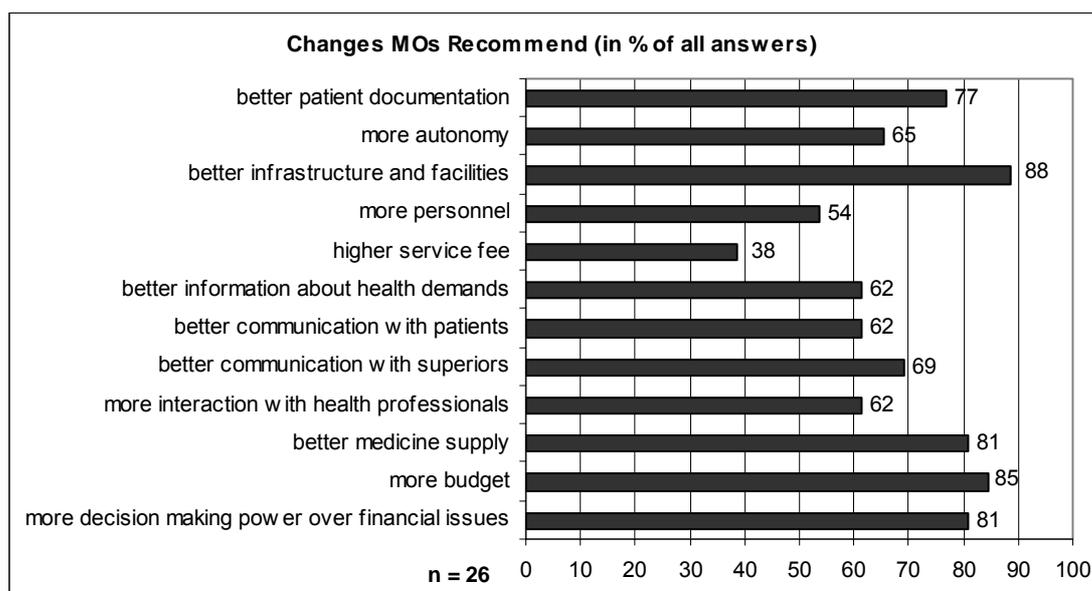


Figure 4.11: Changes MOs Recommend to Improve Health Care at Their Facility

Table 4.3: Map of Decision Space for Himachal Pradesh, Shimla and Kangra District (adapted from Bossert 1998: 1519)

Function	Indicator	Range of Choice		
		narrow	moderate	wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total health spending	High %	Mid %	Low %
Allocation of expenditure	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms
Human Resources				
Salaries	Choice of salary range	Defined by law or higher authority	Moderate salary range defined	No limits
Contract	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits

Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service
Access rules				
Targeting	Defining priority populations	Law or defined by higher authority	Several models for local choice	No limits
Governance rules				
Facility boards	Size and composition of boards	Law or defined by higher authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by higher authority	Several models for local choice	No limits
Community participation	Size, number, composition, and role of community participation	Law or defined by higher authority	Several models for local choice	No limits

4.1.2.2. Community Participation

In the Shimla and Kangra districts 26 NGOs were interviewed with the aid of a standardized questionnaire (see Annex II). Group discussion with further five NGOs and expert interview with one of the MNGOs (Himachal Pradesh Voluntary Health Association (HPVHA)), which built an own network of NGOs, complete the survey. NGOs were either met in the field, at their office in Shimla, at HPVHA office or GTZ office. The majority of them work on district level (63 %). A smaller group (29 %) work on state level. Hence, not all NGOs were confined to the two selected districts. One works on block level and one on national level. The average age of the interviewed NGOs is 17 years. The interviewed persons worked for their respective NGO for 8 years on average. The major reasons for starting work on health subjects were that the health situation was so bad and that the success of other activities also depended on health (see Figure 4.12). All NGOs undertake other activities besides health, mainly women empowerment, welfare and environmental protection measures. Within the health sector women and child health as well as AIDS and sexually transmitted diseases are dominant issues for these NGOs. Health in general, primary health care and environmental health are less important. The NGOs are registered under the Society Registration Act (see above), except for one who is not registered at all and one who is registered under Society Registration Act and as Public Charitable Trust. More than half of the NGOs are also eligible for foreign funding, being registered under FCRA. On average 16 people work for an NGO in the two districts including voluntary and paid staff, the range is from 2 to 80 employees. The funding for NGOs mainly comes from central government sources, 81 % of NGOs receive these funds (see Figure 4.13). Next important source of funding are international agencies

(65 %), followed by the state (62 %). Funding through membership fees or from community is low, only 31 % and 27 % receive funding from these sources respectively.

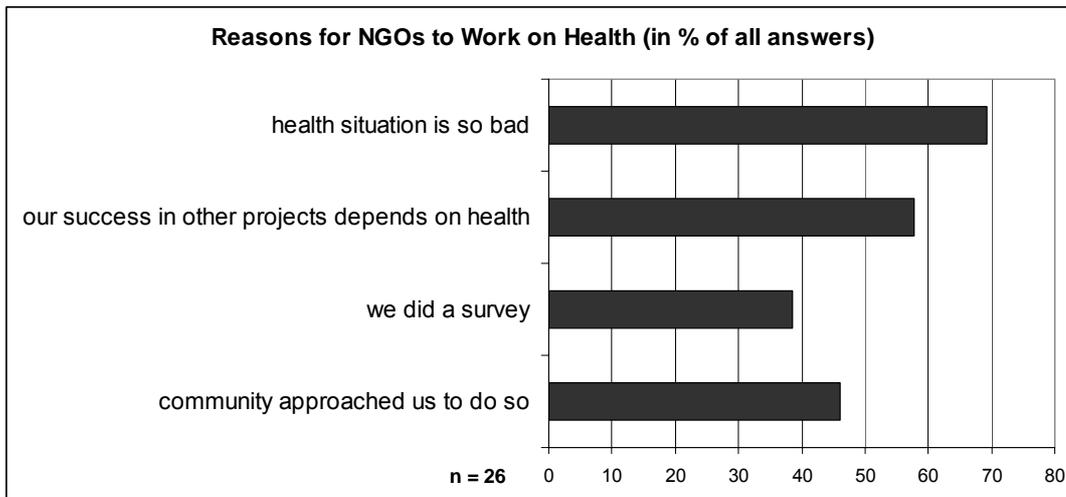


Figure 4.12: Reasons for NGOs to Work on Health Issues in Shimla and Kangra

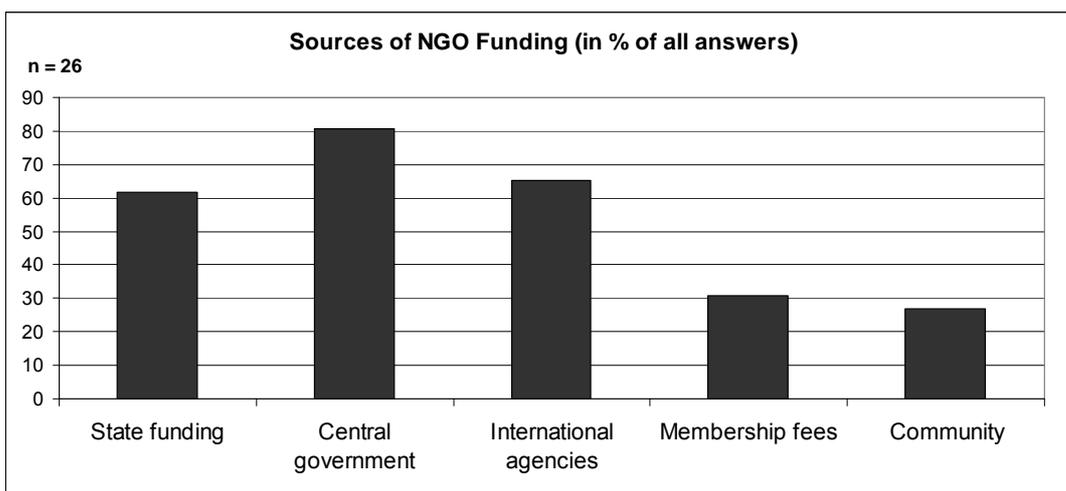


Figure 4.13: Sources of NGO Funding in Shimla and Kangra

In Murthy's and Klugman's framework the definition of community is the first step to assess the degree of community participation (see Table 2.1; Murthy/ Klugman 2004: i79). Community in the health programmes is defined through the purpose of the programmes. NGOs mostly target certain groups of population. Women are the major target group, 88 % of NGOs define them as target for their programmes, because they are perceived as a marginalized group in health care. General population comes next (68 %), followed by children and men. Women are not targeted as single persons but through women groups like Mahila Mandals. Although NGOs try to reach especially the marginalized groups, it is difficult to motivate them for health issues (see below). NGOs have only access to relatively easy to reach people in an area. Another definition of community is formulated through the establishment of PARIKAS and the regulation of membership for this group. Since only heads and representatives of organizations are invited to participate,

marginalized groups are left out. Hence, community participation for the function definition of community reaches a middle degree (see Table 4.4).

The National Health Policy defines PRIs including PARIKAS and NGOs as representatives of community (see above). NGOs work through women groups and PRIs. Most NGOs characterise PRI members as uneducated and unaware of health issues (NGOs 27.10.2003; 28.10.2003). None of the community groups know their rights or what to expect from the health system. NGOs voiced the opinion that the interests of community in health are low, because economic activities are the first concern for survival especially for the poor (NGO 08.10.2003; DHO 13.10.2003). However, in the questionnaire when asked about the importance of health for the community each rating from “very important”, “important”, “not so important” to “not at all important” received about the same percentage of positive answers. The ambiguity of these answers lies in the different perceptions. NGOs which answered that health is “very important” or “important”, either expressed their own view that health should be important to them or they had already created the awareness. The answers “not so important” or “not at all important” mostly came from NGOs who had difficulties in motivating the PRIs for health issues or from NGOs which took a more holistic view on health. As one NGO realised during the training of female MPWs: “Without reducing their economic burden, people would not work on health.” (NGO 29.10.2003).

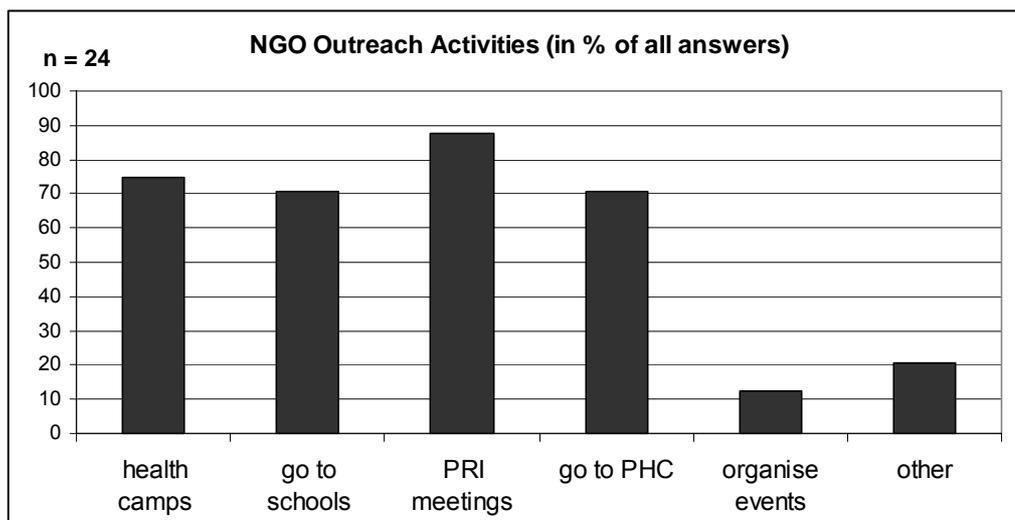


Figure 4.14: NGO Outreach Activities in Shimla and Kangra

Community participation is still far from the representation through marginalized groups, because they are difficult to reach and do not have the required education for participation (see above, see 2.2.1.2.). Furthermore, NGO outreach activities are mainly aimed at PRIs (see Figure 4.14). Although the majority of NGOs also organize health camps and visit schools as well as PHCs, their focus for these community contacts are mostly powerful groups. Therefore, it is powerful groups who represent community pointing towards a middle degree of community participation (see Table 4.4).

The health policy wants to use community participation as a means to improve quality of care including accountability, therefore, aiming at a higher degree of community participation (see Table 2.1). The goal is clear but it remains open if it can be achieved

(see below). The district level on the contrary views community participation rather as a means to expand the outreach of their services. They want NGOs to fill the gap between health workers and villagers and raise awareness for their services (CMO 23.05.2003). Hence, the degree of community participation at the district level is low (see Table 4.4).

Depth, scope and mode of community participation are the remaining criteria to assess the degree of community participation. The main work of NGOs consists in awareness raising and IEC activities. Among the services offered to the community giving information on health comes first (see Figure 4.15). All NGOs in Shimla and Kangra undertake this activity. Doing health check-ups (72 %) and rendering help in health decision-making (64 %) are the next two in the hierarchy of NGO services. Thus, besides informing the community about health issues, NGOs also offer advice and consultation, which stand for a middle degree of community participation (see Table 4.4).

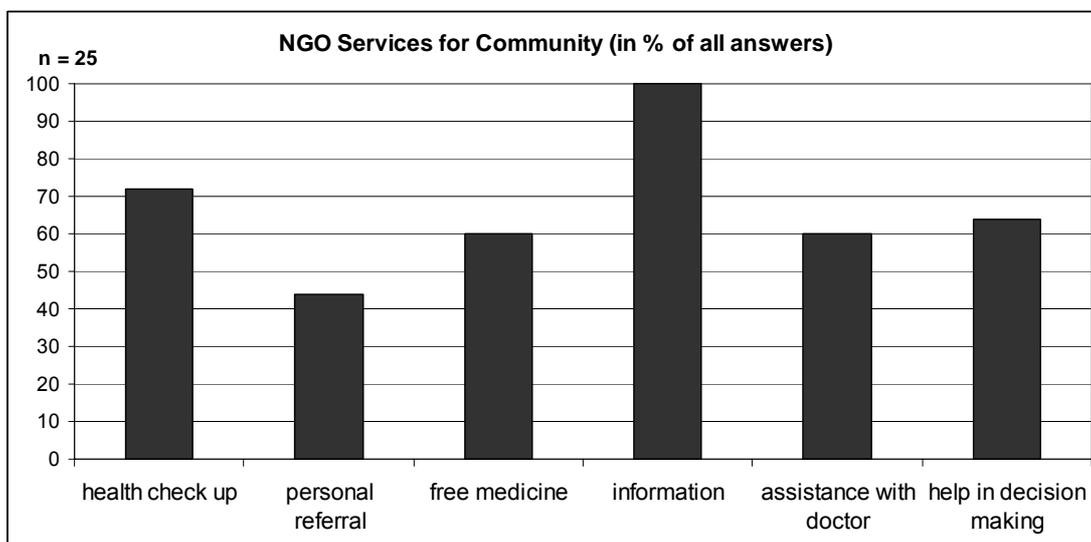


Figure 4.15: NGO Services for Community in Shimla and Kangra

The scope of community participation is hard to assess, because it depends on the representatives. NGOs in Shimla and Kangra who work on a state and national level partly try to influence health policy, health management and service delivery at all levels but only big NGOs with strong organizational capacity have the means to do so. In the two districts and also in the whole state of Himachal Pradesh only MNGOs such as HPVHA are involved in health policy and even their influence is marginal. The “right-based” approach is rare among NGOs in the state (NGO 22.09.2003). Hence, the scope of community participation reaches a middle degree (see Table 4.4). It is also difficult to distinguish between the influence of NGOs on health policy and the influence of international funding agencies. While one could argue that NGOs became involved as they did good work in the health sector, one could also assume that funding from international agencies earmarked for NGOs forced the government to include them. Both assumptions were neither falsified nor verified by NGOs and public health officials. The mode of community participation in Shimla and Kangra is clearly through invitation by the government. Mass-based organizations with a health focus do not exist in Himachal Pradesh (see GTZ 1998). Since PRI members are elected representatives of the

community who form a small collective, a middle degree of participation is reached here (see Table 4.4).

Table 4.4: Degree of Community Participation in Himachal Pradesh, Shimla and Kangra District
(Murthy/ Klugman 2004: i79)

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents community	Powerful clients	Powerful groups in population; NGOs who represent community	Marginalized groups in population; NGOs who represent their interests
Rationale for CP in health	District administration level CP as a means to - expand outreach - raise resources - support infrastructure	CP as a means to - improve management of local health services (efficiency)	Central or State government level CP as a means to - increase effectiveness - improve accountability - CP as a right by itself
Depth of CP	Manipulation Informing	Advice/ Consultation	Collective or community decision- making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals Through invitation by government	As members of small collectives Often through invitation by government	As members of mass-based organizations and small collectives Both through invitations and demands from below

4.1.2.3. Prerequisites for Successful Participation

The indicators for successful participation include interest in participation, communication and information transfer, responsiveness, motivation, accountability, sustainability, control over resources and experience of participation (see Table 4.2). NGOs and MOs from Shimla and Kangra were asked for their perceptions and experiences. Their characteristics have already been pointed out above.

4.1.2.3.1. Interest in Participation

Information on the interest in participation of MOs can be gathered from their already existing cooperations with health professionals and the community and from their views about NGOs. All MOs already cooperate with other health professionals, especially with lower levels of public staff working on health and related issues like Anganwadi and Traditional Birth Attendants (TBA)²³(see Figure 4.16). Outside the public system, cooperations exist to a smaller extent with private practitioners, 52 % of MOs have links with the private system. Cooperations with traditional healers are rare; only 15 % of MOs indicated contacts here. Community health committees be it PARIKAS or MSS also have a large share in cooperation, 70 % of MOs cooperate with them. MOs voice that they have strong links to the community as all but one cooperate with community (see Figure 4.17). Closest links exist between MO and PRIs (93 %), followed by schools (89 %) and NGOs (78 %).

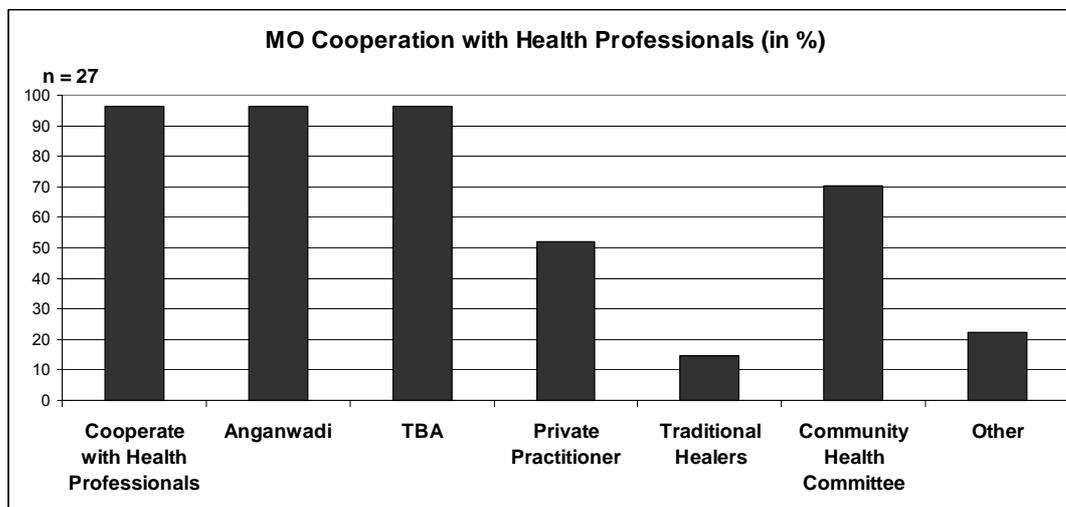


Figure 4.16: MO Cooperation with Health Professionals in Shimla and Kangra

However, cooperation is a wide term and can range from one phone call or informal meeting to joined work and shared initiatives. When asked how cooperation between MO and communities occurs, it becomes obvious that the focus is on “top-down” delivery of information or services.

²³ - TBAs are village women trained in deliveries and pre- and postnatal care by the government system under the Family Planning Programme. They receive a small payment for each birth attended.

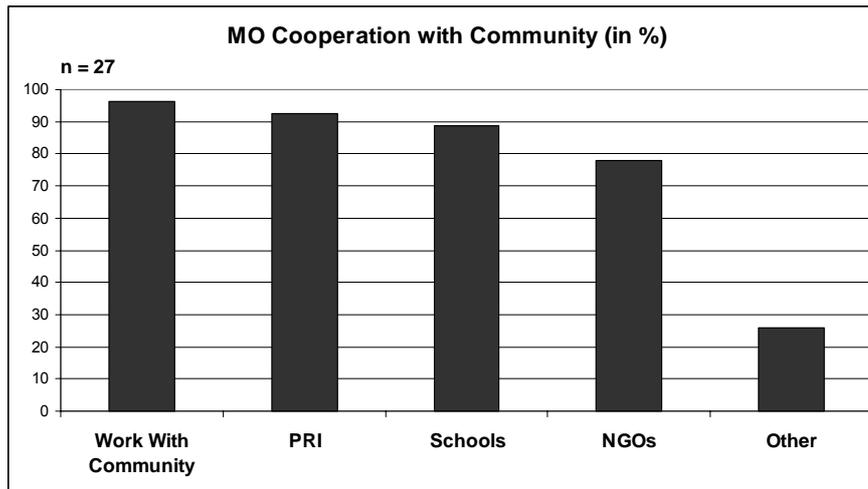


Figure 4.17: MO Cooperation with Community in Shimla and Kangra

Promotion of public health services, meetings with community, presentations for the village population, health education in schools and health needs assessment all received 96 % of MO agreement. Visits to families and feedback from the community occurred less often. It turned out that community contacts were mostly spatially confined to the PHC or BPHC and doctors had to be contacted by community members first. General outpatient practice as well as immunization activities or other programme components were already perceived as cooperation with the community. Participation of community is equated with compliance, more patients coming for follow-up services or immunizations are seen as community participation. Feedback from communities is not institutionalised but people complain about the service. The existing misconception about what cooperation or participation means might be the result of the general “top-down” structure within all government agencies experienced by the MOs and of government rural development programmes.

The attitude towards NGOs mirrors the general trends for participation and cooperation among MOs. Of all MOs 68 % know NGOs working on health issues in their area (see Figure 4.18). Opinions about these NGOs were mostly positive. NGOs speak out for community and NGOs do good work received a high acceptance of 100 % and 71 % respectively. On the other hand NGOs are seen as money-minded (60 %) and have no medical expertise (75 %). Nevertheless, 96 % of all MOs think that NGOs could help them to improve their work, but mainly with information activities like informing villagers about their service (95 %) or about the National Health Programmes (90 %) (see Figure 4.21). Control functions of NGOs for quality of MO services, taking over some services from the MOs and giving medication did not get much approval. Hence, MOs would like NGOs to help and to participate, but only as a supplement to their services and for the increase of utilization rates. Own initiatives like controlling were not seen as appropriate forms of participation. Therefore, it can be summarized that MOs are interested in “top-down” participation which is an indicator for a moderate chance of successful participation (see Table 4.5).

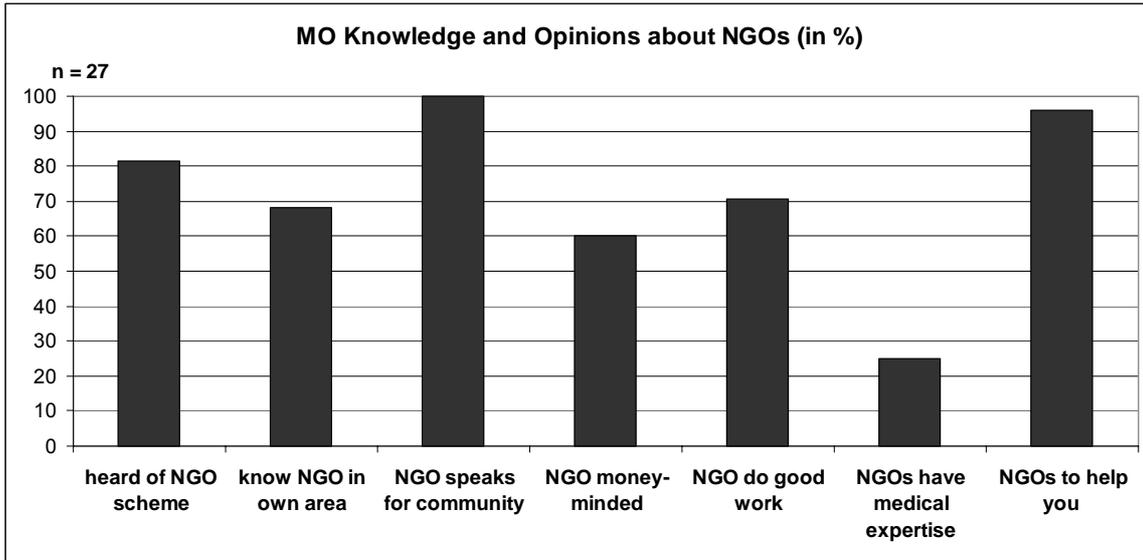


Figure 4.18: MO Knowledge and Opinions about NGOs in Shimla and Kangra

All interviewed NGOs cooperate with other institutions (see Figure 4.19). The ranking of cooperation partners shows a clear preference for women groups (96 %), PRIs (80 %), and Traditional Birth Attendants (80 %).

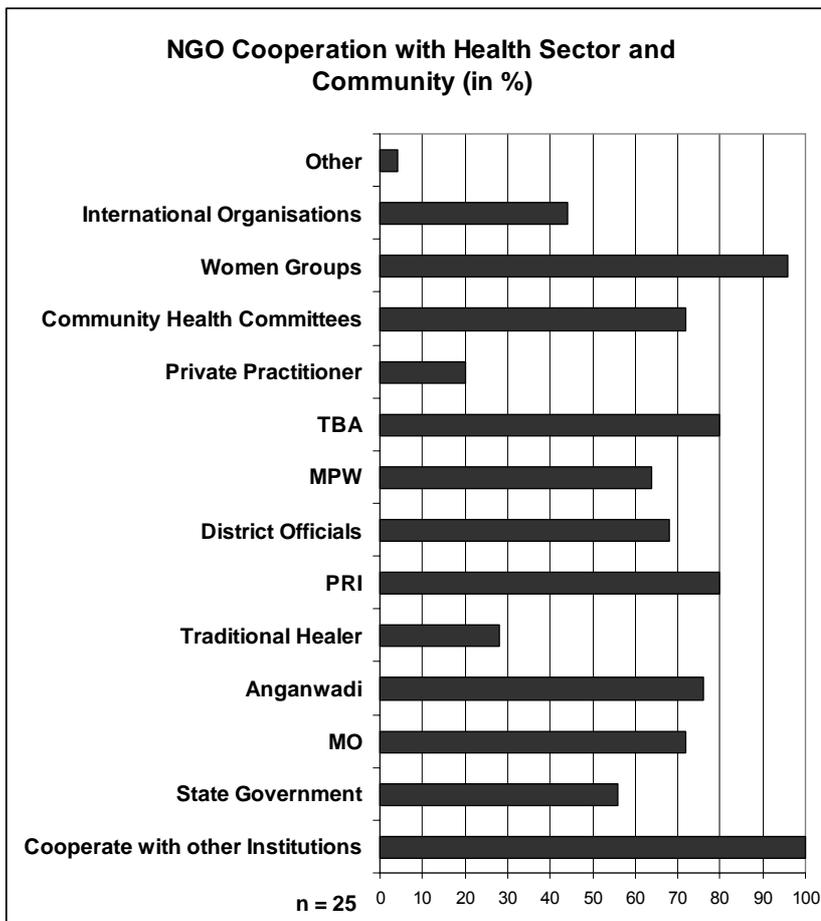


Figure 4.19: NGO Cooperation with Health Sector and Community in Shimla and Kangra

The next partners identified were Anganwadi workers (76 %), MOs (72 %), community health committees (72 %), district officials (68 %) and MPWs (64 %). Cooperation with state government (54 %) and international organizations (44 %) is less important for NGOs but ranks far above traditional healers (28 %) and private practitioners (20 %). Cooperation mainly takes place through joint discussions of problems, exchange of information and joint work planning. Events are organised together with the cooperation partners. Since NGOs mostly do not come from a medical background, they need the people from the public health service to participate in their health awareness activities or health check-up camps. Most NGOs invite MOs or MPWs for these activities and therefore rely on their good rapport with them (NGO 22.09.2003). Hence, it is not surprising that monitoring of public services through NGOs or of NGO activities are rare. NGOs mostly see their tasks in motivation of public health personnel, awareness raising in the public health system, and information of villagers about their rights (see Figure 4.22). Discussions, workshops, presentations and posters are the major mediums in NGO community work (see Figure 4.20). NGOs see the reasons why community cooperates with them primarily in the expected health and information gains, followed by empowerment. More influence on the public health system and financial gains are in their view less important for the community. From their activities and interactions with the different groups from the public health system and the community it seems that NGOs are interested in “bottom-up” participation (see Table 4.5).

4.1.2.3.2. Communication and Information Transfer

Communication and Information Transfer within the Public Health System

Communication and information transfer within the public health system was often criticised during the interviews from within the public health system and from outside. All different administrative levels meet once a month. At the PHC the MO meets with Sub-Centre staff, at the BPHC the MOs from the area meet with the BMOH, and at the district level all BMOHs of the district come together. The monthly meetings have important functions. Subordinated staff hand over their reports on performance and fulfilment of targets, and superior staff give out wages and allotted budgets for the programmes. The reports include all relevant health data. They are an essential means for information transfer. The meetings also serve as a platform to discuss problems and to give counsel. The atmosphere at the meetings can be very different depending on the leadership of the meeting. It influences communication and information transfer.

At the BMOH meeting at Shimla district people were crammed in a small room at the district hospital and BMOHs sat opposite the district officers like in a school setting. In Kangra on the contrary the meeting took place in a spacious room outside the district administration building and BMOHs were seated in a round table fashion. Consequently, the meetings were very different in nature and revealed different power structures. The meeting in Kangra was of a more participatory nature while the meeting in Shimla was characterised by “top-down” communication. The meeting in Shimla started with an expression of general dissatisfaction with all programme performance from the CMOH.

After that, the different district level officers, District Tuberculosis Officer, District Aids Programme Officer, and Medical Officer Health, made presentations. They demanded more action, more activities and better performance from the BMOHs, thus, exercising more pressure on them. One especially well performing block and one bad performing block were asked for explanations about the status of their services. BMOHs were allowed to ask questions regarding the programme but the general atmosphere hindered “bottom-up” communication. The meeting was short and ended with a joint meal in a nearby restaurant. The informal get-together was used for communication among the BMOHs, but again CMOH sat separately.

In Kangra the meeting started with the distribution of the last meeting’s minutes, followed by the district officer’s reports. Lively discussions took place about the Sex Determination Act, transfer of staff and several diseases like malaria, gastrointestinal diseases and typhoid. BMOHs were able to voice their problems and openly discuss possible solutions for performance improvement. Nobody was individually criticised. After the discussions the BMOHs read out loud parts of their monthly reports with the performance indicators. Information on the individual performance, thus, could be shared among all BMOHs. The district officers took notes and later collected the handwritten reports which lack a unique format. The joined lunch were held at the meeting place and gave way for informal discussions among the BMOHs and with the district level officers. The CMOH had already left. However, since the CMOH did not contribute to the meeting, which was managed by the Medical Officer Health, he did not seem to be important for discussions about programmes and problems. It was felt that the CMOH had a rather representative function in Kangra while the Medical Officer Health manages the district work.

The observation of these meetings already highlights that communication and information transfer are dependent on individual personalities and district leadership. Management skills of district officials are needed but not sufficiently developed everywhere. When asked about the monthly reports the majority of BMOHs indicated that they receive feedback on these reports and most think that their reports are used for district level planning. However, open critique on superiors or central programmes was rare. The “top-down” nature of the programmes (see above) affects communication and information transfer. Information is handed down from one level to the next, important information gets lost on the way. Information on the government NGO schemes in the National Health Programmes for example was only known to 81 % of the MOs although all should have been aware especially since the majority hold the post of BMOH. During the interviews it became obvious that information was either only partly handed down or was not understood at lower levels. The lower the MOs rank in the hierarchy, the smaller is their information pool. Information is also a means to generate power, hence, information might be withheld to keep the own status. However, an in-depth assessment of information transfer and personal communication is too extensive to be attempted here. Nevertheless, the questionnaires clearly indicate that the majority of MOs want to have better communication with their superiors (see Figure 4.11). The indicator communication and information transfer within the public health system in Shimla and Kangra was found to

show a moderate chance for successful participation as it is dominated by a “top-down” approach, confined to intra-hierarchical and selected information transfer (see Table 4.5).

Communication and Information Transfer within NGOs

While some NGOs in Shimla and Kangra were founded as service organizations, other come from a welfare background or have a missionary character. The information gathered from the interviews reveals that all NGOs, irrespective of their background, have a strong leadership figure. The leaders are all male except for Chinmaya Tapovan Trust, come from an educated background and are mostly identical with the founder of the NGO. All NGOs hold staff meetings but none could be observed during the field visits due to time shortage. Information about health issues is mostly obtained from questioning health professionals or from books. Furthermore, the majority of interviewed NGO workers receive training from their organization or other organizations about data collection, interviewing or other tasks. Volunteers are used by all NGOs for the implementation of programmes and village surveys. If volunteers are selected from the local villagers themselves, they possess a large amount of knowledge of the local situation. Some NGOs like Science Awareness Trust, Friends Club Rey, Society for Rural Development and Action, Chinmaya Tapovan Trust etc. use this local knowledge for programme design and development. “Bottom-up” information is essential for NGO programmes. However, it could not be assessed how much influence NGO worker or volunteers have on the programme outlines or how much say they have within the organization. It appears that NGOs also have strong hierarchies, depending on the assigned posts and duration of stay with the organization. The longer an organization has been established and the more people are employed, the more likely does it have a board of trustees or an external advisory committee, who are also involved in decision-making. None of the NGO leaders in Shimla and Kangra is democratically elected. Decisions about programme outlines, although discussed with all workers, are still made at the management level. However, limited decision space for NGO workers does not play a role for communication and information transfer. “Top-down”, “bottom-up” and intra-hierarchical communication and transfer of all information takes place in all NGOs, indicating a high chance for successful participation (see Table 4.5).

Communication and Information Transfer between Public Health System and Community

The way community participation is perceived by MOs has already been described above. This perception is also reflected in the communication and information transfer patterns. Information on health is delivered to the communities through various activities as defined by the health programmes. Health check-up camps, presentations, health education at schools etc. are all ways to disseminate information. Health campaigns of the central government also use radio and other mass media to reach the villagers (see MoHFW 2005). The information is programme-specific and does not contain general advice for healthy living. The programme dominant at a time, for example Pulse Polio, is promoted through all channels while other programmes have to stay behind. Programmes with the most funding (see 3.2.3.) consequently get the most promotion. Interaction with villagers

is confined to programme activities and general outpatient service at the health facilities. Although the participation of community in programme activities such as free health check up is huge, “bottom-up” communication is rare. Lack of education and respect for superior government employees hinders the articulation of demands or needs. The nature of programme activities is also “top-down”. It is significant that presentations are always delivered seated at a table or standing at a lectern with a microphone in front of villagers who are seated at the ground. The contents of the presentations are similar to school lessons, where important messages are repeated over and over again. Furthermore, messages come from the central or state government and are not adapted to local knowledge or educational level. Questions hardly occur and only panel discussions are held. The divide between the villagers and the government personnel is thus manifested in space and communication.



Picture 4.7: Immunization Camp in CHC Sandasu, Shimla District

Communication and information during outpatient service is hindered by time constraints and lack of privacy (see Picture 4.7). The average number of patients per day in Shimla and Kangra district is 82, with a mean of 6 minutes per patient for examination, communication and writing down the treatment. The observed practice is that all patients form a line crowding the examination room and the adjoining corridor, communication is thus overheard by other people.

Treatment time is very short. Patients tell their ailments, the doctor asks one or two questions and then writes out the medication. Physical examination was hardly observed. Neither pulse, nor heartbeat, nor fever was measured. Although the majority of MOs indicated in the questionnaires that they explain the causes of disease and their treatment in detail to the patient, this practice could not be observed during visits. The patients did not ask questions either.

Other contacts to the community exist through PARIKAS. Although only 59 % of MOs pointed out that they have this board of control or advisory committee, the experiences with this institution seems to be good. The majority of MOs felt that the board is useful for the functioning of their health facility and that most decisions are implemented. The committees are mainly composed of PRI members and staff of the health facility, marginalized groups of the community can only participate as part of PRIs. Furthermore, it was observed during field visits that PARIKAS often exist on paper only and meetings are not held (NGO 23.10.2003).

The existence of PARIKAS is a result of government laws and regulations and not of community demand. Thus, communication and information transfer between the public health system and the community follows the “top-down” approach and is only programme-related. Chances for successful participation are moderate (see Table 4.5).

Communication and Information Transfer between NGOs and Community

Communication and information transfer between NGOs and community is very different from the communication between the public health system and the community. First of all, all NGOs undertake outreach activities for their programmes (see Figure 4.14). Attending PRI meetings, organizing health camps, going to the PHC and to schools are the means to reach the target population. Contacts are also established with Mahila Mandals. Furthermore, all NGOs carry out community needs assessments. Information is mainly accessed through discussions with community members. Standardized interviews or quantitative questionnaires were less used. NGO work with community has more a participating character. Awareness-raising and delivery of information about health take place during workshops with the community and joint discussions (see Figure 4.20).

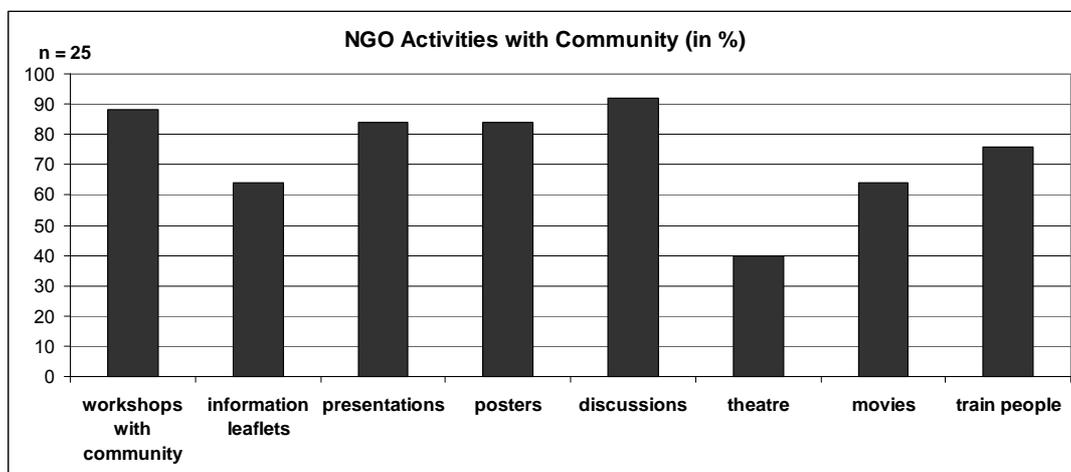


Figure 4.20: NGO Activities with Community in Shimla and Kangra

Presentations, posters and training of people also play a role for the dissemination of information. Some NGOs even used theatre or puppet show as a way to reach the community. However, reactions and open discussion only develop slowly. A trust relationship had to be established first. Only through joint activities and permanent presence of NGOs do people develop enough confidence to speak their minds. Empowerment is also essential for articulation of needs. Some NGOs ask village women to give speeches regarding common subjects like village environment, thus, enabling them to speak out (NGO 21.10.2003). Most NGOs in Shimla and Kangra support this villager-to-villager communication and see themselves as facilitators for discussions. Sensitive issues like HIV/AIDS are discussed in small homogenous youth or women groups, making sure that the subject is addressed in a culturally adequate and gender-sensitive way (NGO 29.10.2003). One point not to be overlooked is the funding NGOs especially receive for these activities while the public health system has no funds. Some MOs hold the opinion that they could work in the same fashion if they had the financial means to do so. However, communication and information transfer between NGOs and communities in Shimla and Kangra functions both ways and constitutes a high chance for successful community participation (see Table 4.5).

Communication and Information Transfer between Public Health System and NGOs

Although NGOs are involved in the National Health Programmes, communication between public health system and NGOs is limited and further characterised by mutual distrust in Shimla and Kangra district. MO perceptions of NGOs were already revealed above. Major points of criticism are that they are money-minded and do not have medical expertise (see Figure 4.18). However, the majority of MOs wants NGOs to help them to improve their services (see Figure 4.18). MOs mainly want NGOs to deliver information to the villagers about public health services and health risks (see Figure 4.21). Other tasks were seen as less appropriate. Quality control through NGOs was identified as a possible task for NGOs by 32 % of MOs only. NGOs in turn perceive their main working areas to be motivation of public health personnel, to make public health system aware of community needs and to inform villagers about their rights (see Figure 4.22). Quality control measures such as helping the community to complain, controlling work absenteeism and pressurising the public health system to render better services received high ratings from the interviewed NGOs. Hence, a conflict of interests between MOs and NGOs exist.

Concerning the cooperation with NGOs contradicting information was collected at state, district and MO levels. While at the state level partnerships with NGOs were positively acknowledged even though more emphasis was put on PARIKAS (Deputy Director Health 13.10.2003), the district level in Shimla was more reluctant to work with NGOs. The CMOH voiced her opinion that NGOs can do good work in some fields like Reproductive Child Health and HIV/AIDS, but not in others (CMOH 07.10.2003). The Medical Officer Health who is responsible for several National Health Programmes including Reproductive Child Health denied that any cooperation with NGOs existed contrary to the CMOH and the state-level interview (Medical Officer Health 13.10.2003). The MNGO from Shimla district was said to be unable to perform to the expected extent (Ibid.). The Medical Officer

Health from Kangra district in turn was even able to deliver names and addresses of partner NGOs (Medical Officer Health 17.10.2003). The high percentage of MOs who know and work with NGOs was already mentioned above. The different information received at the district, state and MO level shows the state of communication between the public health system and NGOs. Good communication seems to be possible at MO level and at state level. At the district level communication again very much depends on the personality of district officers.

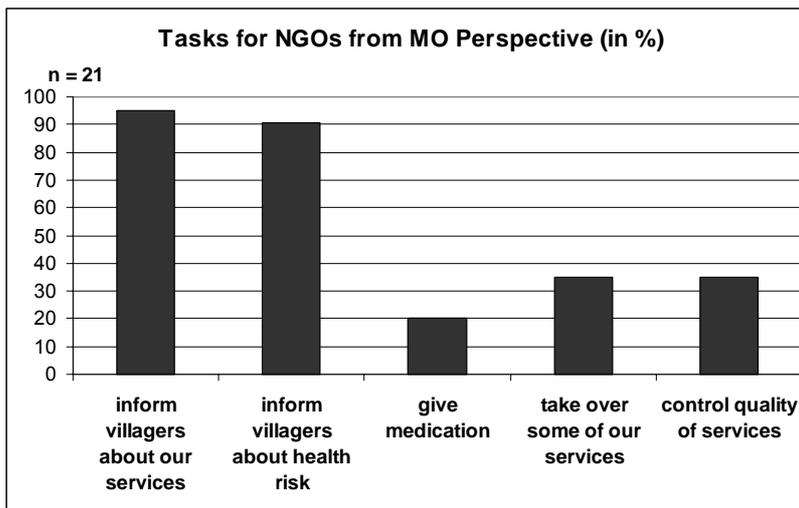


Figure 4.21: Tasks for NGOs from MO Perspective in Shimla and Kangra

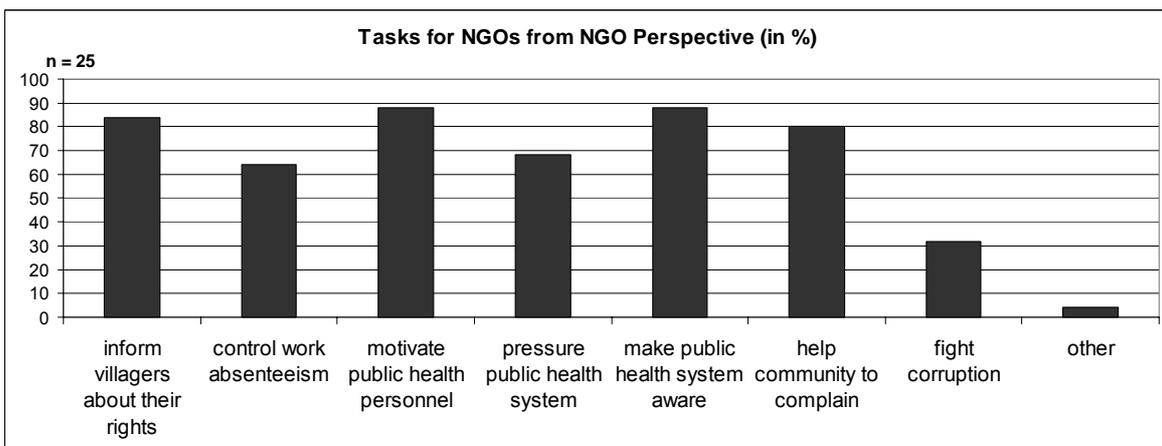


Figure 4.22: Tasks for NGOs from NGO Perspective in Shimla and Kangra

The majority of NGOs is convinced that NGOs and the public health system can work together well on the base level and on the state level. When asked for possible cooperations with the public health system, MOs came first, followed by state government and district officials. Lower-level health workers were less important. MO was seen as the major connecting link. The major problems hindering cooperation from the NGOs' point of view is the shortage of funds, distrust by government came immediately after that (58 %). Laws, bureaucracy, political interference, ignorance and even the caste system are other stumbling blocks on the way to successful cooperation mentioned by the NGOs. Communication and information transfer worked best at the local level where reputation could be established with the aid of the MOs. Nevertheless, not all NGOs have good

relationships, especially when they are involved in helping the community to complain about health services. Access to district or state officials is mainly through the NGO network of HPVHA.

Although the relationship between NGOs and the public health system is not free of problems, communication and information transfer take place in both directions, hence, indicating a good chance for successful cooperation (see Table 4.5).

4.1.2.3.3. Responsiveness

Responsiveness to community needs is a prerequisite for successful participation as it enables the concerned organization to react in favour of the community it is supposed to serve. The responsiveness of MOs is limited, since their decision space is small (see above). The health system in Shimla and Kangra can only respond to urgent health care needs like epidemics or other disease outbreaks reflected in the MO reports. In case of epidemics MOs have to report immediately to their superior. However, outbreaks of gastrointestinal diseases for example are common but the response is slow. During the field visit an outbreak of “mysterious fever” was reported in Himachal Pradesh and cases were admitted to the district hospital in Shimla (see The Tribune, Chandigarh, 20.-23.09.2003). The hospital was soon overcrowded and patients had to be accommodated on the floor. Patients were suffering from high fever, the origin of which was unknown. The local laboratory did not have the right testing facilities. After three weeks of epidemic a sample was sent to the National Institute of Communicable Diseases in New Delhi. Before receipt of the report identifying the disease as typhus several people had died. The CMOH Shimla confirmed the high death toll due to insufficient testing facilities (CMOH 07.10.2003). However, this was not an uncommon disease outbreak, since epidemics occur every year.

Water-borne diseases are a major problem in Shimla and Kangra district but cooperations between the health department and other departments concerned with water and sanitation do not exist. The preventive aspects of health care are restricted to immunization activities. Responsiveness of the public health system thus is low and only follows the programme outlines (see Table 4.5). Even timely responses to disease outbreaks are not possible, although this is perceived to be the strength of the public health system.

Responsiveness of NGOs to community needs is high as good communication and information channels exist. The majority of NGOs in Shimla and Kangra took up work in the health sector because the health situation in their areas was so bad. They felt that the community need for health services was not met. It cannot be ruled out that some NGOs also started working because funding was available but they nevertheless identified needs through own surveys and discussions with their target populations. NGOs in the districts have a more holistic view on community needs, this is reflected by their work on other issues like women empowerment or environment. Through the empowerment approach villagers are enabled to voice their demands (see above) and NGOs try to respond to it. Therefore, NGOs show an open responsiveness to all community needs and a good chance for successful participation (see Table 4.5).

4.1.2.3.4. Motivation for Participation

Participation of NGOs in health programmes is defined in the National Health Policy 2002. Thus, MOs have to work with NGOs. As one MO says: “We have instructions from CMOH to work together with NGOs, otherwise we are not required to do so.” (SMO 08.10.2003). Although the majority of MOs think that NGOs could help them to improve their work (see above), motivation is low. The government offers no incentives or benefits for MOs to encourage participation by NGOs or community. Furthermore, MOs work motivation is already affected by lack of staff and facilities (see above). Although the majority of MOs is satisfied with their work (78 %), 41 % indicate that working conditions are not so good or bad (see Figure 4.23 and 4.24).

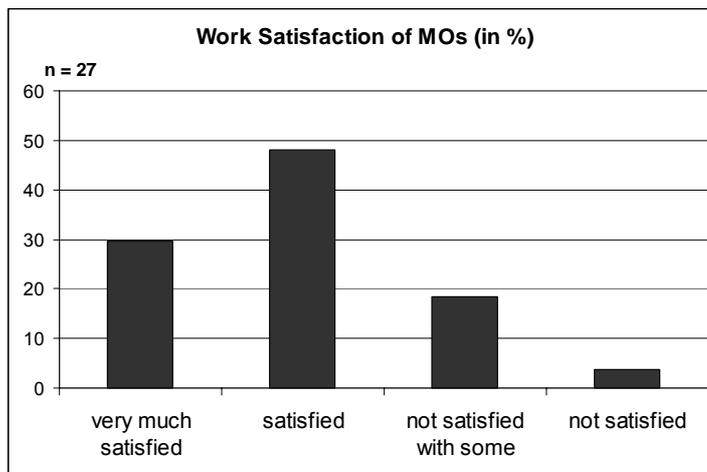


Figure 4.23: Work Satisfaction of MOs in Shimla and Kangra

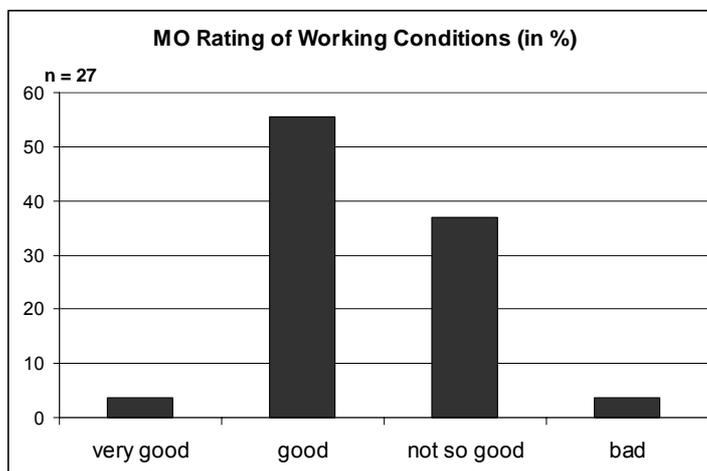


Figure 4.24: MO Rating of Working Conditions in Shimla and Kangra

All MOs made recommendations for improvement of services (see Figure 4.11). Among the things MOs dislike about their work political interference and overburden through work and lack of facilities rank first. The recommendations include better infrastructure and facilities, more budget, followed by better medicine supply and more decision-making power over financial issues.

In view of the already high workload for MOs including outpatient and inpatients services, execution of all National Health Programmes, documentation and administrative tasks motivation for participation is low. MOs feel that they do the majority of work but never receive any positive incentives. In fact the health department does neither offer any financial gains to well-performing health centres, nor other encouragements despite internal mention at meetings etc. In former times awards were given for the highest sterilization rates in the district (BMOH 30.10.2003). Nevertheless, transfer to health facilities near cities and nominations for trainings are perceived as positive incentives. Benefits and incentives from the community would be more awareness expressed through higher utilization rates. Since the doctors are already overburdened with work and lack staff and facilities, it is unlikely that they wish to have higher utilization rates. Other benefits from the community side could be respect, trust and appreciation of high service quality, but no MO indicated that he/she is lacking these benefits. Either because they nevertheless receive these benefits or because they are unaware or uninterested in it. It can be summarised that the range of motivation for participation and, therefore, of success for participation is low (see Table 4.5).

NGOs in turn receive incentives and benefits from their funding agencies including the government and from the community they serve. On the one hand they are paid for participation, on the other hand they cannot successfully implement their programmes without participation. Hence, their intrinsic and extrinsic motivation for participation is high, indicating a good chance for successful participation (see Table 4.5).

4.1.2.3.5. Accountability

Accountability of MOs has again been discussed above. They are mainly accountable to their superiors and the higher government authorities at the district level. Local government authorities like PRI do not receive performance reports. Although 44 % of MOs indicate that they have meetings with PRI members, they are the chairperson and, therefore, unlikely to discuss their own service quality. NGOs also feel that they cannot control health facilities or public health personnel, a view that is shared by the state government (Deputy Director Health 13.10.2003), which further points towards a low accountability to the community (see Table 4.5).

NGOs are accountable to their funding agencies including the government and to the community. Most NGOs share their survey findings with the community. Performance evaluation can be measured in community participation. If the communities are not satisfied with the NGO services, they will not continue to participate. However, donor funding is often short-term oriented and NGOs might not continue working in the area after funding has stopped. Funding agencies and the government usually define performance indicators before the funding is released. NGOs have to send their reports according to the time frame agreed upon. Since funding through the communities (27 %) or membership fees (31 %) is low among the NGOs interviewed, dependency on the government and international funding agencies is high (see Figure 4.13). NGOs also criticised the short term view of these agencies (NGO 22.09.2003) and the availability of funds only for certain areas but not for other. The performance indicators selected by the

funding agencies do not necessarily have to be identical with community expectations. Although NGOs were committed to accountability to the community, none indicated whether this process is institutionalised or whether it always takes place. Taking this discussion into account and acknowledging that NGOs mostly work through local organizations like women groups, it can be summarised that a moderate range of accountability exists. Hence, the chances for successful participation are also moderate (see Table 4.5).

4.1.2.3.6. Sustainability, Control over Resources, and Experience of Participation

Sustainability is important for participation as only long-term participation can ensure quality improvements of the public health system. The public health system aims at a “top-down” approach with community involvement in its programmes while NGOs are engaged in a “bottom-up” approach with community involvement (see above). Sustainability is in both cases dependent on the interest in participation, the motivation and funding (see above). Government policies can quickly change. NGO involvement can become unwanted. Therefore, it is crucial for NGOs in Shimla and Kangra to make different funding sources available also from the local level in order to reduce dependability on the government. It has been shown that interest and motivation for participation are very different among the MOs and NGOs. Hence, chances for sustainability also vary from moderate for MOs to high for NGOs (see Table 4.5). So far community is mostly involved through NGOs. Community participation as such through PARIKAS, PRIs, and MSS has not been successful. Interest in and motivation for participation as well as empowerment are needed at the community level to make community participation possible.

One goal of community participation is the control over resources (see Westergaard 1986; Rifkin 1996). Control over resources is defined by law or higher authorities for MOs (see above), hence, chances for successful participation are low. NGOs have several models for control over resources available. They are funded from different sources, use volunteers and receive donations in the form of medication. Their chances for successful participation are moderate (see Table 4.5). Free control over resources does not seem possible for NGOs or MOs at the moment. It is also questionable whether free control is desirable as funds could be misused.

Experiences of participation influence motivation and interest for participation. The majority of MOs have experiences with participation through board of controls or PARIKAS (59 %), or through cooperation with community (96 %) and NGOs (78 %). Even though the experiences of MOs are mixed, the majority feels that participation of NGOs can be helpful. The experiences of participation of NGOs are good as all of them already cooperate with community groups and the public health system and the ratings for possible cooperation with health officials is high. Therefore, the indicator for successful participation is high for both groups (see Table 4.5).

Table 4.5: Map of Participation for Himachal Pradesh, Shimla and Kangra District (adapted from Atkinson 2002; Murthy/ Klugman 2004; Metzger 2001; Rifkin 1996; Westergaard 1986)

Indicator for successful participation	Range of indicators		
	low	moderate	high
Interest in participation			
for MO	No interest	Interested in top-down participation	Interested in bottom-up participation
for NGO	No interest	Interested in top-down participation	Interested in bottom-up participation
Communication and Information Transfer			
within public health system	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
within NGOs	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
between public health system and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between NGOs and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between public health system and NGOs	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up
Responsiveness			
MO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
NGO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
Motivation for participation			
MO	No incentives/ benefits	Incentives/ benefits by government (extrinsic)	Incentives/ benefits by government and community (extrinsic and intrinsic)
NGO	No incentives/ benefits	Incentives/ benefits by government and donors (extrinsic)	Incentives/ benefits by government, donors and community (extrinsic and intrinsic)

Accountability			
MO	To higher government authorities	To local government authorities	To community
NGO	To higher government authorities, donors	To local government authorities, local organizations	To community
Sustainability			
MO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
NGO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
Control over resources			
MO	Defined by law or higher authorities	Several models for control over resources	Free control over resources
NGO	Defined by law or higher authorities, donors	Several models for control over resources	Free control over resources
Experience of participation			
MO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful
NGO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful

4.1.3. Conclusion of Case Study Himachal Pradesh

The National Health Policy 2002 envisions NGOs to deliver health services, participate in National Health Programmes and to motivate and inform community to participate. Himachal Pradesh's small NGO sector is involved in health programmes and PARIKAS. The current status of community participation only reaches a middle degree (see Table 4.4). Participation in Himachal Pradesh mainly concentrates on relatively easy-to-reach people. Community is represented through powerful groups in the population and NGOs. At district level community participation is used as a means to expand outreach and support the infrastructure. People participate through small collectives like PRIs or PARIKAS which are established through invitation by the government. Advice, consultation and service delivery for the community are the focus of community participation as well as some community involvement in the management of health facilities at the periphery. The heterogeneity of communities and their fragmentation through class and caste barriers hinder community participation. Low living standards in the selected districts and the low literacy rates are further obstacles to community participation.

Decentralization in Himachal Pradesh's public health sector focuses on PRIs and PARIKAS, but fails to create more decision space for MOs and BMOHs (see Table 4.3). Decision space is narrow in the districts. Control of the agents by central levels of administration at the state or national level is thus strong. MOs lack the means to implement PRI suggestions and recommendations as they do not have the autonomy to react. Responsiveness of the public health system is moderate (see Table 4.5). Furthermore, dependency on allocated budgets is strong up to the district level, disabling public health officials to respond to community demands.

Although the interviewed NGOs in the two selected districts show a high chance for successful participation (see Table 4.5), their number is limited. The map of participation discussed the indicators for successful participation in detail and proved useful for the identification of problem areas for participation at the local level. Accountability, control over resources, sustainability and motivation have the lowest values (see Table 4.5). Lack of accountability negatively affects responsiveness. The key role of MOs as stakeholders in the community participation process has been overlooked by policy makers. Incentives and benefits to enhance their motivation are missing. Another obstacle to successful participation is the conflict of interests between MOs and NGOs, who both have different conceptions of community participation (see Figure 4.21 and 4.22). While NGOs want to empower the community to request better public services, MOs want the community to comply with their health programmes. Empowerment of the community especially of marginalized groups endangers the existing local power structures including the position of the MO. Hence, his/her attitude towards community participation is rather "top-down" oriented. The educational gap between the doctor and his/her patients enhances the MO's distrust. The lack of decision space not only disables the MO to react to community demands, but also leads to inactivity on his/her side. Doctors rather blame the government for the lack of facilities, staff and budget than to take responsibility for their

own actions and search for solutions. Narrow decision space in the public health sector and dependency on funding of NGOs limit the control over resources. Sustainability cannot be achieved with low motivation and lack of accountability.

At the district level low quality of health services has always been explained by the low budget and the lack of staff too, motivation did not figure in these explanations. However, from the case studies and field visits it became obvious that work motivation of MOs can make a difference regarding cleanliness for example. MOs are under high pressure to fulfil all their administrative tasks, to manage the health facility, the staff and the National Health Programmes and to treat patients at the same time. Furthermore, it is the MOs who are blamed if the targets are not reached. Thus, their resignation in view of all these problems is comprehensible.

MOs expect from community participation through NGOs a reduction of their tasks and relief for their work. The majority of them like to treat patients and rather want to concentrate on this part of work. The health services at the facilities suffer from the administrative work, not only due to time constraints but also as MOs have to travel to attend meetings and trainings and to control subordinate facilities. Therefore, it is the organization of work as such which requires improvement. The case study shows that the establishment of trust relationships between NGOs and the community requires time. Dialogue between the community and the doctor takes time as well. Up to now the framework for community participation is missing. The multi-sectoral approach as recommended by the Primary Health Care Approach is also needed here. The basic requirements in the population have to be created first before community participation can take place. The government seems to skip that step but will not be able to achieve the expected results.

Quality of care is influenced by the degree of decentralization, community participation, empowerment, accountability and responsiveness (see Figure 2.2; Atkinson et al. 2000). Figure 4.25 shows the range of indicators in their relation to quality of care. Narrow decision space stands for a low degree of local autonomy in the public health sector, which has a negative influence on participation. The less local autonomy is available the less space for local voice exists. Community participation takes a middle degree (see Table 4.4). Hence, its impact on empowerment and accountability will also be moderate. The findings from the study show that accountability in the public health sector is low (see Table 4.5). Low accountability and narrow decision space cannot improve the moderate responsiveness. The current policy of decentralization and participation is not fit to improve the quality of health care. The benefits of decentralization for quality of care will thus be low to moderate (see Figure 4.25).

The current status of quality of public health care has been highlighted in 3.2. The findings from this case study support the literature. Following the explanations from above, it is unlikely that utilization rates for public services in the sample districts will increase through decentralization and community participation. Incidences of diseases will hardly be influenced through these measures. It can be anticipated that people will further rely on private health services. Inequalities in utilization and inequalities in access to health

services will remain. The primary health care goal of equity thus continues to be out of reach.

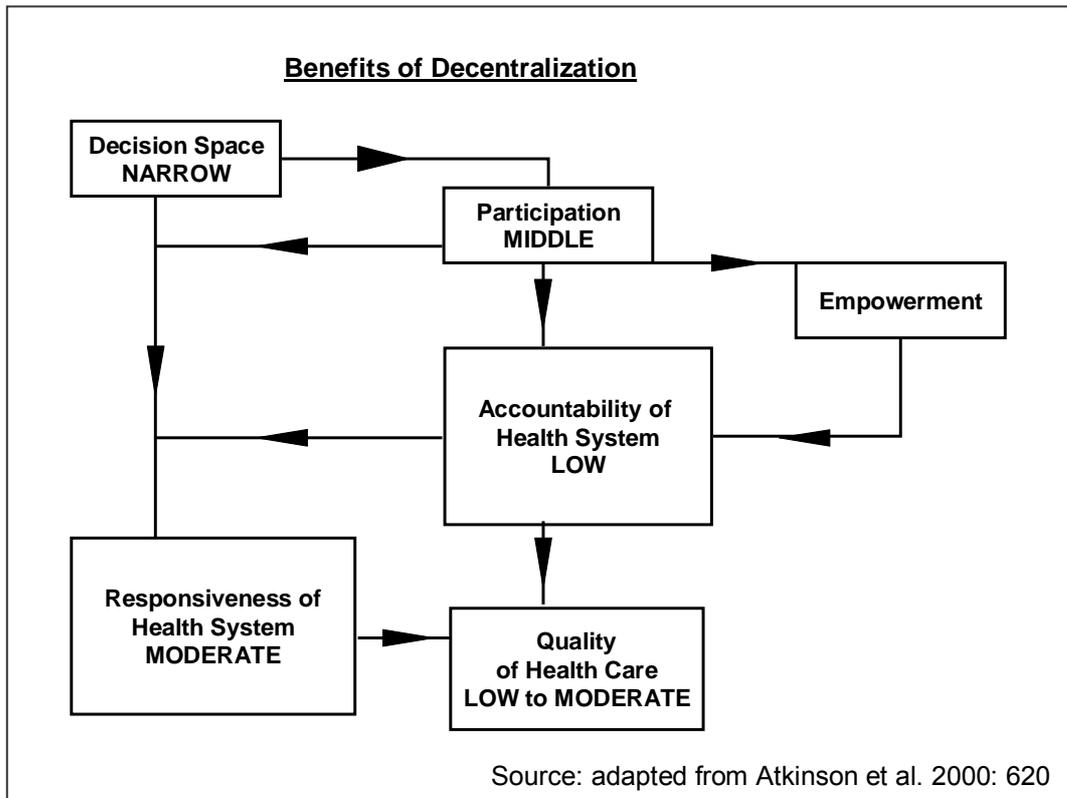


Figure 4.25: Benefits of Decentralization in Himachal Pradesh

4.2. CASE STUDY: MAHARASHTRA

4.2.1. Background Information on Case Study Maharashtra

Maharashtra is a large state on the West coast of India with 97 million inhabitants. Its flat coastal area is bordered to the East by the Western Ghats. The tropical monsoon climate is responsible for hot summers, hot rainy season and mild winters. The capital of Maharashtra is Mumbai. The state is economically well developed and has a high per capita net state domestic product (see Figure 3.4). However, industries have mainly settled in the larger agglomerations around Mumbai, further adding to the growth of the megacity. Economic development is confined to the urban areas of Mumbai and Pune. Large parts of rural Maharashtra cannot participate in the economic uplift, 56 % of its population lives in rural areas. One quarter of the population is below the poverty line, with urban areas having a higher share of poor people than rural areas (see Figure 3.5). Scheduled castes and scheduled tribes each make up 10.9 % of the population. The majority of Maharashtra's population is Hindu (80 %), largest minority are Muslims (11 %), followed by Buddhists (6 %), Christians (1 %) and Jains (1 %) (Ministry of Home Affairs 2005b). The rural-urban dichotomy is again visible in the literacy rates, in urban areas 85.5 % are literate, compared to 70.4 % in rural areas (Ministry of Home Affairs 2005a). The male-female dichotomy in rural areas is significant with 82 % of male and only 58 % of female literates residing there (Ibid.). Although Maharashtra has large industries, 55 % of the workforce is in the agri-sector. In rural areas the percentage of workers in the agri-sector is much higher (80.3 %). More women (90 %) than men (72.8 %) work in this sector in rural areas (Ibid.). The sex ratio in rural areas is 960 women to 1000 men, which shows a clear preference for the male child. However, some districts have positive sex ratios, caused by work migration of men to urban areas. Rural-urban differences can also be seen in the access to water and electricity or in the availability of facilities. Access to tap water in rural areas is much lower than for urban areas (45.5 %, 89.2 % respectively). A quarter of the rural population relies on wells, 19.1 % rely on handpumps (Ibid.). Access to electricity in rural areas is also limited to 65.2 % of the population, while 94.3 % of urban dwellers have electricity for lighting. Likewise, more than half of the rural population has no drainage facilities and 81.8 % have no latrine. Lack of latrine is also high in urban areas (41.9 %), but lack of drainage facilities is only 12.4 %. Housing structures in rural areas are more fragile, semi-permanent and temporary houses are dominant here (Ibid.).

4.2.1.1. Health Care

Maharashtra is already in an early to middle stage of health transition, reflected by better health indicators (see Table 3.2, Figure 3.10). Nevertheless, rural infant mortality rates are nearly double as high as urban rates (see Figure 3.10). Inequality in health also exists in Maharashtra which can be seen in lower immunization coverage for scheduled castes and tribes (see Figure 3.13). Similarly, coverage with antenatal care services for scheduled castes and tribes in the state is nearly ten percent lower than for other groups of

population (Misra et al. 2003: 135). Leading causes of mortality are diseases of the circulatory system, followed by infectious diseases and injuries and poisoning (see Figure 4.26; MoHFW 2003: 307). Diseases of the respiratory system rank fourth, followed by diseases of the digestive system. The distribution of diseases also points towards a more advanced state of health transition than Himachal Pradesh has, where infectious diseases were dominating (see above).

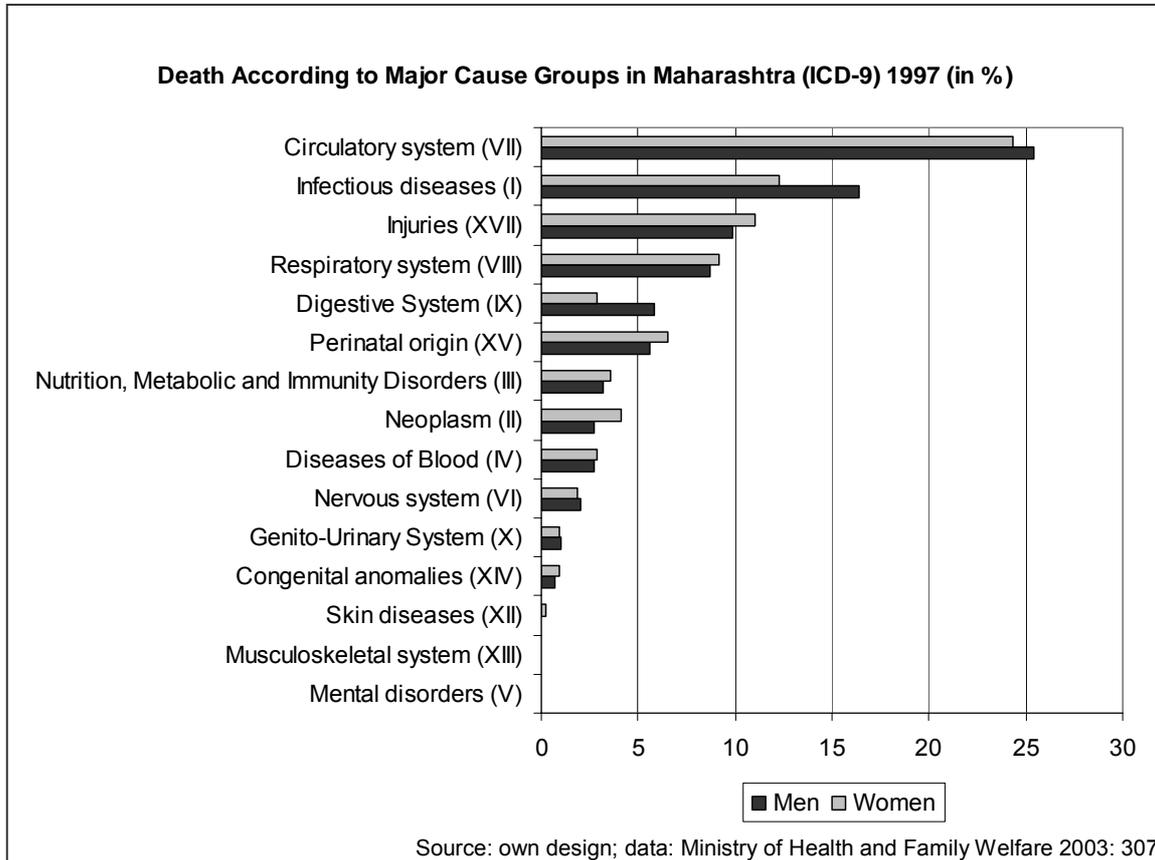


Figure 4.26: Causes of Mortality in Maharashtra

Maharashtra has a three-tier rural primary health care system as explained in 3.2.1.3. (see Figure 3.16). Medical officers of PHCs are directly under the control of district health officials, there is no block-level health system as in Himachal Pradesh. The district health system includes SCs and PHCs. It is managed by the District Health Officer (DHO). CHCs function under the Public Health Department. The Civil Surgeon is responsible for their performance. Thus, curative services are separated from preventive health services. Only at the level of Divisional Officer do preventive and curative services come together. The Divisional Officer supervises MOs, PHCs and CHCs of three to six districts which are combined to divisions. Maharashtra has 8 such divisions (Public Health Department 2002). He or she also supervises the work of all health departments in the division (ADHO 06.12.2003).

Contrary to Himachal Pradesh Maharashtra has not enough health facilities (see Figure 4.1). According to its population there should be thirty percent more CHCs, twenty percent more SCs and thirteen percent more PHCs. Another problem of Maharashtra's public

health system is the lack of staff. Lab-technicians are most wanted, followed by pharmacists and to a lesser extent doctors (see Figure 4.2). The public sector is furthermore characterised by high absence rates of staff (see Figure 3.18). Absence of doctors and other health workers is 30 % (Devarajan/ Shah 2004: 910).

4.2.1.2. Decentralization

Decentralization of health system functions to PRIs has also been initiated in Maharashtra. Panchayat Raj was started in the state as early as 1962, following the "Maharashtra Zilla Parishad and Panchayat Samiti Act" 1961 (Panse 1998: 1). The Family Welfare Programmes in Maharashtra were decentralized and handed over to Zilla Parishad in 1967 (PRIA 2003b: 13). With the 73rd Amendment to the Constitution the act was revised and the government passed the "Mumbai Grampanchayat and Maharashtra Zilla Parishad and Panchayat Samiti revised Videheyak 1994" (Ibid.). The same functions as described for Himachal Pradesh were handed down to the three-tier structure of PRIs (see Rai et al. 2003). Health and sanitation, family welfare, women and child development and social welfare activities fell into their scope of responsibility. Revenue is generated through government programmes and local taxes. Primary health care up to the PHC level was placed under the control of PRIs. The DHO offices are located at the district level panchayat (Zilla Parishad). Zilla Parishad controls all PHCs and their staff, it also makes budget decisions. The Chief Executive Officer of Zilla Parishad is even responsible for staff transfers since 2004 (DHO 09.02.2004). CHCs or rural hospitals are not controlled by Zilla Parishad. They are under state control. Some districts also have Ayurvedic dispensaries, but they are few in number. These dispensaries are also controlled by Zilla Parishad.

Similarly to the PARIKAS, community health committees were established at the district and PHC levels in 1999 including PRI members, NGOs, public health staff, women groups and other representatives to involve community in planning, implementing and monitoring. The community health committees are supposed to meet every 3 month. They decide how to use the registration fee for outpatient services collected at the PHC (DHO 09.02.2004). Opinions about the functioning of community health committees, however, differ. Some claim that they are not functional and meetings do not take place (NGOs 19.11.2003; 24.11.2003). While others say that they are established and working (NGO 21.11.2003).

4.2.1.3. Participation

Maharashtra, contrary to Himachal Pradesh, has a long history of voluntary organizations working in the field of health. Some of the model projects in health which were later adopted by the central government, such as the community health worker scheme, were started from NGOs in the state²⁴. The PRIA study found that the state has an estimated number of 88,549 NGOs including registered and unregistered organizations, with 60 % of

²⁴ - Most famous is the Comprehensive Rural Health Project in Jamkhed founded by Dr. Arole, which was enlisted by WHO as one of the successful health model projects for Alma Ata.

them located in rural areas (PRIA 2003b: 35). Health activities are only taken up by 2 % of NGOs. For rural areas the number is even smaller, only 1 % has health activities on their agenda here. Even though the percentage is small, there are nevertheless 489 rural NGOs working on health issues (Ibid.: 39). More than 20,000 people work on health issues in these NGOs. The majority of them are unpaid volunteers (67 %) (Ibid.: 42). Small NGOs are most characteristic for these organizations in the state, 74 % of them have one or no paid employee (Ibid.: 50). Rated according to expenditure groups, the same picture emerged with small NGOs dominating the scene. NGOs with less than Rs. 50,000 expenditure per year constitute 80 % of all organizations (Ibid.: 49). Self-generated funds are the most important form of revenue for the NGOs in Maharashtra. More than half of all funds come from community contribution (24 %), fees and services charges (16 %) and membership fees (5 %) (Ibid.: 45). The second biggest share in revenue are grants from central and state governments as well as from other agencies (24 %), while donations and loans are less important. Foreign funding to NGOs in the form of donations made up only 2.9 % of the total funds. The revenue is predominantly spent on salary and other benefits (56.1 %) as well as on operating activities (35.4 %) (Ibid.: 48).

In the public health sector NGOs are involved in the Mother NGO scheme under the Family Welfare Programme. Four MNGOs have been selected in Maharashtra by the central government. Each of these organization works through 17 to 37 Field NGOs (Public Health Department 2002: 21). NGOs also work in all other important National Health Programmes like Polio Eradication as described in the government guidelines (see 3.2.3.). Some big NGOs are engaged in service delivery. They offer health services or even own hospitals, SCs or PHCs. However, their number is small (see above). Therefore, NGOs mainly concentrate on Information, Education and Communication (IEC) activities. On the community level NGOs mostly work through Self-help Groups (SHGs) or other youth and women groups. SHGs are women saving groups involved in micro-financing activities for their members. According to their economic status and the monthly amount they can contribute for saving women form small local groups. The savings are used for economic activities like establishment of joint poultry farms etc. The major goal is to improve the economic and social status of group members. SHGs are often initiated by NGOs as a form of community participation. Motivation is ensured through economic activities. The formation of SHG is a government policy under the Rural Development Programme. Dissatisfaction with the functioning of Gram Panchayats and their participation in the government programmes and schemes led to the shift of focus towards women groups.

4.2.1.4. Method

In Maharashtra the districts of Pune and Raigarh were selected for analysis. The field survey is based on experiences from Junnar and Khed block in Pune district and Pen and Mahad block in Raigarh. Contact to the public health system was first established through expert interviews with state officials in the State Family Welfare Bureau located in Pune. The district level meeting of all MOs could only be visited in Raigarh district, but the questionnaires were distributed at the meeting in Pune also through the district health officials. The standardized questionnaire was slightly modified after the Himachal Pradesh field survey, incorporating the experiences from the state. The main changes were on questions concerned with budget and participation. Ratings for cooperation with community were introduced as well as ratings for the importance of quality issues for the community and questions to identify problem areas for MOs more in detail (see Annex III; questions 38, 39, 40, 43-45, 52, 53.1). The reason for the changes lay mainly in the concern about superficial answers concerning the above mentioned issues. It was anticipated that ratings would better reflect MO opinions than simple "Yes-No" answers. Field visits were planned without the involvement of district officials but with the help of GTZ staff. Contrary to Himachal Pradesh it was not possible to inform MOs in advance, because the district meeting took place after the visits and the chosen PHCs mostly lacked a telephone. However, the surprise visits nevertheless received a good response if the doctor was there, since the researcher obtained a letter from the state government requesting the cooperation of all district and sub-district level staff. Expert interviews with district health officials took place at the district headquarters in Pune and Alibag.

Contacts to the NGO sector were established through workshops organised by GTZ and BAIF Development Research Foundation²⁵ and through research and work contacts of these organizations to NGOs. The selection of NGOs for interviews was not dependent on size, age or affiliation of the organization; only their involvement in health issues was crucial. Although the sample is small compared to the overall number of health NGOs in the state; it is representative since it reflects the diversity of the sector. For interviews with the founder or executive directors of the NGOs, appointments were made via telephone. Interviews took mainly place in the offices of the respective NGOs, in the field or at the headquarters in Pune. Similarly to the MO questionnaire the questionnaire for NGOs was also slightly adjusted (see Annex IV). One question about accountability of NGOs was added (question 8). In the questions about community activities the issue frequency was attached (question 23) and ratings for cooperations were included (questions 27, 32) to obtain more detailed information.

The stakeholder analysis used quantitative and qualitative data (see 2.1.). While standardized questionnaires helped to quantify attitudes and interests of the interviewees, expert interviews and participant observation delivered the framework to interpret the data. The same processes affecting reliability of data as in Himachal Pradesh were also encountered in Maharashtra (see 4.1.1.4.).

²⁵ - BAIF is an NGO working on the national level for sustainable rural development, food security and clean environment as well as on health issues. It was established in Pune in 1967.

4.2.1.5. General Characteristics of Districts and Blocks

The districts of Pune and Raigarh each have a population of 7.2 and 2.2 million respectively. Raigarh district just starts South of Mumbai and lies on the coast. Pune district borders Raigarh to the East. Both districts are well connected through highways with Mumbai. While the majority of Raigarh’s population resides in rural areas (75.8 %), Pune has slightly more urban population (58.1 %).



Picture 4.8 (left): Typical Landscape with Lake in Khed Block, Pune District

Picture 4.9 (above): Fisher Village in Alibag, Raigarh District

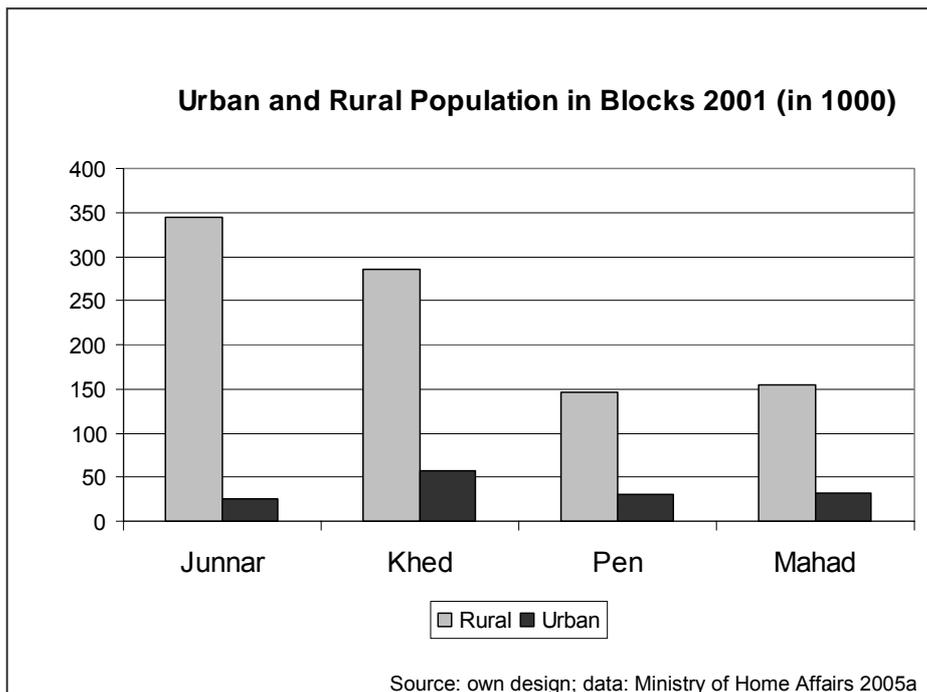


Figure 4.27: Urban and Rural Population in Selected Blocks of Pune and Raigarh

The selected blocks, however, are characterised by rural features like a large rural population and high percentage of workers in the agri-sector (see Figure 4.27 and 4.28, see Picture 4.8 and 4.9). In Raigarh less people work in the agri-sector as the economically well-developed areas surrounding Mumbai are in the North of the district. The percentage of women working in the agri-sector is in all blocks higher than for men. Thus, opportunities for women employment outside this sector might be low. Work migration of men to urban areas is high in both districts. Mahad in Raigarh district has a high female ratio (1035) as men permanently migrate to the cities. Pen is well connected to Mumbai and Pune through highways, hence, migration is more temporary. Junnar and Khed in Pune district are more interior places but are nevertheless connected to Pune.

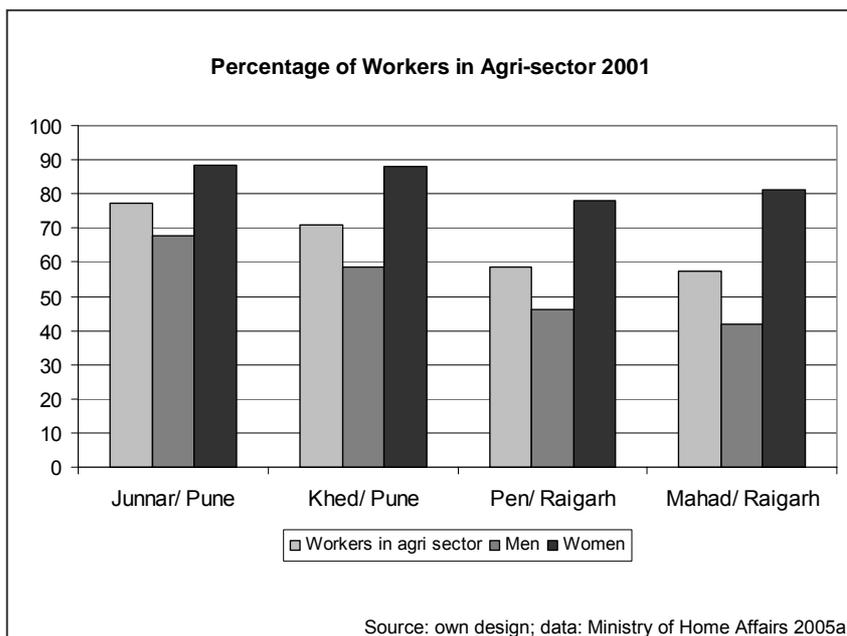


Figure 4.28:
Percentage of Workers
in Agri-Sector in Pune
and Raigarh

Rural literacy rates in all blocks are lower than urban literacy rates (see Figure 4.29). The percentage of literate women is on an average more than 20 % lower than for men in rural areas of the selected blocks. Since health-awareness is linked to the educational status of people (see above), it will also be low. A further result is the manifestation of gender inequalities in education and employment patterns.

The deprivation of rural areas in Pune and Raigarh is visible in low access to water, lack of sanitation facilities and assets. Less than half of the population in both districts has access to tap water (see Figure 4.30). Wells are the second most important source for drinking water, followed by handpump and tubewells. The water quality is consequently lower for households without tap water and leads to water-borne diseases. Diarrhoea is very common especially among children.

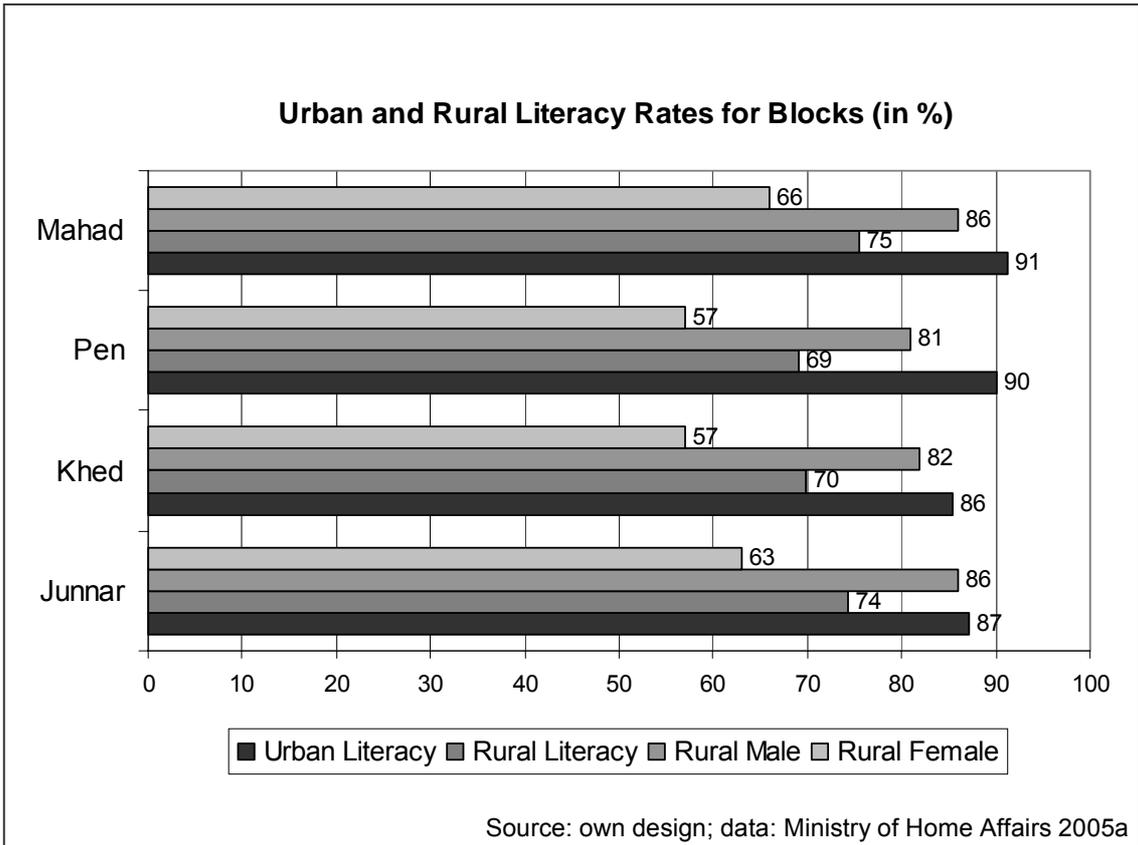


Figure 4.29: Urban and Rural Literacy Rates for Selected Blocks in Pune and Raigarh

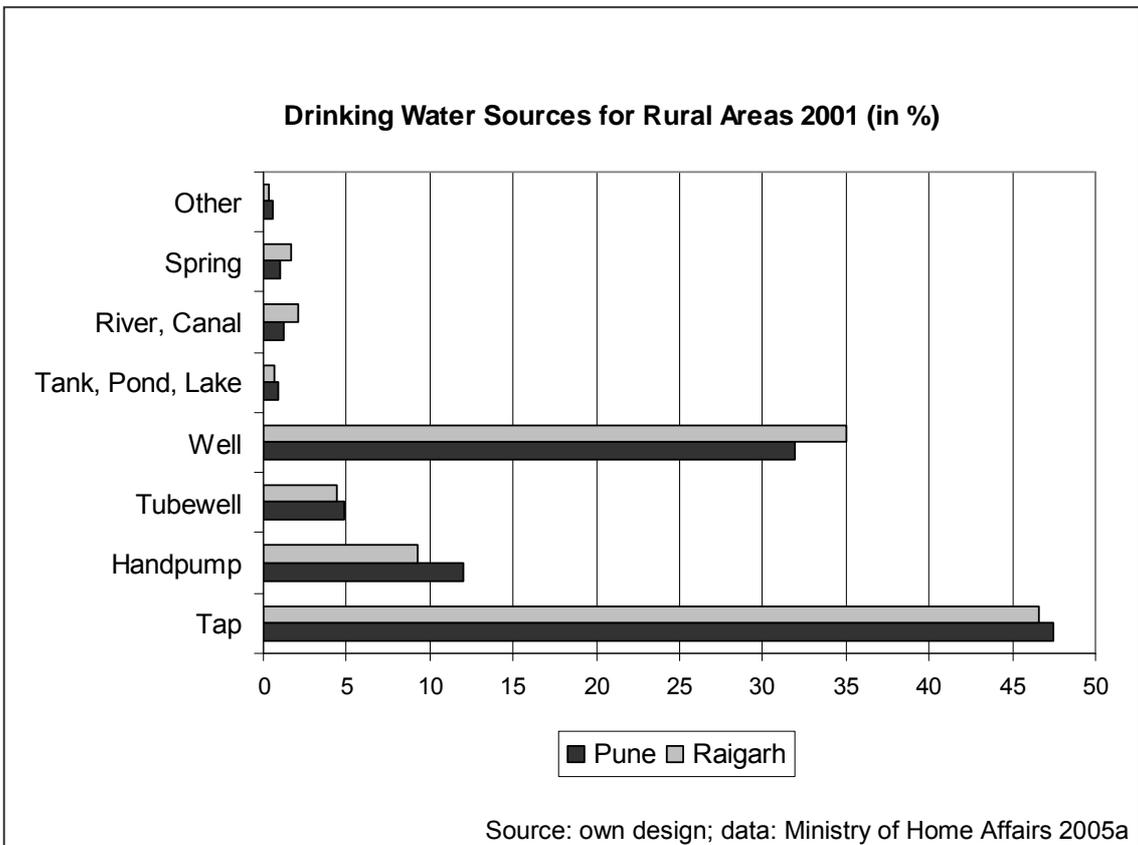


Figure 4.30: Drinking Water Sources for Rural Population in Pune and Raigarh

Fire wood is the major fuel used for cooking by more than 60 % of the rural population (see Figure 4.31). The use of LPG and kerosene is below twenty and twelve percent respectively. Crop residue, cowdung cake and biogas are also used but to a lesser extent. As already mentioned before cooking with firewood leads to indoor air pollution and may cause health problems. Deforestation is another major problem created through firewood usage. More than 70 % of population in rural Pune and Raigarh districts do not have a latrine or drainage facility (see Figure 4.32). The lack of these facilities has a polluting effect on water bodies, therewith, affecting health.

Availability of household assets is very low in both districts. In rural Raigarh nearly half of the population does not possess any household assets, while in Pune it is more than 30 % (see Figure 4.33). Rural areas in Pune are slightly better equipped with radio, television and especially with transport vehicles. The availability of bicycles and scooters is twice as high in Pune than it is in Raigarh. It is also Pune where more people own a car. Hence, mobility in Pune is higher and absolute poverty measured in available assets is lower than in Raigarh. Since both districts are geographically well connected to Mumbai and Pune, the road infrastructure is good and public transport is available. Nevertheless, health facilities in more interior areas like in Junnar, Khed or Mahad block can only be reached by individual means of transport, hence, walking to health facilities is also common here.

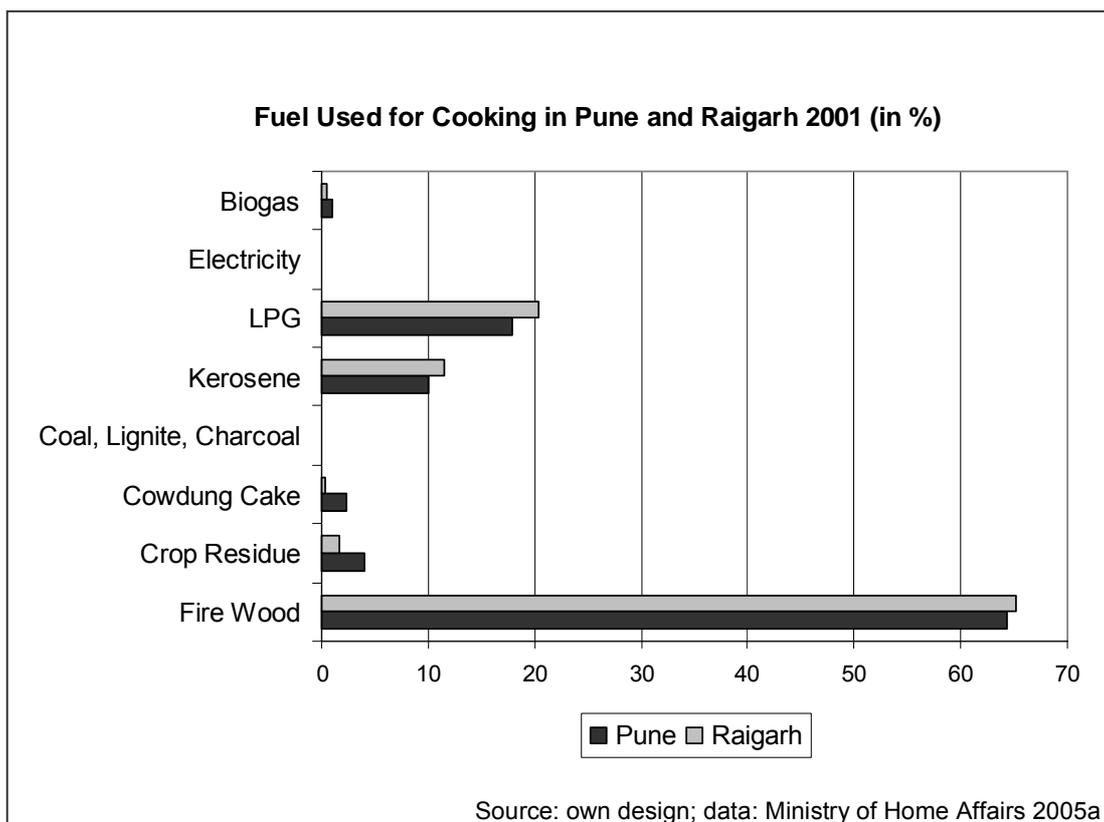


Figure 4.31: Fuel Used for Cooking by Rural Population in Pune and Raigarh

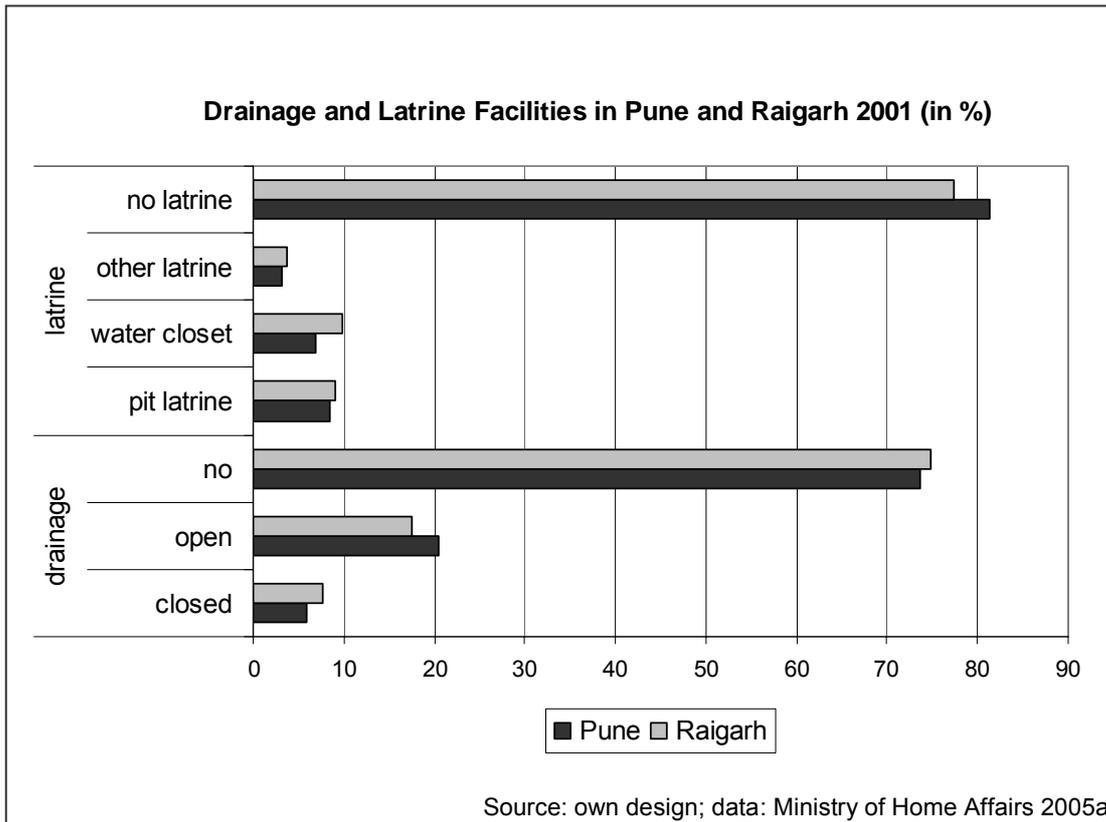


Figure 4.32: Drainage and Latrine Facilities for Rural Population in Pune and Raigarh

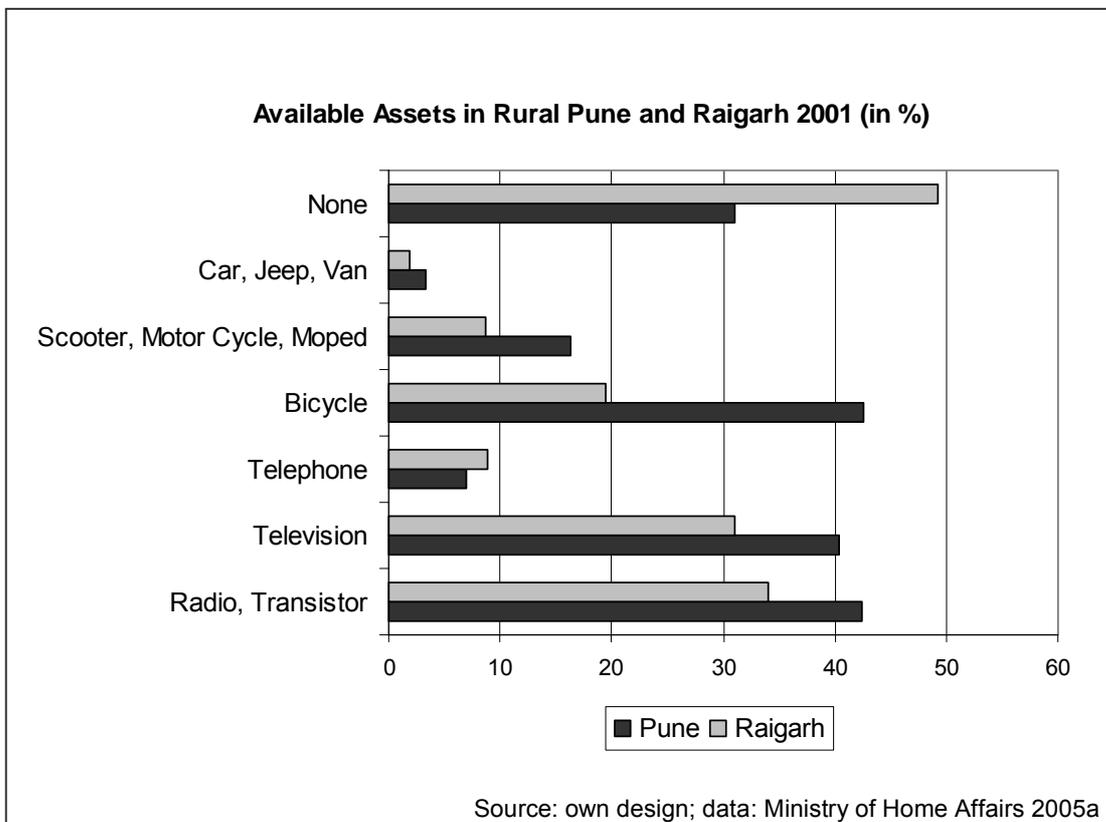


Figure 4.33: Available Assets for Rural Population in Pune and Raigarh

4.2.2. Analysis

The analysis for Maharashtra follows the same pattern as the analysis for Himachal Pradesh (see above, 4.1).

4.2.2.1. Decision Space of Medical Officers

In Pune and Raigarh district 116 MOs were interviewed with the aid of a standardized questionnaire (see Annex III). Not all questionnaires were completed due to the time shortage in the monthly MO district level meetings hence, 15 % are incomplete. The majority of the interviewed MOs are based at PHCs, only two were from SCs and one from a Rural Hospital. Picture 4.10 and 4.11 show the typical working space for MOs in Pune and Raigarh. The officers have been employed in the public health system for 9 years on average, ranging from one month to 34 years. At the current location officers served for 3 years on average, ranging from one month to 18 years. The majority of MOs lives at the health facility, only 12 % do not reside there. The survey included also expert interviews with 8 district health officials and 3 state health officials including the Assistant Director Public Health and the Additional Director Health Services. District officials were met in their offices at Zilla Parishad in Pune and Alibag while the state officials were met in their respective offices in Pune.

Decision space of MOs in Pune and Raigarh depends on the range of choice of certain functions (see Table 4.1). Sources of revenue, allocation of expenditure, fees and contracts are part of the finance function. The revenue for PHCs in the two districts comes from the state government. The budget is first calculated by the planning department according to population norms and then handed down to the district health officers (DHO 09.02.2004). In the perception of district officials the budget for the National Programmes, which partly comes from the central government, is sufficient (Ibid.). The Family Welfare Programme is fully sponsored by the central level. The budget for drugs, maintenance and vehicles from the state level on the other hand is not sufficient (Ibid.). The only budget available to MOs is the registration fee of Rs. 2 collected at the PHC for outpatient services. The revenue from this registration can be used for environment, sanitation or minor repairs according to government guidelines (Ibid.). The MO cannot decide alone how to use the money. It is the community health committee which has to come to a joined decision. Most MOs (77 %) find the budget insufficient or by far insufficient to manage their PHCs (see Figure 4.34). Since intergovernmental transfers are the main source for health spending, the range of choice for sources of revenue is narrow (see Table 4.6).



Picture 4.10: Rural Hospital Mahad, Raigarh District



Picture 4.11: PHC Wada, Khed Block, Pune District

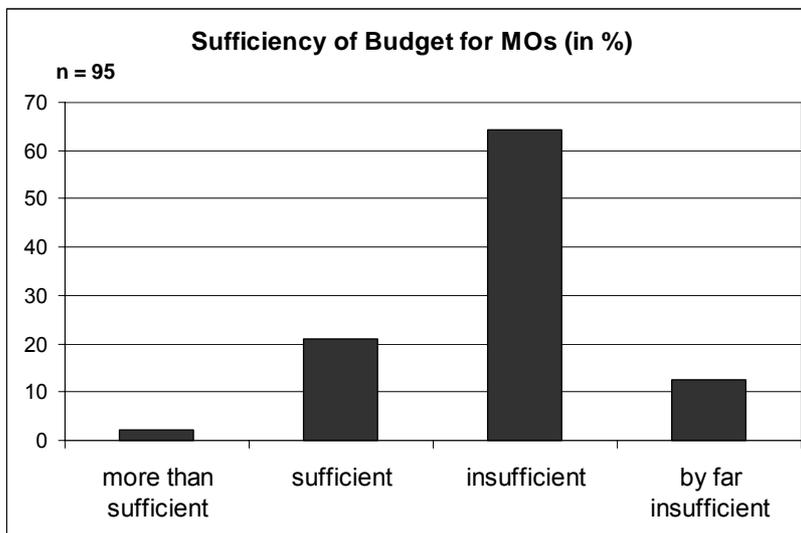


Figure 4.34: Sufficiency of Budget for MOs in Pune and Raigarh

The allocation of expenditure is also decided at higher authorities at the state level. All local spending is earmarked for specific programmes or activities. The system of allotted budget is the same as in Himachal Pradesh (see 4.1). Service fees are decided at the state level too. The registration fee for outpatient service at the PHC is Rs. 2 in all of Maharashtra, otherwise all services at the PHC are free. Patients below the poverty line are exempted from this fee. MOs cannot award contracts for major works but they can use the funds from the registration fees to hire locals for minor work (ADHO 06.12.2003). In case of major works funds have to be released from the state level Health Department to the Public Works Department (PWD), which is responsible for the maintenance of PHCs as in Himachal Pradesh. The PWD is not under the administrative control of the Health Department. At the district level the executive engineer Zilla Parishad is responsible for the maintenance of PHCs and SCs (DHO 09.02.2004). The usual procedure in case of broken equipment for MOs is to call their superiors, 92 % do call their superiors at the district level. The superior performs all following action in most of the cases (57 %) or advises the MOs what to do (35 %). Half of the MOs also call the PWD. On an average it takes 7 weeks to have a repair carried out. External repair is called by 53 % of MOs, in these cases it takes 2 weeks for repair. If equipment is broken and cannot be repaired, purchase of new equipment is rare. Only 29 % of MOs reported new purchases in these cases. The major reasons for no new acquisitions are financial shortage (60 %) and no permission (38 %). The example shows that even in case of repairs money has to be allocated by higher authorities and the decision space for MOs is narrow (see Table 4.6). The range of choice for external contracts for repairs depends on the available funds and the decisions of the community health committee. Only half of all MOs use this chance. Therefore, the range of choice is still narrow and the maintenance of PHCs is very bad (see Picture 4.12 and 4.13).



Picture 4.12 (left): IPD in PHC Abtali, Junnar Block, Pune District

Picture 4.13 (above): Non-functioning Operation Theatre, PHC, Raigarh District

The functions for service organization are hospital autonomy and required programmes. It has already been outlined above that the decision space is narrow for finance. The range of autonomy for PHCs is defined by law or higher authorities as even the rules for community health committees are made at state level. Therefore, MOs cannot make free decisions or use the budget for other purposes than the ones stated in the rules. Norms or targets for local programmes are also decided at state level, due to rigid norms the range of choice is narrow (see Table 4.6). Targets for family planning for example are set according to the number of eligible couples in the area and the couple protection rate²⁶ (ADHO 06.12.2003). The ground data is collected by MPWs. Although Maharashtra has adopted the target-free approach in 1997 (Public Health Department 2002: 12), targets are still felt to be there (MO 30.04.2003).

Salaries, contracts and civil service come under the function human resources. The salary for MOs ranges from Rs. 10,000 to 20,000 per month depending on their years of service (ADHO 06.12.2003). Extra allowance of Rs. 300 to 400 is paid to MOs serving in tribal areas²⁷. Half of the MOs interviewed (53 %) find the salary insufficient or by far insufficient (see Figure 4.35). Salary range is defined by law or higher authorities. The decision is made at the state level, indicating a narrow range of choice (see Table 4.6).

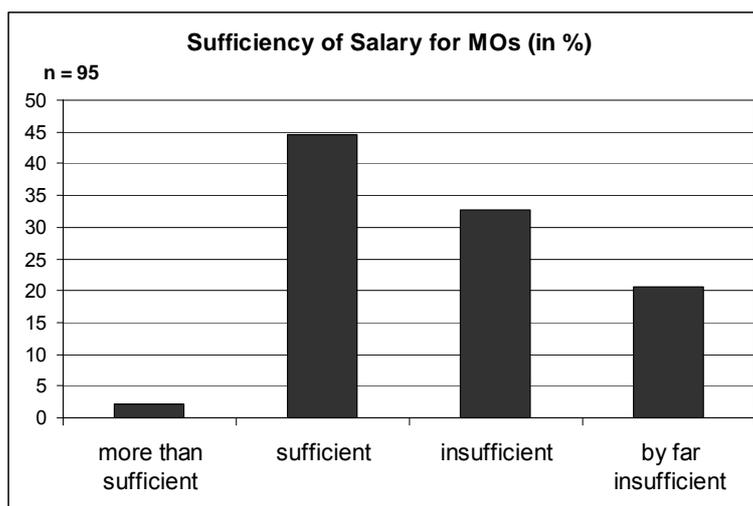


Figure 4.35: Sufficiency of Salary for MOs in Pune and Raigarh

Contracting non-permanent staff is not possible at the PHC level. The range of choice is thus narrow. The lack of staff is experienced at 75 % of PHCs questioned in Pune and Raigarh district. Most PHCs require MOs, MPW and nurses but service personnel and specialists are also needed (see Figure 4.36). Among the specialists lab assistant and gynaecologists are most sought after. Although two MPWs are required for each SC by law, every PHC in the two districts has in its service area a mean of one SC without MPW, four SCs with one MPW and three SCs with two MPWs. SCs with none or only one MPW are not fully functionable. Hence, 63 % of SCs under the supervision of one PHC cannot perform the required tasks.

²⁶ - couple protection rate = percentage of people using contraception (ADHO 06.12.2003)

²⁷ - high percentage of scheduled tribe population in one area

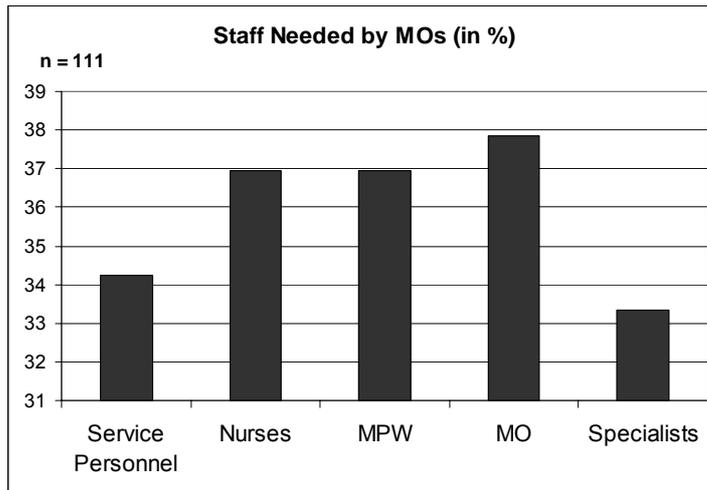


Figure 4.36: Staff Needed by MOs in Pune and Raigarh

The state government thinks about hiring private doctors for public services to circumvent the lack of doctors in the public sector. However, private doctors are also unwilling to work in remote areas and decisions are again made at the state level without local involvement. Firing of permanent staff is only possible in most severe cases. In case of very bad performance the annual rise can be frozen (ADHO 06.12.2003). Work absenteeism is punished by cuts in pay for the absent time. If doctors are absent all the time the annual rise is stopped (Ibid.). Hiring of staff is decided at the state level. The existence of the national civil service allows only a narrow range of choice in hiring and firing practice. Sanctions for misbehaviour are thus weak in character and rare in appearance.

The definition of priority populations and the definition of size and composition of facility boards and district offices are made by higher authorities at the state level. The functions access rules and governance rules for these indicators are therefore narrow (see Table 4.6). The composition of priority population depends on the respective National Health Programme. Since the Family Welfare Programme has the largest budget, the main focus in health care delivery is on women and children. Facility boards only exist at higher levels, PHCs and SCs do not have these boards. Although the district health administration is under the control of Zilla Parishad, it has no influence on size and composition of this administration. Size and composition of Zilla Parishad is defined by central government law (see Rai et al. 2003). Community participation through community health committees, NGOs and the community needs assessment approach adopted in 1997 is codified by law or defined by higher-level authorities. Thus, the range of choice is narrow again.

So far the decision space for all functions listed in Table 4.1 is narrow (see Table 4.6). The experiences from the MOs support this finding. The majority of them agreed that all planning is done at the district level (60 %), fewer hold the opinion that all planning is done at the state level (31 %). However, they also voiced that they deliver a plan to the district (36 %) and that planning is demand-based (61 %). Decentralization in Pune and Raigarh district involves financial and administrative decentralization, but the decision space is narrow (see Table 4.6). It can be summarised that decentralization did not create more autonomy at the lower administrative levels. Nevertheless, only 25 % of MOs recommend

more autonomy to improve their health facilities and 55 % want to have more decision-making power over financial issues (see Figure 4.37).

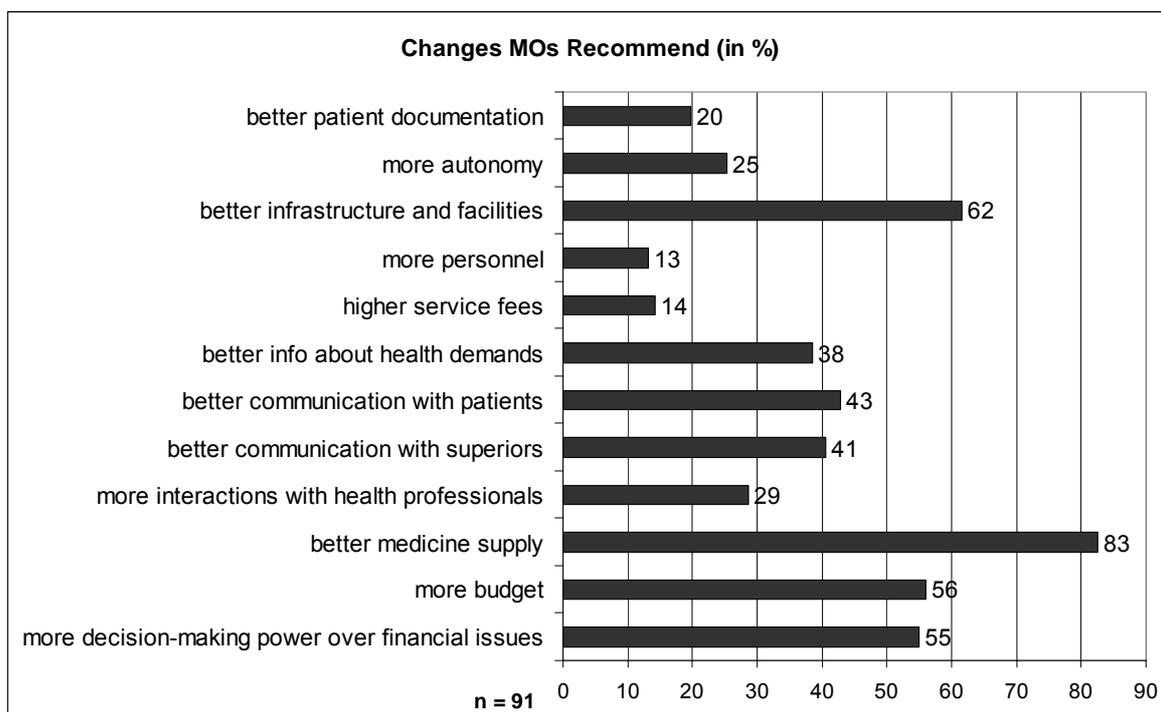


Figure 4.37: Changes MOs Recommend to Improve Public Health Care in Pune and Raigarh

Table 4.6: Map of Decision Space for Maharashtra, Pune and Raigarh District (adapted from Bossert 1998: 1519)

Function	Indicator	Range of Choice		
		narrow	moderate	wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total health spending	High %	Mid %	Low %
Allocation of expenditure	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms

Human Resources				
Salaries	Choice of salary range	Defined by law or higher authority	Moderate salary range defined	No limits
Contract	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service
Access rules				
Targeting	Defining priority populations	Law or defined by higher authority	Several models for local choice	No limits
Governance rules				
Facility boards	Size and composition of boards	Law or defined by higher authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by higher authority	Several models for local choice	No limits
Community participation	Size, number, composition, and role of community participation	Law or defined by higher authority	Several models for local choice	No limits

4.2.2.2. Community Participation

In the Pune and Raigarh districts 17 NGOs were interviewed with the aid of a standardized questionnaire (see Annex IV). In addition, expert interviews with these NGOs and three additional organizations, group discussions with NGO members, and field visits to their project sites took place. One workshop for NGOs about health insurance organised by GTZ as well as one internal NGO meeting were attended. Most of the interviewed NGOs were located in Pune and were visited more than once. Research material and reports about health projects of these NGOs were collected. One of the interviewed NGOs is one of the four MNGOs for Maharashtra chosen by the state government. The size of the NGOs and their scope of work in Maharashtra are different from Himachal Pradesh. The average age of an organization is 24 years, ranging from 10 to 52 years of service. Hence, interviewed NGOs in Maharashtra are older than in Himachal Pradesh. They are involved in health issues for 18 years on average, ranging from less than one year to 52 years. A large share of NGOs (41 %) is involved in health issues since their foundation. The interviewed NGO members are working for their organization for 11 years on average. The majority of them work on state level (41 %), national and district are also prominent with 29 % and 24 % respectively. Only one NGO is confined to the block level. The size of the interviewed NGOs is quite big with a mean of 261 employees including paid and voluntary staff. The smallest NGO has 8 people working, while the largest counts 2000 employees. However, the majority had less than 50 employees (47 %). More than one third of the organizations is registered as society (35 %), the same percentage is registered as trust and less than one third is registered under both acts. Eligible for foreign funding are 82 % of the NGOs. They are registered under FCRA. The three organizations not registered under FCRA are neither small nor restricted to local areas as could be expected. Thus, there is no registration pattern for FCRA visible here. International funding agencies are the most important source for NGO revenue in the two districts, 71 % receive funding from these organizations (see Figure 4.38). Second important source is the state government (65 %), followed by other sources (35 %) like individuals or industries. Central government funding is less essential, only 29 % of NGOs use this source. Membership fees and funds from the community served rank last with 12 % and 6 % of NGOs using these sources respectively.

The main working areas of the interviewed NGOs are besides health (94 %), rural development (82 %), community mobilization (65 %), women employment (59 %), and environment (53 %). A large percentage of the NGOs also undertake other activities (76 %) like women empowerment and education activities. The major reasons for NGOs to start working on health issues was the lack of health services in their areas (41 %), the severe health situation of the population (35 %), survey findings (29 %) and community approaches to take up the issue (24 %) (see Figure 4.39). Some NGOs were also influenced by the medical background of their founders (18 %).

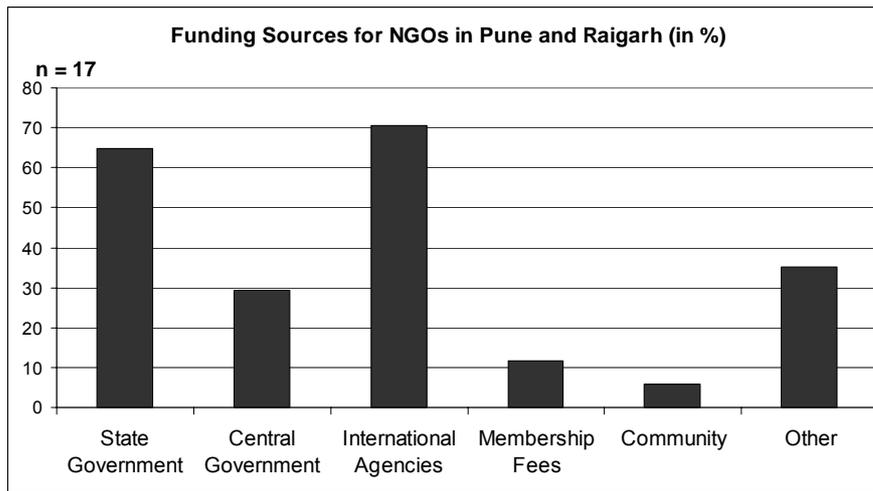


Figure 4.38:
Funding Sources
for NGOs in Pune
and Raigarh

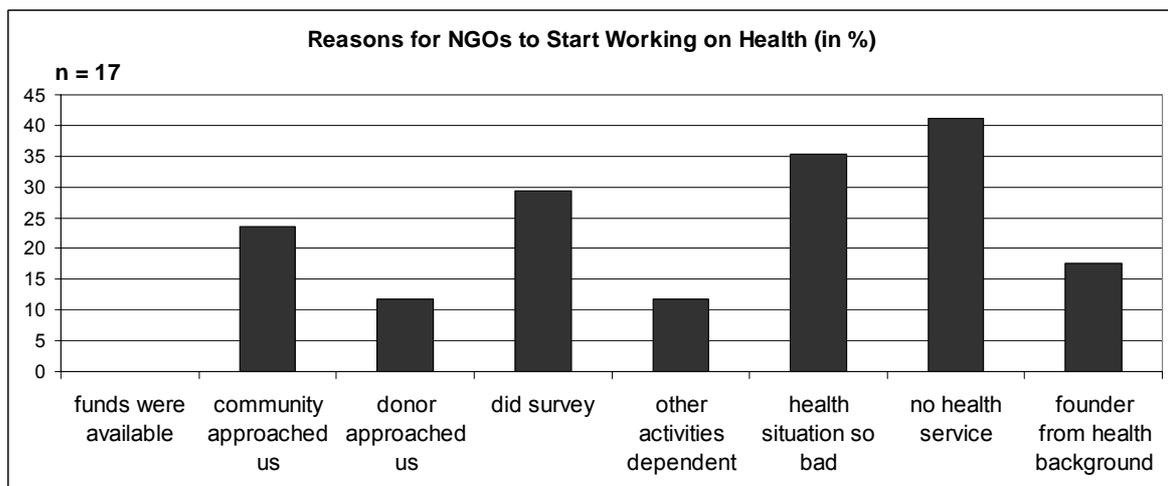


Figure 4.39: Reasons for NGOs to Start Working on Health in Pune and Raigarh

Donor approaches to start working on health and the dependency of other activities on health were less important, only 12 % of the interviewed organizations agreed while the availability of funding did not play a role at all. In health the focus is on women and child health (88 %), followed by reproductive child health and primary health care (65 % each). AIDS and Sexually Transmitted Diseases (STD) as well as health in general are of minor importance (47 % each), followed by environmental health (29 %) and tuberculosis (24 %).

The degree of community participation depends on the definition of community, the kind of representation of community, the rationale for community participation and on depth, scope and mode of community participation (see Table 2.1; Murthy/ Klugman 2004: i79). Target population of NGOs in Pune and Raigarh as their foci in health activities already indicate are mainly women (65 %), children and the general population (59 % each). Two approaches for community participation were dominant. On the one hand interviewed NGOs started SHGs, established community groups or organizations for example parents committees. The SHGs and groups are then used for the management of health projects and other health programme activities. Target population for these groups are mainly women. On the other hand NGOs trained villagers as volunteer workers or activist to function as a link between NGOs and villagers. Often, women were trained as health

worker following the example of CHV (see 2.2.3.2.2.). The preference for SHGs and women groups is also visible in the outreach activities of NGOs (see Figure 4.40). Community participation started with the building of village level institutions. Apparently, existing village level institutions like PRIs or Mahila Mandals proved to be insufficient for the intended NGO work. Sample NGOs define target community in the two districts as marginalized groups of population. For the training of volunteer health workers some NGOs prefer women from low castes. But not all NGOs reach out to the marginalized groups. Membership in SHG requires that money is available for saving and time for meetings. However small the amount might be, the very poor will not be able to participate. Thus, NGOs in the two districts are also confined to relatively easy-to-reach people living in an area, therefore, reaching a middle degree of community participation (see Table 4.7).

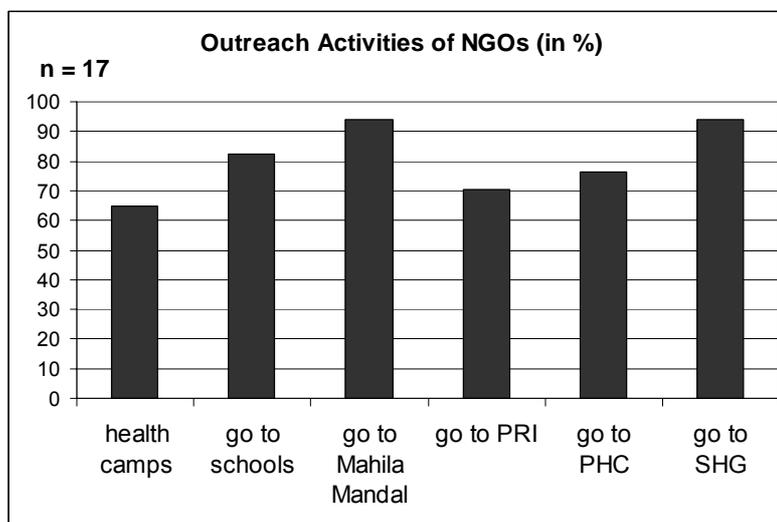


Figure 4.40: Outreach Activities of NGOs in Pune and Raigarh

Closely linked to the question of community definition is its representation. It is difficult to assess to which extent NGOs represent the interests of marginalized groups of population. It would only be possible to research representation through interviews with all community members asking them whether they are represented by the respective organizations who claim to do so. Since community level studies were not possible within the scope of this study, only general assumptions can be drawn from the NGO interviews and the field visits. The National Health Policy defines PRIs and NGOs as representatives of community (see above). Within the PRIs seats are reserved for women, scheduled caste and scheduled tribe members. However, the last two groups only hold a small percentage of seats as they only make up a small percentage of Pune and Raigarh population. Participation of women in PRI is not without problems, since bias against women still persists in the districts (Kanade/ Sutar 1998: 7). Hence, marginalized groups have difficulties influencing PRI decisions. The majority of NGOs (82 %) connect with PRIs through their programmes and through community health committees (see Figure 4.41). In the opinion of NGOs this cooperation is good (1.9) (see Figure 4.42). Although cooperation with community health committees takes place to a lesser extent (72 %), it receives a slightly better rating than PRI cooperation (1.7). NGOs further cooperate with

women groups, but marginalized groups of population or of women were not especially mentioned as target groups. It has already been described above how community is defined. The assumption from this definition and the facts that marginalized groups are hardly represented by PRIs or NGOs is that community is represented by powerful groups and NGOs. Therefore, a middle degree of community participation is reached (see Table 4.7).

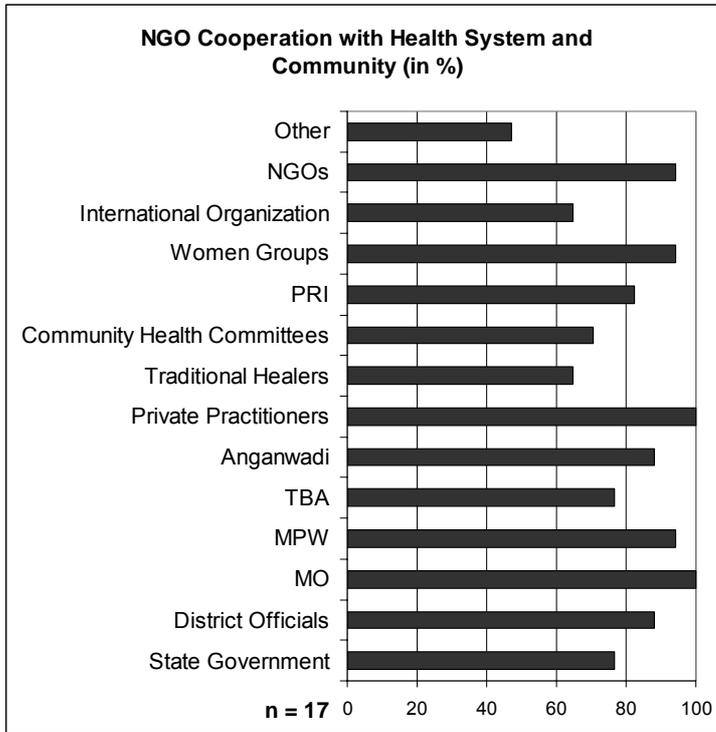


Figure 4.41: NGO Cooperation with Health System and Community in Pune and Raigarh

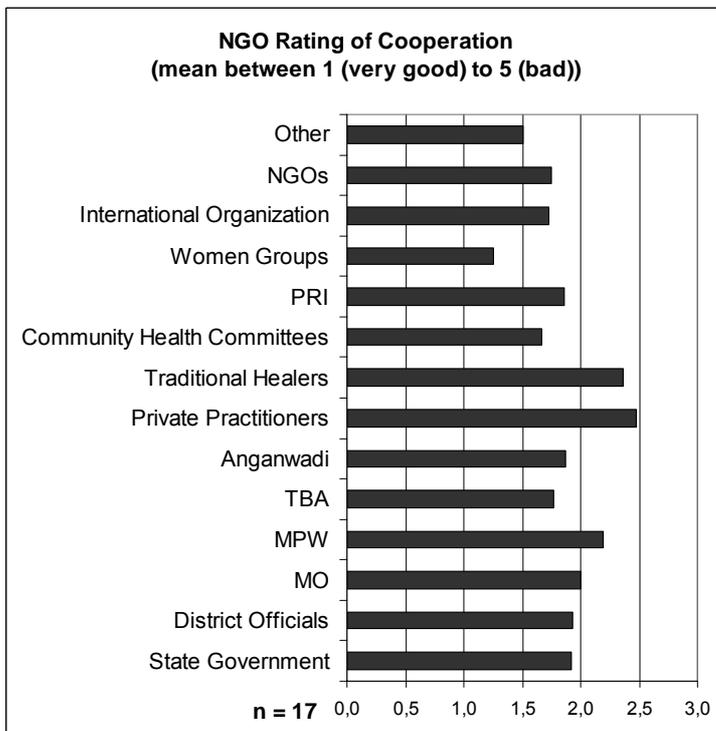


Figure 4.42: NGO Rating of Cooperation in Pune and Raigarh

The rationale for community participation in Pune and Raigarh is to increase effectiveness, improve accountability and define community participation as a right by itself. However, this rationale was developed at the central level as a part of the National Health Policy 2002 (see above), the ground reality is different. The goal of community participation at the district level and below seems to be to increase utilization through more outreach, to raise additional resources through PRIs and to support the infrastructure. The emphasis of NGO work lies in information and education activities, pointing towards a lower degree of community participation (see Table 4.7).

The depth of community participation in the two districts varies for each NGO. While some are at the manipulation and informing stage of community participation, some have already arrived at collective or community decision-making. One example for the higher degree of community participation is the establishment of community committees who decide together with the NGO about the use of funds for the project (NGO 13.02.2004). However, the main service offered to the community is to give information on health, all NGOs undertake this activity (see Figure 4.43). Health check-up is also an important service, which 94 % of NGOs offer. Family planning activities (76 %) come before help in health decision-making (59 %). Through the establishment of SHGs NGOs present a platform for discussion about health. Hence, the depth of community participation lies mainly in advice and consultation, indicating a middle degree of community participation (see Table 4.7).

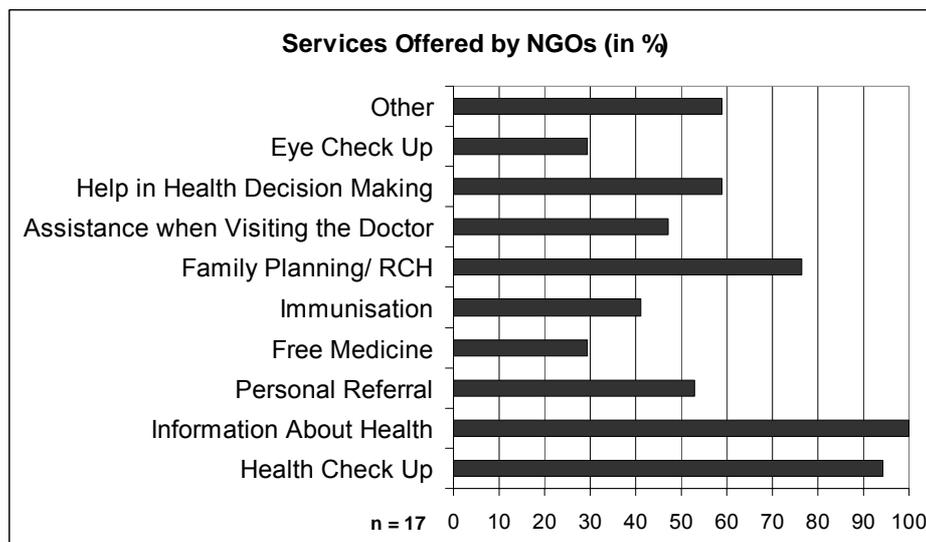


Figure 4.43: Services Offered by NGOs in Pune and Raigarh

The scope of community participation is service delivery and management at the periphery through community health committees and PRIs which represents a middle degree of community participation. Although some NGOs are already involved to some extent in health policy making through their advocacy work, for example the “Right to Health” campaign, the majority has no influence on health policy, health management and service delivery at all levels. Similarly, PRIs who are in charge of the district primary health system in Maharashtra, are not involved in policy-making and can only act according to the government guidelines and laws (see above). Community in the two

districts participates as members of small collectives like SHGs or through invitation by the government like community health committees and PRIs. Community participation, therefore, reaches a middle degree (see Table 4.7).

Table 4.7: Degree of Community Participation in Maharashtra, Pune and Raigarh District (adapted from Murthy/ Klugman 2004: i79)

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents community	Powerful clients	Powerful groups in population; NGOs who represent community	Marginalized groups in population; NGOs who represent their interests
Rationale for CP in health	District administration level CP as a means to - expand outreach - raise resources - support infrastructure	CP as a means to - improve management of local health services (efficiency)	Central or State government level CP as a means to - increase effectiveness - improve accountability - CP as a right by itself
Depth of CP	Manipulation Informing	Advice/ Consultation	Collective or community decision-making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals Through invitation by government	As members of small collectives Often through invitation by government	As members of mass-based organizations and small collectives Both through invitations and demands from below

4.2.2.3. Prerequisites for Successful Participation

The indicators for successful participation are already explained above. Table 4.2 shows the range for these indicators. Interviews with MOs and NGOs as well as field visits are used to assess changes for successful participation. The characteristics of the two groups have been highlighted above.

4.2.2.3.1. Interest in Participation

Successful participation requires that stakeholders are interested in participation. The extent and mode of MO cooperation in Pune and Raigarh with health professionals and community groups including NGOs already highlights their degree of interest. Likewise, existing NGO cooperation shows their attitude towards participation. Nearly all MOs cooperate with health professionals or the community in one way or the other. Preference for cooperation with Anganwadi workers (93 %), TBA (85 %) and private practitioner (82 %) becomes obvious from the questionnaires (see Figure 4.44). Community health committees, traditional healers and Ayurvedic systems of medicine take up the next ranks. Cooperation with Anganwadi workers was not only preferred, but also received the best ratings from MOs (see Figure 4.45). When asked how good the cooperation was, MOs rated Anganwadi workers with “good” (mean 1.6). Similarly good ratings received TBA (2.1) and community health committees (2.2). Traditional healers got the worst results, their cooperation was rated as “ok” (mean 3.1). From the community side, MOs liked best to cooperate with schools (91 %), Mahila Mandals (86 %) and PRIs (85 %) (see Figure 4.46). NGOs were ranked fifth place (72 %) after the Block Development Committee (78 %). Cooperation with Self-help Groups was the least important with 67 % of positive replies. However, all links with community received positive ratings and were judged as “good” by the MOs (see Figure 4.47). The range is from 1.9 as the mean for schools to 2.3 as the mean for SHGs. Hence, MOs are actively involved in various cooperations with other health professionals and community. They gained experiences in these activities. Furthermore, the amount of cooperation seems to indicate interest.

MOs cooperate with community and health professionals in two ways. On the one hand they undertake activities with certain groups, on the other hand they engage people’s help for the National Health Programmes. Among the activities undertaken with the community delivery of health education in schools comes first (see Figure 4.48). But all activities receive a high positive reply. Even the task to ask the community for feedback is carried out by 80 % of MOs. Meeting with communities, visit to families, health need assessment and promotion of service area take place in most of the PHC areas (90 % or above). Nevertheless, the frequency varies. While meetings with the community take place every four month on average, promotion of service areas occurs every two years. Visits to families are also rare and take place every 14 months on average but all other activities are more frequently held at intervals of less than six months.

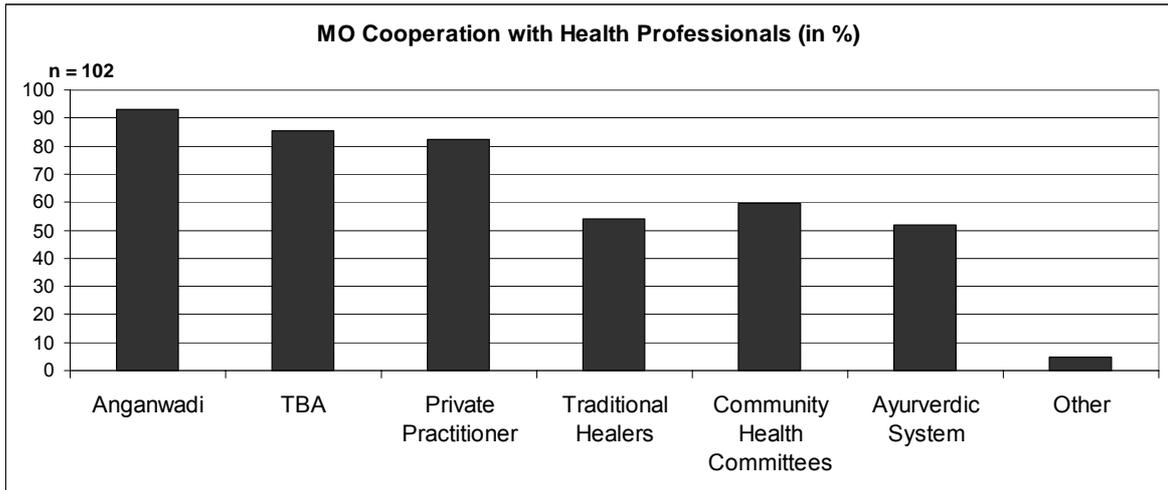


Figure 4.44: MO Cooperation with Health Professionals in Pune and Raigarh

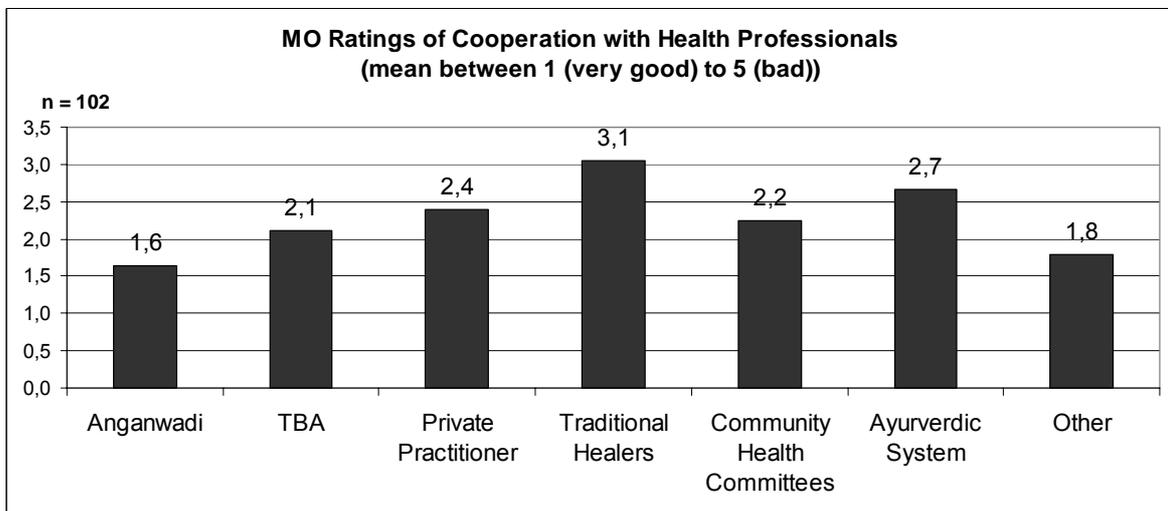


Figure 4.45: MO Ratings of Cooperation with Health Professionals in Pune and Raigarh

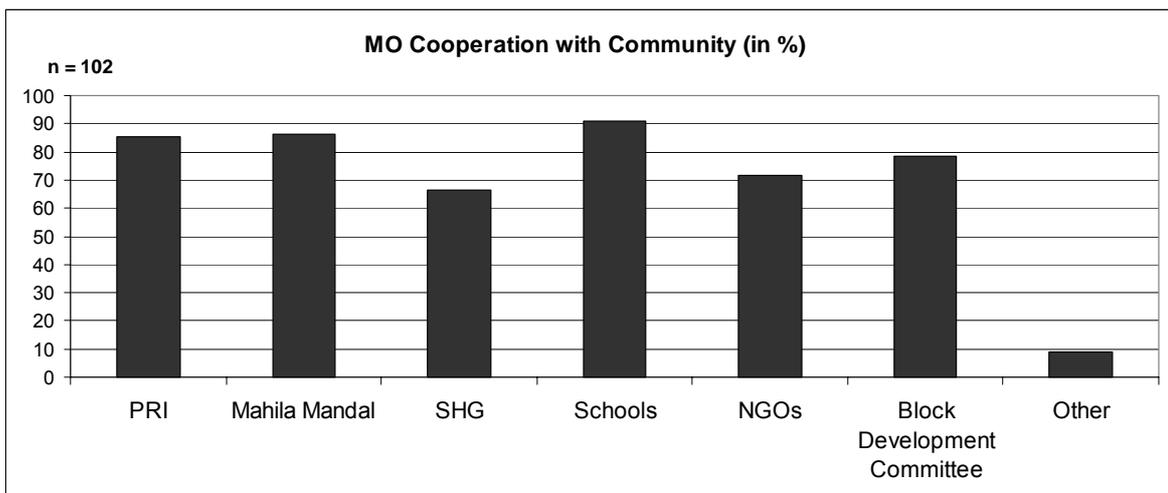


Figure 4.46: MO Cooperation with Community in Pune and Raigarh

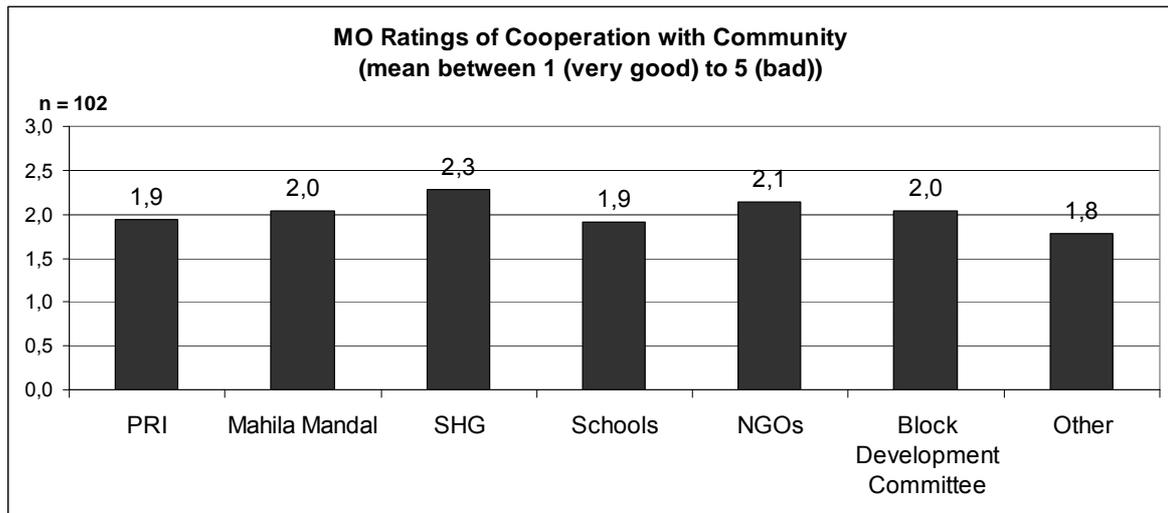


Figure 4.47: MO Ratings of Cooperation with Community in Pune and Raigarh

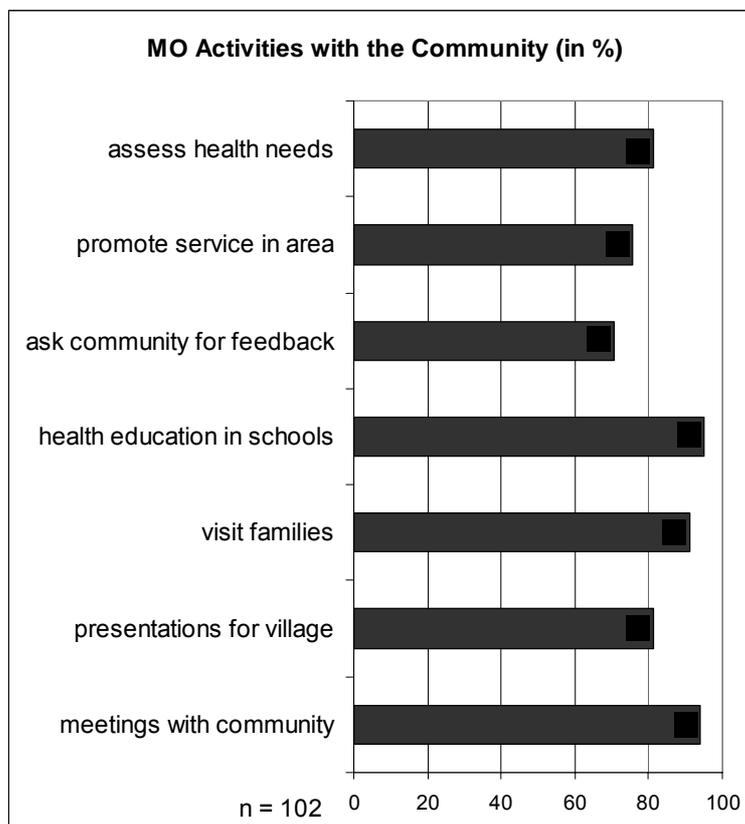


Figure 4.48: MO Activities with the Community in Pune and Raigarh

In the National Health Programme MOs predominantly receive help from the Anganwadi worker (97 %), followed by TBA (69 %). Since their help is part of their duty, it is not surprising that they are most important to the MOs. From the community help is rendered by Mahila Mandals (54 %), NGOs (40 %), PRIs (33 %) and SHG (23 %). Thus, for service delivery in the National Health Programmes community is still less important. Women groups are engaged more often than NGOs.

The relationship with NGOs seems to be good. The majority of MOs knows the government NGO schemes (83 %) and most of them also know NGOs working in their area (68 %) (see Figure 4.49). The statements that NGOs speak out for the community and do good work in health and health-related sectors met the approval of the MOs. Nearly all MOs think that NGOs could help them in their work (83 %). However, MOs believe to a lesser extent that NGOs do have medical expertise (45 %) and a quarter of them define NGOs as money-minded (27 %). MOs are interested in NGO cooperation and would like NGOs to help in delivering information about PHC health services and the national programmes to the community (46 % and 45 % respectively) (see Figure 4.50). Direct service like giving medication to the villagers received less agreement (29 %) as did the taking over of some of the PHC services (17 %). Quality control of public health services through NGOs was the least favourite, it only received 5 % of positive replies. Hence, MOs would like the help of NGOs in IEC activities but would not like to be controlled by them. Furthermore, they do not see NGOs to be fit to take up service delivery themselves.

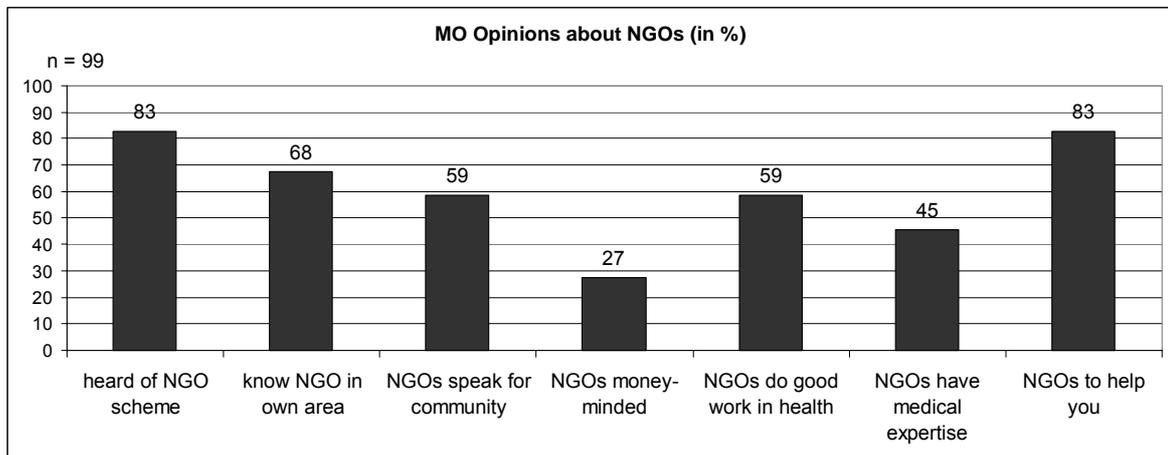


Figure 4.49: MO Opinions about NGOs in Pune and Raigarh

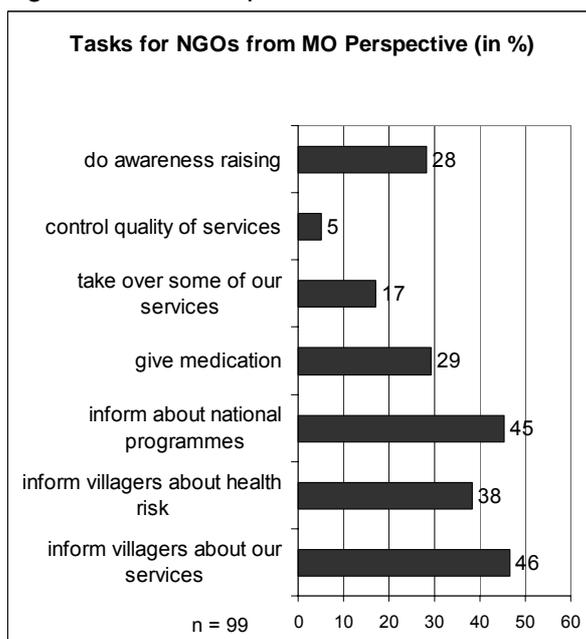


Figure 4.50: Tasks for NGOs from MO Perspective in Pune and Raigarh

The activities MOs undertake and their perceptions of cooperation and NGOs point towards an interest in “top-down” participation (see Table 4.8). They undertake the activities as described in the health policy but do not expect community suggestions or active participation from below. Participation from community is again seen as compliance with medical treatment regimes and utilization of immunization or other services offered by the PHC. Public health programmes are not designed to involve “bottom-up” participation. NGOs on the other hand need “bottom-up” cooperation. They cooperate with public health institutions and community. All interviewed NGOs cooperate with MOs and Private Practitioners (see Figure 4.41). Most of them also have contacts with MPWs, women groups and other NGOs (94 % each), followed by district officials and Anganwadi workers (88 %). PRIs (82 %), state officials and TBA (76 %) are also important partners as are community health committees (71 %). International organizations and traditional healers are on the last ranks, but 65 % of NGOs still cooperate with them. The ratings for the different cooperations vary between a mean of 1.3 for women groups and 2.5 for private practitioners (see Figure 4.42). Women groups were the only partner where cooperation was rated as “very good”. All other partners received “good”, except the private practitioners. Community health committees and international organizations are just ranked behind women groups (1.7 each), while MOs and MPW are behind (2.0 and 2.2 respectively). The cooperation mainly takes place in the form of information exchange and the joint organization of events. In their work with the community NGOs follow the “bottom-up” approach, hence, workshops and discussions with the community are their priority (see Figure 4.51; 100 % each). Another important point is training of community members for health issues or other activities which 88 % of NGOs undertake. Through these trainings and workshops awareness about health issues is created and community members become empowered to participate. In the opinion of NGOs community cooperates with them as they mainly expect information and health gains. The indicator interest in participation for NGOs is high, chances of successful participation are therefore good as well (see Table 4.8).

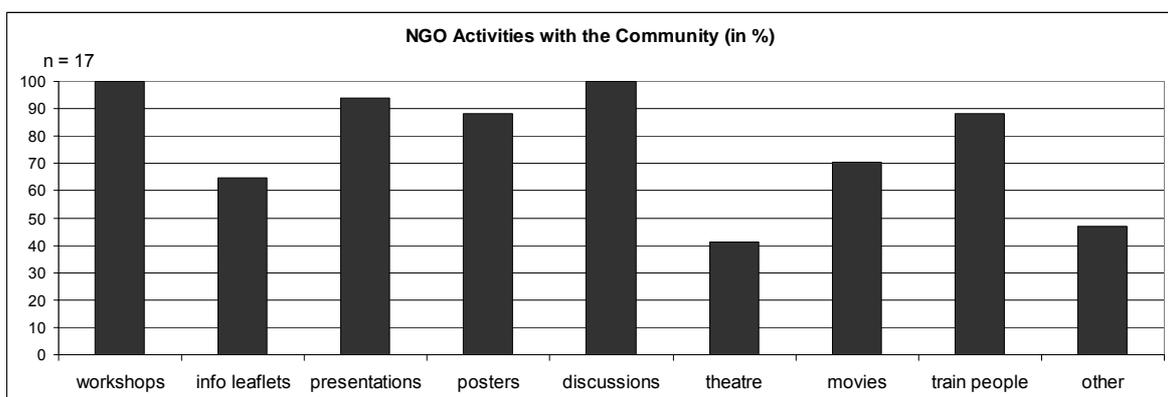


Figure 4.51: NGO Activities with the Community in Pune and Raigarh

4.2.2.3.2. Communication and Information Transfer

Communication and Information Transfer within the Public Health System

Communication and information transfer within the public health system takes place through several channels. Similar to Himachal Pradesh monthly meetings at all hierarchical levels up to the district are an important setting for communication and information. MPWs and MOs have to write monthly reports including their achievements in the National Health Programmes and general performance indicators like utilization. Individual reports are not discussed at the district level meetings as every meeting is attended by more than 50 MOs. The time for the meetings is limited. Discussions are thus confined to new government guidelines and general procedures. Information is handed down from the district officials to the MOs. Although only one meeting in Raigarh district could be observed, the “top-down” approach was also visible in Pune. The meeting was postponed from one day to another as it was convenient for the District Health Officer²⁸. Since not all MOs have a telephone connection it is questionable in which way they were informed about the postponement. The meeting in Raigarh was very crowded. A small percentage of attending MOs was female. The room selected for the meeting was too small, so the meeting had to be shifted to another room which also did not have enough chairs. The organizational mismanagement of this meeting could point towards the lack of interest of the district officials. The observed power structure in both districts showed that district officials and especially the DHO perceive themselves and are perceived by their subordinates as positioned far above the lower levels like MO. The hierarchical gap is a hindrance for successful “bottom-up” communication (see Table 4.8).

The majority of MOs hold regular staff meetings every 3 weeks on average. All receive monthly reports from their subordinates and give feedback on those. MOs deliver monthly reports to their superiors and 96 % receive feedback on them. Furthermore, a high percentage of MOs (95 %) feels that their reports are used for district-level planning. Superiors visit their facilities every 2 month on average. In fact, all ADHOs look after 3-4 blocks for intensive monitoring (ADHO 06.12.2003) and can therefore manage to visit the facilities. However, the maximum was 12 month between each visit, which shows that some places are more regularly visited than others. Although institutionalized communication channels like reports and meetings exist, information is only partly handed down or understood. Only 83 % of all MOs had heard of the government schemes to involve NGOs in RCH which was started in 2000. District officials subordinate to the DHO on the other hand were well-informed about the status of health care delivery at the PHC level and the existing problems. They receive this information through informal communication channels which are, thus, important for “bottom-up” communication and information transfer. Even though “bottom-up” communication is limited to informal channels and institutionalized reports, it nevertheless takes place. Still “bottom-up” communication does not reach all levels. Statistics and reports do not reflect the real status of the public health system at the PHC level and below. Infrastructure like beds or

²⁸ - The District Health Officer has the same administrative function in Maharashtra like the CMOH in Himachal Pradesh.

personnel does exist on paper, but is often not traceable during field visits. Furthermore, a large percentage of MOs (41 %) wishes to have better communication with their superiors (see Figure 4.37). The indicator for communication and information transfer, therefore, points towards a moderate chance for successful participation (see Table 4.8).

Communication and Information Transfer within NGOs

Communication within NGOs in Pune and Raigarh is good but differences among the organizations exist. Some larger NGOs such as K.E.M. Hospital Research Centre, BAIF Development Research Foundation or CEHAT have a board of trustees and other advisory groups like scientific advisory committee or social accountability group. Communication is enhanced through these different groups. Since most of the interviewed NGOs are of considerable size, research groups and teams are a common form of work organization. Information flow within these research groups and to the director takes place in formal and informal ways. Reports about research projects are given to the director. Regular meetings take place within the research group and also within the organization. Information is further shared through newsletters or workshops. Smaller NGOs use the resources of the large NGOs for training of their employees and volunteers. The majority of interviewed NGO members (83 %) received training, mainly about health issues and project management. Communication among NGOs is thus also enhanced and further developed through the various NGO networks in Maharashtra. Information about health is mostly obtained from books or discussion with health professionals.

The same relationship between size of an organization and the extent of hierarchical levels within the organization like in Himachal Pradesh was also observed here. The director of the NGO represents the organization to the donors and government officials. All interviewed directors except for one are male and either come from a medical background holding a doctoral degree or were involved in the freedom movement of India. The seniority principle is evident in all interviewed NGOs. The longer people are working for their organization, the higher is their position within, provided that they have the required qualifications. The educational level of the interviewed NGO directors or project leaders was high, most of them hold a university degree. However, field workers of NGOs were mostly less educated, holding a school degree or below. The percentage of women was also considerably higher at the lower hierarchies. Although communication and information transfer within the NGO headquarters was observed to be good, field offices seemed to be less informed and involved in the NGOs proceedings. Since field workers are mostly recruited for specific projects, their part knowledge about the assigned project is sufficient for them to carry out their tasks. Linkages between field workers based at the project sides and the headquarter staff were not always strong. It was clearly visible that headquarter staff has more power and influence and is also better paid than the field workers. Hence, strong hierarchies also exist within NGOs but information is shared “top-down”, “bottom-up” and within the same hierarchy. The chance for successful participation is thus high (see Table 4.8).

Communication and Information Transfer between Public Health System and Community

Although all MOs cooperate with the community, communication and information transfer between the public health system and the community is not always smooth. Communication habits become traceable through health services offered including National Health Programmes, cooperation with community, complaint procedures and MOs attitude towards patients. Cooperation with community has been highlighted above, PRIs and schools received the best ratings. Contacts to the community are established through outpatient services, outreach activities as laid down in the government policies and through community health committee meetings.

Communication and information transfer between MOs and patients during outpatient services is limited due to the high patient load and the lack of privacy. The average number of patients per day in Pune and Raigarh is 46, ranging from 2.5 up to 150. Since outpatient treatment is confined to the mornings, the time per patient is very limited. Although MOs said that they spent an average of 7 minutes with each patient and that they do explain the health problems to them in detail, it is not possible when looking at the simple mathematics. Firstly, seven minutes is a very short time considering that it includes history telling of the patient, examination and prescription. Secondly, if one multiplies the number of patients with the average time spent per patient, the opening times are exceeded by far²⁹. Unfortunately, no outpatient service could be observed during the field visits as the doctor was either taking a break for the interview, no patients were there or the visit took place in the afternoon when no patients come for outpatient services. Inpatients are rare and only admitted when family planning operations take place or in most severe cases like snake bite (see Picture 4.14).

Since most PHCs (55 %) do not have separate waiting rooms, patients usually crowd in the examination room and the adjoining corridor. Privacy in the doctor-to-patient contact does not exist, which is especially problematic in case of stigmatized diseases like Reproductive Tract Infections, Sexually Transmitted Diseases (STD), HIV/AIDS and Tuberculosis. Patients might be hesitant to tell about these health problems in front of fellow villagers.

Outreach activities include immunisation camps (93 %), Reproductive Child Health (RCH) services (83 %), health check-up camps (75 %) and eye camps (70 %). Other activities like meetings with community and health education in schools are also important (see above). MOs consider information about health to be most important after attitude of staff for villager's decision about the use of the public health service. Therefore, all outreach activities include information delivery. However, messages are spread through posters and presentations. Discussions, which are found to be the most successful way for spreading information by NGOs, are not used by MOs. Posters and messages are kept simple, one example is the family planning slogan "We two, Our two" advertising for the two-children policy. Although the messages are easy enough to be understood, underlying problems like lack of pension schemes or poverty are not addressed.

Furthermore, the workload at outreach activities is quite high limiting interpersonal communication. At a three-day health check-up camp in Pen, Raigarh district, in February

²⁹ - The maximum opening time calculated was 45 hours.

2004 nearly 10,000 people came to get treatment (NGO 14.02.2004). Although doctors from all surrounding PHCs tended to the villagers, the camp was nevertheless very crowded and people had to queue up for hours in the sun (see Picture 4.15). It was further observed that even though the participants wore traditional clothes indicating that they come from the villages, the clothing was still of good quality and very clean showing a higher social status. Only a very small percentage of participants were women. Hence, marginalized groups of society including the poor and women did not participate to the full extent. Better situated parts of the population benefited more from the health check-up camp. The treatment at the camp showed the same procedures as observed before. People queued in the examination room and outside in the corridors up to the courtyards. No privacy for individual patients existed. The time spent with each patient was about one minute, examination did not take place. Communication and information transfer between patients and the public health system hardly occurred.



Picture 4.14: Women in IPD after Family Planning Operation, PHC Neral, Raigarh District



Picture 4.15: People Queuing for OPD at Health Mela in Pen, Raigarh District

Other interactions with community outside the doctor-patient relationship take place through community health committees. Advisory committee is another word for this committee. All MOs answered that they have an advisory committee. The committees were mainly composed of PRI members, MO and Block Development Committee members. Other members were less often mentioned. The committee was said to be useful and decisions were implemented in the most cases. Meetings take place every 4 months on average. However, in individual talks MOs revealed that these interactions are difficult since PRIs are only interested in economic activities and do not understand public health issues (MO 02.12.2003).

The attitude of MOs towards their patients also influences communication and information transfer. Patients voice dissatisfaction with services through complaints. The majority of MOs (85 %) receive patient's complaints which are mainly verbal. The content of these complaints is mostly lack of medicine (77 %), followed by attitude of staff (49 %) and lack of equipment (49 %) (see Figure 4.52). Complaints about the treatment and the hygiene of the facility were less important. The MO side also felt that attitude of staff is most important to attract patients while free medicine only came fourth after information about health and hygiene of facility. Although many MOs receive complaints, only 37 % of those file a report, 57 % follow up the complaint, 64 % meet the complaining person and 64 % investigate if the complaint is true. The MOs who take further action after the complaint do so because they feel it is their duty, they want to satisfy the patient and improve their services. However, some also feel that it is not useful to follow up all complaints and that complaints are sometimes politically motivated. Communication in case of complaints can clearly be further improved.

Taking all facts together, it becomes obvious that communication and information transfer between public health system and community rather follows a "top-down" approach, is programme-related and is neither oriented on demand nor culturally sensitive. Thus, the chance for successful participation is moderate (see Table 4.8).

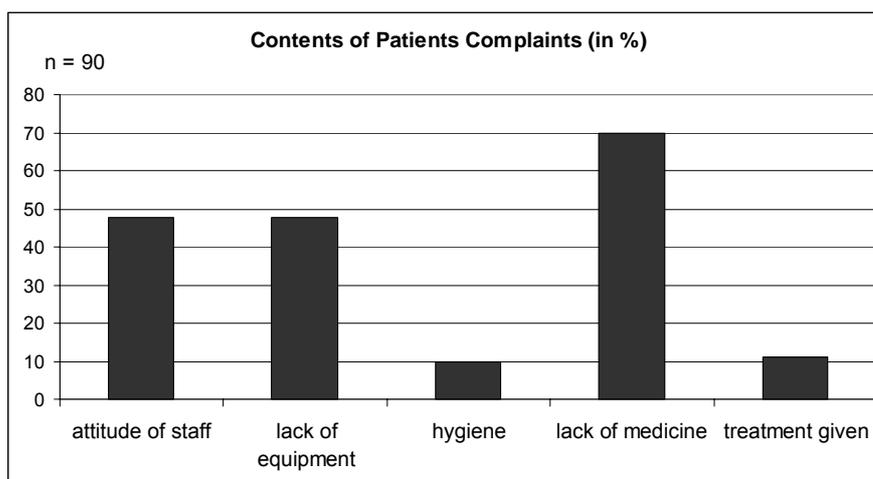


Figure 4.52:
Contents of
Patient's
Complaints in Pune
and Raigarh

Communication and Information Transfer between NGOs and Community

All NGOs work with community. NGOs feel that community mainly cooperates with them as they expect better information. Hence, information about health is the main service offered to the community. Workshops, discussions, presentations, training and posters are important for NGO work with the community as it has already been pointed out above. Furthermore, discussions are also the most important tool for community needs assessment which all NGOs undertake. Communication and information transfer between NGOs and community functions both ways “top-down” and “bottom-up”. The best rating for cooperation received women groups, followed by community health committees and international organizations. NGOs in Pune and Raigarh work through SHG, which are small homogenous women groups, sensitive issues can be addressed in these small settings. Trust between the members of the groups and between them and the NGO field person is established over the time through the joint saving initiative. Women feel more free to discuss their health problems there than in the PHC. Furthermore, one NGO even organizes a dialogue between the MOs and other public servants and the community. They took up this programme to improve the understanding of the needs and limitations on both sides (NGO 19.11.2003). It has been already mentioned in the Himachal Pradesh assessment that NGOs rely on “bottom-up” communication. On the one hand they need community participation as they are required to involve the community by their funding agencies. On the other hand, they need volunteers from the community to implement their programmes. A mutual dependency is created. Nonetheless, the chance of successful community participation is good as communication and information channels between NGOs and community do exist and are used in both directions (see Table 4.8).

Communication and Information Transfer between Public Health System and NGOs

The NGO ratings for cooperation with community groups are better than for public health personnel. However, they rank before private practitioners and traditional healers. All NGOs cooperate with MOs. The majority of MOs (72 %) also cooperate with NGOs (see Figure 4.46). Cooperation is rated as “good” from both sides (see Figure 4.42 and 4.47). Furthermore, 40 % of MOs receive help from NGOs for the National Health Programmes. MO’s mostly positive opinions about NGOs have already been indicated above. Nevertheless, 27 % still think that NGOs are money-minded. The DHO also voiced his opinion that NGOs are controlled by funding agencies (DHO 09.02.2004). The cooperation between the public health system and NGOs in Pune and Raigarh is about ten years old (Ibid.), hence, distrust and prejudice are less common than in Himachal Pradesh, where the cooperation is younger.

The cooperation between NGOs and the public health system rather takes place on the local level which is shown by the NGOs’ affinity to cooperate with MOs, MPWs and Anganwadi workers rather than cooperating with district officials. The finding is also supported by the following statements of district officials.

- “NGOs work at the local level, not with us.” (ADHO 06.12.2003)
- “NGOs work at the PHC level. They have contact with MO not with DHO.” (DHO 09.02.2004)

Although cooperation exists more on a local level all NGOs except for one are convinced that cooperation with the public health system will be successful at the state or national level as well. All cooperations of NGOs with public health officials were rated as helpful to improve the public health system by the NGOs. Cooperation with MOs and district officials was even rated as very helpful. It is easier for NGOs to communicate with lower levels of the public health hierarchy. However, without the consent of higher levels successful participation is not possible. MOs partly rely on the help of NGOs. They receive donations in the form of infrastructure needed for National Health Programmes (tables, food). Motivation of villagers by NGOs is also essential for MOs work. The help of NGOs is valued at the district and state level. The positive opinions of cooperation from both sides indicate that communication and information transfer works both ways. The chance of successful participation is thus high (see Table 4.8).

4.2.2.3.3. Responsiveness

The public health system in Pune and Raigarh can hardly respond to community needs. Although funding and health targets are calculated according to population figures, health status does not play a role. High incidences in a particular disease do not translate into more funding from the central government. It has already been stated above that the results from the community needs assessment are used to evaluate the performance of PHCs but programmes are not changed. It takes a long time for programmes to adapt. The lack of decision space for MOs limits their responsiveness, because they do neither have the means nor the permission to take action. In case of an epidemic they have to report to their superiors immediately. International funding also influences responsiveness. Maharashtra is among the states with the highest HIV/AIDS incidence. For this reason, HIV/AIDS is labelled an epidemic here. Large funds are available for HIV/AIDS from international sources. It has become a priority issue in Maharashtra now. Outbreaks of water-borne diseases and malaria occur regularly every year, even though preventing epidemics is a priority of the public health system. The response to these epidemics is slow. Although measures like fish tanks³⁰ at the PHC are available for malaria prevention (see Picture 4.16), their use by the villagers still seems to be limited. The lack of infrastructure and testing facilities at the PHCs prolong the specification of diseases. Officially all PHC should be able to test for malaria. Tests for tuberculosis or HIV/AIDS are only carried out at CHCs. However, malaria tests also hardly take place in the visited facilities because either the lab technician or the testing kit is not available. Picture 4.17 shows a typical lab in the PHC. Responsiveness to the community needs is thus confined to the National Health Programmes, a moderate chance for successful participation (see Table 4.8).

NGOs in turn show a very open responsiveness to all community needs as the assessment of communication and information transfer between the two indicates (see above). All NGOs do a community needs assessment and receive their information through open discussion with community groups. Although NGOs are also sometimes

³⁰ - Small fish eat mosquito larvae. Villagers can obtain these fish free of charge from their PHC and put it into standing water bodies.

confined to the funding of their programmes, they are able to open new resources when the need arises. The history of the interviewed NGOs reveals that all programmes taken up were responses to community needs. NGOs try to serve as role models for the government. However, it has to be kept in mind that NGOs do not necessarily represent all marginalized groups of the society. They often have to find a consensus among the heterogeneity of individual needs within a community. The chances of successful participation are nevertheless high (see Table 4.8).



Picture 4.16 (above): Fish Tank for Malaria Prevention at PHC Abtali, Pune District



Picture 4.17 (right): Lab Facility at PHC Abtali, Pune District

4.2.2.3.4. Motivation for Participation

The government in Maharashtra offers no incentives or benefits to motivate MOs for participation, the situation is similar to Himachal Pradesh. Work motivation among the MOs is also low. Although MOs said that they are satisfied with their work, they rated their working conditions as not so good (see Figure 4.53 and 4.54). Major problem areas are political interference (64 %), lack of financial power and lack of infrastructure (56 % both) (see Figure 4.55). Work overburden, no budget for repairs, lack of medicine and lack of staff were also important problems mentioned by the majority of MOs. Political interference already points towards the influence of local elites on the work of MOs. Hence, it can be translated as interference of other powerful groups. The purpose of community participation is interference and control over resources. NGOs in Pune and Raigarh see their major working areas in “pressure public health system for better performance”, “make public health system aware of community needs” (88 % each) and “inform villagers about their rights” (82 %) (see Figure 4.56). Their goal is thus political interference as well. MOs motivation for participation is negatively affected through this conflict of interests. Furthermore, previous discussions have already shown that they are more interested in “top-down” participation. Other incentives or benefits for participation

could come from the community or NGO side. In fact, NGOs support MOs through small donations in kind or through motivation of villagers for the health programmes. NGOs also voiced their opinion that they can further motivate public health personnel (76 %) as one task to improve the public health system. High attendance of PHC outreach activities and fulfilment of targets are positive for the MO's image in front of his/her superiors. Although some interest for participation and some benefits exist, motivation for participation is set back through the lack of infrastructure which is the foremost problem of all MOs in the two districts. The chance of successful participation is thus moderate (see Table 4.8).

The motivation for NGOs to participate is high. They receive benefits and incentives from their funding agencies including the government and from the community. Improvements in the public health system or the health status of the population as well as more empowerment of the communities they serve immediately translate into work satisfaction, because the overall goal of NGOs is the uplift of society. Hence, the chance of successful participation is high (see Table 4.8).

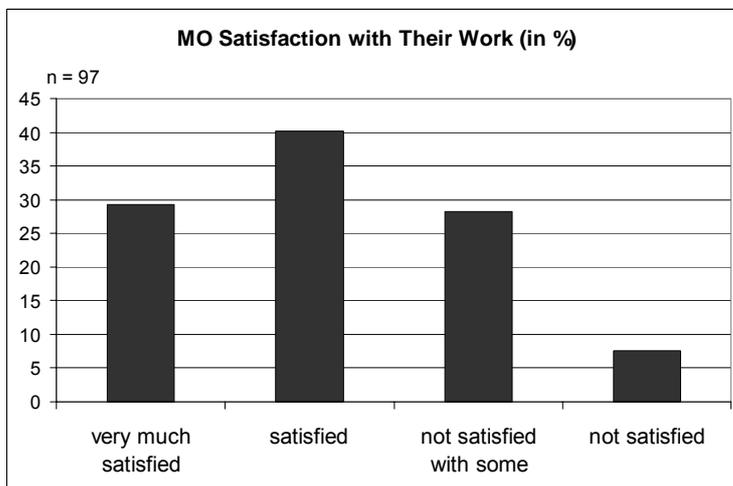


Figure 4.53: MO Satisfaction with Their Work in Pune and Raigarh

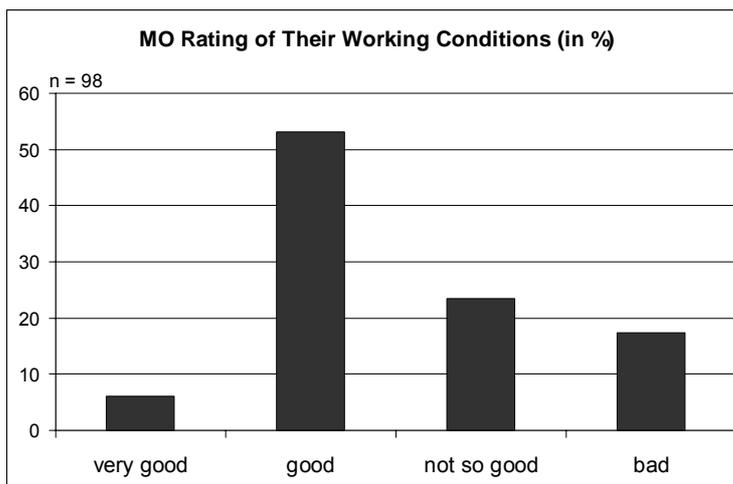


Figure 4.54: MO Rating of Their Working Conditions in Pune and Raigarh

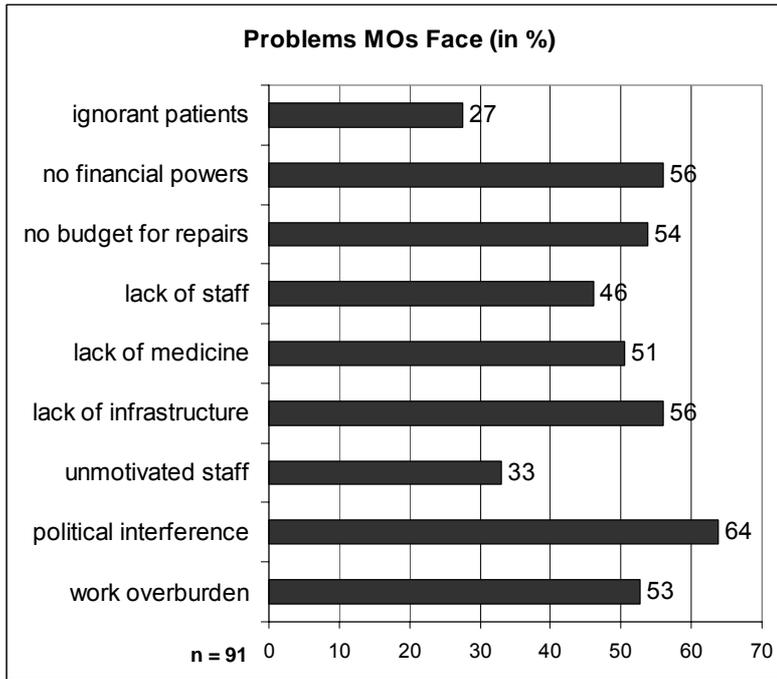


Figure 4.55: Problems MOs Face in Pune and Raigarh

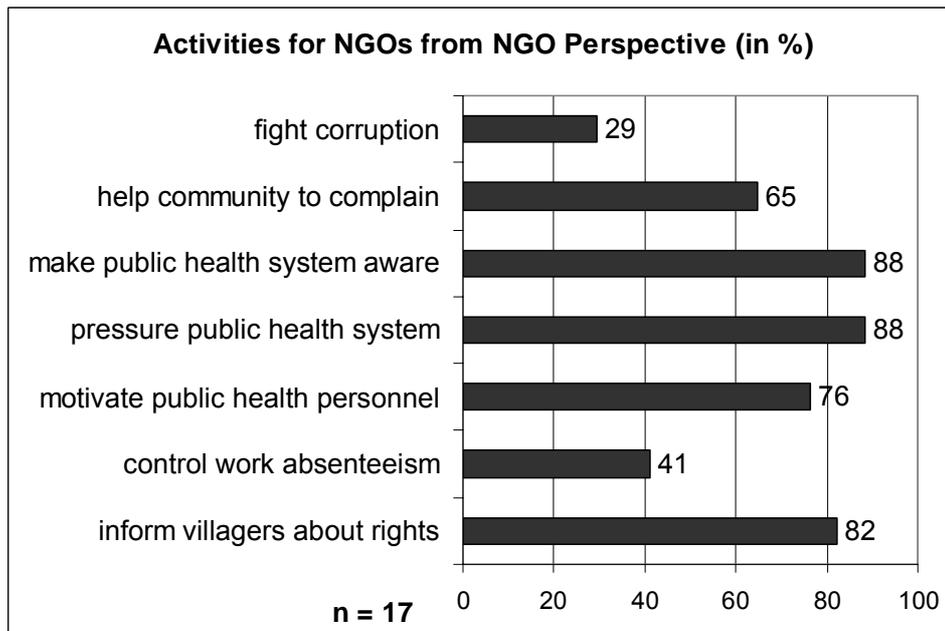


Figure 4.56: Activities for NGOs from NGO Perspective in Pune and Raigarh

4.2.2.3.5. Accountability

Accountability of MOs to community is low. The example of handling complaints showed that accountability depends on the individual attitude of the MO. MOs are mostly accountable to their superiors and the higher government authorities at the district level as discussed under the heading of decision space. Meetings with local government authorities like PRIs take place regularly in the community health committees but the lack of education among the members and the lack of understanding of public health issues among them prevent the questioning of the MO. NGOs can only control MOs indirectly through informing villagers about their rights and through exercising pressure. A large minority however felt that they can also control work absenteeism (41 %) (see Figure 4.56).

NGOs are accountable to higher government authorities and to their donors through their dependence on registration procedures and funds, to local government authorities and local organizations through their working relationship and to the community. Accountability of NGOs to funding agencies is higher (93 %) than to their own board of control (73 %) or to the community (64 %) (see Figure 4.57). Since funding does mainly come from international sources or the state and only a very small share is received from membership fees or from the community, accountability to higher entities is even more important for NGOs. An example of excellent accountability to the community is the joint management of project funds of the community and one NGO (NGO 13.02.2004). Otherwise, accountability to the community is usually not institutionalised by the NGOs and mainly takes place through joint discussions and interactions within the SHGs. The chance of successful participation is thus moderate (see Table 4.8).

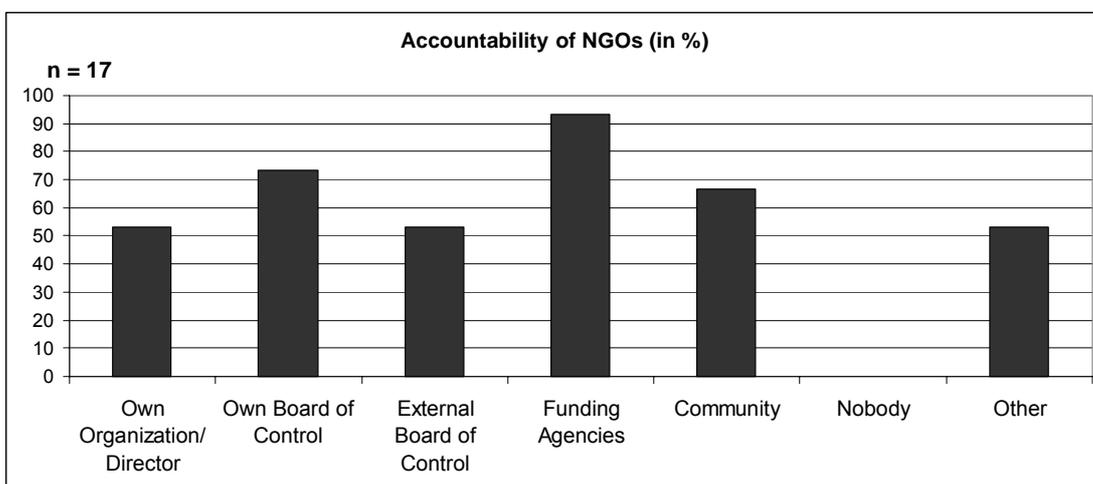


Figure 4.57: Accountability of NGOs in Pune and Raigarh

4.2.2.3.6. Sustainability, Control over Resources and Experience of Participation

Sustainability depends on several factors, which have already been discussed above such as interest in participation, motivation or depth, scope and mode of community participation. Moderate interest and motivation from the MO side on the one hand meet high interest and motivation from the NGO side on the other hand. Depth, scope and mode of community participation in the two districts only reach a middle degree. The decentralization programmes of the government have not shown the desired output in

participation or improvement of quality of services, they might therefore be tempted to revise their programmes and go back to a more centralized health service provision. Policies can change after elections. Sustainability can only be ensured by success and anchorage of programmes in the population. Since the public health system mainly works through “top-down” approaches, community involvement in the sense of the “bottom-up” approach is still rare. The chance of successful participation is moderate. NGOs use the “bottom-up” approach and rely on community involvement but they are also dependent on funding. Their anchorage in the population is nevertheless strong. The chance of successful participation is high (see Table 4.8).

Control over resources for MOs is defined by law and higher-level authorities (see above) while NGOs have several models for control of resources depending on their source. Chances of successful participation are thus low for MOs and moderate for NGOs. Both parties have gained good experiences with participation. Participation helps MOs and NGOs in their work. Therefore, chances of successful participation are high for both of them (see Table 4.8).

Table 4.8: Map of Participation for Maharashtra, Pune and Raigarh District (adapted from Atkinson 2002; Murthy/Klugman 2004; Metzger 2001; Rifkin 1996; Westergaard 1986)

Indicator for successful participation	Range of indicators		
	low	moderate	high
Interest in participation			
for MO	No interest	Interested in top-down participation	Interested in bottom-up participation
for NGO	No interest	Interested in top-down participation	Interested in bottom-up participation
Communication and Information Transfer			
within public health system	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
within NGOs	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
between public health system and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between NGOs and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive

between public health system and NGOs	No communication, no information transfer	Top-down, only programme-related	Top-down, bottom-up
Responsiveness			
MO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
NGO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
Motivation for participation			
MO	No incentives/benefits	Incentives/benefits by government or other groups (extrinsic)	Incentives/benefits by government and community (extrinsic and intrinsic)
NGO	No incentives/benefits	Incentives/benefits by government and donors (extrinsic)	Incentives/benefits by government, donors and community (extrinsic and intrinsic)
Accountability			
MO	To higher government authorities	To local government authorities	To community
NGO	To higher government authorities, donors	To local government authorities, local organizations	To community
Sustainability			
MO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
NGO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
Control over resources			
MO	Defined by law or higher authorities	Several models for control over resources	Free control over resources
NGO	Defined by law or higher authorities, donors	Several models for control over resources	Free control over resources
Experience of participation			
MO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful
NGO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful

4.2.3. Conclusion of Case Study Maharashtra

Maharashtra has a long tradition of community participation and possesses a well-established NGO sector. Decentralization mechanisms are in place since the 1970ies. Therefore, it is understandable that NGOs and the public health system in Maharashtra work together and have good experiences with participation. All indicators for NGOs point towards successful community participation except for accountability and control over resources (see Table 4.8). The good ratings could be explained by internal NGO features or by funding requirements. It is overly optimistic to assume that all NGOs perceive community participation as an essential commodity. Although some outstanding examples for community participation like the doctor-patient dialogue or the joint management of project funds have been encountered, they are only an example from one NGO and do not represent the whole sector. NGOs are all very different in their organizational structures and working habits, which represents an advantage for them as it facilitates innovation. Streamlining diverse NGOs into the government programmes means not only a loss of diversity and innovation; it also changes NGOs from advocates to service deliverers. Looking into the different understandings of community participation the same mismatch between NGOs and MOs like in Himachal Pradesh becomes obvious in Maharashtra as well. NGOs want to exercise pressure and to empower the community. MOs want NGOs help to fulfil their targets. There is agreement that education is important for both goals.

The indicators selected for the map of participation mostly show a moderate range for MOs and the public health sector (see Table 4.8). Exceptions are accountability and control over resources where the indicator has a low value and experience with participation where the high value indicates a high chance for successful participation. The map of participation again proved useful for the identification of problem areas for participation in detail. The lower values for MOs and the public health system are strongly linked to the lack of decision space in case of accountability and control over resources. For other indicators the influence of organization of work and internal management seems to be more important.

In the selected districts community participation has only a middle degree (see Table 4.8). Participation mainly takes place through invitation by the government and people act as members of small collectives like PRIs, Mahila Mandals, SHGs or community health committees. The targets for community participation are relatively easy-to-reach people in the districts. Powerful groups represent community. Furthermore, community participation at the district level is seen as a means to expand the outreach of public health services and to support infrastructure. More accountability or effectiveness is not included in the rationales yet. In view of Maharashtra's history higher levels of community participation could be expected. The same holds true for the level of decentralization.

The decision space for MOs in Maharashtra is narrow (see Table 4.6). Functions for finance, service organization, human resources, access rules and governance rules all show a high level of control through the state or central government. The role of MOs as stakeholders in community participation has again been examined. They do not have

more autonomy than their colleagues in Himachal Pradesh. In fact, the only difference encountered between the sample districts in Himachal Pradesh and Maharashtra is that the motivation for participation is higher among the MOs in the later state. Hence, more experience with participation seems to influence motivation positively. Although Maharashtra's district health systems are under the control of PRIs, no quality difference is traceable. According to the study about performance of public health services Maharashtra performed second best, while Himachal Pradesh took the 5th rank (see Table 3.1). The different performance indicators as well as the economical differences between the states do not seem to influence the outcome of decentralization or community participation in the health sector either.

Figure 4.25 shows the range of indicators and their relation to quality of care for the Himachal Pradesh case study. Since the indicators from the Maharashtra case study have no different values, the outcome will be the same. Lack of decision space disables MOs to respond to community needs. The middle degree of community participation and low accountability further prevent pressure on the public health system for better performance. Empowerment of the community is not included in the participation process as it is planned by the government. Hence, quality of health care cannot be improved with the current decentralization and participation policies here. The benefits of decentralization for the quality of health care will be low to moderate.

The rural population of the selected districts is already deprived of access to water and sanitation as well as of household assets (see Figure 4.30, 4.32 and 4.33). Hence, they are most vulnerable to environmental and political influences. The low performance of the public health sector adds to their burden. Poor living conditions are linked to higher morbidity and mortality rates (see 3.2.2.). Therefore, the people most in need of good public health services or good policies to improve them are also the ones who lack these services the most. Thus, the goals from the Primary Health Care Approach are distant as ever.

4.3. CASE STUDY: WEST BENGAL

4.3.1. Background Information on Case Study West Bengal

West Bengal is a large state in the North-East of India, bordering Bangladesh in the East and Bhutan in the North. It stretches from the Bay of Bengal in the South up to the Himalayas and encompasses a variety of landscapes like coastal areas, plains and mountains. The state has a population of 80 million of which 72 % live in rural areas. The share of Muslim population in West Bengal is higher than in the two other states. Muslims make up 25 % of the population while Hindus still comprise the majority with 72 % (Ministry of Home Affairs 2005b). Less than one percent of the population are Christians or Buddhists. Other religions including natural religions are also important for one percent of the population. More than one fifth of the population are classified as scheduled castes and scheduled tribes (Ministry of Home Affairs 2005a). Most of them live in rural areas. The economical performance of West Bengal lags behind Himachal Pradesh and Maharashtra. The state shows a moderate performance compared to other states (see Figure 3.4). The poverty rates of the state are just behind Maharashtra, but the percentage of rural population below the poverty line is nearly twice as high as for urban population (see Figure 3.5). Rural areas in West Bengal also have much lower literacy rates and lesser assets available than urban areas as it was the case for rural Himachal Pradesh and Maharashtra too. The literacy rate in rural areas is with 63 % nearly twenty percent below the urban rate (Ibid.). The gender gap is also wider here. Only half of the women in rural areas are literate compared to three fourth of the male population. Assets like radio, television, phone, scooter or car are less available in rural areas. Only the percentage of bicycle owners is higher here. One third of the rural population does not possess any of the above mentioned assets (Ibid.). Access to tap water in rural areas is as low as 7 %. The majority of rural population has to rely on handpumps (69 %), tubewells (11 %) and wells (11 %). But even in urban areas half of the population has no access to tap water (Ibid.). Electricity in rural areas is available to 20 % of the population for lighting while the majority uses kerosene. Fire wood and crop residue but also cowdung are the most important fuels for cooking in rural areas. In the cities LPG is the dominant fuel for cooking used by 80 % of the population. Furthermore, residency in rural areas means lesser quality of houses, lack of drainage facilities for 84 % and lack of latrines for 73 % of the population. The majority of rural population (59 %) works in the agri-sector, the share of men and women in this sector, contrary to the other two states, is equal.

4.3.1.1. Health Care

In terms of infant mortality rates West Bengal shows a better performance than all other states except Kerala (see Figure 3.10). Like Maharashtra West Bengal is in an early to middle health transition and owns a health system with a low to moderate capacity (see Table 3.2). The prevalence of infectious diseases is nevertheless still high in the state,

every year more than one million cases of diarrhoea are detected (MoHFW 2003: 182). The number of infections with tuberculosis and malaria is also high. Men in West Bengal are more affected by these diseases than women (Wang 2003: 2). However, non-communicable diseases are on the rise.

West Bengal has a three-tier rural primary health care system. Similarly to Himachal Pradesh the districts are sub-divided into blocks. BPHCs and BMOHs exist and form a separate hierarchical level between the PHC at the basis and the hospitals at the district level. Contrary to Himachal Pradesh or Maharashtra Sub-Centres are not supervised by the PHC but by the BPHC. Preventive and curative care is under one administration at the district level. The health infrastructure in the state is worse than in Maharashtra or Himachal Pradesh. The lack of CHCs, PHCs and SCs is very high (see Figure 4.1). Concerning the provision of staff West Bengal experiences a lack of doctors but not of other health personnel (see Figure 4.2). Furthermore, the absence rates for doctors and other health workers are higher than in Maharashtra, 39 % and 35 % respectively are missing from work (see Figure 3.18). Given the lack of infrastructure and personnel it is not surprising that quacks and homeopathic doctors were found to be more easily available in rural areas than BPHCs, PHCs or SCs by a study covering six districts of West Bengal (ORG Centre for Social Research 2003: 27). Walking was the major mode to reach a health facility and public health facilities were reached in less than thirty minutes by 90 % of the respondents. Although public health facilities were preferred for minor ailments, people rather used private ayurvedic doctors for major ailments and qualified private practitioners for RCH (Ibid.: 30). The study also revealed that waiting times in public facilities are longer than in private facilities and medicines are less available. Furthermore, public services were more used by poor residents of rural areas, because of the low costs of treatment (Ibid.: 33-34). However, the users of different health facilities voiced that confidence in the medicine system of private providers especially herbalist and homeopathic practitioners, the availability of medicine at these facilities and familiarity and loyalty of the doctor is much better than in the public system (Ibid.: 36). The study corresponds with the general findings for public and private health system use and satisfaction in India (see 3.2.2./ 3.3.1.).

4.3.1.2. Decentralization

West Bengal is committed to decentralization in the form of devolution and delegation in the health sector. The state has a long experience of decentralization as panchayats were introduced as early as 1973 and regular elections took place every five years since 1978 (PRIA 2002: 6, 12). Decentralization of health planning and management to the district level took place through the formation of District Health and Family Welfare Societies in 2001. The District Societies will involve PRIs in the planning process and are chaired by the head of Zilla Parishad (ORG 2003: 20). Members of the society come from the elected Zilla Parishad members. The CMOH is the Member Secretary of the District Health and Family Welfare Society (World Bank 2004: 40). All decisions concerning quality improvement of the health system including resource allocation will be taken by these new

societies (DFID 2002: Annex 1). They formulate the District Health Plan. The involvement of PRIs through the societies is one form to implement the 73rd Amendment to the Constitution (see above). Gram Panchayats at the local level have to form micro plans for health. Block Health and Family Welfare Societies formed by the Panchayat Samiti will supervise, monitor and control the Gram Panchayats (ORG 2003: 20). Other community members and NGOs will also be included in the societies. The Health Sector Reforms of September 2002 further declare that the Block Societies will implement, monitor and control all activities, schemes and programmes for better management of health institutions in the block (DFID 2002: Annex 2). Hence, Health and Family Welfare Societies at district and block level can be compared to PARIKAS in Himachal Pradesh or community health committees in Maharashtra, although their composition varies a little. The State Health and Family Welfare Society oversees all district and block societies. Although, the societies are registered under Society Registration Act, they are not NGOs, as their members are mostly from the government sector. The Societies are vested with wide administrative and financial powers. The CMOH for example can now sanction leave for all MOs or paramedical staff (World Bank 2004: 40).

Since December 2001 powers of the CMOH have been delegated to the ACMOHs of the sub-divisions to improve supervision and activation of BPHCs and Rural Hospitals (DFID 2002: Annex 2). ACMOHs are now in charge of the National Health Programmes. The Health Sector Reform also places all SC workers under the control of Gram Panchayats to ensure the coordination between PRIs and grass-root health workers (Ibid.). Thus, panchayats at all levels up to the district are involved through societies or direct supervision of SCs in public primary health care in West Bengal.

4.3.1.3. Participation

The Health Sector Reform 2002 also envisages partnerships with the private sector, NGOs and Community Based Organizations (CBOs). Contracting out of non-medical activities of the hospitals, for example the installation of C.T. Scan Machines in public medical colleges by private companies is part of the new joint ventures (DFID 2002: Annex 2; World Bank 2004: 41). The private companies are responsible for the operational and maintenance costs while the government provides rent-free accommodation. The private sector in turn has to provide these services free of cost to at least 35 poor patients per hospital and pay 25 % commission from the charges back to the government (Ibid.). Cleaning, scavenging work and security has also been handed over to private companies in some government hospitals (ORG 2003: 21). For the improvement of diet in the hospital, cooking will be outsourced preferably to women's SHGs who will then deliver cooked food to the hospitals. SHGs further play an important role in the government policies to increase community involvement and ownership in the public health programmes (Ibid.). SHGs will receive training from NGOs to carry out certain health tasks under these programmes (World Bank 2004: 41). Members of CBOs will also be recruited for training as Voluntary Health Workers (VHWs) in Family Welfare and Public Health Programmes. The scheme is very similar to the Community Health

Volunteer Scheme tried on a national level in the 1980ies (see 2.2.3.2.2.). VHWs are to cover 200 households and their sponsoring organization, meaning the SHG or Community Based Organization, will receive a performance based incentive (ORG 2003: 21). Under a World Bank project primary health care services were handed over to NGOs in the coastal Sunderban area of West Bengal (Ibid.). However, expectations were not met. Schemes for the management of ambulances by NGOs are now part of the new health policy and have already been developed and approved (World Bank 2004: 41). The new health sector policy will also outsource non-functioning PHCs and establish private drug shops at the BPHCs (Ibid.).

Although West Bengal has a long history of voluntary organization, the development of the NGO sector after independence was slow due to the negative attitude of the state government (see PRIA 2002). Large organizations and movements focusing on welfare and education of the population like Ramakrishna Mission or Swadeshi movement were formed during the colonial time. The state however felt that socio-economic programmes are its responsibility and should be executed through the PRIs. Dependency of NGOs on foreign funds and the fear of this external influence were responsible for the state's attitude. Only in the 1980ies did the state under the Left Front government recognise the positive achievements of NGOs and their usefulness for government programmes (see Ibid.). Today the state has an estimated total of 87,086 registered and unregistered NGOs of which 63 % are based in rural areas (PRIA 2002: 33). Most NGOs are based in the recreation, sports and culture sector (34.5 %), followed by the religious sector (26.9 %) and the educational sector (23.3 %) (Ibid.: 37). The percentage of NGOs working on health is only 4 %, in rural areas it is even smaller with 1.6 % (Ibid.). Furthermore, the majority of health sector NGOs is not registered. Nonetheless, 96,641 persons are engaged in NGO health work and mainly work on a volunteer basis. Less than two percent are paid employees (Ibid.: 41). NGOs in West Bengal fund their activities mainly through grants from the state government (45.4 %) while grants from foreign sources only make up one percent of all funding (Ibid.: 53). All grants to NGOs compose 51.3 % of NGO receipts. Self-generated funding is also important and amounts to 23.4 % of all funding, followed by loans (17.5 %) and donations (7.8 %) (Ibid.).

4.3.1.4. Method

In West Bengal the districts of Darjeeling and Bankura have been selected for analysis. In Darjeeling the blocks of Kurseong, Phansidewa and Sukiapokhri were visited while in Bankura the focus was on Ranibundh, Hirbandh and Saltora block. Districts and blocks were selected after discussions and expert interviews with the GTZ staff in Kolkata, who have the experience of working in these districts and could give insights into the district characteristics. Bankura was chosen as an example of a very backward district and Darjeeling as contrast representing a more affluent district in West Bengal. The chosen method to contact the public health system and NGOs followed the experiences from Himachal Pradesh and Maharashtra. Expert interviews with officials from the State Health Ministry were first held in Kolkata. The authorization for research was acquired from them.

NGOs working on health issues on a national or state basis like the Ramakrishna Mission or acting as umbrella organizations for NGOs in the health sector like the West Bengal Voluntary Health Association were interviewed in their Kolkata offices. Other NGOs were then interviewed in their field offices in the selected districts or blocks. Even though the sample is small, it reflects the NGO sector in the state in its diversity. The monthly meeting of BMOHs at the district level could only be visited in Bankura due to the unsuitable timing of the meeting in Darjeeling. Standardized questionnaires were given to the participants of the meeting, but contrary to former experiences in Himachal Pradesh and Maharashtra the return was very low. Time constraints at the meeting were the major reason. Expert interviews with the district officials in both districts were held. Further questionnaires with public health personnel and NGOs were completed during the field visits.

The use of quantitative and qualitative methods in the stakeholder analysis guaranteed rich information (see 2.1.). Bias towards the researcher and aspects of limited reliability of data were similar to previous experiences in Himachal Pradesh and Maharashtra (see 4.1.1.4/ 4.2.1.4.). The mismatch between official positions of policy makers or superiors, individual standpoints of subordinated personnel, and actual practice in the public health system was visible here too (see below).

4.3.1.5. General Characteristics of Districts and Blocks



Picture 4.18 (above): Typical House in Bankura District

Picture 4.19 (above, left): Landscape in Bankura District

Picture 4.20 (left): Landscape in Darjeeling

While Darjeeling is located in the Himalayas (see Picture 4.20), Bankura is a district in the plains to the West of Kolkata (see Picture 4.18 and 4.19). Consequently, landscape and climate differ. Darjeeling has high mountain slopes and hilly areas with a cool climate, moderate summers, heavy rains throughout the year and cold winters. The district is well known for its tea plantations. Bankura district comprises flat and dry plains with a hot climate, very hot summers, rain only in the monsoon time and warm winters. Darjeeling and Bankura have a population of 1.6 million and 3.2 million respectively. A large percentage of Darjeelings population are Gurkhas, Nepalese who migrated in the 19th century to the district. The recession in the 1980ies led to civil turmoil and fights for an autonomous Gurkha hill state. Owing to this situation, the Darjeeling Gurkha Hill Council, a partly autonomous body functioning as sub-government for certain issues like tourism, education, tea or other local issues including health, was founded in 1988 and received administrative and financial powers from the state. Both districts have a large rural population amounting to 68 % in Darjeeling and 93 % in Bankura. The visited blocks have a population between 71,000 (Kurseong) and 171,000 (Phansidewa). All blocks, except for Kurseong, have only rural population.

The share of scheduled caste and scheduled tribe in the population of the blocks varies. While Kurseong and Sukiapokhri in Darjeeling have a very small share of SC and ST population, one third of Phansidewa's population belongs to these groups (see Figure 4.58). In Bankura it is Ranibundh block where nearly half of the population belongs to STs. Although Hirbandh and Saltora have less SC and ST population than Ranibundh, they have a higher share than the blocks in Darjeeling, except for Phansidewa. High percentage of SC and ST population might point towards less development and higher poverty rates. The literacy rates in the blocks support this assumption. Although general literacy rates in the blocks with high SC and ST rates are comparably high, except for Phansidewa, female literacy is lagging far behind male literacy (see Figure 4.59). The blocks with less SC and ST population also have much higher literacy rates for women. Dependency on the agri-sector is high in all blocks of Bankura district. More than two thirds of the population are employed in this sector (see Figure 4.60). Furthermore, the share of women is higher than the share of men working in agriculture. In the selected blocks of Darjeeling less than one fifth of the population is in the agri-sector, except for Phansidewa, where more than one third is in this sector. The same distribution pattern is also visible here, blocks having high SC and ST population are more dependent on the agri-sector. Access to drinking water in rural Darjeeling is better than in rural Bankura as at least 27 % have access to tap water, which is also very low compared to the districts in Maharashtra and Himachal Pradesh (see Figure 4.61; see above). Most people in Bankura have to rely on handpumps and wells. Wells are also the major source for drinking water in Darjeeling, followed by tap water and spring water. In both district fire wood is used for cooking while in Bankura coal is also an important fuel (see Figure 4.62). The majority of the population in the two districts has no latrine and no drainage facilities available (see Figure 4.63). However, sanitation infrastructure for the rural population in Darjeeling is slightly better than in Bankura. Hence, pollution of open water bodies and ground water through the lack of sanitation and deforestation are environmental problems

found in these districts. Water shortage is an essential problem in Bankura, where the climate is drier and more water is needed for irrigation. Last but not least the available assets in the two districts are presented in Figure 4.64. The percentage of population having no assets available is higher in Darjeeling, even though the district is economically better situated than Bankura. Nonetheless, more people in the Himalayan district possess a car, telephone or television. In the plains ownership of bicycle and radio is more widespread. In the hilly areas of Darjeeling a bicycle would not be useful. It can be summarized that overall living conditions are low in both districts.

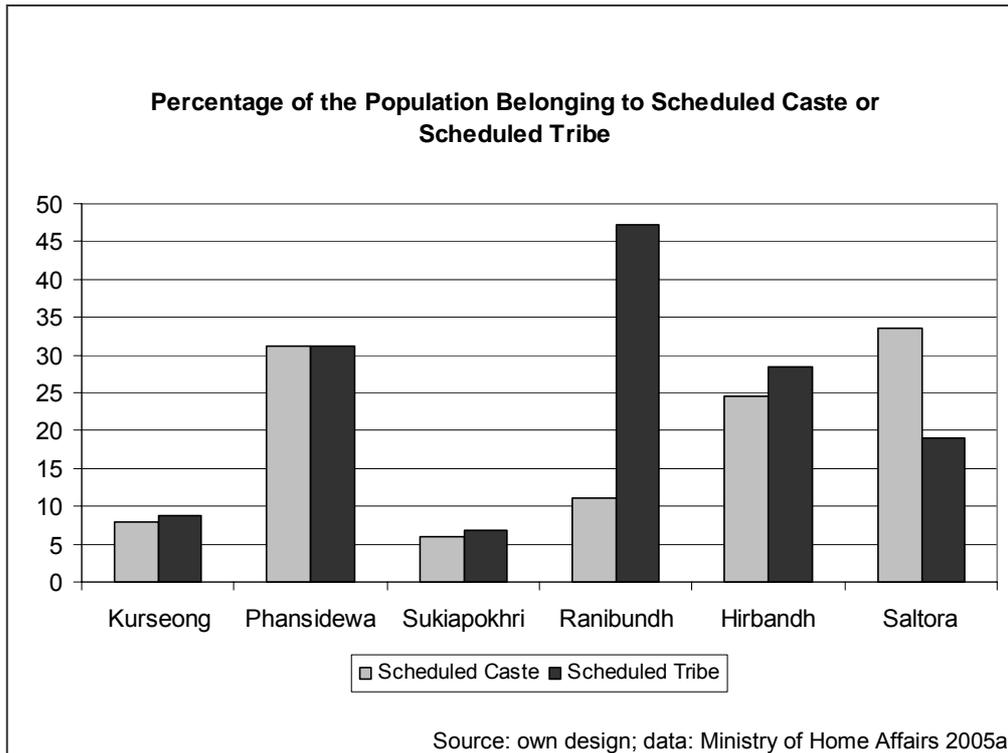


Figure 4.58: Percentage of the Population in Darjeeling and Bankura Blocks Belonging to Scheduled Caste or Scheduled Tribe

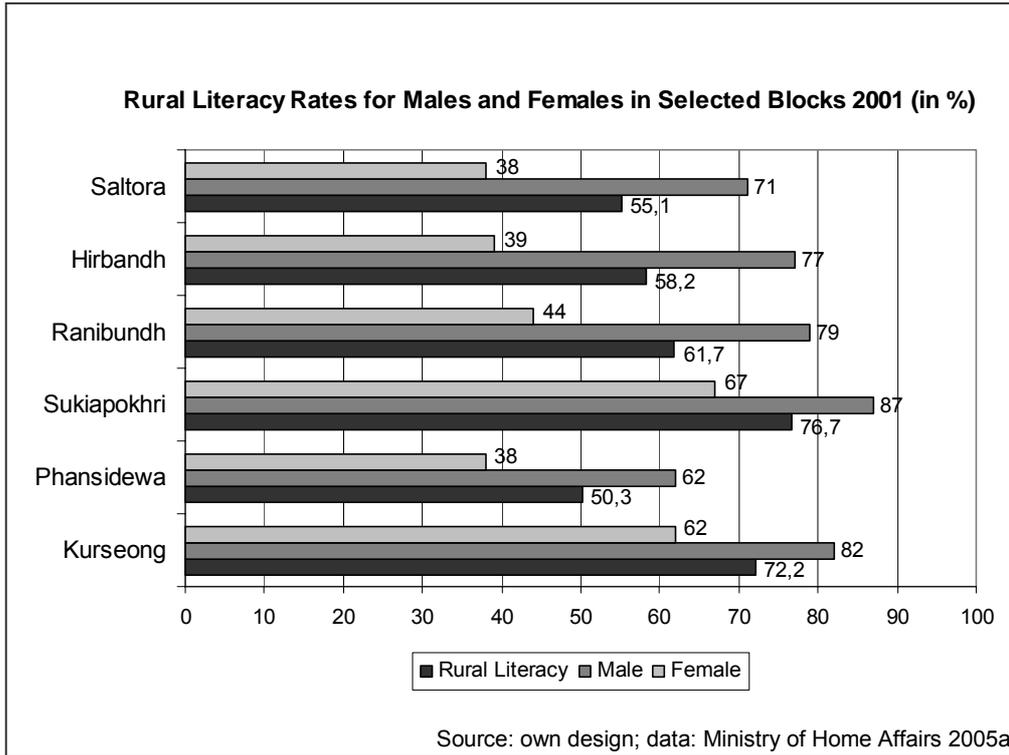


Figure 4.59: Rural Literacy Rates for Males and Females in Selected Blocks of Bankura and Darjeeling

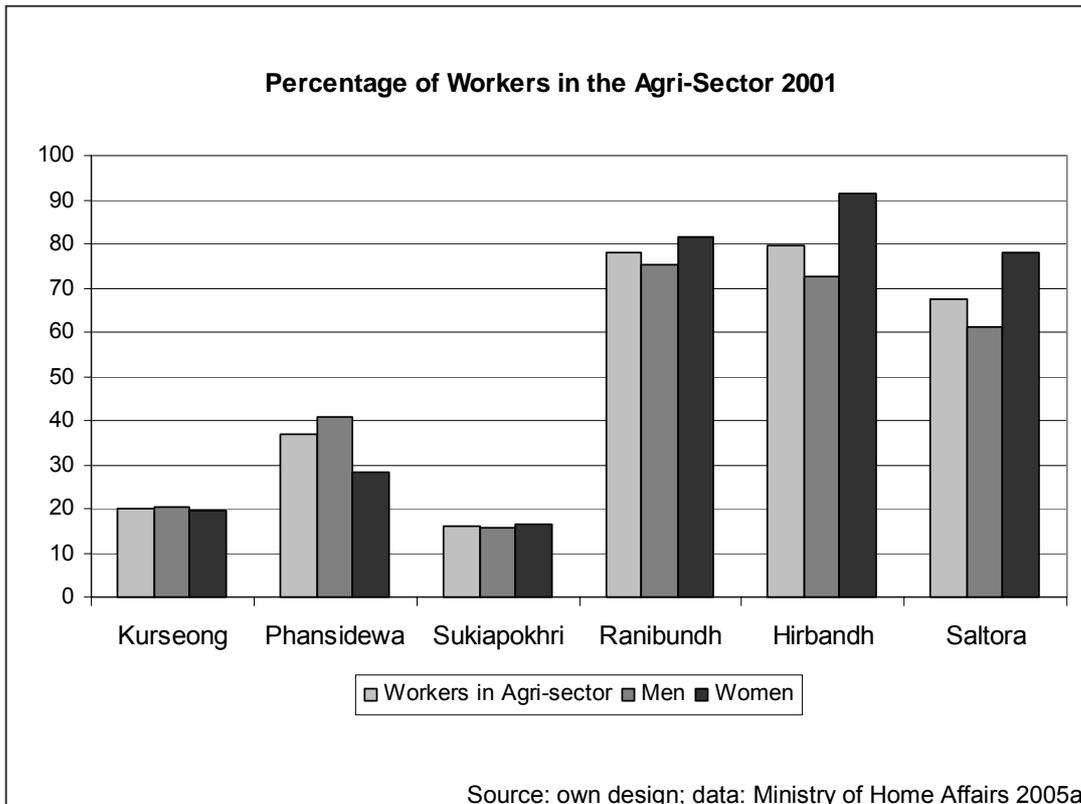


Figure 4.60: Percentage of Workers in the Agri-Sector in Selected Blocks

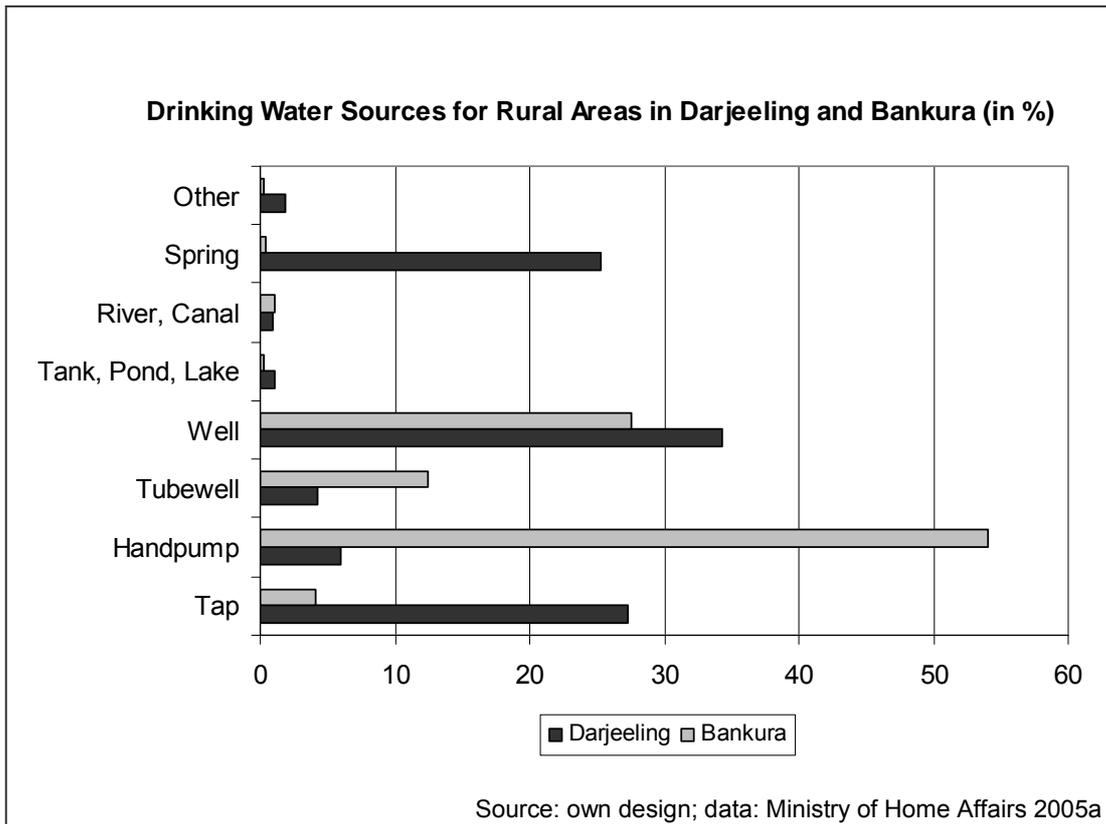


Figure 4.61: Drinking Water Sources for Rural Areas in Darjeeling and Bankura

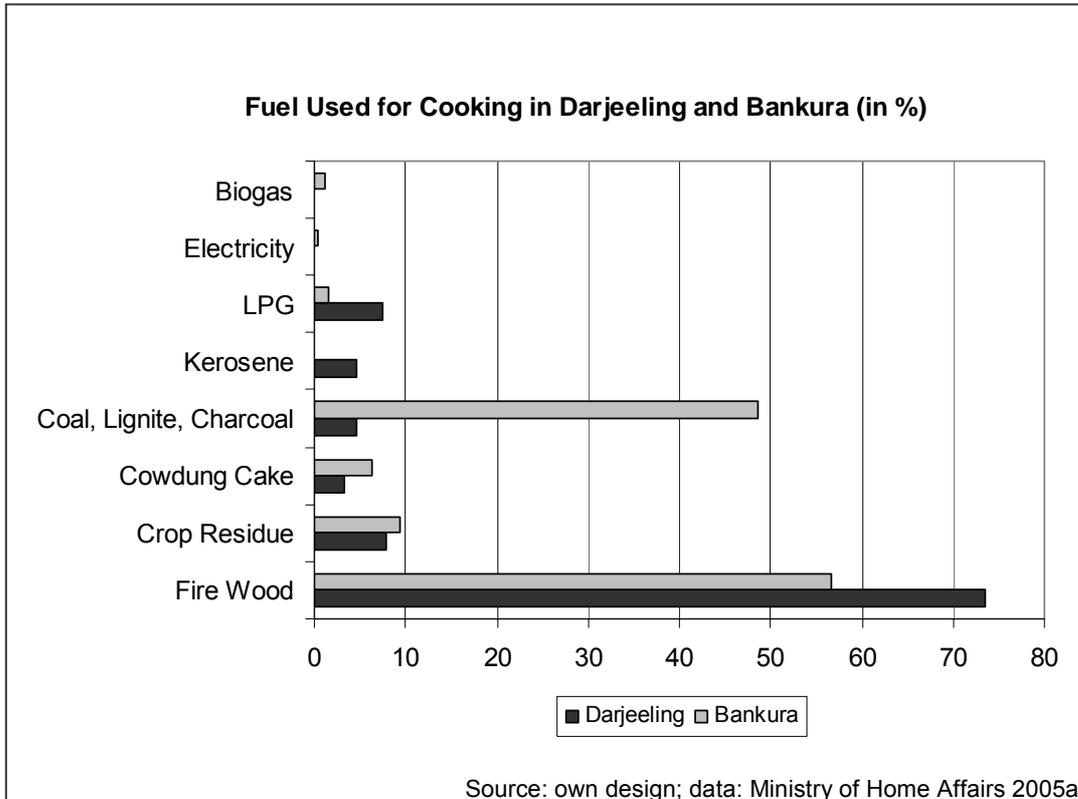


Figure 4.62: Fuel Used for Cooking in Darjeeling and Bankura

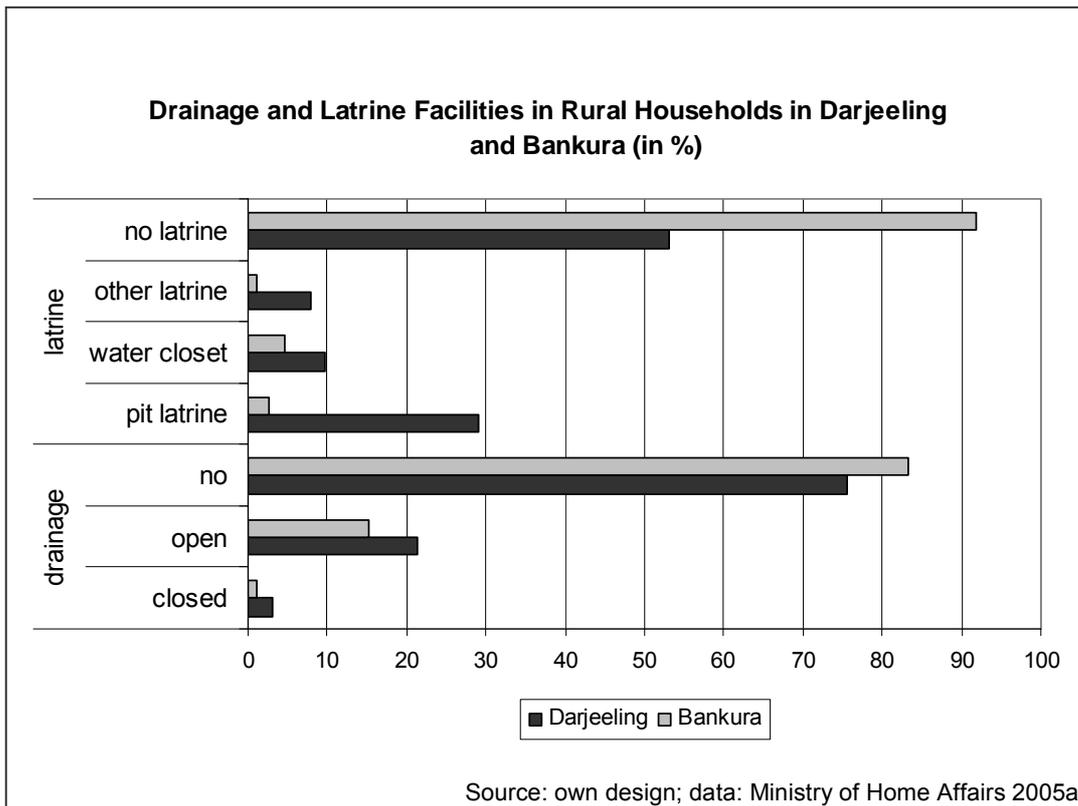


Figure 4.63: Drainage and Latrine Facilities in Rural Households in Darjeeling and Bankura

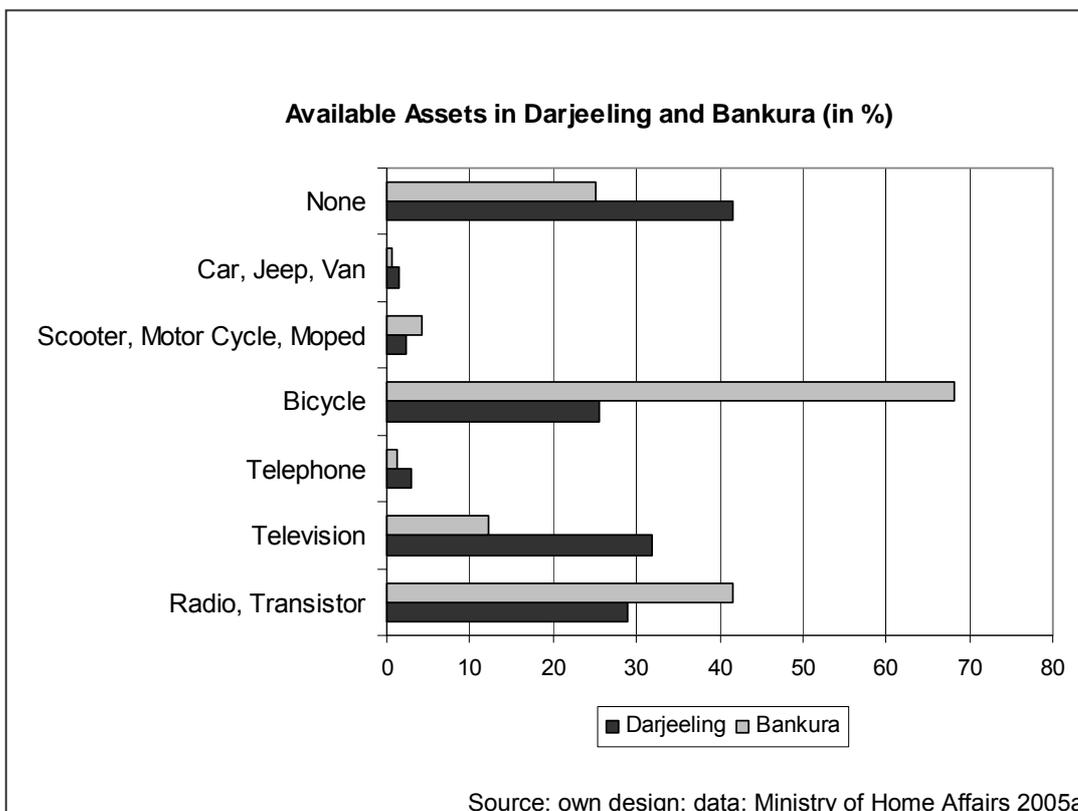


Figure 4.64: Available Assets for Rural Population in Darjeeling and Bankura

4.3.2. Analysis

The analysis for West Bengal follows the same patterns as the analysis for Himachal Pradesh and Maharashtra (see 4.1 and 4.2).

4.3.2.1. Decision Space of Medical Officers

In Darjeeling and Bankura 13 Medical Officers were interviewed with the aid of a standardized questionnaire (see Annex III), 10 of them were assigned the post of BMOH. Pictures 4.21 and 4.22 show typical BPHCs in the two districts. However, not all BMOHs were working at BPHCs, two were located at Rural Hospitals and five at BPHCs. The rest worked in PHCs. In addition, expert interviews and group discussions were held with seven district officials including CMOH and ACOH, five BMOHs, five MOs, nine paramedical staff including Block Public Health Nurse, pharmacist, clerk, MPW female, Block Sanitary Inspector and Anganwadi worker, and one hospital superintendent, amounting to a total of 30 interviews in the public health sector in the districts. At the state level three expert interviews were held. The interviewed MOs were on average five years in the civil service and posted at their current location for three years. The maximum of years in both cases was 14 years in service and at the current location. The population served by the PHCs is 98,000 on average while the mean for BPHCs is 129,000 and for Rural Hospitals it is 160,000 in the two districts. Thus, they exceed the recommended population figures from the government.



Picture 4.21 (above): BPHC Hirbandh, Bankura District



Picture 4.22 (right): BPHC Phansidewa, Darjeeling District

The function finance for decision space includes sources of revenue, allocation of expenditure, fees and contracts (see Table 4.1). The revenue for the district health systems comes to one hundred percent from the state. The allotted funds are under different programme heads. Even the funds for NGOs are channelled through the district health administration. MNGOs from the state level on the other hand have to ask for the approval of their projects from the district level first before they get funding from the state (NGO 08.03.2004). The CMOH receives funds for medicine, maintenance, vehicles, equipment and office expenditure (CMOH 25.03.2004). Medicines are then bought at the district level and contributed to the BPHCs (Ibid.). The budget for each BPHC is fixed by the state who channels the money through the district administration (ACMOH 16.03.2004). Interviewed MOs find the budget insufficient and recommend more budget for the facilities (see Figure 4.65), a view which is shared by the ACMOH (Ibid). Contingency funds are available to BMOHs in case of emergencies (BMOH 16.03.2004). The programme officers at district level allot the funds to the BPHCs according to their requirements (ACMOH 16.03.2004). The contingency funds can vary between Rs. 5,000 and Rs. 15,000. PHCs have no budgets and no contingency funds. Requests for everything have to be sent to the CMOH (MO 18.03.2004). In one case the doctor told that he had not received instruments for 6 years and his requests were not answered (Ibid.).

Only hospital superintendents who are at the same administrative level as ACMOHs can use contingency funds to purchase medicine (Superintendent 17.03.2004). BMOHs can get additional medicine from the District Reserve Store if they are available there (BMOH 19.03.2004). MOs can only get more medicines through the BMOH (MO 18.03.2004). The majority of MOs (75 %) said that essential medicaments are mostly available. However, 17 % of them also indicated that they are hardly available. The majority of interviewed MOs want to have better medicine supply (see Figure 4.65), indicating a lack of medicines. Additional medicines can be acquired by 73 % of the interviewees. It then takes approximately 3 weeks to get new supply. However, as one Block Public Health Nurse (BPHN) points out: "We are advised not to subscribe outside medicines. But we have so many diseases for which no medicines are stocked here. So we have to write subscriptions." (BPHN 25.03.2004). The lack of medicine thus leads to higher expenditures for patients.

Facilities below the BPHC and the BPHC itself have no service fees. Registration for outpatient services is paid at the rural hospitals only. No models for outside contracts exist. The Engineering Department is responsible for the maintenance of equipment. In case something is broken most BMOHs call their superior. In 70 % of the cases the superior takes up all the following actions, otherwise he or she advises the BMOHs how to proceed. Half of the BMOHs also call external repair services and about 70 % call the Engineering Department. MOs neither call their superiors nor other departments, either because they have no telephone or because they have to deliver written requests anyway. External repair takes two weeks on average while the Engineering Department takes about four weeks to repair the equipment. Broken equipment which cannot be repaired is not replaced mainly because BMOHs have no permission to do so and due to financial

shortage. The decision space for the finance functions is thus very narrow. The actual state of the visited facilities was very bad (see Picture 4.23 and 4.24). Most MOs did not know how often the facility is whitewashed. The average time between whitewashing was estimated to be 72 month. All facilities were dirty, waste was lying around openly in the compounds and sanitation facilities for patients were not useable.



Picture 4.23 (left): IPD in BPHC Phansidewa, Darjeeling District



Picture 4.24 (right): Operation Theatre in BPHC Ranibandh, Bankura District

The function service organization includes hospital autonomy and required programmes. The choice of range of autonomy for hospitals is narrow as it is defined by law. Even at the rural hospitals all purchases above Rs. 5,000 have to get sanctioned by the District Health Department, even though the money is self-generated through registration fees (Superintendent 17.03.2004). BPHCs or PHCs can only manage their facility according to the government rules and have no freedom to develop own models. Hence, 33 % of interviewed MOs wish to have more autonomy (see Figure 4.65). Accordingly, the required programmes at the facilities are decided at the state or national level. The National Health Programmes in West Bengal also follow the target-free approach. However, immunization rates or targets for other programmes do still exist like in the other two states. They are geared to the size of the respective target population. Hence, decision space for programmes is also narrow (see Table 4.9).

The function human resources containing salaries, contracts and civil service is narrow too (see Table 4.9). Even the CMOH cannot employ new staff, even though many Sub-Centres are vacant. Staff is recruited at the state level and posted by the CMOH (CMOH 25.03.2004). Salaries are defined by higher authorities at the state level, like it is done in Maharashtra and Himachal Pradesh. Slightly more MOs find their salary sufficient (58 %) while for 42 % it is insufficient. Contracting non-permanent staff to substitute the lack of doctors at the PHCs is part of the new government policy (BMOH 24.03.2004). However,

it is again the state who contracts the staff and not the district level authorities. One case was encountered where the contractual doctor was hardly available at the PHC and did not send the required monthly report to the BPHC. The BMOH did not give sanction or asked for explanations. It seems that control of contractual staff to control their quality of health service performance is not well-developed yet. Hence, the advantage of contractual doctors is questionable. Since the permission to hire only rests with the state, other staff problems also wait to be solved. For example service personnel at the health facilities come in short supply too. In one case the PHC had no sweeper for two years. After the death of the old sweeper no new one was sanctioned and the regular staff had to take over this task (Block Sanitary Inspector 25.03.2004). Hiring and firing permanent staff is difficult, because all belong to the national civil service.

Priority populations are defined through the National Health Programmes according to local population figures (see above), the range of choice is therefore narrow. The size and composition of facility boards or district offices are defined by the state authorities or the law. The same applies to size, number, composition, and role of community participation. District and Block Health and Family Welfare Societies are assigned specific tasks by the policy makers at the state level. Rules and regulations determine the composition and the role of these societies in detail. They receive their funds from the state government (ACMOH 16.03.2004). Models for local choice do not exist. Hence, the decision space for the functions governance rules is narrow as well (see Table 4.9).

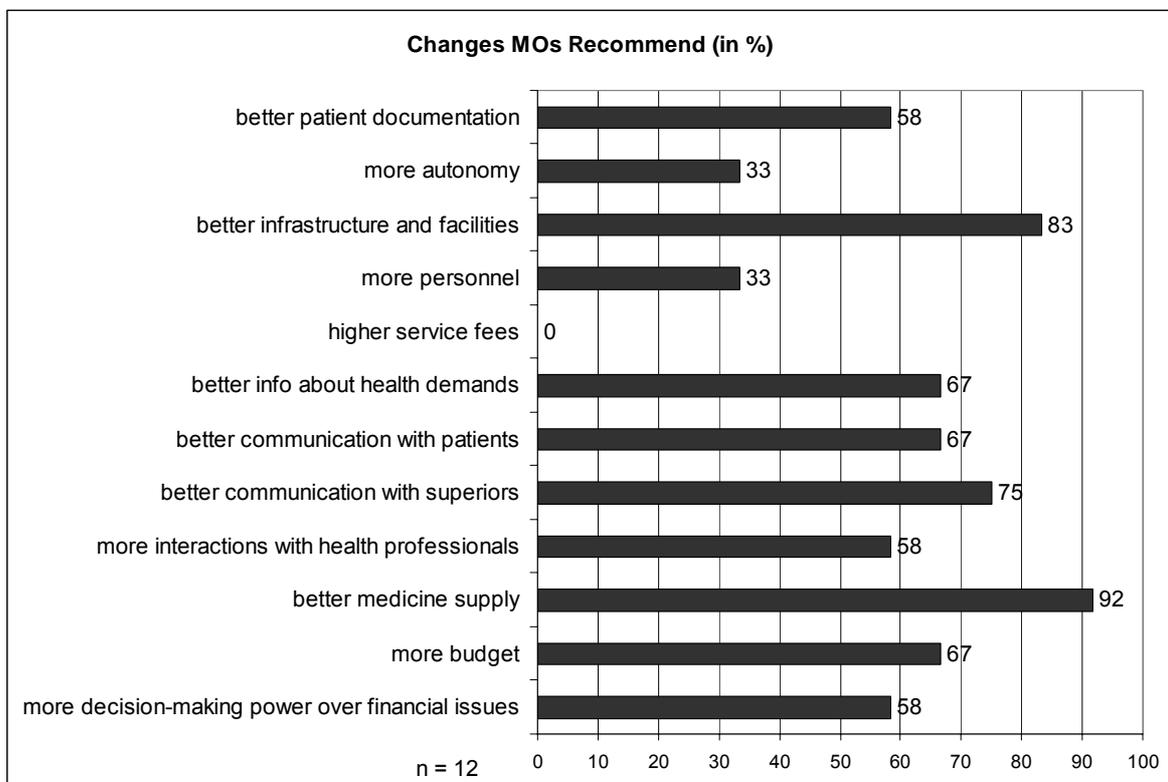


Figure 4.65: Changes MOs Recommend in Darjeeling and Bankura

Table 4.9: Map of Decision Space for West Bengal, Darjeeling and Bankura District (adapted from Bossert 1998: 1519)

Function	Indicator	Range of Choice		
		narrow	moderate	wide
Finance				
Sources of revenue	Intergovernmental transfers as % of total health spending	High %	Mid %	Low %
Allocation of expenditure	% of local spending that is explicitly earmarked by higher authorities	High %	Mid %	Low %
Fees	Range of prices local authorities are allowed to choose	No choice or narrow range	Moderate range	No limits
Contracts	Number of models allowed	None or one	Several specified	No limits
Service organization				
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Required programs	Specificity of norms for local programs	Rigid norms	Flexible norms	Few or no norms
Human Resources				
Salaries	Choice of salary range	Defined by law or higher authority	Moderate salary range defined	No limits
Contract	Contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Hiring and firing permanent staff	National civil service	Local civil service	No civil service
Access rules				
Targeting	Defining priority populations	Law or defined by higher authority	Several models for local choice	No limits
Governance rules				
Facility boards	Size and composition of boards	Law or defined by higher authority	Several models for local choice	No limits
District offices	Size and composition of local offices	Law or defined by higher authority	Several models for local choice	No limits

Community participation	Size, number, composition, and role of community participation	Law or defined by higher authority	Several models for local choice	No limits
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4.3.2.2. Community Participation

In Darjeeling and Bankura district 17 NGOs were interviewed with the aid of a standardized questionnaire (see Annex IV). Group discussions with several members of staff took place with two of these NGOs and one additional NGO. Among all interviewed NGOs were two Mother NGOs, West Bengal Voluntary Health Association (WBVHA) and Child in Need Institute (CINI). Directors or resource persons of NGOs were all met at their respective head or field offices. Furthermore, one NGO workshop held by WBVHA was attended. The interviewed NGOs have a minimum history of 6 years of services. Ramakrishna Mission has the maximum work experience with 106 years. The mean of work experience for all NGOs is 28 years. The interviewees are employed in their respective organizations for 15 years on average, ranging between 6 month and 31 years. The majority of organizations operate at district level, only two are confined to the block level. The rest of the NGOs work on state level (2), national level (3) or worldwide (Red Cross). Registration as society under the Society Registration Act is common, 88 % of NGOs are registered here. Only one NGO is registered as trust. The majority of NGOs can also receive foreign funding, 88 % are registered under FCRA. The size of the NGO's workforce varies between 7 and 2300 employees, but the majority (64 %) count less than 100 employees including paid staff and volunteers. Health issues are part of NGO work for 16 years on average, ranging from 3 to 54 years. Besides health, community mobilization and rural development are the major activities of NGOs, followed by human, women and children rights and others like women empowerment and education. Most NGOs (65 %) started working on health issues as their surveys identified health as a community need (see Figure 4.66). Other reasons to start health activities were the bad health situation in their area (47 %) and requests by the community (41 %). Within health the major issues are women and child health (76 %) and RCH (71 %), followed by AIDS/STD (59 %) and primary health care (53 %). Funding for the interviewed NGOs comes mainly from the state government and international agencies (82 % both) (see Figure 4.67). Central government funds ranked third with 65 % recipients, followed by membership and other sources like individuals or industries (53 % both). Membership fees and community contributions are much higher for the interviewed NGOs in West Bengal than in Himachal Pradesh and Maharashtra. The community served by NGOs contributes in 35 % of cases here.

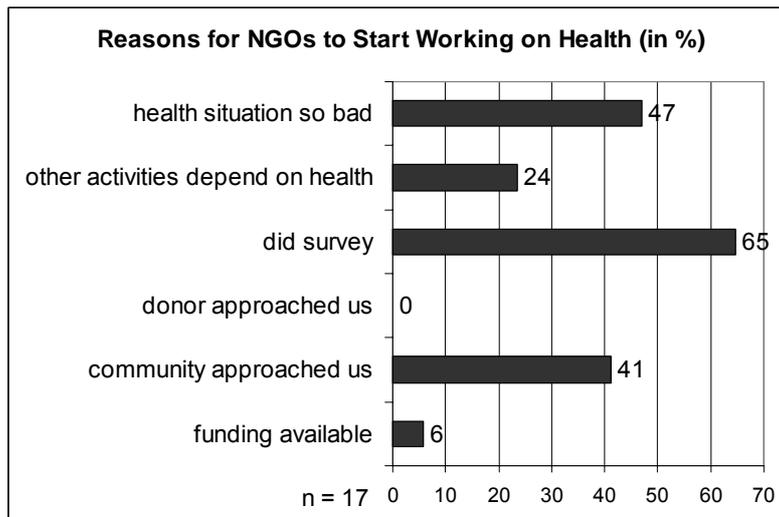


Figure 4.66: Reasons for NGOs to Start Working on Health in Darjeeling and Bankura

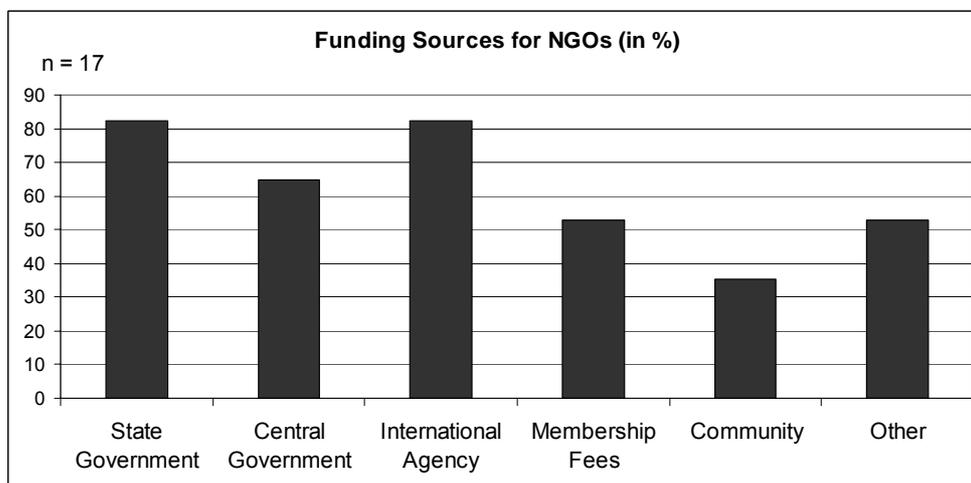


Figure 4.67: Funding Sources for NGOs in Darjeeling and Bankura

The degree of community participation depends on the definition of community and its representation. Health policy aims at marginalized groups of the population and tries to reach them through NGOs like it is the case in the other two states as well. The target groups depend on the programmes undertaken by the NGOs. Since most of them work in women and child health and RCH, it is not surprising that the target population of NGOs are mainly children and women (76 % each). General population and other groups, such as adolescents, truck drivers, disabled people or scheduled castes and tribes are of lesser importance for NGO work (41 % each). The target groups are further specified through the funding agencies or own programme strategies. NGOs in Darjeeling and Bankura mostly work through community-based organizations like SHGs or Mahila Mandals. It is very common for them to create SHGs for economic activities, which will then also discuss health issues (NGO 09.03.2004). Starting up own groups for community mobilization is a strategy employed in Maharashtra as well, as shown above. However, other community groups are essential for NGO outreach activities too (see Figure 4.68). PRIs are the foremost institutions to be contacted; all NGOs reach out to them. SHGs come second with 88 % of NGOs addressing them. The third rank is taken by Mahila Mandals (82 %).

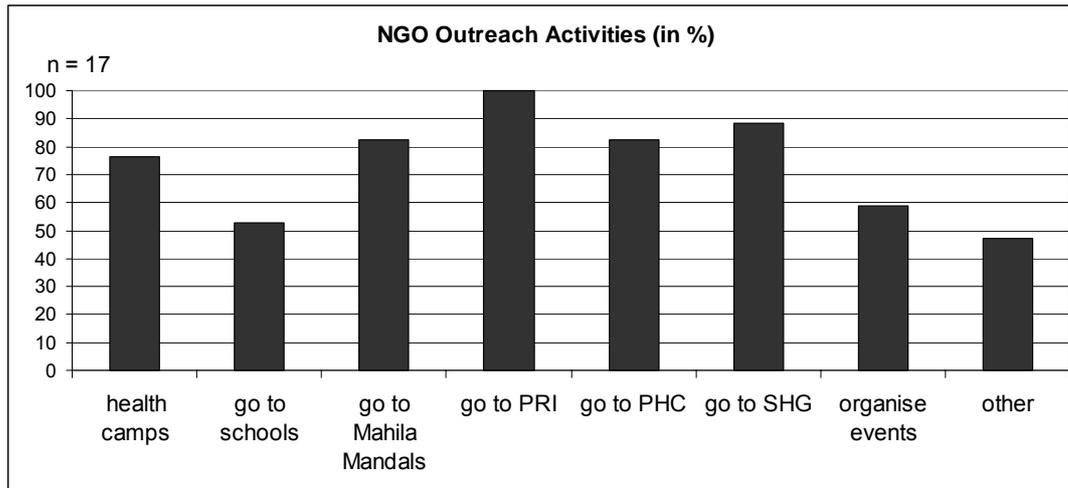


Figure 4.68: NGO Outreach Activities in Darjeeling and Bankura

The formation of SHGs and outreach activities to different community groups are part of NGO work. Another pattern encountered in the two districts is the training of “change agents” (NGO 09.03.2004; NGO 22.03.2004). One person of the village is trained in health issues and is then supposed to spread this knowledge (NGO 09.03.2004). Furthermore, the trained agents have to help the community to access health services and to create demand. The use of community volunteers as peer educators or health workers is an approach already encountered in Maharashtra. In West Bengal the government approach of Information, Education and Communication (IEC) has been renamed in Behaviour Change Communication highlighting the process of behaviour change as an expected result of communication and information. Most NGOs in the two districts have applied this new strategy to their work in some way or the other, be it through SHGs or “change agents”.

Although the community is defined as marginalized groups of the population by the government and by the NGOs, outreach activities mostly target relatively easy-to-reach people living in an area. Therefore, community participation reaches a middle degree here. Representation of community follows similar patterns. Powerful groups in population, namely PRIs and women groups as well as NGOs represent community in the majority of cases. They are powerful and not marginalized in the sense that they have already formed an institution and thus have the power, however small it may be, to control resources. The middle degree of community participation is also evident here (see Table 4.10).

The rationale for community participation in health is twofold. On the one hand community participation is seen as a means to increase effectiveness, to improve accountability and as a right by itself by policy makers at the national and state level. On the other hand it is perceived as a means to expand outreach, raise resources and support infrastructure by government health officials at the district and block level. NGOs in turn want to create ownership and demand for health services of the population through community participation. Hence, they see community participation as a means to improve management of local health services first, while effectiveness and accountability are

improved on a larger scale later on through these activities. Since it is the government sector which makes the definitions, it can be concluded that while a higher degree of community participation is officially envisioned at a state scale, the reality at the district level and below points towards a lower degree of community participation (see Table 4.10).

Depth, scope and mode of community participation in Darjeeling and Bankura are also determined by government policies. The main service offered by NGOs is the delivery of information on health (94 %) (see Figure 4.69). Health check up (82 %) and family planning advice (76 %) are also important services. Hence, advice and consultation are features characterising the depth of community participation.

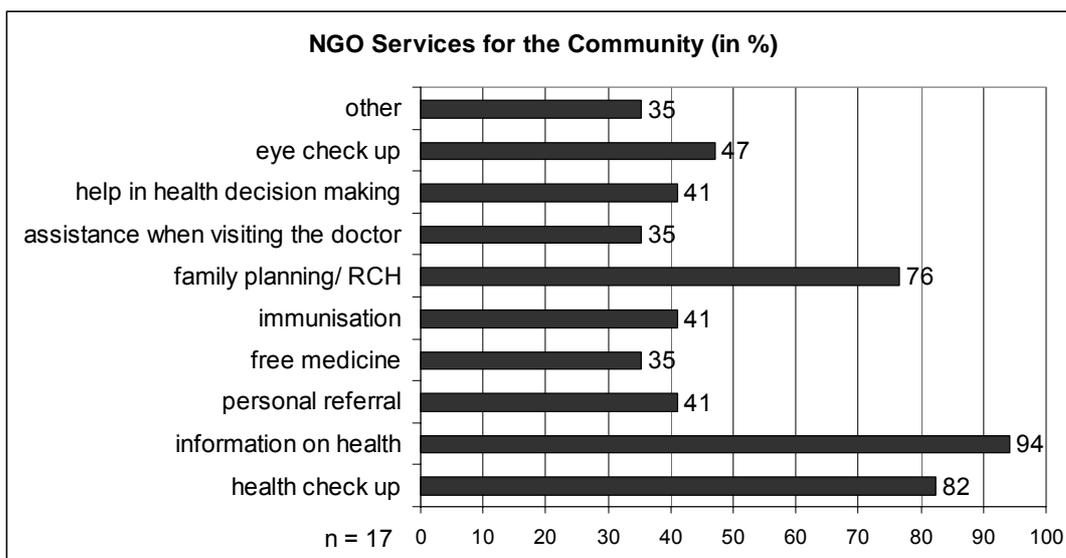


Figure 4.69: NGO Services for the Community in Darjeeling and Bankura

Collective or community decision-making is planned through the panchayat's micro-health plans which will be a part of district health plans. However, the health plans are only another form of monitoring the health infrastructure and counting the target population as this is the information collected by the panchayats. Although, the micro-plans might be a form of community-decision making since the panchayats decide which information they pass on, the impact of these is unknown. Furthermore, the acquisition format for the plans is again specified by the government, leaving only a small decision space for panchayats. Thus, a middle degree of community participation is reached (see Table 4.10).

The scope of community participation is limited to service delivery and management at the periphery as NGO influence on health policy and health management is small. Although big and long-established NGOs exist on the state level which do lobby for the communities, the government is slow to adopt their models. Lobbying for example for new farmland in case of natural disasters was successful once (NGO 08.03.2004) but general policies are hardly affected by these small concessions. Hence, a middle degree of community participation is reached (see Table 4.10).

The mode of community participation is through members of small collectives like SHGs, Mahila Mandals or other community based organizations. All NGOs and the government also work through and with these groups. Furthermore, community participation takes

place through District Health and Welfare Societies and Block Health and Welfare Societies as defined by the law. Membership in these societies cannot be acquired by demands from below. Mass-based organizations are not targeted at by health policies. It is again a middle degree of community participation which becomes visible (see Table 4.10).

Table 4.10: Degree of Community Participation in West Bengal, Darjeeling and Bankura District
(adapted from Murthy/ Klugman 2004: i79)

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents community	Powerful clients	Powerful groups in population; NGOs who represent community	Marginalized groups in population; NGOs who represent their interests
Rationale for CP in health	District administration level CP as a means to - expand outreach - raise resources - support infrastructure	CP as a means to - improve management of local health services (efficiency)	Central or State government level CP as a means to - increase effectiveness - improve accountability - CP as a right by itself
Depth of CP	Manipulation Informing	Advice/ Consultation	Collective or community decision- making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals Through invitation by government	As members of small collectives Often through invitation by government	As members of mass-based organizations and small collectives Both through invitations and demands from below

4.3.2.3. Prerequisites for Successful Participation

The indicators for successful participation can be seen in Table 4.2. The chance for successful participation was again assessed through interviews with MOs and NGOs as well as through field visits. The details of the interviewed groups are already examined above.

4.3.2.3.1. Interest in Participation

Interest in participation can be assessed by looking into existing cooperations and participation patterns of the public health system and NGOs. The evaluation of these linkages to the community gives an insight into the potential for successful participation. All MOs in Darjeeling and Bankura cooperate with health professionals, if available, and the community. They also receive help for their health programmes from other health professionals and the community. The extent and the valuation of cooperation vary. While most MOs cooperate with Anganwadi workers (92 %) and TBAs (83 %), cooperation with community health committees (67 %), private practitioners and Ayurvedic system (58 % both) take place to a lesser extent (see Figure 4.70). Contacts with traditional healers were indicated by 50 % of the interviewees. Only the work with Anganwadi workers, TBAs and the Ayurvedic system was rated as good, all other working relationships were valued as “ok” except traditional healers who received “not so good” (see Figure 4.71). The relationships with other health professionals are also reflected in their willingness and ability to help in the National Health Programmes. The MOs in the two districts voiced that help is mainly rendered by Anganwadi workers (83 %) and TBAs (67 %), who are part of the public health system. The help from the Ayurvedic system, private practitioners and traditional healers is neglect able, one to two MOs received help from them.

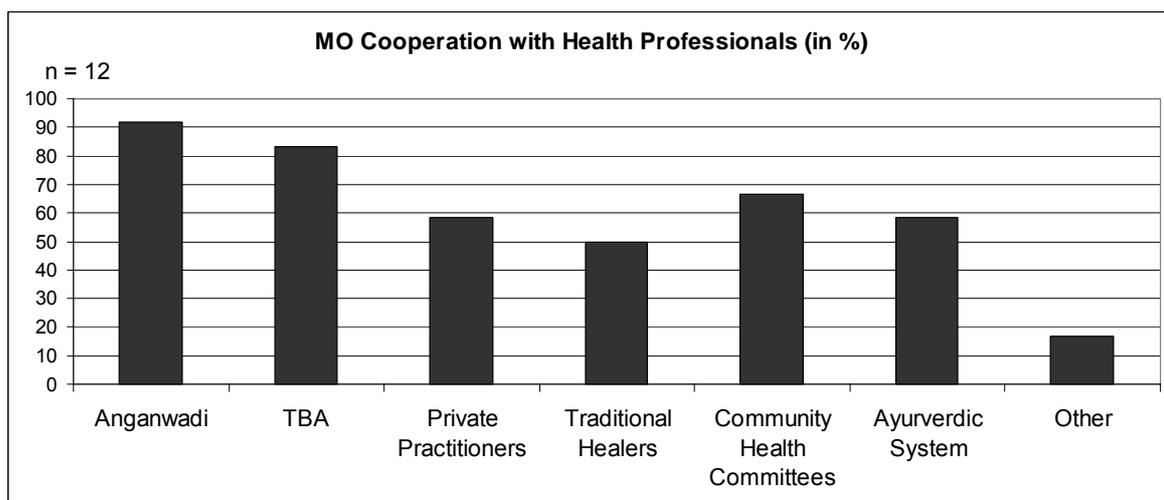


Figure 4.70: MO Cooperation with Health Professionals in Darjeeling and Bankura

MOs cooperate differently with diverse community groups. All interviewed MOs do cooperate with PRIs, the cooperation was on an average rated as good (see Figure 4.72 and 4.73). The majority of them further had contacts to Mahila Mandals, schools and NGOs (83 % each). Cooperation with the Block Development Committee existed in 75 % of the cases while only half of the MOs had contacts with SHGs as well. Other contacts for example to tea garden cooperations also exist. The best ratings from MOs for cooperation received NGOs, followed by Block Development Committee, schools and PRI. The cooperation with SHGs was also rated as “good” while Mahila Mandals received “ok” and other “not so good”.

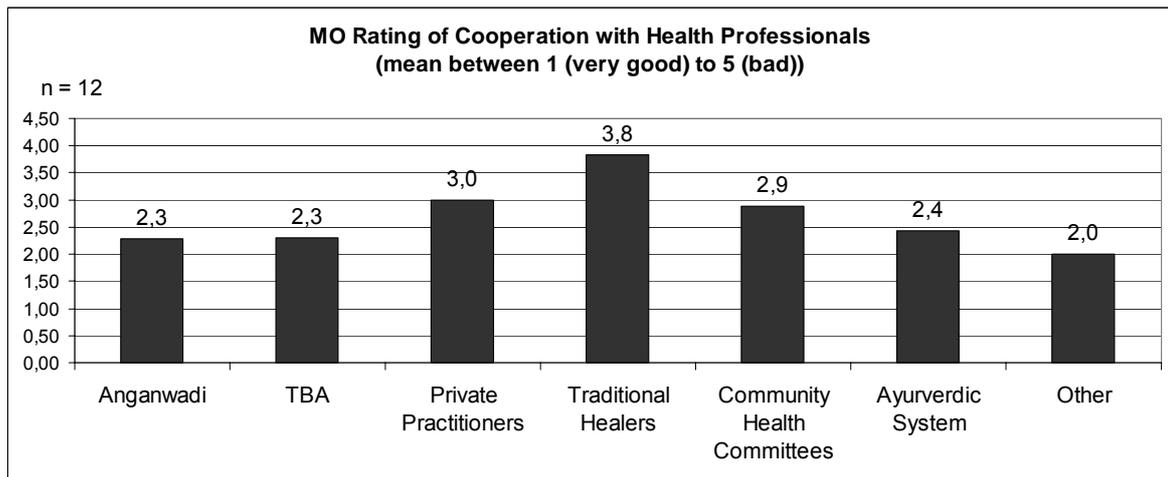


Figure 4.71: MO Rating of Cooperation with Health Professionals in Darjeeling and Bankura

Help for the National Health Programmes mainly comes from PRIs and NGOs (67 % each), which further supports the findings from above that close contact and help for the programmes positively influences the valuation of cooperation. Block Development Committees (58 %) also render help to MOs while Mahila Mandals (42 %) and SHGs (25 %) are less often involved. Among the activities carried out with the community promotion of health services ranks first (83 %). Other important activities include meetings with the community and assessment of health services (67 % each). MOs are further involved with the community through presentations for the villagers, visit to families and health education in schools but these activities were less important. Asking the community for feedback received the least positive responses. Only 42 % of MOs undertake this activity. The frequency of these activities does not follow the same pattern. So presentations for the villagers are carried out seven times per year on average while promotion of health services takes place six times and assessment of community needs four times. Health education in schools has the lowest frequency with two times per year on average.

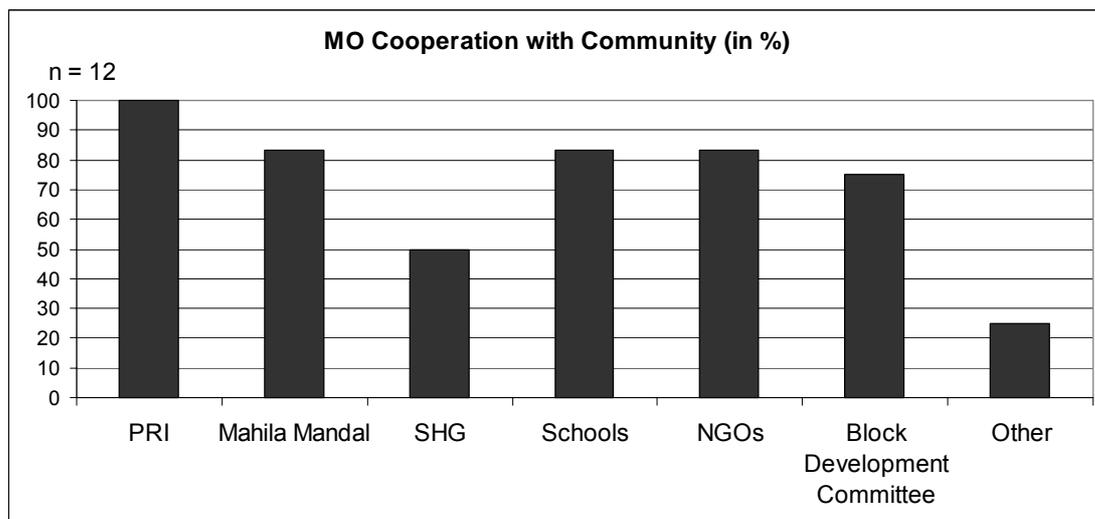


Figure 4.72: MO Cooperation with Community in Darjeeling and Bankura

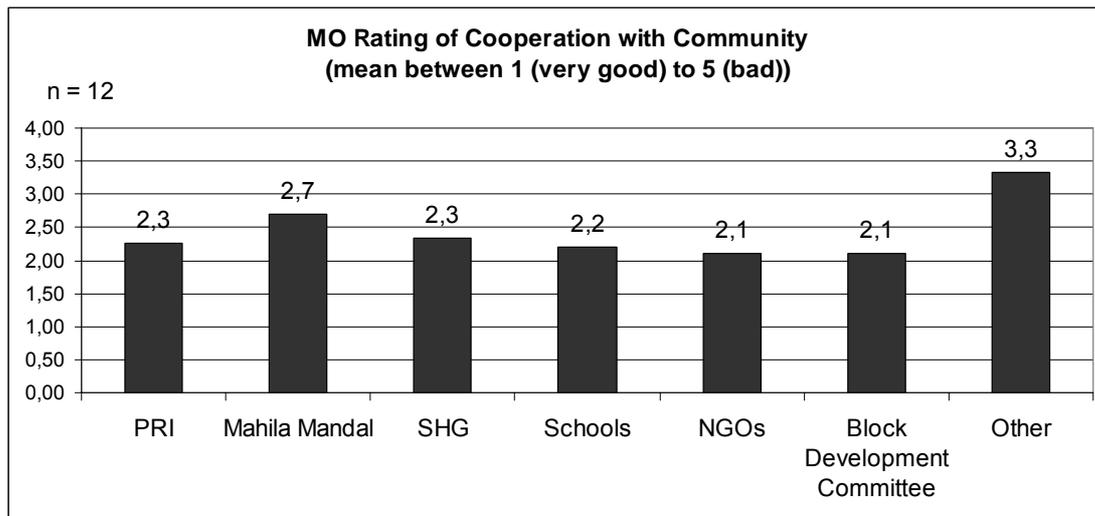


Figure 4.73: MO Rating of Cooperation with Community in Darjeeling and Bankura

The high percentage of MOs cooperating with NGOs and the good rating of this cooperation as shown above should also be positively reflected in the opinions of MOs about NGOs. Accordingly, the response shows that most MOs find that NGOs speak for the community (90 %) and do good work in health and health-related areas (88 %) (see Figure 4.74). Although only 58 % answered the question if NGOs are money-minded, they all negated it. However, most MOs do also deny NGOs medical expertise. Only 22 % of them think that NGOs possess this knowledge. The majority still wants NGOs to help them. Awareness raising and information to villagers about health risks, National Health Programmes or public health services are the tasks NGOs could and should carry out in the opinion of the interviewed MOs (see Figure 4.75). Tasks like giving out medication, taking over some of the public health services or controlling the quality of public services received less positive replies. Hence, MOs want NGOs to carry out information activities which are thought to help increase utilization rates and fulfil targets. NGOs are rather wanted as field help, than as equal partner.

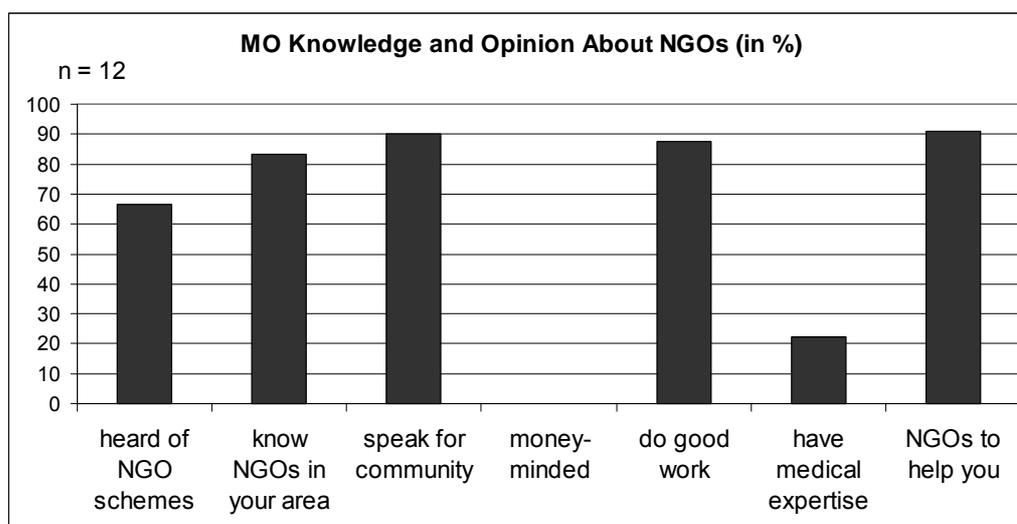


Figure 4.74: MO Knowledge and Opinion About NGOs in Darjeeling and Bankura

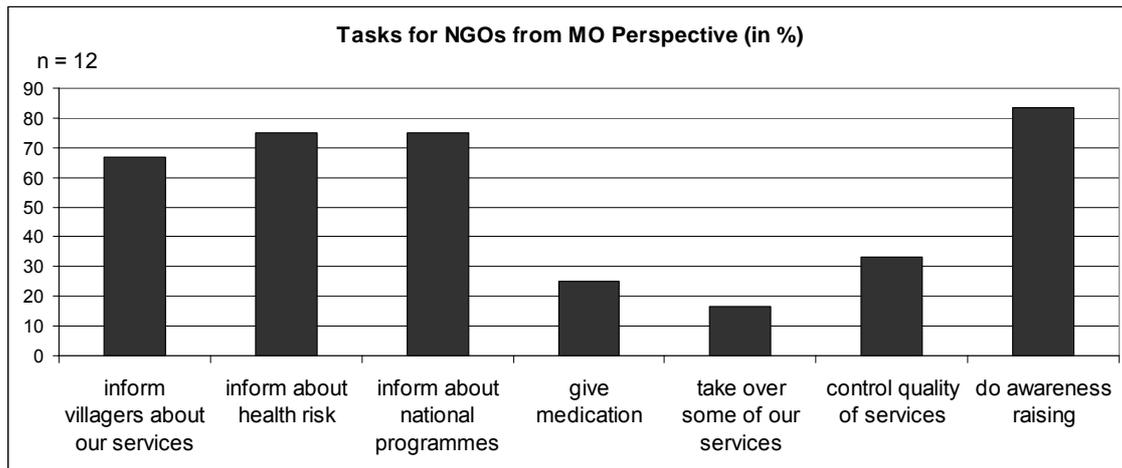


Figure 4.75: Tasks for NGOs from MO Perspective in Darjeeling and Bankura

The same holds true for the cooperation with community. Meetings with community are institutionalised through existing government health policies (see above). Cooperation with PRIs and other groups also serves the purpose of delivering information and education to the community for higher utilization rates and better target fulfilment. Interference in the management of health facilities by community groups is not wanted. Thus, MOs in Darjeeling and Bankura are more interested in “top-down” participation, indicating a moderate chance of successful participation (see Table 4.11).

All NGOs cooperate with MOs, Anganwadi workers, TBAs, PRIs and women groups (see Figure 4.76). Less of them cooperate with state or district officials, private practitioners or MPWs. Contacts with other NGOs (82 %), international organizations and community health committees (76 % each) were also important for the majority of NGOs. Even traditional healers were involved in cooperation by 71 % of NGOs. Thus, most NGOs have a great variety of contacts. The best ratings for cooperation were received by women groups (mean 1.6), followed by international organizations (1.8), NGOs (1.9) and PRIs (2.1) (see Figure 4.77). All other groups also got good ratings from NGOs except for private practitioners and traditional healers, which were rated “ok”. Among the officials from the public health system, Anganwadi workers were valued best, followed by district officials and state officials. The better ratings for district and state officials are a good indicator for functioning cooperation as NGOs rely on these institutions for funding.

The exchange of information and discussion of problems as well as joint organization of events are the main features of cooperation with other institutions. Joint planning of work or mutual monitoring is important to fewer of the NGOs. In the cooperation with community workshops are the main tool employed by all NGOs (see Figure 4.78). Information leaflets are given to the community and discussion with the community are carried out by 88 % and 82 % of the NGOs respectively. Presentations and posters are equally important tasks undertaken by 76 % of NGOs.

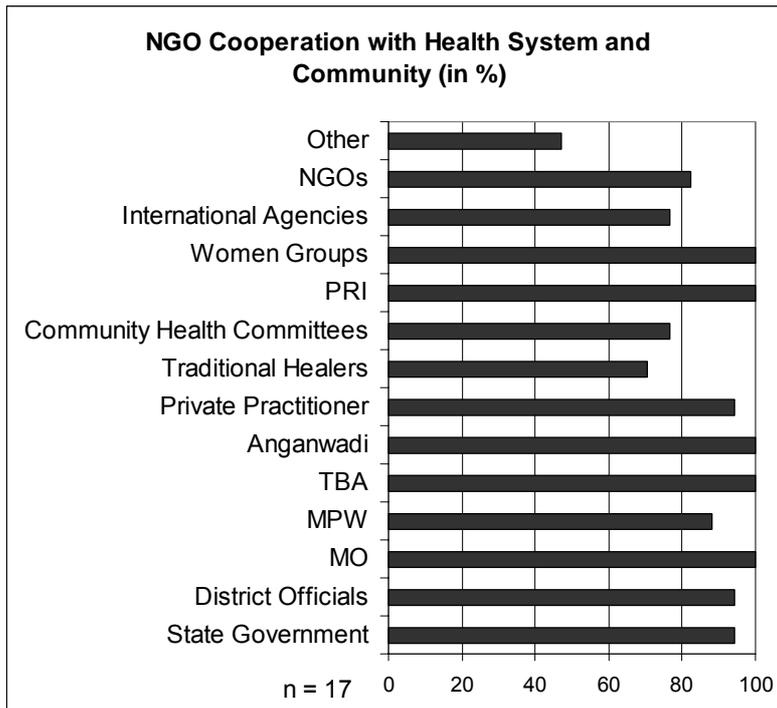


Figure 4.76: NGO Cooperation with Health System and Community in Darjeeling and Bankura

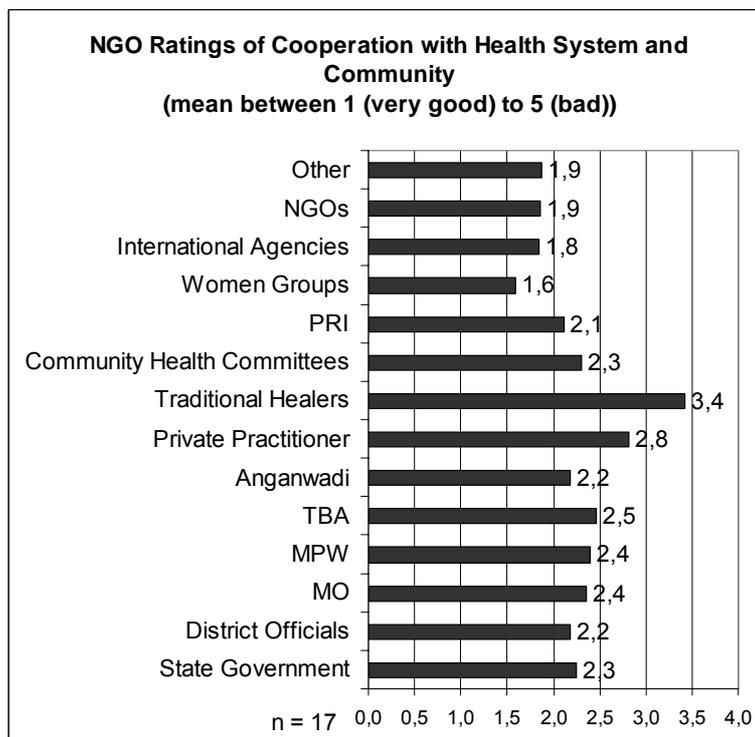


Figure 4.77: NGO Ratings of Cooperation with Health System and Community in Darjeeling and Bankura

It has already been mentioned above that training of community workers is essential for community participation to some of the NGOs, 65 % of them train people from the community. Theatre, movies and other activities like mime show, puppet show, folk songs or house-to-house meetings are less often employed by NGOs. All of the activities involve community groups in an active way.

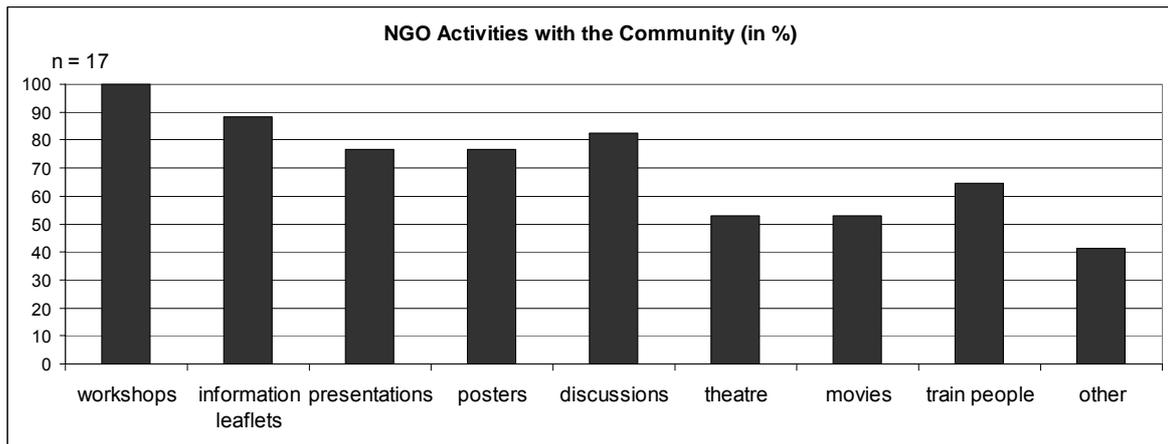


Figure 4.78: NGO Activities with the Community in Darjeeling and Bankura

Furthermore, NGOs want to use these cooperations to help the communities to voice their demands. All of them want to inform villagers about their rights and the majority also want to help the community to complain (76 %) (see Figure 4.79). Therefore, NGOs are interested in “bottom-up” cooperation, pointing towards a high chance of successful participation (see Table 4.11).

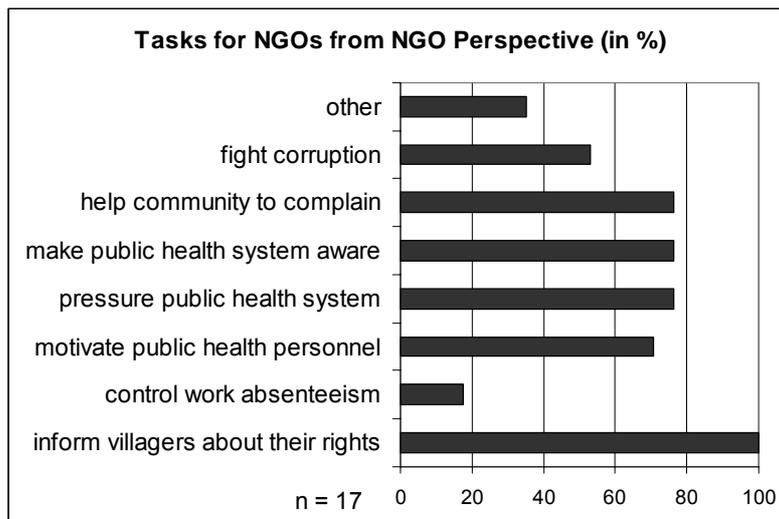


Figure 4.79: Tasks for NGOs from NGO Perspective in Darjeeling and Bankura

4.3.2.3.2. Communication and Information Transfer

Communication and Information Transfer within Public Health System

Communication and information transfer within the public health system in Darjeeling and Bankura takes place through reports and meetings, hence, in oral and written forms. Monthly meetings are held at the BPHC level where all staff from PHCs and SCs come together and at the district level where all BMOHs meet. Nonetheless, only 83 % of BMOHs and MOs said in the questionnaire that they hold regular staff meetings at their facilities. BMOHs receive reports from MOs and MPWs of their division once a month and send their own reports to the district headquarter once a month. Most of the BMOHs (73 %) receive feedback on these reports. All interviewed MOs and BMOHs indicated that they also give feedback to the reports of their subordinates. However, only 58 % of MOs feel that their reports are used for health system planning at the district or higher levels. Contacts are also established through visits. MOs pointed out that they are visited by superiors every two months on average, the range was from a minimum of once a year to a maximum of every month. Accordingly, they also have to visit their subordinated facilities which they do every one and a half months on average, ranging from each week to every four months. Furthermore, MOs and staff receive training from higher government authorities or NGOs, but there is no schedule for these trainings. Trainings are mostly given for programme initiatives, but not for developing or increasing management capacities. Therefore, trainings and funding for them are included into National Health Programmes. Since training is irregular and depends on programmes and funding, communication and information transfer through this activity is limited. Nevertheless, channels for communication are institutionalised through reports and monthly meetings. Only one monthly meeting at the district level in Bankura could be attended which also functioned as training for the Pulse Polio Programme by a WHO representative. The meeting appeared to be disturbed by constant talking among the BMOHs and BPHNs. Satisfaction with the information transfer at this meeting was low among the participants, questions to the district officials and the WHO representative reflected this. However, the participants felt open to voice questions and to argue with their superiors, an indicator for open communication channels. The practice of partial information transfer is also visible in the knowledge held by MOs. Only 67 % have heard of the NGO schemes in the National Health Programmes, although most of them hold the post of BMOH and are responsible for the implementation of programmes. The knowledge about the NGO schemes in Maharashtra and Himachal Pradesh was much better. The programme was not implemented in all blocks. Since the amount of MOs who have heard about the scheme and who receive help of NGOs for the National Health Programmes corresponds it can be rightly assumed that those who do not run the programme in their blocks also lack the knowledge about it. It is not surprising that 75 % of the interviewed MOs recommend better communication with superiors for the improvement of health services (see Figure 4.65). Likewise, better information about the health demands of the population were recommended by 67 %. The collected findings indicate that information and communication transfer within the public health system is partial and “top-down” oriented.

Since institutionalised channels exist, the chances of successful participation are moderate (see Table 4.11).

Communication and Information Transfer within NGOs

NGOs interviewed in Darjeeling and Bankura possess hierarchical organization structures including a director, secretaries and field workers. The same relationship between size and organizational degree like in Maharashtra was visible in West Bengal as well. The more people work for the NGO, the more differentiated are its hierarchies. Information and communication transfer takes place through meetings, trainings and reports. The majority of NGO staff receives training (88 %). Project management and health issues are the predominant subjects of these trainings, followed by training about data analysis and holding workshops. Laws and regulations are the least important subjects. NGO personnel obtain information on health issues mainly from science magazines, health books and from asking health professionals. During projects similar communication processes take place in all NGOs. As soon as projects are decided and finalised at headquarter or main office and funding is available, field officers or volunteers are trained for the execution of programmes (NGO 08.03.2004; NGO 09.03.2004). The influence of field workers or volunteers on the programme outlines as such is marginal. Although the success of programmes largely depends on the motivation and skills of the field staff, they are hardly involved in the formulation of programmes. However, contrary to the public health system, the feedback of field workers in the form of reports or discussions during the project seems to be taken seriously and NGOs can react to it. Meetings between field staff and headquarters are institutionalised and regularly take place. Field workers mostly hand in their reports personally (NGO 27.03.2004). Thus, personal contact between NGO workers at different levels is established. Another important aspect of NGO work is its corporate identity. During the interviews it became clear that identification with the organization and its goals is essential for field workers. Working for social benefits for the communities creates pride in the field workers and functions as motivation. The level of information at the field offices was different from the main offices, as it is the case in Maharashtra as well. While field workers have extensive knowledge about their target groups and their programme activities, they do not see the bigger political arena, which is not essential for their work. The main offices on the other hand are involved in networks and political activities as they have to generate funds and want to change policies through their advocacy work. Even though field staff is not involved in decisions about programme policies, they nevertheless shape the programmes at the local level and contribute towards changes at the headquarters. Communication and information transfer thus takes a “top-down” and a “bottom-up” approach and includes most information indicating a high chance for successful participation (see Table 4.11).

Communication and Information Transfer between Public Health System and Community

Interactions between the public health system and the community take place either as doctor-patient contacts in outpatient services and National Health Programmes or as public health system-community contacts through Block or District Health and Family

Welfare Societies and advisory committees. The existing cooperation between MOs and the community has already been examined while looking into the interest in participation (see above). The best ratings received NGOs and Block Development Committees.

During outpatient services at BPHCs and PHCs the doctor sees 88 patients on average, varying between 11 and 350 per day. At the rural hospitals the patient load was between 200 and 500 patients per day. The time spent with each patient is short, five minutes is the average ranging from a minimum of one to a maximum of ten minutes. Nevertheless, all but one MO indicated that they explain the health problem to their patients in detail. Given the shortage of time, this is questionable. Furthermore, no detailed explanation was observed during field visits. The lack of privacy further hinders doctor-patient communication. Similar to the procedures in Himachal Pradesh and Maharashtra patients crowd in the examination room and adjoining corridors (see Picture 4.25 and 4.26). They build a very tight queue with no distance to the man or woman in front of them. Since most patients carry infectious diseases, the health risks for the doctors and other patients is high (MO 25.03.2004). In some cases heartbeat and pulse of the patient was examined by the doctor, other physical examination did not take place. Appropriate facilities for the doctor to sanitise his/her hands after each patient were not available (see Picture 4.27). During the examination the patient cannot sit down due to lack of space, chairs and time. In one BPHC an open patient waiting room was constructed outside, but nobody used it as the waiting procedure was not organized. The amount of patients and the lack of time, privacy and confidential space hinder the doctor-patient communication during outpatient services. Information is hardly passed on. The questionnaires reflect this finding as most MOs wish for better communication with their patients (67 %) (see Figure 4.65). Half of the interviewed MOs also numerated ignorant patients as one of their work problems, showing the lack of information existing at the patient side.

Under the National Health Programmes most MOs undertake outreach activities like immunisation camps and reproductive child health camps. Health check up camps, eye camps or other activities like pulse polio campaign or school health check up are also carried out but to a lesser extent. For these programmes MOs mostly receive help from PRIs and NGOs. Overall all interviewed MOs cooperate with different community groups and valued the cooperation as “good” or “ok” (see Figure 4.72 and 4.73). Besides the health workers at the community level, PRIs and NGOs are used by the MOs to inform the villagers about the date and time of the camps. No health camp was scheduled during the field trip but from the interviews it can be gathered that the procedure is similar to Himachal Pradesh and Maharashtra. Thus, lack of privacy and time as well as the divide between villagers and public health staff does not allow for “bottom-up” communication and information transfer in Darjeeling and Bankura.



Picture 4.25 (above, left): OPD at BPHC Saltora, Bankura District

Picture 4.27 (above): Dysfunctional Washbasin in PHC Mosiara, Bankura District



Picture 4.26 (above): OPD in BPHC Hirbandh, Bankura District

Block Health and Family Welfare Societies were just in the process of registration and did not yet function. However, advisory committees composed of government personnel and community members exist at 60 % of the interviewed facilities. Members mostly come from PRIs, Block Development Committee and other programmes like Integrated Child Development Scheme. Meetings take place every 2.4 months on average. Most decisions of the committee are implemented. On an average the committees are found to be very useful for the MOs. Quality of services, hospital development or evaluation of work is discussed in these committees (BMOH 24.03.2004). Hence, communication and information transfer in the advisory committees seems to be successful.

Last but not least the attitude of doctors towards their patients also influences communication and information. It has already been emphasised that 50 % of doctors hold the opinion that patients are ignorant and therefore pose a problem for their work (see Figure 4.81). On the other hand MOs think that their behaviour and health information for patients are most important for people to choose public health services.

When asked about complaints from patients three quarters of the interviewees indicated that they receive complaints. Complaints are mainly verbal. They are predominantly concerned with lack of medicine (67 %) (see Figure 4.80). Hygiene (33 %), lack of equipment and attitude of staff (22 % each) were less often subjects of complaints. Although the MO who answered this question might be biased concerning his/her own behaviour or the behaviour of staff, patients seem to be more satisfied with the behaviour of staff than with the availability of medicine. The majority of MOs (89 %) follow up the complaint, meet the person who uttered the complaint and investigate whether the complaint is true. A report to the supervisor is only written by 44 % of the MOs. Even though the follow-up of complaints seems to be good, changes hardly take place. As the ACMOH indicates: “We send community complaints to the state level. We cannot follow it up ourselves. Our problem-solving capacity is very limited, because we cannot do anything without informing the department.” (ACMOH 16.03.2004).

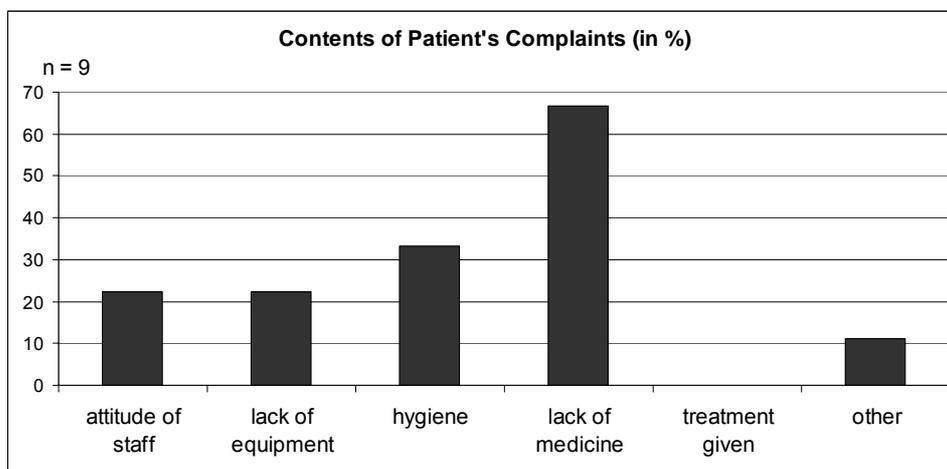


Figure 4.80: Contents of Patient's Complaints in Darjeeling and Bankura

Although some channels like Block Health and Family Welfare Societies seem to be more open for “bottom-up” communication, other are not. Therefore, communication and information transfer between the public health system and the community in Darjeeling and Bankura is “top-down” oriented and programme-related. The chance for successful participation is moderate (see Table 4.11).

Communication and Information Transfer between NGOs and Community

NGO work with the community includes workshops, discussions, trainings and information activities as already indicated above (see Figure 4.78). Communication and information transfer is part of all programmes. Analogous to NGOs in Maharashtra, NGOs in the two districts built SHGs or women groups or train change agents from the community and work through them. Other outreach activities like contacts to PRIs and schools are also important (see Figure 4.68). Information about health issues, family planning advice and health check-ups are the main services offered to the community (see Figure 4.69). NGOs think that community cooperates with them as they expect health gains, empowerment and more influence on the public health system. Better information only ranked fourth together with financial gains. All NGOs do community needs assessment. Discussions

with the community are the main tool, pointing towards a “bottom-up” approach. Community needs assessment is also used for the evaluation of programmes which takes place on a regular basis as required by the funding agencies. Since NGOs mainly work through small groups, they can adjust to the educational level and the information needs of the group members. Long-term relationships with the community create trust and positively influence communication and information transfer. Members of SHGs become confident and discuss health issues in their small homogenous groups (see Picture 4.28). Change agents from the community know community needs and speak their language. Hence, communication and information transfer between NGOs and communities is “top-down” and “bottom-up”, demand-oriented and culturally sensitive, indicating a high chance for successful participation (see Table 4.11).



Picture 4.28: SHG Meeting at NGO Office in Bankura District

Communication and Information Transfer between Public Health System and NGOs

The positive opinions about NGOs held by the MOs in Darjeeling and Bankura have already been highlighted above. Likewise NGOs value their cooperation with MOs and other public health personnel as good. NGOs do not only help in the National Health Programmes but are also involved in advisory committees. In future, NGOs will have more influence on the public health system through the Block and District Health and Family Welfare Societies. NGOs need communication with the public health system to fulfil their main goals like pressure public health system for better performance, make public health system aware of community needs and help the community to complain about missing infrastructure or health services (see Figure 4.79). The majority of NGOs (76 %) sees these activities as their main tasks to improve the public health system in rural areas. However, creating demand among the villagers and helping them to complain can also create problems in the NGO relationship to the public health system, which can even lead to withdrawal of cooperation from the BMOH or MO side (NGO 24.03.2004).

The public health system in turn needs NGOs to inform the villagers about their health services and the National Health Programmes (see Figure 4.75). The majority of MOs want NGOs to help them with these tasks. MOs see NGOs as a link to the community which can help them to increase their utilisation rates and fulfil their targets. None of the interviewed MOs characterised NGOs as money-minded (see Figure 4.74). In Darjeeling district the public health system works with NGOs for 30 years and is satisfied with their help to perform some of the public health services (ACMOH 16.03.2004). The ACMOH voiced that it would be good to have NGOs in other programmes as well (Ibid.). Problems mentioned were transport of NGO personnel for programme activities since NGOs often do not own vehicles. More objectiveness, manpower and effectiveness in their programmes are also important areas for improvement.

Distrust by government officials was only seen as a problem by 35 % of NGOs, indicating good communication channels. Nevertheless, differences between official records from the public health system and NGO observations can create opposition (NGO 24.03.2004). Rating the cooperations with public health personnel after their helpfulness for the improvement of services, NGOs prefer to work with local public health staff like MPW and Anganwadi workers. Hence, they perceive cooperation with local workers as more helpful than links with the district officials or even with the MO. Cooperation with the state government however ranks before district officials and MOs. Indicating that approval from high administrative level, including funding, is also important for NGO cooperation. Nonetheless, communication and information transfer between the public health system and NGOs is “top-down” and “bottom-up” pointing towards a high chance of successful participation (see Table 4.11).

4.3.2.3.3. Responsiveness

The public health system’s responsiveness to community needs in Darjeeling and Bankura is low. Although population data is collected at the local level, MOs cannot influence budget decisions. The limited decision space for MOs further hinders responsiveness. They can neither take action without the approval of district or higher

authorities nor can they influence decisions at these levels. Lack of infrastructure, personnel, equipment and medicine restrain their work. Among the changes MOs recommend improving public health services, better medicine supply and better infrastructure and facilities as well as better information about health demands of the population rank first (see Figure 4.65). Missing testing facilities for example prevent the clear identification of diseases and therefore their timely treatment. Problems in communication and information transfer within the public health system and between the public health system and the community are another hindrance for responsiveness. The lack of responsiveness is also reflected in the attitude of one doctor.

- “We have mostly Muslim population here. They are illiterate and do not understand our language.” (BMOH 16.03.2004).

The doctor highlights that part of his service population does not understand him. The reason could be that his language or communication is not adjusted to the local circumstances or the local demand. However, it also shows his attitude that it is the population who has to understand him and not vice versa. He is not alone with this perception as 50 % of MOs voiced that ignorant patients are a problem. Responses to community demands also depend on the budget.

- “Sometimes we can adjust our service if funds are available, otherwise we inform the state level.” (ACMOH 16.03.2004).

If pressure is exercised by the District or Block Health and Family Welfare Societies, the district level can respond, so the ACMOH but only sometimes and if funds are available. The limiting factor is money, given the shortage of funds, the chance for responsiveness is small. Since the budget is allotted according to population numbers and the respective National Health Programme the chance of successful participation is moderate (see Table 4.11).

NGOs in turn all do community needs assessments and are open to community demands. Nevertheless, they also depend on funding from different sources including the state. Acting as pressure groups they can influence the public health service to a certain extent, but as already emphasised the responsiveness of the public sector is low. NGOs do not necessarily have the medical expertise or the facilities to react to health needs. Their responsiveness is more long-term oriented. Poverty reduction and education to prevent diseases are more important for them than curative services. In case of natural disasters the state asks big NGOs like West Bengal Voluntary Health Association, CARE India West Bengal and others for their help. During flooding events NGOs were able to react immediately and to mitigate the impact of disasters for the population (NGO 08.03.2004). Although NGOs cannot respond to all community needs since they also present certain groups of the population, they are open for all community demands. Their programmes and projects try to incorporate most of the community needs. The chance of successful participation is thus high (see Table 4.11).

4.3.2.3.4. Motivation for Participation

MOs in Darjeeling and West Bengal do not receive incentives or benefits from the government for community participation as it is the case in Maharashtra and Himachal Pradesh as well. The benefits MOs get are from the community groups themselves offering help for the National Health Programmes. The majority of NGOs (71 %) sees motivation of public health personnel as one of their possible activities to improve public health services (see Figure 4.79). Good performance of MOs in the programmes, meaning high utilization rates and fulfilment of targets, is not rewarded by the superiors. Bad performance and non compliance in turn does hardly lead to sanctions against the MO. Motivation is thus low. The majority of MOs (67 %) is not satisfied with some aspects of their work. Working conditions are rated as not so good (mean 2.7). Some of the problem areas have already been highlighted above. Political interference is a problem encountered by 42 % of the MOs, holding the same rank as unmotivated staff and lack of staff (see Figure 4.81). In comparison with Maharashtra or Himachal Pradesh political interference is less important. Other problems like lack of infrastructure (83 %), no budget for repairs (67 %), lack of medicine (58 %), ignorant patients, no financial powers and work overburden (50 % each) come before it. Although MOs do not receive incentives or benefits from the government, they feel that community cooperation is helpful for them. The chance of successful participation is moderate (see Table 4.11).

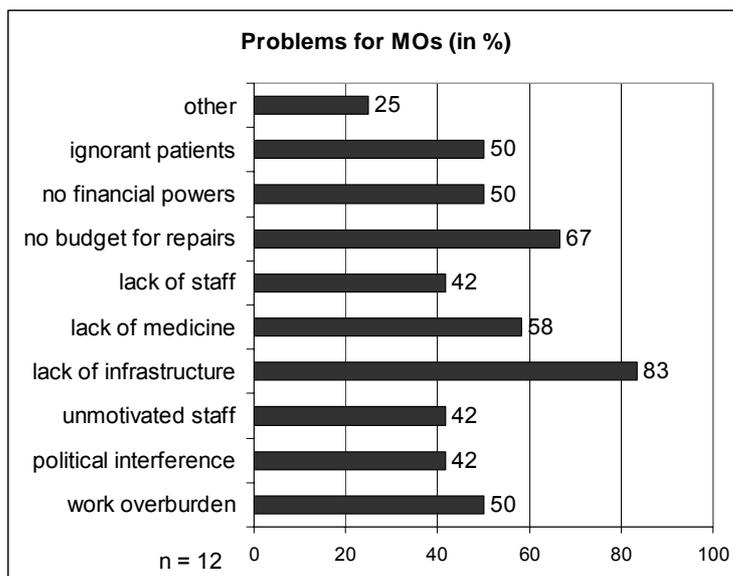


Figure 4.81: Problems for MOs in Darjeeling and Bankura

NGOs are highly motivated because they receive funds from the government and the funding agencies for community participation and they are rewarded by the community as well. The chance of successful participation is high (see Table 4.11).

4.3.2.3.5. Accountability

MOs are mainly accountable to higher government authorities as it has been explained under the decision space section. Local government authorities like Gram Panchayats or Panchayat Samitis have no power over MOs, but do look after the Sub-Centres. Accountability to the community is low, even though most MOs follow-up community

complaints (see above). As members of advisory committees or Block Health and Family Welfare Societies MOs have to discuss quality of health service with community representatives. However, the high social status of the doctor and the dependency on his/her services might prevent evaluation of performance. It is rather higher authorities or shortage of funds which are blamed for low quality of services. Asking the community for feedback is also rare, only 42 % of MOs indicate that they do so. The chance of successful participation is low (see Table 4.11).

NGOs are foremost accountable to their own board of control (82 %), followed by donor agencies (65 %) and the community (53 %) (see Figure 4.82). Since funding from state or international sources is more important than community funding or membership fees, accountability to these institutions is also higher. However, NGOs have to get approval for their projects from the public district administration. Furthermore, they need the support of the community as they cannot undertake their programmes without community participation. Therefore, they have to be accountable to their beneficiaries. NGOs mainly work through SHGs or women groups. They rely on the trust they built up in these groups. Accountability to people is a prerequisite for this trust. Hence, the chance of successful participation is moderate (see Table 4.11).

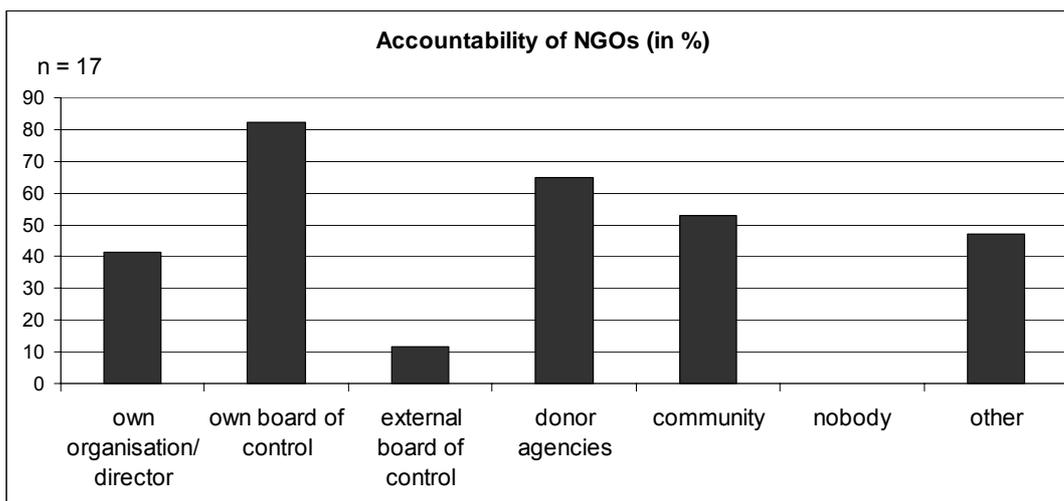


Figure 4.82: Accountability of NGOs in Darjeeling and Bankura

4.3.2.3.6. Sustainability, Control over Resources and Experience of Participation

Sustainability of community participation is influenced by all factors discussed above. If the range of indicators points towards the high end, then sustainability is also high. The chance of successful participation for the public health sector side varies between low accountability to high communication and information transfer with NGOs. However, the indicator predominantly took a moderate value. The public health system mostly follows the “top-down” approach and does involve community only as it fits in their programmes. Interest, motivation, communication and information transfer with the community, responsiveness to community demands and accountability need to be improved. So far the chance for sustainability to ensure successful participation is moderate (see Table 4.11). NGOs show a more positive profile. Although the indicators range from moderate

accountability to high interest, the overall score shows a high chance of successful participation and therefore for sustainability. Community involvement and the “bottom-up” approach are the core of their work. However, NGOs and MOs are both dependent on government policies and budgets which are subject to change.

Thus, control over resources is a critical issue. MOs do have narrow decision space over financial issues. Resources are allocated according to the policies of higher authorities. The chance of successful participation is low. NGOs in turn have several models for control over resources including membership fees and community donations. However, the majority of their funds come from state or central government and from international donors (see Figure 4.67). The funding agencies control where the resources are spend and how. NGOs can nevertheless decide which programmes they want to take up. The chance of successful participation is moderate (see Table 4.11).

MOs and NGOs both have good experiences with participation as indicated above. Participation is helpful for their programmes and their goals. The chance of successful participation is high for both (see Table 4.11).

Table 4.11: Map of Participation for West Bengal, Darjeeling and Bankura District (adapted from Atkinson 2002; Murthy/Klugman 2004; Metzger 2001; Rifkin 1996; Westergaard 1986)

Indicator for successful participation	Range of indicators		
	low	moderate	high
Interest in participation			
for MO	No interest	Interested in top-down participation	Interested in bottom-up participation
for NGO	No interest	Interested in top-down participation	Interested in bottom-up participation
Communication and Information Transfer			
within public health system	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
within NGOs	Top-down, limited information	Top-down and within the same hierarchy, selected information	Top-down, bottom-up and within the same hierarchy, all information
between public health system and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive
between NGOs and community	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up, demand oriented and culturally sensitive

between public health system and NGOs	No communication, no information transfer	Top-down, only programme related	Top-down, bottom-up
Responsiveness			
MO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
NGO	No responsiveness to community needs	Responsiveness to community needs as defined by the programme (top-down)	Open responsiveness to all community needs
Motivation for participation			
MO	No incentives/ benefits	Incentives/ benefits by government or other groups (extrinsic)	Incentives/ benefits by government and community (extrinsic and intrinsic)
NGO	No incentives/ benefits	Incentives/ benefits by government and donors (extrinsic)	Incentives/ benefits by government, donors and community (extrinsic and intrinsic)
Accountability			
MO	To higher government authorities	To local government authorities	To community
NGO	To higher government authorities, donors	To local government authorities, local organizations	To community
Sustainability			
MO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
NGO	Top-down approach	Top-down with community involvement	Bottom-up approach, community involvement
Control over resources			
MO	Defined by law or higher authorities	Several models for control over resources	Free control over resources
NGO	Defined by law or higher authorities, donors	Several models for control over resources	Free control over resources
Experience of participation			
MO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful
NGO	No or bad experience	Indifferent experience, participation was not helpful	Good experience, participation was helpful

4.3.3. Conclusion of Case Study West Bengal

West Bengal like Maharashtra has a long history of decentralization and participation. Part of the primary health care system, for example the management of SCs, was given to PRIs. The NGO sector is wide and well established in the state. Nevertheless decision space is narrow (see Table 4.9). MOs have no autonomy to decide about the use of their budgets or contracts. All indicators for the finance function show a high degree of central control from the state and national government. The functions service organization, human resources, access rules and governance rules are also characterised through this control mechanism by the principal, what Silverman called the “top-down” principal agency (see 2.3.1.4.). The narrow decision space influences indicators for successful participation too. Low values for MOs for accountability and control over resources as well as the moderate value for responsibility can be linked to it (see Table 4.11). Communication and information transfer or motivation in turn are rather related to management failures or work organization within the public health system.

The degree of community participation is moderate in the two sample districts (see Table 4.10). Like in Himachal Pradesh and Maharashtra community is represented through powerful groups in the population and through NGOs. People participate as members of small collectives like PRIs, Mahila Mandals, SHGs or Block Health and Family Welfare Committees, which are established through government initiatives. Target groups for NGOs and the public health sector are relatively easy-to-reach people living in the two districts. Support of infrastructure and expand of outreach are again the foremost rational for community participation at the district level. Services offered to the community concentrate on educational activities like advice and consultation from the NGO side or on service delivery and involvement in management at the periphery from the MO side.

Although West Bengal has very different economical and social features from Maharashtra or Himachal Pradesh the indicators needed for successful participation have the same values, except for motivation of MOs (see Table 4.11). The features are neither better nor worse than in the other two states, even though West Bengal ranks second last in the performance study for public health services (see Table 3.1). Decentralization and community participation at the sub-district level seem to be either invariant to greater economical, social and political characteristics of states or the processes themselves have not reached these levels yet. Most indicators for NGOs point towards a high chance for successful participation. Accountability and control over resources taking a moderate degree are an exception. The dependency of NGOs in the two districts on funding from the state and from international agencies (see Figure 4.67) could be one reason for the minor relevance of community for these issues. The same two indicators are also problem areas for MOs. Lack of accountability and less control over resources for them can be linked to the lack of autonomy in decision making (see above). A high chance for successful participation from the public health system side only exists for the indicator experience. Most MOs have good experiences with participation but that does not seem to influence their motivation. Incentives and benefits would be needed to increase their motivation as without them successful participation will be difficult to achieve. The “top-

down” approach of the public health system to community participation was visible for all indicators. Their “target-oriented-frame” does not include empowerment of the community (see Rifkin 1996). The different perceptions of NGOs and the public health system about community participation are not only reflected in the indicators but also in their understanding of participation. While NGOs see their tasks in awareness-raising, information about rights and pressure to the public health system for better performance (see Figure 4.79), MOs want them to help with information and awareness activities (see Figure 4.75) to increase their utilization rates.

The indicators needed to evaluate the influence on quality of care in West Bengal’s districts have the same values as for Maharashtra and Himachal Pradesh. Therefore, Figure 4.25 which shows the range of indicators and their relation to quality of care for Himachal Pradesh is also applicable for West Bengal. Narrow decision space for MOs hinders their responsiveness to community demands. Their influence on participation is not high as communication and information transfer with the community is moderate (see Table 4.11). The “top-down” approach of the public health system could be seen as one reason for the middle degree of community participation (see Table 4.10). Empowerment of the community is hindered by this approach and cannot fully evolve under a middle degree of community participation. Low accountability and moderate responsiveness has already been linked to the lack of local autonomy above. The middle degree of participation and the low amount of empowerment further weaken accountability and responsiveness. The impact of all indicators on quality of care is thus low to moderate. It can be summarised that decentralization and community participation in the sample districts of West Bengal will not be able to improve the quality of health care. Since the researched areas are already deprived, the low quality of health care adds to their vulnerability. Comprehensive primary health care has not been achieved.

5 OUTLOOK – PRIMARY HEALTH CARE IN RURAL INDIA

Decentralization and community participation are the leading principles in India's new National Health Policy. More equity in health service provision and better quality of care are the proposed goals. The implementation of the two processes in India's rural health system was the focus of this work. Former policies to introduce decentralization and community participation had failed (see 2.2.3./ 2.3.4.). The major reason can be seen in the absence of process monitoring. Process monitoring generates information about the status of policy implementation at different scales and offers starting points for management changes (see Rifkin 1988). Understanding the process is necessary for the elimination of obstacles and the creation of problem solutions. Processes are not detached from space and place. Geography realizes that space as a social construct influences and is influenced by processes such as health policies. Geographical tools and methods are therefore appropriate for research in the health field. Medical geography has adopted a broader social geographic perspective in research as it looks into the social and political context of health (see 2.1.). The study of decentralization and community participation processes follows this approach. The research presented in this work only shows the status of health policy implementation at one point in time. Even though process monitoring requires continuous evaluation, this study is valuable because it recommends appropriate tools and can be used for further supervision.

Bossert's concept of decision space to assess decentralization (see Bossert 1998; 2.3.1.5.), Murthy and Klugman's approach to measure the degree of community participation (see Murthy/ Klugman 2004; 2.2.1.2.) and the new tool for the analysis of prerequisites for successful participation (see 2.3.2.2./ 4.1.2.) build the analytical framework for research based on the conceptual framework explained in the theoretical section (see 2.2.1./ 2.3.1.-2.3.2.). The analytical framework uses nominal data to quantify variables. Nominal data is less precise than ratio data, nevertheless, it can be used to check apparent and instrumental validity (see 2.1.). The value of variables mostly depends not on one set of data but rather on several, because the indicators cannot be easily measured (see 4.). Therefore, the results from the standardized questionnaires, from the non-standardized interviews and from participant observation were combined. The discussion of their characteristics adds up to the value of variables. Quantitative and qualitative methods were both important for the study, nonetheless, their significance changed during the process. While qualitative methods were essential to structure the research field at the beginning and to verify data in cross comparisons at the end of the study, quantitative methods delivered the bulk of primary data which helped to quantify variables.

The selection of case studies followed the sampling strategy of Miles and Huberman and criteria lined out by Curtis et al. (see Miles/ Huberman 1994; Curtis et al. 2000; 2.1.). Himachal Pradesh, Maharashtra, and West Bengal generated rich information on decentralization and community participation processes at a local scale (see 4.). All three sample states are in an early to middle health transition with Himachal Pradesh lacking behind. Diseases of the circulatory system are increasing, but communicable diseases

prevail. The health systems are organized in three-tiers, sub-centre, primary health centre and community health centre. Himachal Pradesh and West Bengal additionally have a block level. Quality of health care is negatively affected by the lack of facilities and doctors in the states. The excess of facilities and public health personnel in Himachal Pradesh does not create more provision since they are unevenly distributed. Remote rural areas in the states have the least resources in health services. Infrastructural deficiencies of the public health system in the researched areas, thus, obstruct health care delivery. The comparison of the three states is transferable to other Indian states with similar characteristics. Stage of health transition (see Table 3.2) and existence of decentralization and community participation policies in the public health system are the decisive factors.

The first research question concerns the status of decentralization. The degree of decentralization in the public health system is low in all three states (see 4.). The analysis showed that decision space is narrow for all indicators. High level of state or central control and less autonomy at the local level are symptomatic for all researched districts. District and sub-district levels are highly dependent on intergovernmental transfers of finance. The expenditure is explicitly earmarked and local authorities are not allowed to choose the range of prices. Hiring and firing permanent staff and contracting non-permanent staff are further decisions made at the state level. Rigid norms for local programmes and the definition of target population by higher authorities prevent adjustment to the specific local situation. It is important to note that limited decision space for public health personnel at the district level and below does not automatically imply deficits in health service provision. Evidence that quality of health care improves with the decentralization of health services is not sufficiently adduced (see 2.3.3.). However, in Himachal Pradesh, Maharashtra and West Bengal limited decision space affects responsiveness of the health system to community needs. Community needs are not only heterogeneous but they also change over time. Health policy needs to address all community groups and adapt to changes. Information for these changes has to come from the local level where social processes take place, but local health personnel has no influence on health policies (see 3.2.1.1.). Individual initiatives are further discouraged by strong hierarchies and lengthy authorization processes.

On the other hand, it has to be kept in mind that widening the decision space for local health personnel in the three states can even lead to a deterioration of service quality if it is not accompanied by other measures. Going back to the principal agent approach which forms the basis for the decision space approach, few points have to be made (see 2.3.1.4.). Local agents have different interests concerning health care. As individuals their actions are based on a wide range of considerations including income generation. To ensure that local agents not only act for their own benefit, monitoring and surveillance mechanisms have to be in place. Incentives and sanctions like performance based payments additionally ensure extrinsic motivation and can improve the quality of work. The studied health care systems in Himachal Pradesh, Maharashtra and West Bengal have monitoring and surveillance mechanisms in place, but loopholes exist (see 4.). Incentives and sanctions on the other hand are rare and need to be developed.

Since community participation is not only a concept on its own but also a result of decentralization, interdependencies exist. The second research question deals with the status of community participation. Community participation in the National Health Policy means that size, number, composition, and role of community participation are defined by law or higher authorities. The “top-down” approach to community participation as defined by Rifkin (Rifkin 1996; see 2.2.1.2.) has negative implications for the process. NGOs in all three states define community as relatively easy to reach people living in an area. Marginalized groups of the population are hardly addressed. According to Murthy and Klugman’s approach (Murthy/ Klugman 2004; see 2.2.1.2.) this stands for a middle degree of community participation. Furthermore, community in the researched districts is represented through powerful groups in the population or through NGOs. While community participation is perceived at the central or state government level as a means to increase effectiveness, improve accountability and as a right by itself, the opinion at the district administrative level is different. Community participation is here seen as a means to expand outreach, to raise resources and to support infrastructure, standing for a low degree of community participation. Participation is only possible as members of small collectives and/or through invitation by government. The scope is service delivery and management at the periphery, whereas depth of community participation reaches till advice and consultation. Although a middle degree of community participation is preferable to a lower degree, it is not sufficient for reaching equity in health care provision. The result for quality of health care is less accountability at the public health system side at the one hand, because community is not able to exercise control, and less support for public health initiatives from the community at the other for the same reasons. It is not clear if community participation can really improve health status of the population, because causal relationships are difficult to establish and scientific proof does not exist (see Rifkin 1988). Nevertheless, community participation encourages responsiveness of the public health system and therewith theoretically better service provision. However, better service provision depends as well on budgets and the political will.

When comparing the three case studies it becomes obvious that community participation cannot be initialized or commanded by the government. Government policies can only offer general conditions. Community participation is a difficult and complex process. Education for and awareness raising of the population, as tried by the National Health Policy through NGOs, might be able to enhance it (see 3.2.2.3./ 3.2.3.2.).

To understand why community participation only shows a middle degree, prerequisites for successful participation were analysed in the third research question. The map of participation splits the complexity of community participation in ascertainable indicators (see 4.1.2.). Interest in participation, communication and information transfer, responsiveness, motivation for participation, accountability, sustainability, control over resources, and experience of participation emerged from the conceptual framework in the theoretical section of this work as the important prerequisites for successful community participation (see 2.2.1./ 2.3.1.-2.3.2.). The range of indicators orientates itself on Rifkin’s approach of “top-down” and “bottom-up” community participation where “bottom-up” is the highest form of community participation (Rifkin 1996; see 2.2.1.2.). While indicators like

interest, motivation and experience engage with attitudes of the stakeholders, communication and information transfer, responsiveness, accountability, sustainability and control over resources are rather concerned with behaviour and organizational processes. The indicators are linked with each other. On the one hand attitude to community participation has an impact on individual behaviour and on organizational processes, on the other individual behaviour and organizational processes also influence attitudes. Needless to say that it is impossible to identify the most important indicator because of their relatedness. Only research can establish a hierarchy which depends on the specific cases.

In Himachal Pradesh, Maharashtra and West Bengal the range of indicators for Medical Officers and the public health system mostly pointed towards a moderate chance for successful participation. The influence of the governmental “top-down” approach to community participation manifests itself here. “Top-down” communication within the public health system and between the system and the community, responsiveness to community needs only as defined by the central programmes, accountability to higher authorities but not to local authorities or community, and no control over resources are barriers to community involvement. Accountability and control over resources have the lowest value. One reason is lack of decision space due to the strong hierarchical organization of the public health system (see above). As mentioned above the degree of decentralization also affects responsiveness and therewith quality of health care. To achieve sustainability community participation has to be anchored in the community itself. In none of the researched states community participation has reached that level, which is not surprising since it is an initiative of the government. But the government policy also has positive results. The attitude of Medical Officers and NGOs towards community participation is encouraging, communication and information transfer between the public health system and NGOs functions both ways. Communication improves cooperation and can change perceptions about the partner. Hence, NGO cooperation is perceived as helpful by Medical Officers in all three states. Even though Medical Officers are more interested in “top-down” participation, their experiences with participation are good.

For NGOs all indicators show a high chance for successful community participation except accountability and control over resources. Interest in “bottom-up” participation, demand oriented and culturally sensitive communication and information transfer with the community as well as open responsiveness to all community needs are characteristic for NGOs in Himachal Pradesh, Maharashtra and West Bengal. The positive outcomes can be explained with the specific features of NGOs. NGOs are organizations formed by community members and for community purposes. They are concerned with the social uplift of population. Therefore, they have already incorporated community participation as a principle. However, it has to be kept in mind that NGOs might not reflect all community interests and that they can also have a “top-down” approach. The dependency on funding from governmental sources and international funding agencies makes NGOs vulnerable to their policies. Accountability and control over resources therefore only stand for a moderate chance for successful community participation.

The most important indicator identified in the study of the three states is motivation. If stakeholders are not motivated to involve community, community participation cannot be successful. Motivation influences all other indicators and has a strong impact on the process. While NGOs are highly motivated for community participation, motivation at the Medical Officer side is only moderate. NGOs receive incentives and benefits for community participation from their funding agencies including the government on the one hand and from the community itself at the other. In engaging in community participation they experience extrinsic and intrinsic motivation, because community participation is one of their principles (see Metzger 2001; see 2.3.2.1.). Incentives and benefits from the government for Medical Officers are limited. Achieving the guidelines as proposed by the government produces extrinsic motivation. Nonetheless, since incentives and sanctions are hardly offered (see 4.), motivation stays low.

The analytical framework chosen for this research proved its usefulness in measuring and quantifying complex theories like decentralization and community participation. Furthermore, the frameworks generated generalizability of the results from the different states. Prerequisites for successful participation were identified with the map of participation. The tool was able to demonstrate attitude of stakeholders towards community participation and to display organizational processes linked with participation. In doing so hidden meanings could be uncovered.

The difference between the range of indicators for NGOs and for the public health system highlights disparity. The study of Himachal Pradesh, Maharashtra and West Bengal clearly indicates that both parties want community participation, but have a different understanding of the term. The joint goal is improvement of public health service quality. Stakeholders from the public health service see community participation as a method to reach compliance with their health guidelines. They want community to understand the medical reasons for diseases like lack of hygiene or poor nutrition and expect attitude change (see 4.). Better quality of health service for them can be translated into better health status of the population. At the same time they realize their shortcomings in infrastructure, budget and autonomy but do not see community participation as a solution to these problems. Community participation for NGOs in turn means empowerment. In their view the community should be able to express their needs for health services and therewith exercise pressure on the public health system for better services. Health infrastructure and service provision are intertwined for them and can be improved if enough pressure is applied. As different as the approaches are, both recognize education and awareness raising as the appropriate methods to develop community participation. The outcomes are education and awareness programmes for the population through NGOs funded by the government (see 3.2.3.2.). It is questionable that the result will be compliance. Firstly, NGOs have other intentions. Secondly, educational efforts do not necessarily lead to attitude change. It is also uncertain if community will act as a pressure group given its heterogeneous character. Furthermore, a pressure group does not automatically represent all community interests including those of marginalized groups.

The discussion above leads to the fourth research question if decentralization and participation in India can help to improve the quality of public health services in rural

areas. The impact on quality of health care has been defined by Atkinson (Atkinson et al. 2000). She states that the key feature of decentralization is “that increased local autonomy over decision-making combined with inputs of voice from the population to be served will increase the responsiveness of health care to local needs, accountability of the actions of the health system to its client population in terms both of the quality of care offered and the use of health system resources and also to social development goals of popular empowerment.” (Atkinson et al. 2000: 621; see 2.3.2.; Figure 2.5). The conditions for quality improvement are not fulfilled. Narrow decision space indicates that local autonomy has not increased. Inputs of voice from the population hardly take place as can be seen in the middle degree of participation. Thus, responsiveness stays moderate and accountability remains low (see Figure 4.25). The prerequisites for successful community participation have been discussed in detail. Community participation is far from reaching empowerment. It can be summarised that current decentralization and community participation policies in India are not able to improve the quality of public health services in rural areas.

ERKLÄRUNG

Ich versichere, dass ich die Arbeit selbständig verfasst habe, dass ich keine anderen Quellen und Hilfsmittel als die angegebenen benutzt und die Stellen der Arbeit, die anderen Werken dem Wortlaut oder dem Sinn nach entnommen sind, in jedem Fall als Entlehnung kenntlich gemacht habe. Das gleiche gilt auch für beigegebene Zeichnungen, Kartenskizzen, Fotos und Abbildungen.

Siegen, den 14.02.2006

ANNEX I - V

ANNEX I: QUESTIONNAIRE FOR MEDICAL OFFICER (23.09.2003)

GEOMED (Medical Geography and Health System Research)
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Place: _____ Date: _____ Time: _____

Purpose of research

We are doing a survey that is part of a PhD research by the University of Munich in Germany. We study which areas of public health care in rural areas of India can be improved by NGOs. There are no right or wrong answers, we just want to know your personal views. This questionnaire is anonymous, all answers will be kept confidential and results will only be used for a general discussion.

A. General Information about YOU:

1. Health service:
 - 1.1 How long are you working in the public health system: _____ years
 - 1.2 Since when are you placed at your current location: _____ years
2. At what kind of facility do you work:

<input type="checkbox"/> Primary Health Centre	<input type="checkbox"/> Sub-Centre
<input type="checkbox"/> Community Hospital/ Civil Hospital	<input type="checkbox"/> Secondary Hospital
<input type="checkbox"/> Other: _____	
3. What is your position:

<input type="checkbox"/> MPW	<input type="checkbox"/> Nurse	<input type="checkbox"/> MO	<input type="checkbox"/> BMO
<input type="checkbox"/> other: _____			
4. Population covered by your health facility: _____
5. Do you live at your health facility?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

If no, how long does it take you to reach work? _____ hours _____ minutes

B. General information about the health facility

6. Where is your health facility located?
 - 6.1. Distance from main village to next higher level of health facility:

<input type="checkbox"/> 0 - 20 km	<input type="checkbox"/> 21 - 40 km	<input type="checkbox"/> 41 - 60 km
<input type="checkbox"/> 61 - 80 km	<input type="checkbox"/> more then 80 km (approx. _____ km)	
 - 6.2 What is the average distance you travel in your area by car in one hour?

<input type="checkbox"/> 0-20 km	<input type="checkbox"/> 21-30 km	<input type="checkbox"/> 31-40 km	<input type="checkbox"/> 41-50 km
<input type="checkbox"/> more than 50 km			

7. What are the opening times of your facility for consultations?
- every day from _____ am to _____ pm and from _____ am to _____ pm
 - Monday to Friday
from _____ am to _____ pm and from _____ am to _____ pm
 - Saturday
from _____ am to _____ pm and from _____ am to _____ pm
 - Sunday from _____ am to _____ pm and from _____ am to _____ pm
- 8 Please indicate: My health facility has the following rooms/ facilities:
- | Rooms: | Facilities: |
|--|--|
| <input type="checkbox"/> Examination room | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Operation theatre | <input type="checkbox"/> Patient toilet |
| <input type="checkbox"/> Sick room/ hospital room | <input type="checkbox"/> Washbasin in each room |
| <input type="checkbox"/> Separate delivery room | <input type="checkbox"/> Sanitation facilities for staff |
| <input type="checkbox"/> Separate immunisation room | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Separate ward for men/women | <input type="checkbox"/> Fridge for medicaments |
| <input type="checkbox"/> Patient waiting room | <input type="checkbox"/> Ambulance |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Car |
| | <input type="checkbox"/> Telephone |
| | <input type="checkbox"/> Computer |
- 9 Water and electricity supply:
- 9.1 We have water for _____ hours a day.
- 9.2 We have electricity for _____ hours a day.
- 9.3 We have water shortage _____ month per year.
- 9.4 We have a water tank for storage: Yes No.
- 9.5 We have a diesel generator: Yes No.
- 9.6 We have a heating system: Yes No.
- 10 How often is your facility cleaned/ disinfected?
- every day 1 - 2 times a week
 - 3 - 4 times a week I don't know
- 11 How do you dispose your waste?
- 11.1 We have an incinerator.
- Yes No.
- 11.2 We dispose our waste on the usual dumping ground.
- Yes No.
- 11.3 We dispose our waste on a special dumping ground.
- Yes No.
- 11.4 We hired an external service for disposal.
- Yes No.
- 11.5 Other _____

12 How often gets your facility (all rooms) white washed?

- every _____ month I don't know

13 How is the equipment in your facility maintained?

13.1 We check the equipment every _____ month.

13.2 If something is broken:

13.2.1 We report it to our superior.

- Yes If yes He/ she takes all follow up action then.
 He/ she advices us what to do.

No

13.2.2 We call the Public Works Department.

- Yes If yes: It takes _____ weeks to get it repaired.
 No

13.2.3 We call an external repair service.

- Yes If yes: It takes _____ weeks to get it repaired.
 No

13.2.4 If something is broken and it cannot be repaired, we buy new equipment.

- Yes If yes: It takes _____ weeks to get a replacement.
 No If no: We cannot get a repair or replacement because
 of financial shortage.
 no permission.
 equipment is not available.
 nobody knows how to repair it.

14 How is the supply with medicaments organised?

14.1 We check the medicaments every _____ days.

14.2 Do you have an Essential Drug List?

- Yes No

14.3 Essential medicaments are...

- ...always available at our facility.
 ...mostly available at our facility.
 ...hardly available at our facility.
 ...not available at our facility.

14.4 If we run out of an essential medicament, we can get additional supply.

- Yes No

If yes: it takes _____ weeks to get fresh supply.

C. General Information about staff and work

15 If you work at a PHC, please indicate ...

15.1 The actual number of MOs _____ Proposed No. _____

15.2 The actual number of nurses _____ Proposed No. _____

15.3 How many of your Sub-Centres have no MPW? _____

15.4 How many of your Sub-Centres have one MPW?

15.5 How many of your Sub-Centres have two MPW (male/female)? _____

16 If you work at a hospital, please indicate...

16.1 The actual number of physicians _____ Proposed No. _____

16.2 The actual number of nurses _____ Proposed No. _____

If you are BMO please indicate...

16.3 How many of your PHCs have no MO? _____

16.4 How many of your PHCs have one MO? _____

16.5 How many of your PHCs have two MOs? _____

17 Do you have enough human resources?

Yes No

If no: where do you need more personnel?

I need more service personnel (sweeper, driver etc).

I need more nurses.

I need more MPWs.

I need more MOs.

I need more specialists, especially

gynaecologist

anaesthetist

lab assistant

I need more _____.

18 How is work organised at your facility?

18.1 Is a job description for each member of staff available at your facility?

Yes No

18.2 Does your facility have weekly working schedules for the staff?

Yes No

If no We have monthly working schedules.

We do not need that, everybody knows what to do.

18.3 Do you have staff meetings with all people working at your facility?

Yes, meetings take place every _____ weeks

No

18.4 Do you use guidelines for decisions about which medical treatment to give?

Yes If yes: We use guidelines given to us by the Ministry.

We developed our own guidelines.

We have a diagnosis-therapy-scheme.

We use Standard Treatment Guidelines.

- No
- 18.5 How do you document the visits of your patients? (all applying answers)
- Patients have health cards.
- Our facility keeps records of patients.
- Patients have health cards, but we keep records of chronic patients.
- We don't have a documentation system.
- We have health statistics in the form of:
- wall charts books
- other _____
- 19 How often do the following specialists visit your health facility?
- 19.1 The gynaecologist comes every _____ weeks.
- never.
- is always there.
- 19.2 The eye specialist comes every _____ weeks.
- never.
- is always there.
- 19.3 The dentist comes every _____ weeks.
- never.
- is always there.
- 20 How often does the health personnel of your facility get additional training for certain issues (e.g. reproductive health, HIV/AIDS, family planning etc)?
- 20.1 MPW get trained
- every _____ month every _____ years no training
- 20.2 Nurses get trained
- every _____ month every _____ years no training
- 20.3 Medical Officers get trained
- every _____ month every _____ years no training
- 21 How often does a health official who gives supervision visit your facility?
- once a month every _____ month
- never
- 22 How often do you visit your subordinated facilities?
- once a month every _____ month
- never
- 23 How often do you submit reports to your superior indicating the health situation in your area?
- once a month every _____ month
- never
- 23.1 Do you get feedback on those reports?
- Yes No
- 23.2 Are your reports used for health system planning at the district level or higher levels?
- Yes No I don't know

24 How often do you get reports from your subordinates indicating the health situation in their area?

- once a month every _____ month
 never

24.1 Do you give them feedback on their reports?

- Yes No

D. Information about your patients:

25 How many patients are coming to your health facility every day?: _____

26 Seasonal variations:

26.1 In summer _____ patients per day

26.2 In winter _____ patients per day

26.3 During monsoon _____ patients per day

26.4 After monsoon _____ patients per day

27 How many patients do you treat per day?

_____ patients treated per day

28 How long do you tend to a patient? approx. _____ minutes

29 Do you explain their health problem to them in detail?

- Yes No

If no, because: there is no time

too many people are waiting

patients will not understand anyway

other _____

30 How many deliveries are carried out in your facility per month?:

_____ deliveries per month

31 How many operations are carried out in your facility per month?:

_____ operations per month

32 How many referrals do you make per month?:

_____ referrals per month

33 What applies to your patients:

33.1 Gender:

- I have predominantly female patients (more than 50%)
 I have predominantly male patients (more than 50%)
 I have male and female patients (50% to 50%)

33.2 Age:

Most of my patients are (min. 1 answer- max. 2 answers)

- younger than 5 years.
 between 6 and 16 years.
 between 17 and 40 years.
 between 41 and 60 years.
 older than 60 years.

- 34 Do you have patients with health insurance coverage?
- Yes If yes, how many of your patients are insured? _____% of patients
- No
- 35 What are the major health problems in your area now? Please estimate cases per month (all applying answers):
- | | | | |
|-------|--------------------------|-------------------------------|----------------|
| 35.1 | <input type="checkbox"/> | Water borne diseases | _____per month |
| 35.2 | <input type="checkbox"/> | Malnutrition | _____per month |
| 35.3 | <input type="checkbox"/> | Diarrhoea | _____per month |
| 35.4 | <input type="checkbox"/> | Cardiovascular Problems | _____per month |
| 35.5 | <input type="checkbox"/> | Cancer | _____per month |
| 35.6 | <input type="checkbox"/> | Diabetes | _____per month |
| 35.7 | <input type="checkbox"/> | Leprosy | _____per month |
| 35.8 | <input type="checkbox"/> | Tuberculosis | _____per month |
| 35.9 | <input type="checkbox"/> | Jaundice/ Hepatitis | _____per month |
| 35.10 | <input type="checkbox"/> | Cholera | _____per month |
| 35.11 | <input type="checkbox"/> | Typhoid | _____per month |
| 35.12 | <input type="checkbox"/> | Malaria | _____per month |
| 35.13 | <input type="checkbox"/> | Filaria | _____per month |
| 35.14 | <input type="checkbox"/> | Reproductive Tract Infections | _____per month |
| 35.15 | <input type="checkbox"/> | HIV/ AIDS | _____per month |
| 35.16 | <input type="checkbox"/> | Accidents (Injuries) | _____per month |
| 35.17 | <input type="checkbox"/> | Flu, cold and cough | _____per month |
| 35.18 | <input type="checkbox"/> | Other: _____ | _____per month |
- 36 How do you plan your services?
- | | | | |
|------|---|------------------------------|-----------------------------|
| 36.1 | The Health Ministry does all the planning. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36.2 | The district headquarter does all planning. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36.3 | I deliver a plan to the district headquarter. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36.4 | Services are planned according to the needs of the respective population. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

E. General information about budget

- 37 How are finances organised at your institution?
- 37.1 Our patients pay a service fee of _____RS for registration, which covers...
- | | | | |
|--------------------------|-----------------------|--------------------------|-------------|
| <input type="checkbox"/> | ordinary consultation | <input type="checkbox"/> | medicaments |
| <input type="checkbox"/> | other _____ | | |
- 37.2 Do you have schemes for patients below the poverty line?
- | | | | |
|--------------------------|-----|--------------------------|----|
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
|--------------------------|-----|--------------------------|----|
- 38 How much budget does your health facility have?

38.1 Is the budget you have at your disposal:

- more than sufficient
- sufficient
- insufficient
- by far insufficient

38.2 How much of your budget is spent on

Staff salary _____% of total 100 %

Staff training _____% of total 100 %

Equipment _____% of total 100 %

Medicaments _____% of total 100 %

Health service _____% of total 100 %

Maintenance _____% of total 100 %

Other (_____) _____% of total 100 %

39 Decision about spending the health budget at your facility (all applying answers):

39.1 I can decide myself where _____% of the health budget at my facility will be spent. It is spent on _____.

39.2 The Ministry decides about _____% of the spending of health budget at my facility. It is spent on _____.

39.3 The District head office decides about _____% of the spending of health budget at my facility. It is spent on _____.

39.4 _____decides about _____% of the spending of health budget at my facility. It is spent on _____.

40 Who is financing your services?

40.1 My services are financed by (all applying answers):

- the State Health Ministry (_____ % of total budget)
- the National Indian Health Ministry (_____ % of total budget)
- user fees (_____ % of total budget)
- private donations from Indian companies (_____ % of total budget)
- international donors (_____ % of total budget)
- other (_____) (_____ % of total budget)

40.2 Donations are accepted in kind: Yes No

40.3 Donations are accepted in money: Yes No

F. Information about coordination and cooperation:

41 Do you coordinate your health care activities with the National Health Programmes?

- Yes If yes:

41.1 We do not offer services, which are already covered by the programmes.

- Yes No

41.2 We meet with people working in those programmes.

- Yes No

41.3 We coordinate our working schedules (e.g. visits to villages) with them.

Yes No

No.

42 Are their other health professionals working in your area?

Yes No

If yes, do you cooperate with them?

Yes No

If yes, with whom do you cooperate?

We cooperate with: Anganwadi workers
 Traditional birth attendants
 Pada workers
 Dais
 Private practitioners
 Traditional healers
 Community health committees
 Other _____

43 Do you work with the community?

Yes, we have contacts to: Panchayati Raj Institutions
 Schools
 NGOs
 Other _____

No.

44 How do you work with the community?

44.1 We organise meetings with the community leaders to discuss health issues.

Yes No

44.2 We give presentations about healthy behaviour to the general public at the village.

Yes No

44.3 We visit families in the villages to give advice on healthy lifestyle.

Yes No

44.4 We give health education for children at school.

Yes No

44.5 We ask the community to give feedback on our services.

Yes No

44.6 We promote our services in our service area.

Yes No

44.7 We assess the health needs of the community.

Yes No

45 Does your health facility have a board of control/ advisory committee?

Yes No

45.1 If yes, who is a member:

- Panchayati Raj Institutions
- Staff members (Specify : _____)
- Other (Specify : _____)

45.2 How often does the board of control/ advisory committee meet?

- It meets every _____ month.
- There are no regular meetings.
- I don't know.

45.3 Are decisions of the board of control/ advisory committee implemented in your health facility? (one answer)

- We implement all decisions made by the committee.
- We implement most decisions made by the committee.
- We can hardly implement decisions made by the committee.
- We cannot implement decisions made by the committee.

45.4 Do you find the board of control/ advisory committee:

- very useful for the functioning of your health facility
- useful for the functioning of your health facility
- hardly useful for the functioning of your health facility
- not useful for the functioning of your health facility

46 Have you heard of the Dept. of Family Welfare supported NGO schemes?

- Yes
- No

46.1 Do you know about NGOs working on health issues in your areas?

- Yes
- No

46.2 If yes, what do you think about these organizations?

46.2.1 NGOs speak out for the community.

- Yes
- No

46.2.2 NGOs are money-minded organizations.

- Yes
- No

46.2.3 NGOs do good work in health related sectors (e.g. sanitation, nutrition).

- Yes
- No

46.2.4 NGOs do have medical expertise.

- Yes
- No

46.3 Do you think NGOs could help you to improve your services?

- Yes, they could
 - inform the villagers about the services we offer.
 - inform the villagers about health risks.
 - give medication to the needy villager.
 - take over some of our services (e.g. _____).
 - control the quality of our service.
 - _____.

- No, because _____.
- 47 What do you know about the health behaviour of your patients?
- 47.1 Patients come to our facility when their disease is well advanced.
 True False
- 47.2 Patients take their medication as long as recommended by us.
 True False
- 47.3 Patients follow our advice.
 True False
- 47.4 Patients come for post-disease-check up when the medication is finished.
 True False
- 47.5 Patients always come for immunisation.
 True False
- 47.6 Patients use the tier of health service, which is closest to their home.
 True False
- 47.7 Patients consult us when the first symptoms arise.
 True False
- 47.8 Patients come again, if our service helped them.
 True False
- 47.9 Patients go to a higher-level health facility if our medication did not help.
 True False
- 47.10 Patients try for family advice first before they come to our facility.
 True False
- 47.11 Patients bypass our health facility and go directly to the hospital.
 True False
- 47.12 Patients hardly take our advice seriously.
 True False
- 47.13 Patients throw away medication when their symptoms have past.
 True False

G. Personal satisfaction

- 48 Are you satisfied with your work?
- I am very much satisfied with my work.
- I am satisfied with my work.
- I am not satisfied with some aspects of my work.
- I am not satisfied with my work.
- 48.1 Is your income for you:
- more than sufficient
- sufficient
- insufficient
- by far insufficient

48.2 Are your working conditions:

- very good, no improvements needed
- good, but could still be improved
- not so good, need some improvements
- bad, definitely need to be improved

48.3 What do you like about your work?

I like _____.

48.4 What do you dislike about your work?

I dislike _____.

48.5 What changes do you recommend to improve the service of your health facility?

- I would like to have
- more decision-making power over financial issues.
 - more budget at my disposal.
 - better medicine supply.
 - more interaction with health professionals in my area.
 - better communication with my superiors.
 - better communication with the patients.
 - better information about health demands of population.
 - higher service fees.
 - more personnel.
 - better infrastructure and facilities.
 - more autonomy and space for self-management.
 - a better patient documentation system.
 - _____.
 - _____.
 - _____.

Thank you very much for your cooperation!

ANNEX II: QUESTIONNAIRE FOR NGOS (23.09.2003)

GEOMED (Medical Geography and Health System Research)
LMU München, Department of Geoscience, Luisenstr. 37, 80 333
Munich, Germany

Researcher: Anja Welschhoff
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Website: <http://www.uni-bonn.de/geomed>

Place: _____ Date: _____ Time: _____

Purpose of research

We are doing a survey that is part of a PhD research by the University of Munich in Germany. We study which areas of public health care in rural areas of India can be improved by NGOs. There are no right or wrong answers, we just want to know your personal views. This questionnaire is anonymous, all answers will be kept confidential and results will only be used for a general discussion.

General information about your organization:

1. What is the name of your organization? _____
2. When was it founded? _____
3. How long are you working there? _____ years
4. Where does your organization work? (state, district, city)

5. Under which acts is your organization registered? (all applying answers)
 - Society Registration Act
 - Trust Registration Act
 - Foreign Contribution Regulation Act (FCRA)
 - Other: _____
6. How many people work for your organization? _____
7. Who is funding your projects?
 - State government
 - International
 - Central government
 - donor organization: _____
 - Membership fees
 - Other _____
 - Community served
8. What are your main working areas? (all applying answers)
 - welfare activities
 - health
 - women employment
 - human rights/ women rights

- Other _____
9. Why have you started working on health issues?
- Community approached us to do so.
 - We did a survey to identify problem areas.
 - The success of our other activities is dependent on health.
 - We realised that this is important, because the health situation was so bad.
 - We realised that this is important, because _____.
 - Other: _____.
10. What are your main focus areas in health? (all applying answers)
- Health in general
 - Women/ Child Health
 - Primary health care
 - Other: _____
 - AIDS/ STD
 - Environmental health
 - Tuberculosis
11. Who is your target group (people you are working with)? (all applying answers)
- General population
 - Children
 - Other _____
 - Women
 - Worker
 - Men
 - Immigrants
12. How many people are affected by your programmes?
Approx. _____

General question about target population:

13. What are the major health problems of your target population?
- Water borne diseases
 - Diarrhoea
 - Cancer
 - Leprosy
 - Jaundice/ Hepatitis
 - Typhoid
 - Filaria
 - HIV/ AIDS
 - Flu, cold and cough
 - Malnutrition
 - Cardiovascular Problems
 - Diabetes
 - Tuberculosis
 - Cholera
 - Malaria
 - Reproductive Tract Infections
 - Accidents (Injuries)
 - Other: _____
14. Why do people have these health problems? (your opinions)
- not enough personal hygiene
 - not enough sanitation facilities
 - not enough infrastructure (water supply etc)
 - not enough knowledge about healthy behaviour
 - people are poor
 - public health system is not meeting their needs

- other _____
15. How significant is health for the communities you are working with?
- health is very important for them, more than any other issue
 - health is important to them, but it competes with other issues
 - health is not so important to them, other issues come first
 - health is not at all important for them, they do not think about it
16. Has the significance changed during your work with the community?
- Yes If yes: it is more important today
 - it is less important today
 - No
17. What health services do people predominantly use?
- public health service
 - private health service
 - traditional healers
 - quacks
 - other _____
18. What influences their decision to use one or the other system? (all applying answers) They are predominantly influenced by:
- price of health service distance to facility
 - quality of health service availability of health personnel
 - availability of medicine attitude of health staff
 - other _____
19. Are people satisfied with the services they have at their disposal?
- they are very much satisfied
 - they are satisfied
 - they are indifferent
 - they are not satisfied
 - they are not at all satisfied
- 19.1 If they are not satisfied, please give reasons why that is so:
- Public health system:
- too expensive
 - health facilities too far from home
 - health staff does not take them seriously
 - doctor does not explain treatment
 - medicaments are not given
 - waiting time is too long
 - hygiene of facility is not good

- treatment does not help them
- other _____

Private health system:

- too expensive
- health facilities too far from home
- health staff does not take them seriously
- doctor does not explain treatment
- medicaments are not given
- waiting time is too long
- hygiene of facility is not good
- treatment does not help them
- other _____

Information about your work:

20. How do you organise your work?

20.1 Do you assess the needs of the community?

- Yes No

If yes: how do you assess it?

- quantitative questionnaire discussion with community
- interviews data analysis
- other: _____

20.2 Do you inform yourself about health issues?

- Yes No

If yes: how do you inform yourself?

- reading science magazines reading newspaper
- reading health books watching television
- reading health brochures
- asking health professional
- other: _____

20.3 Does your organization give you training or organises training from other institutions for you about specific health issues or working methods?

- Yes No

If yes: What kind of training did you receive? I got trained in:

- data collection data analysis
- interviewing giving presentations
- holding workshops laws and regulations
- project management financial management

- health issues: _____
- other: _____

21. How do you work with the community?

21.1 We do workshops with our target population.

- Yes No

21.2 We give out information leaflets.

- Yes No

21.3 We give presentations on health issues.

- Yes No

21.4 We show poster to inform them.

- Yes No

21.5 We discuss health issues with them.

- Yes No

21.6 We do theatre plays about health issues.

- Yes No

21.7 We show information movies.

- Yes No

21.8 We train people from the community in awareness raising.

- Yes No

21.9 Other: _____

22. How do you reach out to the community?

- We organise health camps. We go to panchayat meetings.
- We go to schools. We go to PHCs.
- We organise events. _____
- Other: _____

23. What services do you offer to the community?

- health check up information on health issues
- personal referral assistance when visiting the doctor
- free medicine help in health decision making
- other: _____

24. Why in your opinion does the community cooperate with you? They expect:

- financial gains to be better informed
- health gains empowerment
- more influence on the public health system
- other: _____

25. Do you cooperate with other institutions?

- Yes No

25.1 If yes: with whom do you cooperate? We cooperate with:

- state government district officials
 Medical Officers (MO) Multi-purpose worker (MPW)
 DAIS
 Traditional Birth Attendants (TBA)
 Anganwadi workers private practitioners
 traditional healers community health committees
 panchayat women groups
 international organizations: _____
 other _____

25.2 If yes: how do you cooperate with them?

- We exchange information.
 We plan our work together.
 We discuss problems together and search for solutions.
 We organise events together (health camps etc).
 They monitor our performance. (who? _____)
 We monitor their performance. (who? _____)

NGOs and the public health system:

26. What do think about the involvement of NGOs in national health programmes?

26.1 General:

26.1.1 It is just about time that NGOs got recognised by the government.

- Yes No

26.1.2 NGOs can do much better work than government employees.

- Yes No

26.1.3 NGOs should be a substantial part in all national health programmes.

- Yes No

26.2 Performance:

- NGOs can improve the performance of national health programmes enormously.
 NGOs can improve the performance of national health programmes.
 NGOs cannot improve the performance of national health programmes.

27. Can NGOs and government institutions work together well?

27.1 They can work together well on national or state level.

- Yes No

27.2 They can work together well on the basis (PHC level).

- Yes No

28. How can your organization help to improve the public health system in rural areas?

- inform villagers about their rights
- control work absenteeism (MO, MPW)
- motivate public health personnel
- pressure public health system for better performance
- make public health system aware of community needs
- help community to complain about missing infrastructure/ health service
- fight corruption
- other: _____

29. How can NGOs in general help to improve the public health system in rural areas?

- inform villagers about their rights
- control work absenteeism (MO, MPW)
- motivate public health personnel
- pressure public health system for better performance
- make public health system aware of community needs
- help community to complain about missing infrastructure/ health service
- fight corruption
- other: _____

30. What kind of cooperations with the public health system could be possible?

Cooperation between NGO and

- | | |
|--|---|
| <input type="checkbox"/> state government | <input type="checkbox"/> district officials |
| <input type="checkbox"/> Medical Officers (MO) | <input type="checkbox"/> Multi-purpose worker (MPW) |
| <input type="checkbox"/> DAIS | <input type="checkbox"/> Anganwadi workers |
| <input type="checkbox"/> other: _____ | |

31. What are the obstacles NGOs have to face now when they want to cooperate with the public system?

- distrust by government officials
- shortage of funds
- funds only available for specific areas
- laws and regulations
- the following: _____

- I don't know.
32. What laws/ regulations have to be changed to enhance cooperation?
- None
 - The following: _____.
 - I don't know.

Thank you very much for your cooperation!!!

ANNEX III: QUESTIONNAIRE FOR MEDICAL OFFICERS (19.11.2003)

GEOMED (Medical Geography and Health System Research)
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Luisenstr. 37, 80 333 Munich, Germany

Researcher: Anja Welschhoff
E-mail: Welschhoff@hotmail.com
Website: <http://www.uni-bonn.de/geomed>

Place: _____ Date: _____ Time: _____

Purpose of research

We are doing a survey that is part of a PhD research by the University of Munich in Germany. We study which areas of public health care in rural areas of India can be improved by NGOs. There are no right or wrong answers, we just want to know your personal views. This questionnaire is anonymous, all answers will be kept confidential and results will only be used for a general discussion.

A. General Information about YOU:

1. Health service:
 - 1.1 How long are you working in the public health system: _____ years
 - 1.2 Since when are you placed at your current location: _____ years
2. At what kind of facility do you work:

<input type="checkbox"/> Primary Health Centre	<input type="checkbox"/> Sub-Centre
<input type="checkbox"/> Community Health Centre	<input type="checkbox"/> Civil Hospital
<input type="checkbox"/> Other: _____	
3. What is your position:

<input type="checkbox"/> MPW	<input type="checkbox"/> Nurse	<input type="checkbox"/> MO	<input type="checkbox"/> BMO
<input type="checkbox"/> other: _____			
4. Population covered by your health facility: _____
5. Do you live at your health facility?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

 If no, how long does it take you to reach work? _____ hours _____ minutes

B. General information about the health facility

6. Where is your health facility located?
 - 6.1. Distance from main village to next higher level of health facility:

<input type="checkbox"/> 0 - 20 km	<input type="checkbox"/> 21 - 40 km	<input type="checkbox"/> 41 - 60 km
<input type="checkbox"/> 61 - 80 km	<input type="checkbox"/> more then 80 km (approx. _____ km)	
 - 6.2 What is the average distance you travel in your area by car in one hour?

<input type="checkbox"/> 0-20 km	<input type="checkbox"/> 21-30 km	<input type="checkbox"/> 31-40 km	<input type="checkbox"/> 41-50 km
<input type="checkbox"/> more than 50 km			

7. What are the opening times of your facility for consultations?
- every day from _____ am to _____ pm and from _____ am to _____ pm
 - Monday to Friday
from _____ am to _____ pm and from _____ am to _____ pm
 - Saturday
from _____ am to _____ pm and from _____ am to _____ pm
 - Sunday from _____ am to _____ pm and from _____ am to _____ pm
 - Emergency Services from _____ am to _____ pm
8. Please indicate: My health facility has the following rooms/ facilities which are fully functioning:
- | Rooms: | Facilities: |
|--|--|
| <input type="checkbox"/> Examination room | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Operation theatre | <input type="checkbox"/> Patient toilet |
| <input type="checkbox"/> (for PHCs) Sick room | <input type="checkbox"/> Washbasin in each room |
| <input type="checkbox"/> Separate delivery room | <input type="checkbox"/> Sanitation facilities for staff |
| <input type="checkbox"/> Separate immunisation room | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Separate ward for men/women | <input type="checkbox"/> Fridge for medicaments |
| <input type="checkbox"/> Patient waiting room | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Ambulance |
| | <input type="checkbox"/> Car |
| | <input type="checkbox"/> Telephone |
| | <input type="checkbox"/> Computer |
9. How many beds do you have in your facility? _____ beds
10. Water and electricity supply:
- 10.1 We have water for _____ hours a day.
- 10.2 We have electricity for _____ hours a day.
- 10.3 We have water shortage _____ month per year.
- 10.4 We have a water tank for storage: Yes No.
- 10.5 We have a diesel generator: Yes No.
- 10.6 We have heaters: Yes No.
11. How often is your facility cleaned/ disinfected?
- every day 1 - 2 times a week
 - 3 - 4 times a week I don't know
12. How do you dispose your waste (all applying answers)?
- 12.1 We have an incinerator.
 Yes No.
- 12.2 We dispose our waste on the usual dumping ground.
 Yes No.
- 12.3 We dispose our waste on a special dumping ground.
 Yes No.

- 12.4 We hired an external service for disposal.
 Yes No.
- 12.5 We bury our waste (deep burial).
 Yes No.
- 12.6 We burn our waste openly (burning).
 Yes No.
- 12.7 Other _____
13. How often gets your facility (all rooms) white washed?
 every _____ month I don't know never
14. How is the equipment in your facility maintained?
- 14.1 We check the equipment every _____ month.
- 14.2 If something is broken:
- 14.2.1 We report it to our superior.
 Yes If yes He/ she takes all follow up action then.
 He/ she advices us what to do.
- No
- 14.2.2 We call the Public Works Department.
 Yes If yes: It takes _____ weeks to get it repaired.
 No
- 14.2.3 We call an external repair service.
 Yes If yes: It takes _____ weeks to get it repaired.
 No
- 14.2.4 If something is broken and it cannot be repaired, we buy new equipment.
 Yes If yes: It takes _____ weeks to get a replacement.
 No If no: We cannot get a repair or replacement because
 of financial shortage.
 no permission.
 equipment is not available.
 nobody knows how to repair it.
15. How is the supply with medicaments organised?
- 15.1 We check the medicaments every _____ days.
- 15.2 Do you have an Essential Drug List?
 Yes No
- 15.3 Essential medicaments are...
 ...always available at our facility.
 ...mostly available at our facility.
 ...hardly available at our facility.
 ...not available at our facility.

15.4 If we run out of an essential medicament, we can get additional supply.

- Yes No

If yes: it takes _____ weeks to get fresh supply.

C. General Information about staff and work

16 If you work at a PHC, please indicate ...

16.1 The actual number of MOs _____ Proposed No. _____

16.2 The actual number of nurses _____ Proposed No. _____

16.3 How many of your Sub-Centres have no MPW? _____

16.4 How many of your Sub-Centres have one MPW? _____

16.5 How many of your Sub-Centres have two MPW (male/female)? _____

17 If you work at a CHC or CH, please indicate...

17.1 The actual number of MOs _____ Proposed No. _____

17.2 The actual number of nurses _____ Proposed No. _____

If you are BMO please indicate...(also answer 16.3 – 16.5)

17.3 How many of your PHCs have no MO? _____

17.4 How many of your PHCs have one MO? _____

17.5 How many of your PHCs have two MOs? _____

18 Do you have enough human resources?

- Yes No

If no: where do you need more personnel?

I need more service personnel (sweeper, driver etc).

I need more nurses.

I need more MPWs.

I need more MOs.

I need more specialists, especially

gynaecologist

anaesthetist

lab assistant

pharmacist

I need more _____.

19 How is work organised at your facility?

19.1 Is a job description for each member of staff available at your facility?

- Yes No

19.2 Does your facility have weekly working schedules for the staff?

- Yes No

If no We have monthly working schedules.

We do not need that, everybody knows what to do.

19.3 Do you have staff meetings with all people working at your facility?

Yes, meetings take place every _____ weeks

No

19.4 Do you use guidelines for decisions about which medical treatment to give?

- Yes If yes: We use guidelines given to us by the Ministry.
 We developed our own guidelines.
 We have a diagnosis-therapy-scheme.
 We use Standard Treatment Guidelines.
- No

19.5 How do you document the visits of your patients? (all applying answers)

- Patients have health cards.
 We use OPD slips.
 Our facility keeps records of patients.
 Patients have health cards, but we keep records of chronic patients.
 We don't have a documentation system.
 We have health statistics in the form of:
 wall charts books register
 other _____

20 How often do the following specialists visit your health facility?

20.1 The gynaecologist comes every _____ weeks.

- never.
 is always there.

The next gynaecologist is _____ km from here.

20.2 The eye specialist comes every _____ weeks.

- never.
 is always there.

The next eye specialist is _____ km from here.

20.3 The dentist comes every _____ weeks.

- never.
 is always there.

The next dentist is _____ km from here.

21 How often does the health personnel of your facility get additional training for certain issues (e.g. reproductive health, HIV/AIDS, family planning etc)?

21.1 MPW get trained

- every _____ month every _____ years no training
 no schedule, but approx. _____ times a year.

21.2 Nurses get trained

- every _____ month every _____ years no training
 no schedule, but approx. _____ times a year.

21.3 Medical Officers get trained

- every _____ month every _____ years no training
 no schedule, but approx. _____ times a year.

- 22 How often does a health official who gives supervision visit your facility?
- once a month every _____ month
- never
- 23 How often do you visit your subordinated facilities?
- once a month every _____ month
- never
- 24 How often do you submit reports to your superior indicating the health situation in your area?
- once a month every _____ month
- never
- 24.1 Do you get feedback on those reports?
- Yes No
- 24.2 Are your reports used for health system planning at the district level or higher levels?
- Yes No I don't know
- 25 How often do you get reports from your subordinates indicating the health situation in their area?
- once a month every _____ month
- never
- 25.1 Do you give them feedback on their reports?
- Yes No
- 25.2 How much are your subordinates motivated to work in your opinion? (only one answer!)
- very much motivated
- motivated
- indifferent to their work
- not much motivated
- not motivated at all

D. Information about your patients:

- 26 How many patients are coming to your health facility every day?: _____
- 27 Seasonal variations:
- 27.1 In summer _____ patients per day
- 27.2 In winter _____ patients per day
- 27.3 During monsoon _____ patients per day
- 27.4 After monsoon _____ patients per day
- 28 How many patients do you treat per day?
- _____ patients treated per day
- 29 How long do you tend to a patient? approx. _____ minutes
- 30 Do you explain their health problem to them in detail?
- Yes No

- If no, because: there is no time
 too many people are waiting
 patients will not understand anyway
 other _____
- 31 How many deliveries are carried out in your facility per month?:
 _____ deliveries per month
- 32 How many operations are carried out in your facility per month?:
 _____ operations per month
- 33 How many referrals do you make per month?:
 _____ referrals per month
- 34 What applies to your patients:
- 34.1 Gender:
- I have predominantly female patients (more than 50%)
 I have predominantly male patients (more than 50%)
 I have male and female patients (50% to 50%)
- 34.2 Age: Most of my patients are (min. 1 answer- max. 2 answers)
- younger than 5 years.
 between 6 and 16 years.
 between 17 and 40 years.
 between 41 and 60 years.
 older than 60 years.
- 35 Do you have patients with health insurance coverage?
- Yes If yes, how many of your patients are insured? _____ % of patients
 No
- 36 What are the major health problems in your area now? Please estimate cases per month (all applying answers):
- 36.1 Water borne diseases _____ per month
 36.2 Malnutrition _____ per month
 36.3 Diarrhoea _____ per month
 36.4 Cardiovascular Problems _____ per month
 36.5 Cancer _____ per month
 36.6 Diabetes _____ per month
 36.7 Leprosy _____ per month
 36.8 Tuberculosis _____ per month
 36.9 Jaundice/ Hepatitis _____ per month
 36.10 Cholera _____ per month
 36.11 Typhoid _____ per month
 36.12 Malaria _____ per month
 36.13 Filaria _____ per month
 36.14 Reproductive Tract Infections _____ per month

- 36.15 HIV/ AIDS _____per month
 36.16 Accidents (Injuries) _____per month
 36.17 Flu, cold and cough _____per month
 36.18 Respiratory Tract Infections _____per month
 36.19 Other: _____per month

37 How do you plan your services?

- 37.1 The Health Ministry does all the planning. Yes No
 37.2 The district headquarter does all planning. Yes No
 37.3 I deliver a plan to the district headquarter. Yes No
 37.4 Services are planned according to the needs of the respective population.
 Yes No

38 Do you receive complaints from patients?

- Yes No
- 38.1 Are these complaints: verbal or written
- 38.2 If yes: What do they complain about? They complain about:
- attitude of staff lack of medicine
 lack of equipment treatment given
 hygiene

- 38.3 What do you do with these complaints?
1. I write a report to my supervisor.
 Yes, because _____
 No, because _____
2. I follow up the complaint.
 Yes, because _____
 No, because _____
3. I meet with the person who complains.
 Yes, because _____
 No, because _____
4. I investigate if the complaint is true.
 Yes, because _____
 No, because _____

E. General information about budget

39 How are finances organised at your institution?

- 39.1 Our patients pay a service fee of _____RS for registration, which covers...
- ordinary consultation medicaments
 other _____

39.2 Do you have schemes for patients below the poverty line?

- Yes No

40 How much allotted budget does your health facility have?

40.1 Is the budget you have at your disposal (only one answer):

- more than sufficient
 sufficient
 insufficient
 by far insufficient

40.2 Donations are accepted in kind: Yes No

40.3 Donations are accepted in money: Yes No

F. Information about coordination and cooperation:

41 Do you coordinate your health care activities with the National Health Programmes?

- Yes No

If yes:

41.1 We run all National Health Programmes in our service area.

- Yes No

If no: We coordinate some of the activities.

We have nothing to do with the programmes.

If yes: What kind of activities do you do?

- eye camps immunisation camps
 RCH camps health check up camps
 other _____

Who helps you to organise these activities? (all applying answers)

- Anganwadi workers Traditional birth attendants
 Pada workers Dais
 Private practitioners Traditional healers
 Ayuverdic System of Medicine Panchayati Raj Institutions
 Mahila Mandals Self- help groups
 Block Development Committee NGOs
 Community health committees/ Parikas
 Other _____

41.2 We meet with other people involved in those programmes.

- Yes No

41.3 We coordinate our working schedules (e.g. visits to villages) with them.

- Yes No

42 What other services are available in your area? Which services do people preferably use?

	Available	Prefered by people
• Private practitioner	<input type="checkbox"/>	<input type="checkbox"/>
• Traditional healer	<input type="checkbox"/>	<input type="checkbox"/>
• Quack	<input type="checkbox"/>	<input type="checkbox"/>
• Private pharmacist	<input type="checkbox"/>	<input type="checkbox"/>
• Other _____	<input type="checkbox"/>	<input type="checkbox"/>

43 Are their other health professionals working in your area?

- Yes No

If yes, do you cooperate with them?

- Yes No

If yes, with whom do you cooperate and how good is the cooperation?

- Anganwadi workers

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Traditional birth attendants/ DAIS

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Pada workers

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Private practitioners

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Traditional healers

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Community health committees/ Parikas

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Ayuverdic System of Medicine

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Other _____

<input type="checkbox"/>				
very good	good	ok	not so good	bad

44 Do you work with the community?

- Yes, we cooperate with: No.

- Panchayati Raj Institutions and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Mahila Mandals and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Self- help groups and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Schools and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- NGOs and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Block Development Committee and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- Other _____ and the cooperation is

<input type="checkbox"/>				
very good	good	ok	not so good	bad

45 How is the cooperation within your department and with other departments?

- cooperation with superiors

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- cooperation with subordinates

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- cooperation with equals

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- cooperation with PWD

<input type="checkbox"/>				
very good	good	ok	not so good	bad

- cooperation with _____ (which department?)

<input type="checkbox"/>				
very good	good	ok	not so good	bad

46 How do you work with the community?

46.1 We organise meetings with the community leaders to discuss health issues.

- Yes, approx. _____ times a year No

46.2 We give presentations about healthy behaviour to the general public at the village.

- Yes, approx. _____ times a year No

46.3 We visit families in the villages to give advice on healthy lifestyle.

- Yes, approx. _____ times a year No

46.4 We give health education for children at school.

- Yes, approx. _____ times a year No

46.5 We ask the community to give feedback on our services.

- Yes, approx. _____ times a year No

46.6 We promote our services in our service area.

- Yes, approx. _____ times a year No

46.7 We assess the health needs of the community.

- Yes, approx. every _____ months No

47 Does your health facility have a board of control/ advisory committee?

- Yes No

47.1 If yes, who is a member:

- Panchayati Raj Institutions
 Block Development Committee
 Subdivisional Magistrate
 PWD
 Staff members

Specify : MO Nurse MPW
 Pharmacist health supervisor
 other _____

- Other (Specify : _____)

47.2 How often does the board of control/ advisory committee meet?

- It meets every _____ month.
 There are no regular meetings.
 I don't know.

47.3 Are decisions of the board of control/ advisory committee implemented in your health facility? (one answer)

- We implement all decisions made by the committee.
 We implement most decisions made by the committee.
 We can hardly implement decisions made by the committee.
 We cannot implement decisions made by the committee.

47.4 Do you find the board of control/ advisory committee: (one answer)

- very useful for the functioning of your health facility
 useful for the functioning of your health facility

51 What do you know about the health behaviour of your patients?

51.1 Patients come to our facility when their disease is well advanced.

 True False

51.2 Patients take their medication as long as recommended by us.

 True False

51.3 Patients follow our advice.

 True False

51.4 Patients come for post-disease-check up when the medication is finished.

 True False

51.5 Patients always come for immunisation.

 True False

51.6 Patients use the tier of health service, which is closest to their home.

 True False

51.7 Patients consult us when the first symptoms arise.

 True False

51.8 Patients come again, if our service helped them.

 True False

51.9 Patients go to a higher-level health facility if our medication did not help.

 True False

51.10 Patients try for family advice first before they come to our facility.

 True False

51.11 Patients bypass our health facility and go directly to the hospital.

 True False

51.12 Patients hardly take our advice seriously.

 True False

51.13 Patients throw away medication when their symptoms have past.

 True False

52 What do you think is most_important to your patients for choosing public health services?

52.1 free service is

<input type="checkbox"/>				
very important	important	not so important	not important	I don't know

52.2 free medicine is

<input type="checkbox"/>				
very important	important	not so important	not important	I don't know

52.3 hygiene of facility is

<input type="checkbox"/> very important	<input type="checkbox"/> important	<input type="checkbox"/> not so important	<input type="checkbox"/> not important	<input type="checkbox"/> I don't know
---	---------------------------------------	---	--	--

52.4 attitude of staff is

<input type="checkbox"/> very important	<input type="checkbox"/> important	<input type="checkbox"/> not so important	<input type="checkbox"/> not important	<input type="checkbox"/> I don't know
---	---------------------------------------	---	--	--

52.5 receiving information about health is

<input type="checkbox"/> very important	<input type="checkbox"/> important	<input type="checkbox"/> not so important	<input type="checkbox"/> not important	<input type="checkbox"/> I don't know
---	---------------------------------------	---	--	--

G. Personal satisfaction

53 Are you satisfied with your work? (one answer)

- I am very much satisfied with my work.
- I am satisfied with my work.
- I am not satisfied with some aspects of my work.
- I am not satisfied with my work.

53.1 What problems do you encounter? (all applying answers)

- I face the following problems:
- work overburden
 - political interference
 - unmotivated staff
 - lack of infrastructure/ equipment
 - lack of medicine
 - lack of staff
 - no budget for repairs
 - no financial powers
 - ignorant patients
 - _____

53.2 Is your income for you: (one answer)

- more than sufficient
- sufficient
- insufficient
- by far insufficient

53.3 Are your working conditions: (one answer)

- very good, no improvements needed
- good, but could still be improved
- not so good, need some improvements
- bad, definitely need to be improved

53.4 What do you like about your work?

I like _____.

53.5 What do you dislike about your work?

I dislike _____.

53.6 What changes do you recommend to improve the service of your health facility?

- I would like to have
- more decision-making power over financial issues.
 - more budget at my disposal.
 - better medicine supply.
 - more interaction with health professionals in my area.
 - better communication with my superiors.
 - better communication with the patients.
 - better information about health demands of population.
 - higher service fees.
 - more personnel.
 - better infrastructure and facilities.
 - more autonomy and space for self-management.
 - a better patient documentation system.
 - _____.
 - _____.
 - _____.

Thank you very much for your cooperation!

ANNEX IV: QUESTIONNAIRE FOR NGOS (19.11.2003)

GEOMED (Medical Geography and Health System Research)
LMU München, Department of Geoscience
Luisenstr. 37, 80 333 Munich, Germany

Researcher: Anja Welschhoff
E-mail: Welschhoff@hotmail.com
Website: <http://www.uni-bonn.de/geomed>

Place: _____ Date: _____ Time: _____

Purpose of research

We are doing a survey that is part of a PhD research by the University of Munich in Germany. We study which areas of public health care in rural areas of India can be improved by NGOs. There are no right or wrong answers, we just want to know your personal views. This questionnaire is anonymous, all answers will be kept confidential and results will only be used for a general discussion.

General information about your organization:

1. What is the name of your organization? _____
1. When was it founded? _____
2. How long are you working there? _____ years
3. Where does your organization work? (state, district, city)

4. Under which acts is your organization registered? (all applying answers)
 - Society Registration Act
 - Trust Registration Act
 - Foreign Contribution Regulation Act (FCRA)
 - Other: _____
5. How many people work fulltime for your organization? _____
6. Who is funding your projects?
 - State government
 - International donor organization: _____
 - Membership fees
 - Central government
 - Community served
 - Other _____

7. To whom are you accountable? We are accountable (projects and budget) to (all applying answers):

- | | |
|---|---|
| <input type="checkbox"/> own organization/ director | <input type="checkbox"/> donor agencies |
| <input type="checkbox"/> own board of control | <input type="checkbox"/> community |
| <input type="checkbox"/> external board of control | <input type="checkbox"/> nobody |
| <input type="checkbox"/> other _____ | |

8. What are your main working areas? (all applying answers)

- | | |
|---|--|
| <input type="checkbox"/> welfare activities | <input type="checkbox"/> women employment |
| <input type="checkbox"/> health | <input type="checkbox"/> human/ women/ children rights |
| <input type="checkbox"/> rural development | <input type="checkbox"/> environment |
| <input type="checkbox"/> watershed management | <input type="checkbox"/> community mobilisation |
| <input type="checkbox"/> Other _____ | |

9. When have you started working on health issues? _____ year

10. Why have you started working on health issues? (all applying answers)

- Funding was available for this subject.
- Community approached us to do so.
- Donor organization approached us to do so.
- We did a survey to identify problem areas and health was the major issue.
- The success of our other activities is dependent on health.
- We realised that this is important, because the health situation was so bad.
- We realised that this is important, because _____.
- Other: _____.

11. What are your main focus areas in health? (all applying answers)

- | | |
|--|---|
| <input type="checkbox"/> Health in general | <input type="checkbox"/> AIDS/ STD |
| <input type="checkbox"/> Women/ Child Health | <input type="checkbox"/> Environmental health |
| <input type="checkbox"/> Primary health care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> RCH | <input type="checkbox"/> Health insurance |
| <input type="checkbox"/> Other: _____ | |

12. Who is your target group (people you are working with)? (all applying answers)

- | | | |
|---|---------------------------------|-------------------------------------|
| <input type="checkbox"/> General population | <input type="checkbox"/> Women | <input type="checkbox"/> Men |
| <input type="checkbox"/> Children | <input type="checkbox"/> Worker | <input type="checkbox"/> Immigrants |
| <input type="checkbox"/> Other _____ | | |

13. How many people are affected by your programmes? Approx. _____

General question about target population:

14. What are the major health problems of your target population?

- | | |
|---|--|
| <input type="checkbox"/> Water borne diseases | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Cardiovascular Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Jaundice/ Hepatitis | <input type="checkbox"/> Cholera |
| <input type="checkbox"/> Typhoid | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Filaria | <input type="checkbox"/> Reproductive Tract Infections |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Accidents (Injuries) |
| <input type="checkbox"/> Flu, cold and cough | <input type="checkbox"/> Other: _____ |

15. Why do people have these health problems? (your opinions)

- not enough personal hygiene
- not enough sanitation facilities
- not enough infrastructure (water supply etc)
- not enough knowledge about healthy behaviour
- people are poor
- public health system is not meeting their needs
- other _____

16. How significant is health for the communities you are working with? (only one answer!)

- health is very important for them, more than any other issue
- health is important to them, but it competes with other issues
- health is not so important to them, other issues come first
- health is not at all important for them, they do not think about it

17. Has the significance changed during your work with the community?

- Yes If yes: it is more important today
- it is less important today
- No

18. What health services do people predominantly use?

- public health service
- private health service
- traditional healers
- quacks
- other _____

19. What influences their decision to use one or the other system? (1– 2 answers) They are predominantly influenced by:

- | | |
|--|---|
| <input type="checkbox"/> price of health service | <input type="checkbox"/> distance to facility |
| <input type="checkbox"/> quality of health service | <input type="checkbox"/> availability of health personnel |
| <input type="checkbox"/> availability of medicine | <input type="checkbox"/> attitude of health staff |
| <input type="checkbox"/> other _____ | |

20. Are people satisfied with the services they have at their disposal? (only one answer!)

- they are very much satisfied
- they are satisfied
- they are indifferent
- they are not satisfied
- they are not at all satisfied

20.1. If they are not satisfied, please give reasons why that is so (all applying answers):

Public health system:

- too expensive
- health facilities too far from home
- health staff does not take them seriously
- doctor does not explain treatment
- medicaments are not given
- waiting time is too long
- hygiene of facility is not good
- treatment does not help them
-

other _____

Private health system:

- too expensive
- health facilities too far from home
- health staff does not take them seriously
- doctor does not explain treatment
- medicaments are not given
- waiting time is too long
- hygiene of facility is not good
- treatment does not help them
-

other _____

Information about your work:

21. How do you organise your work?

21.1. Do you assess the needs of the community?

Yes No

If yes: how do you assess it?

quantitative questionnaire discussion with
community

interviews data analysis

other: _____

21.2. Do you inform yourself about health issues?

Yes No

If yes: how do you inform yourself?

reading science magazines reading newspaper

reading health books watching television

reading health brochures asking health
professional

other: _____

21.3. Does your organization give you training or organises training from other institutions for you about specific health issues or working methods?

Yes No

If yes: What kind of training did you receive? I got trained in:

data collection data analysis

interviewing giving presentations

holding workshops laws and regulations

project management financial management

health issues: _____

other: _____

22. How do you work with the community?

22.1. We do workshops with our target population.

Yes, approx. _____times a year No

22.2 We give out information leaflets.

Yes, approx. _____times a year No

22.3 We give presentations on health issues.

Yes, approx. _____times a year No

22.4 We show poster to inform them.

Yes, approx. _____times a year No

23.5 We discuss health issues with them.

- Yes, approx. _____times a year No

23.6 We do theatre plays about health issues.

- Yes, approx. _____times a year No

23.7 We show information movies.

- Yes, approx. _____times a year No

23.8 We train people from the community in awareness raising.

- Yes, approx. _____times a year No

23.9 Other: _____

- Yes, approx. _____times a year No

24 How do you reach out to the community?

- We organise health camps. We go to panchayat meetings.
 We go to schools. We go to PHCs.
 We go to Mahila Mandals. We go to self-help groups.
 We organise events. _____
 Other: _____

25 What services do you offer to the community?

- health check up information on health issues
 personal referral assistance when visiting the doctor
 free medicine help in health decision making
 immunisation eye check up
 family planning advice/ RCH
 other: _____

26 Why in your opinion does the community cooperate with you? They expect:

- financial gains to be better informed
 health gains empowerment
 more influence on the public health system
 other: _____

27 Do you cooperate with other institutions?

- Yes No

27.1 If yes: with whom do you cooperate and how is the cooperation? We cooperate with:

- state government**

<input type="checkbox"/>				
very good	good	ok	not so good	bad

district officials

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 Medical Officers (MO)

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 Multi-purpose worker (MPW)

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 Traditional Birth Attendants (TBA)/ DAIS

<input type="checkbox"/>				
very good	good	ok	not so good	Bad

 Anganwadi workers

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 private practitioners

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 traditional healers

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 community health committees

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 panchayat

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 women groups

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 international organizations: _____

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 NGOs

<input type="checkbox"/>				
very good	good	ok	not so good	bad

 other _____

<input type="checkbox"/>				
very good	good	ok	not so good	bad

27.2 If yes: how do you cooperate with them?

- We exchange information.
- We plan our work together.
- We discuss problems together and search for solutions.
- We organise events together (health camps etc).
- They monitor our performance. (who? _____)
- We monitor their performance. (who? _____)
- Other _____

NGOs and the public health system:

28 What do think about the involvement of NGOs in national health programmes?

28.1 General:

28.1.1 It is just about time that NGOs got recognised by the government.

- Yes No

28.1.2 NGOs can do much better work than government employees.

- Yes No

28.1.3 NGOs should be a substantial part in all national health programmes.

- Yes No

28.2 Performance (only one answer!):

- NGOs can improve the performance of national health programmes enormously.
- NGOs can improve the performance of national health programmes.
- NGOs cannot improve the performance of national health programmes.

29 Can NGOs and government institutions work together well?

29.1 They can work together well on national or state level.

- Yes No

29.2 They can work together well on the basis (PHC level).

- Yes No

30 How can your organization help to improve the public health system in rural areas?

- inform villagers about their rights
- control work absenteeism (MO, MPW)
- motivate public health personnel
- pressure public health system for better performance
- make public health system aware of community needs

- help community to complain about missing infrastructure/ health service
- fight corruption
- other: _____

31 How can NGOs in general help to improve the public health system in rural areas?

- inform villagers about their rights
- control work absenteeism (MO, MPW)
- motivate public health personnel
- pressure public health system for better performance
- make public health system aware of community needs
- help community to complain about missing infrastructure/ health service
- fight corruption
- other: _____

32 What kind of cooperations with the public health system would be helpful to improve the public health system?

Cooperation between NGO and

state government

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

district officials

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

Medical Officers (MO)

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

Multi-purpose worker (MPW)

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

DAIS

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

Anganwadi workers

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

other: _____

<input type="checkbox"/>				
very helpful	helpful	no difference	not very helpful	not helpful

33 What are the obstacles NGOs have to face now when they want to cooperate with the public system?

- distrust by government officials
- shortage of funds
- funds only available for specific areas
- laws and regulations
- the following: _____
_____.
- I don't know.

34 What laws/ regulations have to be changed to enhance cooperation?

- None
- The following: _____.
- I don't know.

Thank you very much for your cooperation!!!

ANNEX V: LIST OF INTERVIEW PARTNERS

in alphabetical order

Ahsan, Aminul, PRI and NGO cooperation project, West Bengal Voluntary Health Association, Kolkata

Akhade, Dileep, Training Centre Manager, Rural Communes, Narangi village

Alavi, Munber, Programme Coordinator, Rural Communes, Narangi village

Armani, Dr. Suresh, Senior Programme Officer & Coordinator Health, DANIDA, New Delhi

Azad, Chet Ram, Chief Executive, SAHAYOG, Theog

Baitalik, Dr. Debases, Medical Officer, Government of West Bengal, Ghoom

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BIBLIOGRAPHY

- Aday, L.A./ Begley, C.E./ Lairson, D.R./ Slater, C.H. (1998): Evaluating the Healthcare System. Effectiveness, Efficiency and Equity. Chicago, Illinois: Health Administration Press.
- Agarwal, A. (1999): The Politics of Decentralization. *Weltrends*, Band 25, Winter 1999/2000, Berlin, p. 53-74.
- Antia, N.H./ Dutta, G.P./ Kasbekar, A.B. (2001): Health and Medical Care. A People's Movement. Foundation for Research in Community Health (FRCH), Pune.
- Atkinson S./ Medeiros RLR./ Henrique P./ Oliveria L./ de Almedia RD. (2000): Going down to the local: incorporating social organization and political culture into assessments of decentralized health care. *Social Science & Medicine*, Vol. 51, No. 4, p. 616-36.
- Atkinson, S. (2002): Political cultures, health systems and health policy. *Social Science & Medicine*, Vol. 55, No. 1, p.113-124.
- Baer, L.D. (2002): Radically changing the research framework during a health geography study. *Social Science & Medicine*, Vol. 55, No. 10, p. 1829-1833.
- Banerji, D. (2003): Reflections on the twenty-fifth anniversary of the Alma Ata Declaration. *Health for the Millions*, October-November 2003 & December 2003-January 2004, Vol. 30, No. 4 & 5, p. 8-11.
- Banerjee, A./ Deaton, A./ Duflo, E. (2004): Health Care Delivery in Rural Rajasthan. *Economic and Political Weekly*, Vol. XXXIX, No. 9, Feb 28- March 5, 2004, p.944-949.
- Barret, Frank A. (1991): 'Scurvy' Lind's Medical Geography. *Social Science & Medicine*, Vol. 33, No. 4, p. 347-353.
- ~ (1993): A Medical Anniversary. *Social Science & Medicine*, Vol. 37, No. 6, p. 701-710.
- ~ (1996): Daniel Drake's medical geography. *Social Science & Medicine*, Vol. 42, No. 6, p. 791-800.
- ~ (2002): The role of French-language contributors to the development of medical geography (1782-1933). *Social Science & Medicine*, Vol. 55, No. 1, p. 155-165.
- Baum, F. (1995): Researching Public Health: Behind the Qualitative-Quantitative Methodological Debate. *Social Science & Medicine*, Vol. 40, No. 4, p. 459-468.
- Bennett, D. (1991): Explanation in Medical Geography: Evidence and Epistemology. *Social Science & Medicine*, Vol. 33, No. 4, p. 339-346.
- Berman, P.A. (1998): Rethinking Health Care Systems: Private Health Care Provision in India. *World Development*, Vol. 26, No. 8, p. 1463-1479.
- Betancourt, R./ Gleason, S. (2000): The Allocation of Publicly-Provided Goods to Rural Households in India: On Some Consequences of Caste, Religion and Democracy. *World Development*, Vol. 28, No. 12, p. 2169-2182.

Bhat, R. (1996): Regulation of the Private Health Sector in India. *International Journal of Health Planning and Management*, Vol. 11, No. 3, p. 253-274.

~ (1999): Characteristics of private medical practice in India: a provider perspective. *Health Policy and Planning*, Vol. 14, No. 1, p. 26-37.

Bhatia, J./ Cleland, J. (2004): Health care of female outpatients in south-central India: comparing public and private sector provision. *Health Policy and Planning*, Vol. 19, No. 6, p. 402-409.

Blair, H. (2000): Participation and Accountability at the Periphery: Democratic Local Governance in Six Countries. *World Development*, Vol. 28, No. 1, p. 21-39.

Bossert T. (1998): Analyzing the decentralization of health systems in developing countries: decision space, innovation, and performance. *Social Science & Medicine*, Vol. 47, No. 10, p. 1513-1527.

Burnett, D. G. (2004): Medical Geography in Historical Perspective. *Journal of the History of Medicine and Allied Science*, Vol. 59, No. 1, p. 154-156.

Brown, L.D./ Ashman, D. (1996): Participation, Social Capital, and Intersectoral Problem Solving: African and Asian Cases. *World Development*, Vol. 24, No. 9, p. 1467-1479.

Brugha, R./ Varvasovszky, Z. (2000): Stakeholder analysis: a review. *Health Policy and Planning*, Vol. 15, No. 3, p. 239-246.

Chacko, E. (2001): Women's use of contraception in rural India: a village level study. *Health & Place*, Vol. 7, No. 3, p. 197-208.

Chakraborty, S./ D'Souza, S.A./ Northrup, R.S. (2000): Improving private practitioner care of sick children: testing new approaches in rural Bihar. *Health Policy and Planning*, Vol. 15, No. 4, p. 400-407.

Chakraborty, S./ Frick, K. (2002): Factors influencing private health providers' technical quality of care for acute respiratory infections among under-five children in rural West Bengal, India. *Social Science & Medicine*, Vol. 55, No. 9, p. 1579-1587.

Chatterjee, M. (1988): *Implementing Health Policy*. Manohar: New Delhi.

~ (1993): Health for Too Many: India's Experiments with Truth. In: Rhode, J./ Chatterjee, M./ Morley, D. (Ed.) (1993): *Reaching Health for All*. Delhi: Oxford Publications, p. 342-377.

Chaurey, A./ Ranganathan, M./ Mohanty, P. (2004): Electricity access for geographically disadvantaged rural communities- technology and policy insights. *Energy Policy*, Vol. 32, No. 15, p. 1693-1705.

Cheema, G.S./ Rondinelli, D.A. (1983): *Decentralization and Development: Policy Implementation in Developing Countries*. Beverly Hills: Sage Publications.

Cohen, J.M./ Peterson, S.B. (1996): Methodological Issues in the Analysis of Decentralization. Harvard Institute for International Development, Development Discussion Papers Nr. 555, October 1996, 24 pp. [accessed 12.01.2005: <http://www.cid.harvard.edu/hiid/#9195>].

- ~ (1997): Administrative Decentralization: A New Framework for Improved Governance, Accountability, and Performance. Harvard Institute for International Development, Development Discussion Papers Nr. 582, May 1997, 37 pp. [accessed 12.01.2005: <http://www.cid.harvard.edu/hiid/#9195>].
- Collins, C./ Green, A. (1994): Decentralization and Primary Health Care: Some Negative Implications in Developing Countries. *International Journal of Health Services*, Vol. 24, No. 3, p. 459-475.
- Curtis, S./ Gesler, W./ Smith, G./ Washburn, S. (2000): Approaches to sampling and case selection in qualitative research: examples in the geography of health. *Social Science & Medicine*, Vol. 50, No. 7-8, p. 1001-1014.
- Dandona, L. (2002): Conceptualizing health policy. *The National Medical Journal of India*, Vol. 15, No. 4, p. 226-231.
- Das, R.J. (2001): The spatiality of social relations: an Indian case-study. *Journal of Rural Studies*, Vol. 17, No. 3, p. 347-362.
- Das, J./ Das, S. (2003): Trust, learning, and vaccination: a case study of a North Indian village. *Social Science & Medicine*, Vol. 57, No. 1, p. 97-112.
- Das Gupta, M./ Rani, M. (2004): India's Public Health System. How Well Does It Function at the National Level. World Bank, Policy Research Working Paper 3447, Washington.
- Deshpande, K./ Shankar, R./ Diwan, V./ Lönnroth, K./ Mahadik, V.K./ Chandorkar, R.K. (2004): Spatial pattern of private health care provision in Ujjain, India: a provider survey processed and analysed with a Geographical Information System. *Health Policy*, Vol. 68, No. 2, p. 211-222.
- Devarajan, S./ Shah, S. (2004): Making Services Work for India's Poor. *Economic and Political Weekly*, Vol. XXXIX, No. 9, Feb 28- March 5, 2004, p.907-919.
- DFID (2002): Health Financing in West Bengal. Structure, Challenges and Options. DFID Health Systems Resource Centre.
- Diesfeld, H. J. (2001a): Die Bedeutung der internationalen Zusammenarbeit im Gesundheitswesen. In: Diesfeld, H.J./ Falkenhorst, G./ Razum, O./ Hampel, D. (Ed.) (2001): Gesundheitsversorgung in Entwicklungsländern. Medizinisches Handeln aus bevölkerungsbezogener Perspektive. 2. Auflage, Berlin/ Heidelberg/ New York, p.28-33.
- ~ (2001b): Das „Primary Health Care“- (PHC-) Konzept. In: Diesfeld, H.J./ Falkenhorst, G./ Razum, O./ Hampel, D. (Ed.) (2001): Gesundheitsversorgung in Entwicklungsländern. Medizinisches Handeln aus bevölkerungsbezogener Perspektive. 2. Auflage, Berlin/ Heidelberg/ New York, p. 45-57.
- Duggal, R. (2000): The Private Health Sector in India. Nature, Trends and a Critique. From the Detail Report of The Independent Commission on Health in India, Voluntary Health Association of India, New Delhi.
- ~ (2001): Evolution of Health Policy in India. 18th April 2001, Foundation for Research in Community Health (FRCH), Library Pune, unpublished.

- Eckardt, U. (1998): Dezentralisierung in Kolumbien. Eine Analyse der Reorganization von Aufgaben, Finanzbeziehungen und Kontrollmechanismen zwischen Gebietskörperschaften. Wirtschaftspolitische Forschungsarbeiten der Universität zu Köln, Band 18, Marburg: Tectum.
- Flick, U./ von Kardorff, E./ Keupp, H./ von Rosenstiel, L./ Wolff, S. (Ed.)(1991): Handbuch Qualitative Sozialforschung. München.
- Gakidou, E./ King, G. (2002): Measuring total health inequality: adding individual variation to group-level differences. *International Journal for Equity in Health*, Vol.1, No. 3 [accessed 03.01.2005 <http://www.equityhealthj.com/content/1/1/3>].
- Gang, I.N./ Sen, K./ Yun, M.-S.(2005): Caste, Ethnicity and Poverty in Rural India. Paper presented at XIX. Annual Conference of the European Society for Population Economics, 16 – 18 June, 2005, Paris [accessed 23.06.2005 http://team.univ-paris1.fr/espe2005/papers/gang_papers.pdf].
- Gesler, W.M. (1992): Therapeutic Landscapes: Medical Issues in Light of the New Cultural Geography. *Social Science & Medicine*, Vol. 34, No. 7, p. 735-746.
- Görgen, R. (2001): Gesundheitsberatung. In: Diesfeld, H.J./ Falkenhorst, G./ Razum, O./ Hampel, D. (Ed.) (2001): Gesundheitsversorgung in Entwicklungsländern. Medizinisches Handeln aus bevölkerungsbezogener Perspektive. 2. Auflage, Berlin/ Heidelberg/ New York, p. 133-150.
- Green, A. (1992): An Introduction to Health Planning in Developing Countries. Oxford/ New York/ Tokyo: Oxford University Press.
- Greinacher, A. (1989): Die Entstehung und Verwirklichung von Primary Health Care in Indien. Unter besonderer Berücksichtigung zweier ländlicher Entwicklungsprojekte in Südindien. Frankfurt (Main): Fischer.
- GTZ (1998): Building Bridges with the Private Sector. Progress Review, Basic Health Project in five Districts of Himachal Pradesh, prepared by Dr. Robert Soeters and Latika Dixit, January 1998, Shimla.
- ~ (2002): Community Involvement, Panchayati Raj Institutions and the Development of PARIKAS. Survey and Training Needs Assessment as Part of the Basic Health Project Himachal Pradesh, prepared by Dr. Antje Linkenbach, August 2002, Shimla.
- Guagliardo, M.F. (2004): Spatial accessibility of primary care: concepts, methods and challenges. *International Journal of Health Geographics*, Vol. 3, No. 3 [accessed 04.01.2005 <http://www.ij-healthgeographics.com/content/3/1/3>].
- Gupta, A.S. (2002): National Health Policy 2002: A brief critique. *The National Medical Journal of India*, Vol. 15, No. 4, p. 215-216.
- Hall, J.J./ Taylor, R. (2003): Health for all beyond 2000: the demise of the Alma Ata Declaration and primary health care in developing countries. *Medical Journal Australia*, Jan 6, Vol. 178, No. 1, p. 17-20.
- Hayes, M. (1999): 'Man, disease and environmental associations': from medical geography to health inequalities. *Progress in Human Geography*, Vol. 23, No. 2, p. 289-296.

- Hotchkiss, D.R. (2001): Expansion of rural health care and the use of maternal services in Nepal. *Health & Place*, Vol. 7, No. 1, p. 39-45.
- Houweling, T.A.J./ Kunst, A.E./ Mackenbach, J.P. (2003): Measuring health inequality among children in developing countries: does the choice of the indicator of economic status matter? *International Journal for Equity in Health*, Vol. 2, No. 8 [accessed 05.01.2005 <http://www.equityhealthj.com/content/2/1/8>].
- Jayaraman, R./ Lanjouw, P. (1998): The Evolution of Poverty and Inequality in Indian Villages. World Bank, Policy Research Working Paper 1870, Washington.
- Jeffrey, C. (2002): Caste, class and clientelism: A political economy of everyday corruption in rural North India. *Economic Geography*, Vol. 78, No. 1, p. 21-42.
- Jeffrey, R. (1988): The Politics of Health in India. Berkeley, Los Angeles, London: University of California Press.
- Jeppson, A./ Okuonzi, S.A. (2000): Vertical or Holistic Decentralization of the Health Sector? Experience from Zambia and Uganda. *International Journal of Health Planning and Management*, Vol. 15, No. 4, p. 273-289.
- Jesai, A./ Duggal, R./ Gupte, M. (1996): NGOs in Rural Health Care. The Foundation for Research in Community Health (FRCH), Mumbai/ Pune.
- Jones, K./ Moon, G. (1993): Medical geography: taking space seriously. *Progress in Human Geography*, Vol. 17, No. 4, p. 515-524.
- Kamat, V.R. (1995): Reconsidering the Popularity of Primary Health Centres in India: A Case Study From Rural Maharashtra. *Social Science & Medicine*, Vol. 41, No. 1, p. 87-98.
- Kanade, S./ Sutar, S. (1998): Panchayat Raj: A Woman Sarpanch's Perspective. *K.E.M. Hospital Research Centre Newsletter*, January 1998, Vol. 6. No. 1, Pune, p. 7.
- Kapiriri, L./ Norheim, F./ Heggenhougen, K. (2003): Public participation in health planning and priority setting at the district level in Uganda. *Health Policy and Planning*, Vol. 18, No. 2, p. 205-213.
- Kearns, R.A. (1993): Place and Health: Towards a Reformed Medical Geography. *Professional Geographer*, Vol. 45, No. 2, p. 139-147.
- Khare, R.S. (1996): Dava, Daktar, and Dua: Anthropology of Practiced Medicine in India. *Social Science and Medicine*, Vol. 43, No. 5, p. 837-848.
- Kishore, J. (2002): National Health Programmes of India. National Policies and Legislation Related to Health. 4. Edition, New Delhi.
- Kölling, V. (1994): Situationskonforme Konzepte der Gesundheitspolitik in Entwicklungsländern. Dissertation, Aachen.
- Krishna, A. (2004): Escaping Poverty and Becoming Poor: Who Gains, Who Loses and Why? *World Development*, Vol. 32, No. 1, p. 121-136.
- Külker, R. (2001): Der Gesundheitsdistrikt- Aufbau und Aufgaben. In: Diesfeld, H.J./ Falkenhorst, G./ Razum, O./ Hampel, D. (Ed.) (2001): Gesundheitsversorgung in Entwicklungsländern. Medizinisches Handeln aus bevölkerungsbezogener Perspektive. 2. Auflage, Berlin/ Heidelberg/ New York, p. 313-337.

- Kumar, N. (2004): Changing geographic access to and locational efficiency of health services in two Indian districts between 1981 and 1996. *Social Science & Medicine*, Vol. 58, No. 10, p. 2045-2067.
- Kumar, R./ Thakur, J.S./ Srivastava, A.K. (2003): Himachal Burden of Disease Study Draft Estimation Report 2003. Department of Community Medicine, Post Graduate Institute of Medical Education and Research, Chandigarh.
- Kumar, S. (2002): Does "Participation" in Common Pool Resource Management Help the Poor? A Social Cost-Benefit Analysis of Joint Forest Management in Jharkand, India. *World Development*, Vol. 30, No. 5, p. 763-782.
- Lee, R.G./ Garvin, T. (2003): Moving from information transfer to information exchange in health and health care. *Social Science & Medicine*, Vol. 56, No. 3, p. 449-464.
- Litva, A./ Eyles, J. (1995): Coming out: exposing social theory in medical geography. *Health and Place*, Vol. 1, No. 1, p. 5-14.
- Low, Anne / Ithindi, T./ Low, Allan (2003): A step too far? Making health equity interventions in Namibia more sufficient. *International Journal for Equity in Health*, 28 April 2003, Vol. 2, No. 5 [accessed 05.01.2005 <http://equityhealthj.com/content/2/1/5>].
- Magnussen, L./ Ehiri, J./ Jolly, P.(2004): Comprehensive Versus Selective Primary Health Care: Lessons For Global Health Policy. *Health Affairs*, May/June 2004, Vol. 23, No. 3, p.167-176.
- Marmot, M. (2001): Economic and social determinants of diseases. *Bulletin of the World Health Organization*, Vol. 79, No. 10, p.988-989.
- Martens, P. (2002): Health transitions in a globalising world: towards more disease or sustained health? *Futures*, Vol. 34, No. 7, p. 635-648.
- Mason, J. (1997): Qualitative Researching. London/ Thousand Oaks/ New Delhi.
- Massey, D. (1994): Space, Place, and Gender. Minneapolis.
- Mayer, J.D. (1993): Challenges to Understand Spatial Patterns of Disease: Philosophical Alternatives to Logical Positivism. *Social Science & Medicine*, Vol. 35, No. 4, p. 579-587.
- McKinlay, J.B. (1993): The Promotion of Health Through Planned Sociopolitical Change: Challenges for Research and Policy. *Social Science & Medicine*, Vol. 36, No. 2, p. 109-117.
- Meade, M.S./ Earickson, R.J. (2000): Medical Geography. New York: Guilford Press.
- Metzger, U. (2001): Dezentralisierung in Entwicklungsländern. Finanzielle Dezentralisierung und Sustainable Human Development. Würzburg: Ergon.
- Miles, M./ Huberman, A. (1994): Qualitative Data Analysis. London.
- Mills, A./ Vaughan, J.P./ Smith, D.L./ Tabibzadeh, I. (1990): Health System Decentralization. Concepts, issues and country experience. World Health Organization, Geneva.

Ministry of Finance (2005): Economic Survey of India 2004-2005. [accessed 17.06.2005 <http://indiabudget.nic.in>]

Ministry of Health and Family Welfare (MoHFW) (1983): National Health Policy 1983. New Delhi [accessed 15.09.2004 <http://mohfw.nic.in/kk/95/ii/95ii0101.htm>].

~ (2002a): Bulletin on Rural Health Statistics in India. March 2002, New Delhi.

~ (2002b): National Health Policy 2002. New Delhi.

~ (2003): Health Information of India 2000 & 2001. New Delhi.

~ (2005): Annual Report 2004. New Delhi. [accessed 27.06.05 <http://mohfw.nic.in/reports/Annual2004/Annual%20Report%20Eng/content.pdf>]

Ministry of Home Affairs (2002): CensusInfo India 2001 (Software). New Delhi.

~ (2005a): Census GIS India. [accessed 15.05.2005 www.censusindiamaps.net].

~ (2005b): Census of India. Data on Religion. [accessed 15.05.2005 http://www.censusindia.net/religiondata/Religiondata_2001.xls]

Ministry of Rural Development (2005): State-Wise Status of Household Sanitation Coverage. New Delhi [accessed 02.07.2005 http://ddws.nic.in/TSC/crsp/pip_rep_hs.asp?ST=&flag=2]

Misra, R./ Chatterjee, R./ Rao, S. (Ed.) (2003): India Health Report. New Delhi: Oxford University Press.

Mitra, S.K. (1992): Power, Protest and Participation: Local Elites and the Politics of Development in India. Routledge: London/ New York.

Mohan, J.F. (1998): Explaining geographies of health care: a critique. *Health & Place*, Vol. 4, No. 2, p. 113-124.

Mosquera, M./ Zapata, Y./ Lee, K./ Arango, C./ Varela, A. (2001): Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation. *Health Policy and Planning*, Vol. 16, Suppl. 2, p. 52-60.

Mukherjee, R. (2000): Caste in Itself, Caste and Class, or Caste in Class. *Journal of World System Research*, Summer-Fall 2000, Vol. 6, No. 2, p. 332-339. [accessed 02.05.2005 <http://jwsr.ucr.edu/archive/vol6/number2/pdf/jwsr-v6n2-mukherjee.pdf>]

Murthy, R./ Klugman, B. (2004): Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. *Health Policy and Planning*, Vol. 19, Suppl. 1, p.: i78-i86.

Musgrove, P. (Ed.) (2004): Health Economics in Development. Health, nutrition, and population series, The World Bank, Washington.

NABHI (2003): Nabhi's Handbook for NGOs. An Encyclopaedia for Non-Governmental Organizations and Voluntary Agencies. Nabhi Publication: New Delhi.

NACO (2005): HIV estimates 2004. [accessed 01.07.2005 http://www.nacoonline.org/facts_hivestimates04.htm]

Nair, M. (2002): Draft National Health Policy 2001: A leap forward in assessment but limping in strategies. *The National Medical Journal of India*, Vol. 15, No. 4, p. 216-220.

Navarro, V./ Shi, L. (2001): The political context of social inequalities and health. *Social Science & Medicine*, Vol. 52, No. 3, p. 481-491.

Omar M. (2002): Health sector decentralization in developing countries: unique or universal! *World Hospital Health Service*, Vol. 38, No. 2, p. 24-30.

ORG Centre for Social Research (2003): Public Private Partnership (PPP) Research in West Bengal. Draft Report submitted to Northern Ireland Centre for Health Care Cooperation and Development (NICARE).

Pallikadavath, S./ Foss, M./ Stones, R.W. (2004): Antenatal care: provision and inequality in rural north India. *Social Science & Medicine*, Vol. 59, No. 6, p. 1147-1158.

Pande, R.P./ Yazbeck, A.S. (2003): What's in a country average? Wealth, gender, and regional inequalities in immunization in India. *Social Science & Medicine*, Vol. 57, No. 11, p. 2075-2088.

Panse, G.A. (1998): Empowerment of Panchayati Raj Institutions. *K.E.M. Hospital Research Centre Newsletter*, January 1998, Vol. 6, No. 1, Pune, p. 1-4.

Paul, S./ Balakrishnan, S./ Gopakumar, K./ Shekar, S./ Vivekananda, M. (2004): State of India's Public Services. Benchmark for the States. *Economic and Political Weekly*, February 28- March 5, 2004, Vol. 39, No. 9, p. 920-933.

Peters, D.H./ Yazbeck, A.S./ Sharma, R.R./ Ramana, G.N.V./ Pritchett, L.H./ Wagstaff, A. (2002): Better Health Systems for India's Poor. The World Bank. Washington.

Planning Commission (2001): Indian Planning Experience- A Statistical Profile. Planning Commission, Government of India, January 2001, New Delhi [accessed 15.05.2005 <http://planningcommission.nic.in/plans/> accessed 07.06.2005].

Pillai, R.K./ Williams, S.V./ Glick, H.A./ Polsky, D./ Berlin, J.A./ Lowe, R.A. (2003): Factors affecting decisions to seek treatment for sick children in Kerala, India. *Social Science & Medicine*, Vol. 57, No. 5, p. 783-790.

Public Health Department/ Government of Maharashtra (2002): Health Status Maharashtra. Mumbai/ Pune.

Putnam, R.D. (1993): Making Democracy Work: Civic Traditions in Modern Italy. Princeton: Princeton University Press.

PRIA (2000): Defining the Sector in India. Voluntary, Civil or Non-profit. Prepared by PRIA in Collaboration with the Centre for Civil Society Studies, John Hopkins University, USA, November 2000, Working Paper Number 1, New Delhi.

~ (2001): Historical Background of the Nonprofit Sector in India. Prepared by PRIA in Collaboration with the Centre for Civil Society Studies, John Hopkins University, USA, June 2001, Working Paper Number 3, New Delhi.

~ (2002): Exploring the Non Profit Sector in India. Some Glimpses from West Bengal. Prepared by PRIA in Collaboration with the Centre for Civil Society Studies, John Hopkins University, USA, December 2002, Working Paper Number 6, New Delhi.

- ~ (2003a): *Invisible, Yet Widespread: The Non-Profit Sector in India*. New Delhi.
- ~ (2003b): *Exploring the Non Profit Sector in India. Some Glimpses from Maharashtra*. Prepared by PRIA in Collaboration with the Centre for Civil Society Studies, John Hopkins University, USA, September 2003, Working Paper Number 10, New Delhi.
- Rai, M./ Nambiar, M./ Paul, S./ Singh, S.U./ Sahni, S.S. (2003): *The State of Panchayats. A Participatory Perspective*. PRIA, 2. Edition, New Delhi.
- Ramiro, L.S./ Castillo, F.A./ Tan-Torres, T./ Torres, C.E./ Tayag, J.G./ Talampas, R.G./ Hawken, L. (2001): Community participation in local health boards in a decentralized setting: cases from the Philippines. *Health Policy and Planning*, Vol. 16, Suppl. 2, p. 61-69.
- Ranga Rao, S.P. (1993): *Administration of Primary Health Centres in India. A Study from the Three Southern States*. New Delhi: Mittal Publications.
- Ray, A.S./ Bhaduri, S. (2001): *The Political Economy of Rural Health Care in India*. From the Detail Report of The Independent Commission on Health in India, Voluntary Health Association of India, New Delhi.
- Rifkin, S.B./ Muller, F./ Bichmann, W. (1988): Primary Health Care: on Measuring Participation. *Social Science & Medicine*, Vol. 26, No. 9, p. 931-940.
- Rifkin, S.B. (1996): Paradigms Lost: Toward a new understanding of community participation in health programmes. *Acta Tropica*, Vol. 61, No. 2, p. 79-92.
- Rondinelli, D.A./ Nellis, J.R./ Cheema, G.S. (1984): *Decentralization in Developing Countries: A Review of Recent Experience*. Staff Working Paper No. 581, Washington D.C.: World Bank.
- Sanders, D. (2003): Twenty-five years of primary healthcare: lessons learned and proposals for revitalisation. *Health for the Millions*, October-November 2003 & December 2003-January 2004, Vol. 30, No. 4 & 5, p. 15-22.
- Scarpaci, J.L. (1993): On the Validity of Language: Speaking, Knowing and Understanding in Medical Geography. *Social Science & Medicine*, Vol. 37, No. 6, p. 719-724.
- Silverman, J.M. (1992): *Public Sector Decentralization. Economic Policy and Sector Investment Programs*. World Bank Technical Paper Number 188, Africa Technical Department Series, Washington.
- Starfield, B. (2001): Improving Equity in Health: A Research Agenda. *International Journal of Health Services*, Vol. 31, No. 3, p. 545-566.
- Tang, S./ Bloom, G. (2000): Decentralizing Rural Health Services: A Case Study in China. *International Journal of Health Planning and Management*, Vol. 15, No. 3, p. 189-200.
- UNAIDS (2005): *A scaled up response to AIDS in Asia and the Pacific*. Bangkok.
- UNDP (2004): *World Development Report 2004*. Washington.

- Uphoff, N.T./ Cohen, J.M./ Goldsmith, A.A. (1979): Feasibility and Application of Rural Development Participation: A State of the Art Paper. Rural Development Committee, Centre for International Studies, Cornell University, New York.
- Varvasovszky, Z./ Brugha, R. (2000): How to do (or not to do)... A stakeholder analysis. *Health Policy and Planning*, Vol. 15, No. 3, p. 338-345.
- Verhasselt, Y. (1993): Geography of Health: Some Trends and Perspectives. *Social Science & Medicine*, Vol. 36, No. 2, p. 119-123.
- Vishnu/ Sudarshan, H. (2003): Public sector- voluntary organization partnership for primary healthcare services. *Health for the Millions*, October-November 2003 & December 2003-January 2004, Vol. 30, No. 4 & 5, p. 52-57.
- Vissandjée, B./ Barlow, R./ Fraser, D.W. (1997): Utilization of health services among rural women in Gujarat, India. *Public Health*, Vol. 111, No. 3, p. 135-148.
- Walsh, J./ Warren, K. (1979): Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. *New England Journal of Medicine*, Vol. 301, No. 18, p.149-160.
- Wang, H. (2003): Sex differences in communicable diseases. Detection and Treatment in West Bengal, India. Master Thesis, University of Heidelberg, Department of Tropical Hygiene and Public Health.
- Waters, H.R. (2000): Measuring equity in access to health care. *Social Science & Medicine*, Vol. 51, No. 4, p. 599-612.
- Werlen, B. (2000): Sozialgeographie. UTB, Bern/ Stuttgart/ Wien: Haupt Verlag.
- Wessel, K. (1996): Empirisches Arbeiten in der Wirtschafts- und Sozialgeographie. UTB für Wissenschaft, Paderborn/ München/ Wien/ Zürich.
- Westergaard, K. (1986): People's Participation, Local Government and Rural Development. The case of West Bengal, India. Centre for Development Research, Report No. 8, Copenhagen.
- Whitehead, M./ Dahlgren, G./ Evans, T. (2001): Equity and health sector reforms: can low-income countries escape the medical poverty trap? *The Lancet*, September 8, 2001, Vol. 358, No. 9284, p. 833-836.
- World Bank (1993): World Development Report 1993: Investing in health. New York.
- ~ (1999): Case Study of World Bank Activities in the Health Sector in India. Report No. 19537, World Bank, Washington.
- ~ (2000): Marketing Sanitation in Rural India. Water and Sanitation Programme- South Asia, World Bank, New Delhi.
- ~ (2004): West Bengal Health Policy Note. Report 30296, June 2004, World Bank South Asia Region.

WHO (1946): Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948 [accessed 12.04.2005 <http://www.who.int/about/definition/en/> accessed 19.04.2005].

Newspaper:

The Tribune, Chandigarh (2003): "Mysterious fever". 19.-23.09.2003. [accessed 17.06.2005 <http://www.tribuneindia.com/2003/20030920/himachal.htm#8>]

TABELLARISCHER LEBENS LAUF

PERSÖNLICHE DATEN

Vorname: Anja
 Nachname: Welschhoff
 Geburtsdatum: 4. August 1977
 Nationalität: Deutsch
 Lebensstand: verheiratet

ADRESSE

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 57223 Kreuztal- Osthelden
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BILDUNGSWEG

Jahr	Universität/ Schule	Fach	Abschluss	Ort
2003- jetzt	Ludwig – Maximilians Universität München	Medizinische Geographie (Promotion)	-	München
1999-2003	Rheinische Friedrich- Wilhelms-Universität	Geographie, Soziologie, Politik	Diplom (Note: sehr gut- 1,2)	Bonn
1998-1999	University of Edinburgh	Political Geography, Feminist Geography	-	Edinburgh, GB
1996-1998	Universität Leipzig	Geographie, Soziologie, Geologie, Recht	Vordiplom (Note: 1,8)	Leipzig
1991-1996	Robert-Koch-Gymnasium		Abitur (Note: 1,6)	Leipzig

ARBEIT/ PRAKTIKUM

- 4/2003 - heute Promotion am Dept. für Geo- und Umweltwissenschaften der LMU München,
Thema: Community Participation and Primary Health Care in India
- 3/2005 - 4/2005 Geomed, Arbeitsgruppe für Medizinische Geographie und
Gesundheitssystemforschung am Lehrstuhl Professor Mauser, Dept. für Geo-
und Umweltwissenschaften der LMU München
- wissenschaftliche Hilfskraft
- 7/2003 - 12/2003 Geomed, Arbeitsgruppe für Medizinische Geographie und
Gesundheitssystemforschung am Lehrstuhl Professor Mauser, LMU München
- freie Mitarbeiterin
- 4/2000 - 12/2002 Geomed, Arbeitsgruppe für Medizinische Geographie und
Gesundheitssystemforschung am Lehrstuhl Professor Ehlers, Geographisches
Institut der Universität Bonn
- studentische Hilfskraft
- 9/2001 - 12/2001 World Health Organization, Regionalbüro Südostasien, Abteilung Umwelt und
Gesundheit, Delhi, Indien
- Praktikantin
- 8/2000 - 9/2000 Institut für Länderkunde, Abteilung Russland, Leipzig
- Praktikantin

TAGUNGEN/ KONFERENZEN

- 8/2004 *Emerging Issues in Medical Geography*, organisiert von International Geographical Union, Irsee bei München
- Vortrag: Developing a Legal and Institutional Framework to Improve Public Health Services in India
- 11/2003 *Health Insurance Schemes for India*, organisiert von Gesellschaft für Technische Zusammenarbeit, Pune, Indien
- 5/2002 *Armutsbekämpfung, Entwicklung und Demokratie*, organisiert von Studienstiftung des Deutschen Volkes, Berlin
- 3/2002 *Green Rating of Automobile Industry*, organisiert vom Centre for Science and Environment, Delhi, Indien
- 3/2002 *Air Toxics*, organisiert vom Central Pollution Control Board India, Delhi, Indien

SPRACHEN

Deutsch: Muttersprache

Englisch: Verhandlungssicher

Spanisch: Basiswissen

Russisch: Basiswissen

COMPUTERKENNTNISSE

Microsoft Office (Word, Excel, Power Point)

Grafikprogramme (MapInfo, Corel Draw, ArcView)

SONSTIGES

- Stipendiatin im Programm zur Förderung der Chancengleichheit für Frauen in Forschung und Lehre, LMU München (7/2004 - 6/2005)
- Stipendiatin der Studienstiftung des Deutschen Volkes (7/1999 - 10/2002)

INTERESSEN

Länder und Kulturen entdecken, Karatesport, Sportklettern und Bergsteigen