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THE ROLE OF COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

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ABSTRACT

This paper deals with the conceptual frame of community participation in primary health care. The meaning, contents, methodology and objectives of the community participation in primary health care are well defined and discussed. A brief account of experiences gained from community participation in primary health care by various countries like China, Bangladesh, Tanzania, Ghana and India are highlighted in this paper. In addition, issues such as people rather than technology, community motivation rather than service, bottom-up rather than top-down approach, flexibility, etc. in relation to community participation in primary health care are presented.

HISTORICAL PERSPECTIVE OF COMMUNITY PARTICIPATION

There has been evidence to suggest that health and medical services have not made any remarkable improvement for a majority of the people in developing countries. For this reason the idea of community participation was initiated by both health planners and field workers who are responsible for the implementation of the health care services. Nevertheless, in other areas of human life the concept of community and neighborhood, centre for community action has remained popular embodying within its statute a philosophy of strengthening family or community life. In fact, the idea is as old as community's life and the members of the community while using the local resources can also solve their problems. Therefore, the idea of community participation can be consciously stimulated through educational and other means which is of recent origin.

The stress on community participation is, in fact as recognition of the people who constitute the most important resource of any country and this very resource remains untapped till now. The community’s active interest and participation in solving their own problems is not only a clear manifestation of social awareness but to some extent self-reliance too. It is also an important factor in ensuring the success of primary health care in the third world countries where the cohesion of social structure continues to persist.

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In a conceptual framework, community participation in primary health care does not lend itself to a single or comprehensive definition. Its meaning, content, methodology, mechanisms and goals to be achieved vary from one country to another and even within the same country depending upon the political commitments, socio-economic, cultural and administrative systems prevailing. The development of participative mechanisms can clearly be delineated when an attempt is made to differentiate between "cooperation", "participation", and "involvement". These terms are used interchangeably but they differ in their approach and methodology. In the first place, "cooperation" entails that an activity, a programme or a social action is initiated by the Government agency in the community for the welfare of its members and the community is expected to take the benefit out of it. Many a times such "cooperation" is treated as "passive participation" from the community's point of view. On the other hand some developing countries are progressively moving towards "participation" which envisages decision-making within the developmental processes including mass contribution in developmental efforts by the community. The idea, however, remains to move from participation to involvement meaning thereby to develop a "sense of belongingness". Involvement is self-generative and in most cases from onset to its finale, all activities and policies are evolved from within the community or a group without any external or governmental support. Some external or internal change agent is often needed to facilitate self-generated development in the community.

United Nations Social Development Division defines "participation", as a process of activities comprising people's involvement in decision-making in the developmental efforts to share benefits. Similarly, United Nations have defined the community participation as an active and meaningful involvement of masses or people at different levels like decision-making and executing the programmes.

According to WHO, involvement was conceptualized as an endeavor on the part of the community to help in the implementation of plans already made and targets set vertically. This kind of participation is based on passive acceptance of services and passive support in cash or kind. The new type of participatory involvement requires identification with the programme which grows out of involvement in thinking, planning, deciding, acting and evaluating for a definite purpose, may it be improvement in the health care or overall development. So community participation is a mental as well as physical process. The most accepted operational definition has been given by Robert Snowdern who claims that community participation is an educational and empowering process in which people are in partnership with those who are able to assist them, identify the problems and needs and increasingly assume responsibility themselves to plan, manage and assess the collective actions that are provided necessary. It is democratic in action.

From the definitions cited earlier, it should be possible to enumerate some of the basic elements of community participation. These elements are expected to be useful for determining the extent of participation in a particular programme or a venture. These elements not only help in clarifying the concept but also in

measuring the extent of participation. The important determinants of community participation are: (i) Generation of resources from within the community; (ii) Decentralization in decision-making; (iii) Enabling the community/group in setting goals and priorities and achieving the same; (iv) Sharing of the benefits by masses in a given community/group; (v) Development of mechanisms in assessing the outcome from within the community; and (vi) Involvement/self-help for sustaining the programme.

The review of literature on "participation" throws considerable light on its varied aspects. An attempt has been made to classify these aspects into a specific pattern, three broad points emerged *viz.* "person", "process" and "product". Although from the definitions no consensus emerges on the usage of the term "participation", as many definitions have emphasized the "process" of participation starting from decentralized decision-making or "setting up of goals etc." Further, the review indicates invariably the "social change as product", not adequately recognizing the importance of "person" which consists of "human factors" on which the "process" of participation depends. The "participation" will be effective only when equal weight age will be given to "person", "process", and "product". The concept of participation is thus a process of unfolding its various dimensions and it is difficult at this juncture to emphasize one element over the other because in most cases the strategies to be adopted and the goals to be pursued have been differing from one to the other and from one community to the other.

INTERNATIONAL EXPERIENCE AND SOME OBSERVATIONS

The first country which took up the challenge of providing health care system where health resources would respond to the needs of the majority of people is China which proved to be an example of how and to what extent decentralization of health care system could be made effective. The Chinese experience of "Village Doctor" who performed functions of Medicare, disease prevention and control. MCH has reached 1.293 million of which 6,43,000 village doctors have acquired training. The Chinese experience emphasized two aspects of health care *viz.* a political entity subject only to change by scientific advances and secondly, great changes could be brought about by mobilizing people to take part in health care activity. This experience turned out to be pivotal to other developing countries like Asia, Africa and Latin America to search for alternatives in health care programmes. It needs to be recognized that Chinese radically changed their traditional health care delivery system by integrating health with other national development plans, decentralized decision-making and placing the health in people's hand through the process of community participation. In these countries including Cuba revolutionary changes were introduced at national and community level in their health care system. The examples of Ghana, Indonesia, Tanzania, Burma and India illustrate the fact that the only way of reaching to the poorest is through community development of which community participation is one of the crucial elements.

Bangladesh recognized the need for a strong community organization and has launched Gram Sarkar (village administration movement) a movement of

integrating health with rural development. The village health worker is catalytic agent for providing health education to the community and other formal health agencies only supervise, guide and support him. In Burma people's health programme provides for primary health care as a part of national development.

In Tanzania, Arusha Declaration focuses on Tanzania's health policy which is within the national socio-economic plan. The policy calls for decentralization of the planning machinery in order to make people participative in formulating the plan.

Ghana's primary health care strategy (1978) also recognises health services as a part of total socio-economic development. Indonesia's approach to primary health care is through village health development programmes with a purpose of strengthening the community institutions capable of people's participation and initiating community based comprehensive health services. Most of these countries have recognized the fact that for achieving success in primary health care programmes, it is necessary to integrate it with the overall socio-economic programme at grassroots level. Secondly, these countries recognized that the process of attaining success depended on the initiation of such programmes through community efforts.

In India, in February 1977, the Ministry of Health an Family Welfare announced a draft plan envisaging provision of health services at the doorsteps of villagers by involving more than 60,000 Community Health Guides and as many dais (traditional birth attendants) after a short period of training. The overall philosophy of the scheme was that the health work which has hitherto been looked after by the Government, now for the first time rest in the hands of people. The Health Guide being the man of the community who will be accountable to the community and the community in turn will supervise his work.

IMPORTANT OBSERVATIONS

On the basis of various countries working in community based health programmes, it is possible to make some observations on community participation in health care programme which are as follows:

a. Community participation emphasizes people rather than technology and it recognizes the limit of modern technology by emphasizing that people have ability to choose, to improve their conditions rather than passive acceptance of the Government or private agencies handouts.

b. Community participation lays stress on community motivation rather than service coverage.

c. Community participation emphasizes the bottom-up rather than top down approach to health planning. In this strategy, outside planners work with community leaders to develop services and communication links which are

responsive to community needs. The health delivery system becomes a supportive and enabling mechanism rather than a dictating agency for the last word in the field of health.

d. Community participation is also a part of a process which means the various methods of identifying the people in communities first be recognized and slowly start to take action for solving their own health problems. Many countries like India have started the formation of health committees and selecting the community health guides through the community itself.

e. The process of community participation emphasizes flexibility rather than rigid replicability. The process, therefore, must be designed to follow general guidelines while maintaining the ability to meet local requirements. Flexibility is, however, the mainstay of the process of community participation.

f. It also needs to be recognized that because the present planning systems are hierarchical in nature and are not given to encourage participation of lower levels of personnel, it becomes a. Challenging task for the planners to change their own role in decision-making.

g. The process of community participation must be seen in terms of long rangegoals rather than short-term achievements. Communities do take time particularly in internalizing unfamiliar ideas. If the process moves too quickly and is not internalized by the community people, it becomes questionable whether the improvements in health status, let alone community participation has really materialized.

h. The participator ventures imply sharing of decision-making power. This redistribution sets in motion a social encounter between different social categories in the community, among different interest groups. Many a times there is a confrontation between the cosmopolitan, metropolitan and community interests. The hitherto excluded, strata of a community confront, the supports and controls of sets of social arrangements which determine the pattern, distribution, services, status, power and the access to resources. Such clashes are to be presumed to occur where decision-making powers are to be reformulated, redefined and redistributed.

i. In almost all cases, where projects and programmes are sponsored by-Governmental, voluntary or international agencies, the community visualizes them as an encounter because the specific approach to the programme or project has often been initiated from above; that the initial 'motor' of participation lies outside the 'powerless' in the relatively privileged sector or section. It implies that there exists a concept of what ought to be done about the poor and underprivileged and a belief that participation of the latter can be secured, provided the right approach is adopted.

j. The participatory approaches cannot be legislated or adopted overnight. Such approaches must grow with the passage of time, experience and practice, with the on-going evaluation of the successes and failures. This calls for the systematic documentation and analysis of participatory situations and experiences to provide new insights and knowledge about participatory development processes.

k. The basic question in community participation programmes is how the members of a given community with all their problems, expectations, diversities and traditions can be motivated to act together to improve their communal environment. Probably the answer may not be in surveys but on developing dialogue. For developing community participation, it is becoming clear that when assisting the poor people and fragile organizations that are operating in the communities in difficult circumstances, it is important that red-tape, bureaucratic delays and demands for information are kept at minimal.

I. Community participation has been viewed and even experimented from different perspectives depending heavily upon as to what requires to be achieved. In some cases the perspectives have been to look at participation as an approach or as a technique or means, and in still other situations as an end in itself. This differential in perspective has introduced a lot of confusion in drawing out the basic elements of community participation. It is because of these reasons that a holistic view of the concept has not been able to be comprehended.

m. Relatively little attention has been paid to the word "community". In some projects and programmes, simple geographic boundaries define its limits, in other cases the beneficiaries are treated as communities. With a project aiming at enthusing the lower ebb of society or community, it may not always be useful to be selective. Every community has inter-action and interpersonal relationship matrix that defines its boundaries and seldom this structural paradigm is ever recognized except in terms of the categories of people defined by their association in formal or non-formal group of institutions. The people identification of the people, the inter-group dynamics, the conflicting values and interests are vital for introducing any basic change in the community. Many a times, the projects on community participation do not succeed because such ventures only scratch the surface and fail to recognize the deep-rooted interests and values of the people. Further, it amounts to treat community as a homogenous whole may not always hold promise, because every community has aspirations, value systems, opinions and heterogeneity in the styles of life and these vital values must be given due consideration for the development of the programmes. The pre-requisites of community participation is in understanding the people, not only their problems and felt needs, but also their aspirations and capabilities which are more crucial for ensuring continuity, consistency and effectiveness of the programmes.

n. The crucial issue of community participation is not always in terms of 'what' has been achieved but how it has been achieved. Most of the projects start with big achievements, but fade-away after either the external support is withdrawn or the performance starts showing decline. The continuity of a particular programme with the same enthusiasm after two or three years gives a warning. This is a big management challenge. In some cases people have been kept motivated by diversification of activities and in still other cases sharing of decisions have kept people together for perusing the same goal. For maintaining the motivation of the community as well as providers of service, it is inevitable to develop appropriate communication strategy in order to obtain useful interaction between the community and the providers. Sunderbani project in West Bengal is an example in this direction. Ultimately, effectiveness of community participation appears to depend on the degree of synthesis between the project or programme objectives and community aspirations. In practical terms, ensuring that those in need are really those in control of resources is one of the most difficult tasks, although an ideal situation for community participation.

o. The major work in community participation relates to sensitizing the community and apprising them of their potential energies and capabilities. The health education approach demands a lot of time not only from workers in health organization, but also from the beneficiaries which the people of both categories can ill afford. The beneficiaries need identification of major services to be followed by ensuring that the health institutions are well organized and managed to take care of their needs. It is futile to enthuse the people for ante-natal care (ANC), unless the sub-centre of PHC is manned by such a person and the service which can take care of the total ANC requirements. It is thus a two way process. In one process it is necessary that the beneficiaries know about what could be made available within limitations and in other case, the providers have to ensure as to how, when, where and what quantum of services or activities can be managed. Once this is achieved one can expect to proceed in enlarging the scope, content and methodology of services taking community along with the existing infrastructure. The missing element in the existing situation relates to disseminating of information to the community about 'what' is available 'where' than 'why' of it.

p. There are very few experiments and projects which are "replicable". The purpose of sharing the experiences, expertise or methodology on community participation is not only to showthat it is possible to make people accept a programme or run it but how such efforts and experience could be utilised for extension of such ventures in other areas. The projects like Jamkhed, Mallur and others are undoubtedly excellent examples on evolving community participation, but none of them has so far been replicated except Tilonia project in Rajasthan. This gives raise to a basic question as to what parameters can be used for assessing whether a

particular venture is replicable or not. Theoretically, it appears pleasurable to think of three necessary conditions which if fulfilled can make a project or a programme replicable. These three necessary conditions are: (a) programme which remains within the affordable limits in terms of the resources of the community and organisation could be replicated; (b) the programme acceptable to the people and able to withstand the socio-cultural constraints after the application of suitable modifications could be replicated; and (c) the benefits of the programme when shared by a larger cross-section of people could be treated as replicable. Some projects like DANIDA project in Madhya Pradesh, if viewed on these three conditions has a potential for its replicability. It is, however, recognised that by definition all community participative ventures have to be community specific, yet is the process and its other attendant attributes which can be considered as basic elements for replication. In this way replicability of the on-going experiments on community participation in the field of health and family welfare could be treated as a measure of success or otherwise of such experiments.

q. The common features of all community participation is based on the projects and the programmes. The "education" has been interpreted differently. In some cases, 'information giving' has been emphasised while in others like DANIDA project the entire strategy of the project was made comprehensive and directed towards developing, making the people realise their own potential energies and capabilities and then channelize them in such a manner so that they could see for themselves and the possible targets to be achieved. The education and communication back-up for any effort on community participation is one of its vital pre-requisites.

r. The most important contributing factor for a successful community participation has been the man behind the show. Experiments like Jamkhed, Tilonia, Rangabellia are known for the dedicated work put in by Raj Arole, Bunker Roy and others. Sincere and throbing projects like Mallur could not stay to the ground because the leadership of the medical officer was withdrawn and the entire project efforts almost crumbled. It is the inner urge of these dedicated persons that kept the soul of the experiments on the move. One way of extending the philosophy of community participation would be to identify such people who can, not only move with people but improve their lots also. While developing leadership styles which are conducive to community participation, it is important to ensure that those only lead who possess enough of commitment. Presently WHO'S thrust area on leadership development can go a long way in this direction. Another possible Strategy in this direction is to make a projects and programmes run as a self-generating and functionally autonomous units. Here instead of a leader, the local committees or institutions are developed for the functioning of the project in its desired direction. The functions of a leader are played by an institution. Since, institutions have inbuilt movement of its

members, the project stays longer and the wisdom of the group prevails over that of a single leader. Here again projects like DANIDA, in Madhya Pradesh, Jamkhed, which are based on strengthening or even creating 1 institutions such as farmers clubs, Mahila Mandals, Yuva Kendras, etc.

s. Many a times, it is argued that lack of participation of the community has been used as an excuse to cover the failure of the governmental health delivery system. As a matter of fact, government has clearly recognised in its Seventh Plan document that community participation is an effective instrument to overcome fallacy in the programme. Management of the health delivery system provides aid for reducing the cost of services also. It is clear, from such evidences that the intention of the government is to make the community realize that health is not only a matterof right but also entails some responsibilities. It istrue.that ensuring community participation, would not only reduce the costs, but a sense of fulfillment would be there for those who are working in the programme.

Factors Inhibiting Community Participation

Depending upon the objectives of the project under experimentation, the socio-cultural millieu, the political system, the nature and type of beneficiaries, the organisational framework, the factors inhibiting community participation can broadly be sub-sumed under the following broad categories:

a. Factors which are rooted in the community, its organization, its socio-cultural normative and the psychology of its people.

b. Factors which are inherent in the administrative organizations, the limitations under which all bureaucratic organizations work.

a. ***Community Oriented Factors****:* These constraints come in force due to deep divisions within the community along the lines of caste, language, sex, age, residence, etc. Absence of workable organizational base at community level makes participation difficult for the people.

Contrary to what is widely believed, most traditional communities are not strongly cooperative minded. Mostly members of such communities are family centered, rather than community welfare oriented. Wherever cooperative mechanisms are existing, they remain restricted between individuals and families, rather than being village-wise. Poverty discourages rather than encourages participation. Hence, the communities are likely to respond to the expected degree in which elementary economic needs are being met primarily.

Participation is equally difficult to achieve where extreme disparities exist in wealth, income, power, caste and status. People in such cases are not able to bring

the weight of their number to bear on the system, by making it more responsive to their requirements.

Where policy and decision-making had remained centralized (be it with the community, voluntary or government level), followed by outward and downward" philosophy, there is no ready evidence that the community would either feel a need for; or want to be involved in such matters. Such efforts naturally become determinants to the community participation.

The community's perception about the governmental policies and the external agencies, particularly whether they are seen as sources of help or exploitation, influence the attitude towards community participation *(e.g.* Tribal).

b. ***Factors Inherent in Administrative Organizations****:* There is a tendency among community development and primary health workers to assume that the basic problems encountered by their programmes are in the community itself. These inappropriate conclusions are drawn because of:

a. The frequent need to show fast result in order to justify budget allotments,
   which lead to 'over-selling' of achievements.

b. A tendency of inter-departmental, inter-sectional competitions and infighting encourages 'empire building' by ambitious programme planners.

c. The tendency of low-level workers to please their supervisors at the expense of the people they are expected to serve.

What needs to be done?

Assuming that primary health care strategy has been accepted and that the importance of the community participation is well documented. In order to reorient the policies and programmes a process can be started and a number of practical steps can be initiated to enhance the community participation in primary health care programme.

The first essential step would be to evaluate the capacity and limitations of the existing structure for the delivery of health care, adoption of appropriate remedial measures, and to change the attitude of the personnel who provide services of health and family welfare in conformity with the principles of community participation. The most difficult task is identifying the shortcomings of the present health services, or changes needed in its organisational set up and changing of attitudes and values of the personnel who have to implement the new mandate.

An effective approach for bringing necessary change in outlook among health personnel is to engage them from top planners and managers at different levels to the lower echelon medical professionals in the field as a process of appraisal and

self-education. Small mixed .teams of health personnel from national, State or regional levels may go out to a few villages of the country to investigate the health status of people, the performance of governmental health services in relation to their basic service needs, the functioning of the traditional system, the amount that villagers spend for their health care, existing village institutions, etc. The personnel from neighboring hospitals, research centers, training institutions can examine and analyze what they can do to reorganize themselves, redefine their goals and functions, and to produce the needed manpower for implementing primary health care strategy with community participation. The results of investigations could be compared and analyzed to identify and formulate the plan of action at different levels.

Following the appraisal, and the formulation of strategy, there would be a need to do a diagnostic exercise in order to identify and assess pertinent factors that affect community participation which would involve at individual and community levels: (a) study of various groups within the community; (b) survey of community resources and constraints, the socio-economic situation and the status of social service institutions. These factors would determine the environment of cooperative development efforts in the community and the nature of perspective community participation in development activities; and (c) survey of the community's health status and health care needs, basic information about health situation supplemented by populations' subjective perception about serious problems and urgent health needs in order to determine prioritization.

This diagnostic exercise should not become an elaborate science research project. Eventually this should become a simplified, quick and relatively standard process carried out under the guidance of local a person responsible for supervising the activities.

In situations where a community is having more local institutions which can be entrusted with the responsibility of ensuring that the benefits of programme are equitably shared and coordination with other developmental efforts — in other words, it would mean improving the functioning of the existing participator institutions. But where such institutional base does not exist, an appropriate participatory mechanism has to be devised or existing weak institutions are required to be rejuvenated. On the basis of local diagnosis, it has to be determined to what extent traditional and existing institutions, such as village councils, neighbourhood associations and women group can serve the purpose and the modifications required in their structure or functioning if necessary.

In all situations, opportunities and appropriate conditions are required to be created for free expression of views, genuine dialogue, for which the community representatives and health service personnel have to jointly set some guiding principles.

Thus, in essence, community participation is a process. Its ultimate aim is to contribute to the improvement in the health and welfare of the community. The

strategies for making this venture effective can happen only when there is a synthesis between the programme objectives and the aspirations of the people. The research should lead to the fact that participation has been evolved with the sole purpose of making it self-generative and-a part of life of the community itself.

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इस पेपर में प्राथमिक स्वास्थ्य रक्षा में सामुदायिक जन भागीदारी के सैद्धान्तिक ढांचे के विषय में बताया गया है। प्राथमिक स्वास्थ्य रक्षा में सामुदायिक जन भागीदारी के अर्थ विषयवस्तु, कार्यविधि और उद्देश्यों को अच्छी तरह परिभाषित और समझाया गया है। प्राथमिक स्वास्थ्य रक्षा में सामुदायिक जनभागीदारी से विभिन्न देशों जैसे चीन बंगलादेश, तंजानिया, धाना व भारत से प्राप्त अनुभवों के संक्षिप्त विवरण को भी इस पेपर में दर्शाया गया है। इसके अतिरिक्त प्रद्योगिकी की जगह व्यक्तियों, सेवाओं के स्थान पर समुदाय का उत्प्रेरण, ऊपर से नीचे के स्थान पर नीचे से ऊपर की एप्रोच, लचीलापन आदि मुद्धों का प्राथमिक स्वास्थ्य रक्षा के सन्दर्भ में सामुदायिक जन भागीदारी की एप्रोच को प्रस्तुत किया गया है।

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ORGANISING SERVICES FOR MENTAL HEALTH IN INDIA: SELECT ISSUES

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ABSTRACT

A comprehensive programme for mental health is being formulated in India. A decision to provide services for mental health through the framework of general health services has been made. There is a felt need to mobilize community resources; create an awareness regarding promotion of mental health; improve competence of health personnel delivering services; augment the organization for programme formulation and coordination; and promote voluntary effort. Select areas for the research have been identified and also issues for organizing mental health services in India, have been dwelt upon.

Recognizing the extent and importance of the problem of mental health, the Government of India is formulating a comprehensive programme for mental health. The objectives of this programme are (i) to ensure availability and accessibility of minimum mental health care for all, particularly to the most vulnerable and underprivileged sections of the population; (ii) to encourage application of mental health knowledge in general health care and in social development; and (iii) to promote community participation in mental health service development and to stimulate efforts towards self-help in the community. Mental Health Services are to be integrated along with the general health services. The Central Councils of Health and Family Welfare, which meets annually, provide guidelines for health care through national consensus in India. The Union Minister for Health is the Chairman, and all the State Ministers of Health are its members. There are 22 States and nine union territories. Provision of health services is primarily the responsibility of the respective State Governments. The Centre has an important role in the formulation of the policy, legislation and coordination. The 8th Joint Conference of Central Councils of Health and Family Welfare held in August 1982 stated that mental health is an integral part of total health and should, therefore, be viewed in that light. It was emphasised that mental health should form as part of the policies and programmes in the fields of health education and social welfare. A suitable action shoud also be taken to strengthen the training curriculae for various personnel[1].

This paper focuses on select issues related to the formulation and implementation of a national programme for mental health in India. These issues are

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discussed with reference to the existing framework of health services organization in India and the observations are based on the study of the relevant structure and processes.

THE PROBLEM OF MENTAL ILLNESS IN INDIA

Though no comprehensive nationwide study has been conducted, several studies provide information on the prevalence of the problem. It is estimated that 10-20 persons per 1000 population suffer from serious mental illness and about three times as many with neurosis and psychosomatic disorders[2]. Of the 740 million people in India, only 23.73 per cent live in urban areas, according to the 1981 census[3]. In rural areas, the prevalence of mental illness was found to be 18.24,39 and 102.8 per 1000 population[4,5,6] respectively. In urban areas it was 24.78, 72 and as high as 140 as reported by other authors[4,7,8]. Differences in the prevalence rate may be attributed to methodological variations in the studies.

Limitations of hospital data for inferring the morbidity pattern are well known -this is presented to indicate current utilization. An analysis of admissions to 46 mental hospitals in India is given in Table 1 for the years 1979 to 1983[9,10,",12]. Schizophrenic psychosis was found to account for over half of the morbidity, other common causes being effective psychoses and neuroses. In a study of 3,346 admissions over a five year period in the psychiatric department of a general hospital found that schizophrenia accounted for 58.3 per cent of the morbidity, affective psychoses 9.8 per cent, neuroses 12.2 per cent, organic brain syndrome 5.2 per cent and mental retardation 3.8 per cent'[3].

It has been stated in several forums that the incidence of mental illness in India is increasing. This cannot be substantiated since reliable estimates are not available from the past and increased numbers may be largely due to improved availability and utilisation of services.

COMMUNITY SELF-RELIANCE AND ACTION

There have been shifts from traditional modes of organizing health services for solving health problems, both internationally and nationally. Developed and developing nations are engaged in a serious review of their health care systems. Questions are being asked about the pattern of organ sing and financing health services. Ways for more equitable distribution of health care facilities are being devised. These issues are evep more urgent in the context of developing countries, where all the meager resources must be effectively utilized and harnessed.

Community participation for health care theoretically requires the promotion and inculcation of a value system which is based on mutual concern for members in the community. Villages in India are not homogeneous entities (where people are alig ned according to their caste and kinship groups) and efforts to organize to whom, and for what, occupy central points. Ideally, we would like to involve people in planning and implementation of the programme for their health, and share the fruits of programme — implementation with a sense of distributive justice. Involving all

TABLE 1

MENTAL DISORDERS DIAGNOSED AT SPECIALISED MENTAL HOSPITALS IN INDIA*

S.No	Causes	1979		1980		1982		1983	
		Number	Percentage	Number**	Percentage	Number	Percentage	Number	Percentage
1.	Senile and presenile organic psychotic conditions	640	1.5	625	1.4				
2.	Schizophrenic psychoses	24651	59.2	26055	58.5				
3.	Affective psychoses	7070	17.0	7057	15.8				
4.	Other psychoses	2569	6.2	3302	7.4	37674	82.2	38912	87.5
5.	Neurotic disorders	1112	2.7	970	2.2				
6.	Personality disorders	627	1.5	1044	2.3				
7.	Alcohol dependence	692	1.7	737	1.7	4229	9.2	5646	1.1
8.	Drug dependence	996	2.4	1260	2.8				
9.	Physiological malfunctioning arising from mental factors	100	0.2	420	0.9				
10.	Other neuroses	962	2.3	752	1.7				
11.	Mental retardation	2255	5.4	2352	5.3	1313	2.9	2082	4.4
	Total	41674		4574		45800		47143	

*Source: Health Statistics of India 1981 and 1982; 1983 and 1984 (Reference 9,10,11 & 12).

**Includes only those cases for which diagnosis available. Total cases seen were 55064.

along with existing village power-groups is a challenge. A critical operational aspect of promoting community participation is the identification of areas where people can participate and what can be done by whom? Farmer's clubs and youth clubs have been found to be effective for survey work; the community, after education, has been able to screen cataract cases requiring surgery, identify cases of leprosy, reduce deaths due to diarrhea through oral rehydration. It is necessary for community psychologists and psychiatrists to identify areas where communities or individuals can help to promote mental health. Youth forums and women's organizations at village level may be used for health care.

With the advent of new channels for communication, and increase in the outreach of media, it is important to design and implement a relevant and comprehensive information, education and communication strategy for mental health. During the seventh five year plan period (1985-1990), it is expected that 70 per cent of India's population will be covered by the television network. Information may include (a) causes of mental illness, (b) simple activities which may be instituted by people themselves to promote to mental health, and (c) existing health care facilities for the mentally ill. Incorporation of this information, in both formal and non-formal channels of education, needs to be promoted. A particular effort will have to be made for removing stigma attached to mental illness and harmful beliefs and practices of communities. A rational and scientific view to treat the mentally ill needs to be promoted.

ORGANISING RESOURCES FOR MENTAL HEALTH

Central and State Level

Provision of services for public health problems is considered to be largely the responsibility of the government. Through a network of health institutions at different levels, health care (including mental health care) is provided. The Directorate General of Health Services advises the Ministry of Health and Family Welfare in various technical matters at the centre. Programme advisors or units have been given the responsibility for formulating and implementing programmes for the control of diseases of public health importance, such as leprosy, tuberculosis, malaria, diarrhoeal diseases, blindness and others. At the different State headquarters, a similar but smaller organisation exists. States have to incorporate mental health as a part of their plan of action for health. There is a need to have permanent units at the Centre and States for formulating and coordinating the programme for mental health. These units will provide necessary continuity to the programme and considerably strengthen the process of programme formulation as well as monitoring. This has also been recommended by the Mental Health Working Group[1]. Presently, expert committees periodically meet for formulating a plan of action and providing technical guidance. The document of National Mental Health Programme for India clearly states that within a year, (reference year 1982), the Government of India will have appointed a focal point within the Ministry of Health specifically for mental health, and that within 5 years (by 1987), each State will appoint a programme officer responsible for organisation and supervision. This is yet to be done.

District Level

The States are divided into several districts. Each district has a population ranging from 1 to 4 million people. There are 420 districts in India. The districts headquarters are accountable to the State Health Directorates, and administer the health services both in rural and urban areas within the district. In a few States, such as Maharashtra and Gujarat, the district health organization is directly responsible to the *Zlla Parishad,* which is the district level representative body of the rural population. The Chief Medical Officer helped by 6-8 officers, is in-coordinating charge of all the health institutions and health programmes in the district. The district administration needs to be oriented to the requirements of mental health care. Several advances in therapy and approach will have to be made known through appropriate training. The creation of a post of psychiatrist in 50 per cent of the districts within five years has been recommended[1]. The psychiatrist at the district level is expected to visit all the primary health centers at least once a month to supervise the mental health programme. Continuing education of health personnel is to be made an integral part of these visits.

Block Level

Each district is further sub-divided into blocks. In the 5011 development blocks in India, 7210 primary health cetnres are functioning[4]. Each Community Development Block in a district has at leastone Primary Health Centre with a team of health personnel.

The medical doctors aided by health supervisor will be trained to provide the following services: (1) supervision of the MPW's performances of specified mental health tasks, (2) elementary diagnostic assessment of cases, using diagnostic and management flow-charts, and performing a standardized basic neurological examination, (3) treatment of functional psychosis, (4) treatment of uncomplicated cases of psychiatric disturbance associated with physical diseases like malaria, typhoid, mild to moderately severe deressive states anxiety syndromes and initial stages of functional psychoses with appropriate drugs, (5) management of uncomplicated psycho-social problems without the use of drugs, and (6) epidemiological surveillance of mental morbidity in the area and compilation of estimates of needs which would be submitted periodically to the next echelon for review and planning future services. In a way similar to the MPW's method of work, the medical officer will be guided by specified cut off points for referral of problems to a higher level of health service set-up. Twenty per cent of all physicians from the primary health centers are to be trained by 1987 (a 2-week course in mental health).

Multipurpose workers (MPWs) and health supervisors will be trained to deal with the following problems within his own community under the supervision and support of the medical officer: (1) management of psychiatric emergencies (e.g. acute excitement, crisis situations) through simple crisis-management skills and appropriate utilization of specified medicines, (2) administration and supervision of maintenance treatment for chronic psychiatric conditions in accordance with guidance by the supervisors, (3) recognition and management ot grandmal epilepsy

(particularly in children) through utilization of appropriate medicines under the guidance of medical doctor, (4) liaison with the local school teacher and parents in matters concerning the management of children with mental retardation and behavior problems, and (5) counseling in problems related to alcohol or drug abuse. The details for the programme implementation need to be worked out.

There are 21,019 beds in 46 mental hospitals in India[12]. There have been around 52,000 to 54,000 admissions in one calendar year, over three years, and an almost equal number of discharges[10,12]. It is believed that a more rational policy for inpatient treatment is required for optimal utilization of beds. There are, in addition, around 3,000 psychiatric beds in various general and teaching hospitals. Further, it has been estimated that there is one psychiatric bed for about 30,000 populations.

The resource requirements, such as for drugs, equipment, level of technology and manpower, need to be clearly spelled out. It has been observed that quite often for want of supplies and equipment, various institutions become ineffective and there is a need to strengthen the logistic and supply system.

TRAINING HEALTH PERSONNEL

Since the policy decision to provide basic health services through multipurpose workers areas was made (instead of the erstwhile unipurpose schemes where each worker provided services for control of specific diseases, such as leprosy, tuberculosis, malaria etc.), orientation training courses were designed. These may be augmented with respect to mental health. In particular, emphasis during training should be given to the development of the necessary skills, rather than only giving knowledge. Health Guides are given training for duration of 200 hours. They are also expected to educate the community about mental illness. However, only 1 hour is earmarked for this. In the curricula for health workers, only 2 hours out of over 2000 hours is devoted to mental health. The manual for basic training of male health workers does not include any information on mental health. An excellent manual has now been developed for multipurpose workers[15]. This could be used for other health personnel at the Block Extension Educators who are the key persons for all health education activities at block level and are trained for 450 hours. Mental health is not part of their curriculum at all[16].

VOLUNTARY AGENCIES AND PRIVATE PRACTITIONERS

Voluntary agencies have played an active role in the provision of medical care to communities, as well as in providing services for several public health problems, such as leprosy, tuberculosis, family planning etc. In addition to provide ambulatory services, the private and voluntary sector provide in-patient facilities in hospitals and homes. It is estimated that there are about 3,000 institutions with 1, 32,628 beds in this sector. Their contribution in mental health is almost negligible.

A large number of private practitioners are involved in providing curative medical care. Over half of the qualified medical graduates are in private practice.

They are most often the first contact for the mentally ill. Support to them by way of technical guidance and provision of back-up services may strengthen the mental care being provided to the community. There are 106 medical colleges, training about 13,000 graduates annually. It is estimated that these are in the ratio of 1:3622. Six thousand four hundred and thirty five seats are available for post-graduate degrees and diplomas, of which 136 are for psychiatry[9]. In 1982, only 17 doctors were awarded post-graduate degrees in psychiatry in India and, 13 were awarded diplomas[12]. About 10,000 graduates are trained annually from 106 Homoeopathic, 84 Ayruvedic, 13 Unani and a single Siddha College. According to the policy of the Government of India health care is to be provided by practitioners of various systems of medicine. A common frame of reference to select important areas of mental health needs to be evolved, in an attempt to improve the programme formulation and coordination.

OPERATIONAL ISSUES AND RESEARCH

Select issues for operational sing the mental health programme and areas of research are identified for improved formulation and implementation of a programme for mental health.

(i) ***Resource allocation:*** It is necessary to identify resource requirements for providing minimum mental health for all. Resource constraints also have to be identified and interventions may be tailored accordingly. How and where to allocate resources will require a careful analysis of inputs and their impact. The optimal strategy mix which would yield maximum benefits will have to be studied, so as to enable programme planners to make correct decisions. Paucity of resources may require choosing between spreading meagre resources thinly over a large population or a defined minimum in selected areas, in a phased manner. If the programme is to be initiated in a phased manner in some geographic areas, the selection criteria for such areas would have to be defined.

(ii) ***Designing a plan of action:*** It has been stated that the mental health programme would be so designed that it reaches those who are underprivileged and vulnerable. There are several socio-economic (poverty, illiteracy, scheduled castes) and demographic (age, sex) criteria to define these persons. They, however, reside in the same geographic region as the more privileged. And the services are planned for population groups in geographical areas. Designing an appropriate programme to reach those who need the services the most, is a challenge.

(iii) ***Graded facilities and referral:*** Defining the scope of services that community level health workers can and are providing is not enough. They are effective in the delivery of primary health care, including mental health care, only if adequate referral services are available. Therefore, it is essential for the experts in this field to determine (a) which category of worker will handle what problem; (b) what should be the range of services at primary, secondary and tertiary levels, as well as at different service facilities such as, sub-centers, clinics, primary health centers, community health centers, district hospitals and referral and specialized

institutions. Guidelines have to be developed for building a referral system which indicates clearly whom to refer, where to refer, when to refer and perhaps even the transportation of such patients.

(iv) ***Assessment of realistic workload****:* It is extremely important to assess the total feasible workload of the health workers in the field. Excellent field studies have shown that it is possible to train multipurpose workers to provide the necessary services for mental health". It is equally important to develop a realistic and feasible 'work module' in accordance with the total responsibilities of the worker. Similarly, while recommending additional training needs for mental health, operational guidelines for incorporating it into the existing training network, as well as additional resource requirements, should be indicated.

(v) ***Mental health and general development:*** Knowledge regarding mental health is to be applied for social development. There is a need to identify elements which promote and hinder mental health, so that appropriate steps maybe instituted. It is not adequate only to identify the elements but also to develop such mechanisms and incorporate these positive elements into the existing organization.

(vi) ***Promoting voluntary effort:*** The government and several international organizations have decided to promote voluntary effort, where well-defined action programmes are formulated. A detailed exercise may be done to identify areas in which voluntary organizations can actively participate, as well as priorities of the government and other funding organizations, where financial support is available. A plan of action could be evolved to select some areas where voluntary organizations can participate, such as (a) delivery of services at community level (particularly in areas not covered by other service agencies), (b) training different personnel providing mental health care, (c) promoting community organization and support, (d) designing effective educational packages on select important areas in mental health, both for technical personnel and the general public, (e) educating the community, (f) providing a technical information service for continuing education of personnel delivering mental health care.

(vii) Developing modules for community participation in mental health care.

(viii) Designing a relevant information, education and communication strategy for promoting mental health.

(ix) Development of more effective training for all categories of health personnel.

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भारत में मानसिक स्वास्थ्य के लिए एक विस्तृत कार्यक्रम बनाया जा रहा है। मानसिक स्वास्थ्य सेवाओं को सामान्य स्वास्थ्य सेवाओं के साथ प्रदान करने का

एक निर्णय लिया गया है। समुदाय के संसाधनों को जुटानेः मानसिक स्वास्थ्य को प्रोत्साहित करने के लिए एक जनजाग्रति उत्पन्न करने, स्वास्थ्य सेवाएं प्रदान करने वाले स्वास्थ्य कर्मचारियों की दक्षता को बढ़ाने, कार्यक्रम संगठन को बनाने व आगे बढ़ाने तथा समन्वय के लिए और स्वैच्छिक प्रयास को प्रोत्साहित करने की आवश्कता महसूस की जाती है। अनुसंधान के लिए चयनित क्षेत्रों की पहचान की गई है और भारत में मानसिक स्वास्थ्य सेवाओं को संगठित करने के मुद्दों पर भी प्रकाश डाला गया है।

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A COMPARATIVE STUDY OF LAPAROSCOPIC AND CONVENTIONAL ABDOMINAL STERILIZATION IN CHICKMAGALUR DISTRICT OF KARNATAKA

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ABSTRACT

This paper deals with Laparoscopic Sterilization Programme in Karnataka. This paper analyses the trends, characteristics of acceptors, people's perception and complication with regard to Laparoscopy. About 149 laparoscopic tubectomy acceptors were interviewed to know their perceptions and complications. The preference for accepting the method is mainly due to no hospitalization, less time for resuming normal activities, etc. The declining trend in laparoscopic tubectomy which may be due to failure of operations resulting in conceptions which have to be tackled more effectively if the programme is to be made successful.

In Karnataka, Laparoscopic Tubectomy was introduced around 1979-80. During 1980 laparoscopic tubectomies were done only in a few districts of Karnataka and in 1981 it was introduced throughout the State. These sterilizations are done both at mass camps as well as at mini camps. The advantage of this method is that it can be used for interval sterilization under local anesthesia and on an out-patient basis. The acceptor can recover within a few hours and resume work much earlier than Conventional Abdominal Tubectomies. Studies on the Indian experience in Laparoscopic Sterilizations are very scanty. Here, an attempt has been made to study the trends in Laparoscopic Tubectomy in Karnataka and also to assess the people's perception and knowledge about this method.

MATERIALS AND METHODS

Household data collected for Evaluation of MCH and FP in Chickmagalur District has been used. The survey conducted in Chickmagalur District covered 149 Laparoscopic and 157 Conventional Abdominal Tubectomy acceptors[1]. The data on performance of Laparoscopic Tubectomy of the district were taken from various issues of Family Welfare Programmes Year Book, published by the Directorate of Health and Family Welfare Services.

Previous Studies Relating Laparoscopic Tubectomy

The previous studies reveal that most of the Laparoscopic Sterilization

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acceptors are from rural areas, most of them were in the age group of 30-34 years. Average number of children ranges from 3.4 to 3.9 per acceptor. In rural areas acceptors indicated to have received information about the method through interpersonal contacts with the family planning workers and the doctors. Mass media were the most important source of information in urban areas. Reasons for preferring this method were mainly: (i) no hospitalisation; (ii) performed by better experts; (iii) rest needed at house; and (iv) interval to resume normal activities was shorter as compared to Conventional Abdominal Tubectomy. It is important to note that 64.5 per cent of the acceptors stated that they would not have undergone sterilization if this method had not been available. Out of 785 Laparoscopic Acceptors, 8 became pregnant after operation, 2 of those after 6-9 months of operation, 6 acceptors more than 12 months according to the D&E Study of Madhya Pradesh. About 73 per cent of Conventional Abdominal Tubectomy operations were done during post-partum period, whereas Laparoscopic Sterilization covered a large number of women as interval cases 96 per cent as per study conducted by the Population Centre, Bangalore. None of the Conventional Abdominal Tubectomy acceptors became pregnant.

Trends in Laparoscopic Tubectomy

The performance of Laparoscopic Tubectomies by district from 1980-81 to 1984-85 is shown in Table 1. During 1980-81, Laparoscopic Tubectomy was introduced only in a few districts. In 1981-82, it was introduced throughout Karnataka. Percentage of Laparoscopic Tubectomy to total Tubectomy during 1980-81, 1981 -82, 1982-83, 1983-84, and 1984-85 corresponds to 12, 33, 39, 25 and 21 respectively. Even though Laparoscopic programme started around 1980 in Karnataka, it reached peak during 1982-83 (39%) and from 1983-84 it started declining which has come down to 21 per cent during 1984-85. Rates of Laparoscopic Tubectomy per thousand population in Karnataka during 1980-81, 1981 -82, 1982-83, 1983-84, and 1984-85 corresponds to 0.48,1.6, 2.3,1.4 and 1.3 whereas Conventional Abdominal Tubectomy corresponds to 3.4, 3.3, 3.6,4.4 and 5.0.

Socio-economic and Demographic Characteristics of the Acceptors

With regard to socio-economic characteristics, it was observed that relatively higher proportion of the women with Laparoscopic Sterilization and their husbands were illiterates, and the percentage engaged in agricultural labour was also higher. The household income of women with Laparoscopic Tubectomies did not differ markedly from the Conventional Abdominal Tubectomies, however, women who had Laparoscopic Sterilizations had slightly lower household income in general.

As far as the demographic characteristics of acceptors is concerned the average ages of Laparoscopic and Conventional Abdominal Tubectomy acceptors were 29 and 28.1 years respectively as given in Table 2. About 62 per cent of

TABLE 1

LAPAROSCOPIC TUBECTOMY'S PERFORMANCE FROM 1980-81 TO 1984-85

	1980-81	1981-82	1982-83	1983-84	1984-85
Bangalore (U)	909	446	2744	1677	1393
Bangalore (R)	1406	2644	9810	1310*	NA
Chitradurga		5977	2928	6440	2735
Kolar		2037	11149	1008*	810
Shimoga		2413	4695	548*	NA
Tumkur		3240	6643	845*	2613
Belgaum		3920	5715	3358	4137
Bijapur	1528	4801	4242	4847	2742
Dharwad	9215	3049	3362	7129	3484
Uttara Kannada	1252	1878	3145	3035	2687
Bellary		7061	5499	2874	2502
Bidar		1544	505*	1051*	1310
Gulbarga		4465	7347	4118	5405
Raichur	1954	2761	4443	4609	6629
Chickmagalur		1693	2993	2286*	1369
Dakshina Kannada	696	3199	5521	4735	7177
Hassan		1434	3857	3143	2974
Kodagu		1433	1675	1431	1004
Mandya		2697	2508	3002	4741
Mysore		4549	1911	928	2302
KARNATAKA	16960	61241	90692	58374	56014

*Figures incomplete.

Source: Monthly Bulletin, Family Welfare and MCH Programme, Karnataka.

TABLE 2

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF LAPAROSCOPIC AND CONVENTIONAL ABDOMINAL TUBECTOMY ACCEPTORS

	Laparoscopic	Conventional Tubectomy
Percentage of Illiterates	51.7	44.6
Percentage of Agricultural Labourers	45.0	26.1
Mean Age of Acceptors	29.0	28.1
Percentage of Acceptors < 30	62.4	74.5
Percentage of Acceptors 30 and above	37.6	25.5
Mean living children	3.5	3.3
Percentage of Acceptors with number of living children 3 or less	61.0	65.6
Percentage of Acceptors with number of living children above 3	39.0	34.3
Mean children ever born	3.9	3.7

Laparoscopic and 74.5 per cent of Conventional Abdominal Tubectomy acceptors were aged below 30 years. Laparoscopic and Conventional Abdominal Tubectomy acceptors had on an average 3.5 and 3.3 living children. About 61 per cent of Laparoscopic and 65.6 per cent of Conventional Abdominal Tubectomy acceptors had three or less number of living children. Mean children ever born among Laparoscopic acceptors is slightly high (3.9) as compared to Conventional Abdominal Tubectomy acceptors (3.7). Percentage of Laparoscopic acceptors coming from slightly higher age group and higher parity is more as compared to Conventional Abdominal Tubectomy which may be due to interval sterilization. Eleven per cent and 55 per cent of Laparoscopic and Conventional Abdominal Tubectomy acceptors had the operation within a month of delivery, 53 per cent of Laparoscopic and 34 per cent of Tubectomy acceptors had the operation within an year of delivery, 36 per cent of Laparoscopic and 11 per cent of Tubectomy acceptors had the operation after one year of delivery.

Knowledge, Motivation and Reasons for Accepting the Method

Health staff have contributed much in providing knowledge and motivation with respect to Laparoscopic Sterilization. Fifty-two per cent of Laparoscopic acceptors, 34 per cent of Tubectomy acceptors were given knowledge about the method by health staff as shown in Table 3. Forty-eight per cent of Laparoscopic and 31 per cent of Tubectomy acceptors were motivated by health workers, and 32 per cent of Laparoscopic and 52 per cent of Tubectomy acceptors were self-motivated. Percentage of self-motivated among Conventional Abdominal Tubectomy acceptors is high (52%) as compared to Laparoscopic acceptors (32%) which may be due to traditional practice.

The major reasons given by Laparoscopic acceptors for preferring this method according to 38.4 per cent of the respondents were that the Laparoscopic Sterilization consume less time, needs less hospitalization and does not affect working. About 16 per cent of acceptors accepted it as per the advice of the health staff while another 12 per cent of them gave multiple responses such as "Doctor said this is a good method", "husband liked it", and "not much stitches in this". Among Conventional Abdominal Tubectomy acceptors as high as 29 per cent of them gave multiple responses for preferring this method such as there is "no fear of conception in this", "people said this is good", and "relatives and neighbors have experienced it". Other than this 21 per cent of them adopted because it was the only method available at that time *(i.e.* regular camps will be held once a week). Twelve per cent of them accepted because it is quite popular method in the area. Eight per cent of them knew only this method. Twenty-six per cent of Laparoscopic acceptors and 25 per cent of Tubectomy acceptors felt that any method was good enough for preventing birth. This was because of the fact that acceptors' motive was just to reduce the family size and not for any other reasons.

TABLE 3

KNOWLEDGE, MOTIVATION AND REASONS FOR ACCEPTING THE METHOD

	Laparoscopy	Tubectomy
SOURCE OF KNOWLEDGE		
Doctor	9 (6%)	4 (2%)
Health Staff	78 (52%)	53 (34%)
Acceptors/Neighbours/Relatives	26 (17%)	70 (45%)
Mass Media/Husband/Others	8 (5%)	4 (3%)
Multiple Response	28 (19%)	26 (16%)
MOTIVATION		
Self	48 (32%)	82 (52%)
Health Worker	71 (48%)	48 (31%)
Doctor	7 (5%)	4 (3%)
Husband/Relatives and Others	11 (8%)	13 (8%)
Multiple Response	12 (8%)	10 (6%)
REASONS FOR ACCEPTING THE METHOD		
Available at that time	8 (5%)	33 (21%)
Popular Method in the area	5 (3%)	19 (12%)
Health Staff recommended this method	24 (16%)	8 (5%)
Consumes less time/less hospitalisation/does not affect working	56 (38%)	-
Know only this method	-	13 (8%)
Any method for limiting the size	38 (26%)	39 (25%)
Multiple Response	18 (12%)	45 (29%)

People's Conception about Laparoscopic and Conventional Abdominal Tubectomy

The percentage of acceptors reporting complications among Laparoscopic Sterilization were 40 per cent and among Conventional Abdominal Tubectomy, it was 34 per cent. Out of these who reported complications, 76 per cent of Laparoscopic and 58 per cent of Conventional Abdominal Tubectomy acceptors reported that the complication started within one year of operation. Majority of them had only stomach pain, back pain, and general weakness in the body. Only 5 per cent of the total Laparoscopy acceptors conceived after the operation.

More than 90 per cent were satisfied by both the methods. Of these satisfied acceptors, 57 per cent of Laparoscopic acceptors and 58 per cent of Tubectomy acceptors have suggested to others of which nearly 45 per cent acceptors respondents of both the methods have accepted the methods.

The interval to resume normal activities was more in case of Conventional Abdominal Tubectomy. Of the Laparoscopic acceptors 60 per cent resumed duty within a month of operation whereas it was only 8 per cent among Tubectomy acceptors. Fifty-four per cent of Tubectomy acceptors took 3 to 6 months to attend normal activities whereas it was only 8 per cent among Laparoscopic acceptors.

None of the Conventional Abdominal Tubectomy acceptors became pregnant. Out of 149 Laparoscopic acceptors who were interviewed for the survey, 5 acceptors reported that they conceived and were delivered after the operation, one acceptor conceived and underwent Tubectomy, one conceived and underwent MTP, and one was pregnant at the time of interview. Of the 8, two of them knew during operation that they had conceived. Only one was not medically examined. All the conceived acceptors were operated in the camps. Further investigations were not made whether these failures were due to camp arrangements or due to technique failure etc. A large sample is needed in order to study the complications and failures of this (Laparoscopic Tubectomy) method. Further investigations are also necessary in this field.

CONCLUDING REMARKS

1. The preference for Laparoscopy compared to Conventional Tubectomy among the acceptors is mainly due to no hospitalisation, less time for resuming normal activities and it is done by experts.

2. It is possible that the declining trend in Laparoscopic Tubectomy is due to failure of the operation resulting in conceptions. Laparoscopic Tubectomy provides good scope for improving the overall performance of the programme because of its perceived advantages. However, the failures due to this method have to be tackled effectively, if the programme is to be made successful.

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इस पेपर में कर्नाटक में लैपरोस्कोपितक बन्ध्याकरण कार्यक्रम के विषय में बताया गया है। यह पेपर लैपरोस्कोपी के विषय में रूख, इसे स्वीकार करने वालों के गुणों लोगों के दृष्टिकोण और इसकी जटिलताओं का विश्लेषण करता है। लैपरोस्कोपिक विधि से वन्ध्याकरण कराए हुई 149 महिलाओं के इन्टरव्यू उनके दृष्टिकोण व जटिलताओं का पता लगाने के लिए आयोजित किए गये। इस विधि को अपनाने की प्राथमिकता का कारण मुख्यतः अस्पताल में भर्ती न होने व सामान्य काम–काज को पुनः संभालने में कम समय आदि के कारण है।

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A STUDY ON THE DETERMINATION OF NUMBER OF MEDICAL OFFICERS REQUIRED FOR AN OUTPATIENT DEPARTMENT IN A HOSPITAL

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ABS TRACT

Health is a state subject. This means that the various States in this country enact their own rules, regulations, norms and procedures for the delivery of health care. It means, the pattern of legislation, execution and implementation of medical care has little uniformity in the country and it is true in respect of the staffing norms of medical and Para-medical workers working in the hospital and health centers. This paper estimates the norms of requirement of medical officers for an out-patient department in a hospital. These norms have been calculated keeping in view the guidelines laid down by the ILO as well as in the work-study techniques. The norms thus worked out would be useful for health and hospital administrators in the country for planning the medical manpower requirements for the out-patient department in a hospital.

Since independence the growth of medical services in urban India has been phenomenal. The rural areas constitute more or less the catchment areas for these urban institutions. The population of India is increasing by 2.25 per cent perannum; concomitantly the morbidity in the population. This has led to an ever increasing workload in these urban medical centers. Thus, the number of patients to be attended to especially in large general hospitals is a factor to be reckon with, in providing effective services to the sick and needy[1],[2].

In providing the services the medical officers play a pivotal role. Not only they should be qualified but also they should be provided in adequate numbers to attend the out-patients and follow-up of the review cases. For the purpose of the estimation of the medical officers necessary for OPD work there is a need to develop a standard procedure with flexibility for modulation according to seasonal trends among patients who come to the hospitals. Such a procedure would help in providing services in an efficient and effective manner and also to guide the hospital administrators in planning the services required. The hospital chosen for the study was the Safdarjang Hospital, New Delhi, which is a general, large-sized and

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teaching hospital catering to patients from different socio-economic backgrounds and providing a variety of diagnostic entities to be treated[3],[4],[5].

METHODOLOGY

The Safdarjang Hospital, New Delhi has been the venue of study. It has a non-paying bed capacity of 1207 beds, spread over 54 wards. It has over 40 departments representing various specialties. The patients drawn are mostly from Delhi and adjoining States and even from neighboring countries. It has supportive services of Medical Records Department, Central Sterile Supply Department, Laundry, Dietary etc. Special mention may be made of the MRD, which is well organized and has a centralized indoor patient record system. The outdoor patient record system is fairly well developed in the specialty clinics. However, it is yet to be developed in general OPDs.

The medical out-patient department consists of three units and is headed by the Professor and Head of the Department of Medicine. It provides OPD services over the week, each unit functioning on two specific days of a week. These units also have special clinics like Cardiology, Nephrology, Haematology, Diabetology etc.

For the purpose of developing a procedure it would be necessary to collect requisite data in different phases of study; retrospective study, prospective study, activity sampling, time study etc. In the retrospective studies information was collected on workload, physical layouts, staffing pattern, seasonal trends etc. This phase of the study was followed by a time study in which the average time taken by the doctor was also computed[6],[7].

In regard to the workload the data were collected for five years (1981-85) according to the classification of new and old cases. For monthly distribution the data were collected for three years (1983-85) from which the seasonal trends were analyzed. For the description of the layout, the space available for the OPD, number of examination cubicles, size of cubicles, staff that work therein, facilities available for the patients, etc. were observed for a period of seven months. This study is self limiting in nature and aims only at estimating the medical manpower requirement for an out-patient department. Therefore, other organizational aspects such as physical layout, patients flow, jobs types and worker types are not described.

Based on the standard timings, the number of doctors required were calculated. The total number of cases for any disease group was obtained by multiplying the proportion of the observed number of cases in the disease group to the average number of cases per day in the medical OPD. These estimated number of cases were in turn multiplied by the standard time to obtain the total time required to examine all patients in the disease group. The sum of the total timings is the overall total time required to examine the average number of cases belonging to various disease groups that attended medical OPD on any day of the year. The total time required (based on the standard timings) was divided by three (scheduled number of hours in the OPD) to obtain the number of doctors required.

The time study was conducted in consultation with the Head of the Department over the period of two months, February-March, 1986. This study was done with a stopwatch and confined to a single chosen doctror who was expected to be available on all OPD days during the period of the unit to which he or she belonged. The purpose of the study was explained to the doctor and necessary rapport was developed in order to create a situation of normal functioning by the doctor without the consciousness of the presence of the investigator. Earlier to the initiation of the time study an inventory of mutually exclusive job elements was made right from the time of entry of patients into the doctors' cubicle upto his exit, the time of each job element was noted by the authors with the help of a stopwatch in minutes and seconds. Fraction of seconds were rounded off to the nearest digit. It may also be noted that the timings for each of the job elements from start to finish were noted and any deviation or disturbance for the doctor by way of being called over the telephone or other discussions related to the patient care activities were not recorded in the time study.

Necessary instructions for modulating the flow of patients were discussed with the doctor. The doctor was taken into confidence and was requested to strictly follow the sequence of operations like calling the patient, history taking, physical examination, investigation writing, prescription writing, advice giving etc. and were strictly followed throughout the study. After the patient has left, the diagnoses provided by the doctor were noted. These diagnoses were subsequently classified into broad disease groups.

Recording was done on a sample of 263 out-patients spread over thirteen OPD days. Thus, during each OPD day an average of twenty patients were observed starting from 9 a.m. to 12 noon, the scheduled duration of OPD operation. Based on the average timings, standard timings were subsequently arrived at in accordance with the procedure laid down by ILO in its publication 'Introduction to Work-Study". Subjectively, all the activities of the doctor were rated and a rating of '100' was taken as normal. The rating was done in multiples of '5'. A rating of more than 100 indicates hurried performance less than 100 indicates slow performance. Basic time was derived from each one of these activities by multiplying mean observed time and rating. Sum of the basic time was Total Basic Time. Contingency Allowance (CA) and Relaxation Allowance (RA) were applied to arrive at the standard timings[8], [9].

RESULTS

It can be noticed from Table 1 that the Medical OPD attendance constitutes nearly 8 per cent of the total attendance. As regards the total attendance the ratio between new and old cases is nearly 1:1, while in medical OPD it is 2:1. The increase among new cases showed good deal of divergence in total and medical OPD attendance, while for the old cases it was only 0.5 per cent in the total attendance the corresponding percentage in the medical OPD was 17 per cent. In respect of the new cases these percentages were nearly 6.50 per cent and 3.40 per cent respectively.

Interesting observations have emerged from Table 2. The seasonal trends in old, new and total cases are shown in the graph. The cases for two consecutive

TABLE 1

NUMBER OF OUTPATIENTS TREATED IN MEDICAL OPD OF SAFDARJANG HOSPITAL ACCORDING TO NEW AND OLD CASES DURING 1983-1985

Year	Total outpatient attendance			Medical OPD attendance		
	New Cases	Old Cases	Ratio	New Cases	Old Cases	Ratio
1983	566680	637824	1: 1.20	60425	32824	1.84: 100
1984	545270	648992	1: 1.20	61677	36962	1.67: 100
1985	603242	640965	1: 1.06	62488	38637	1.62: 100
Average	571731	642594	1: 1.12	61530	36141	1.70: 100

TABLE 2

AVERAGE MONTHLY ATTENDANCE *OF* NEW AND OLD MEDICAL OUTPATIENTS FOR THE YEAR 1983-85

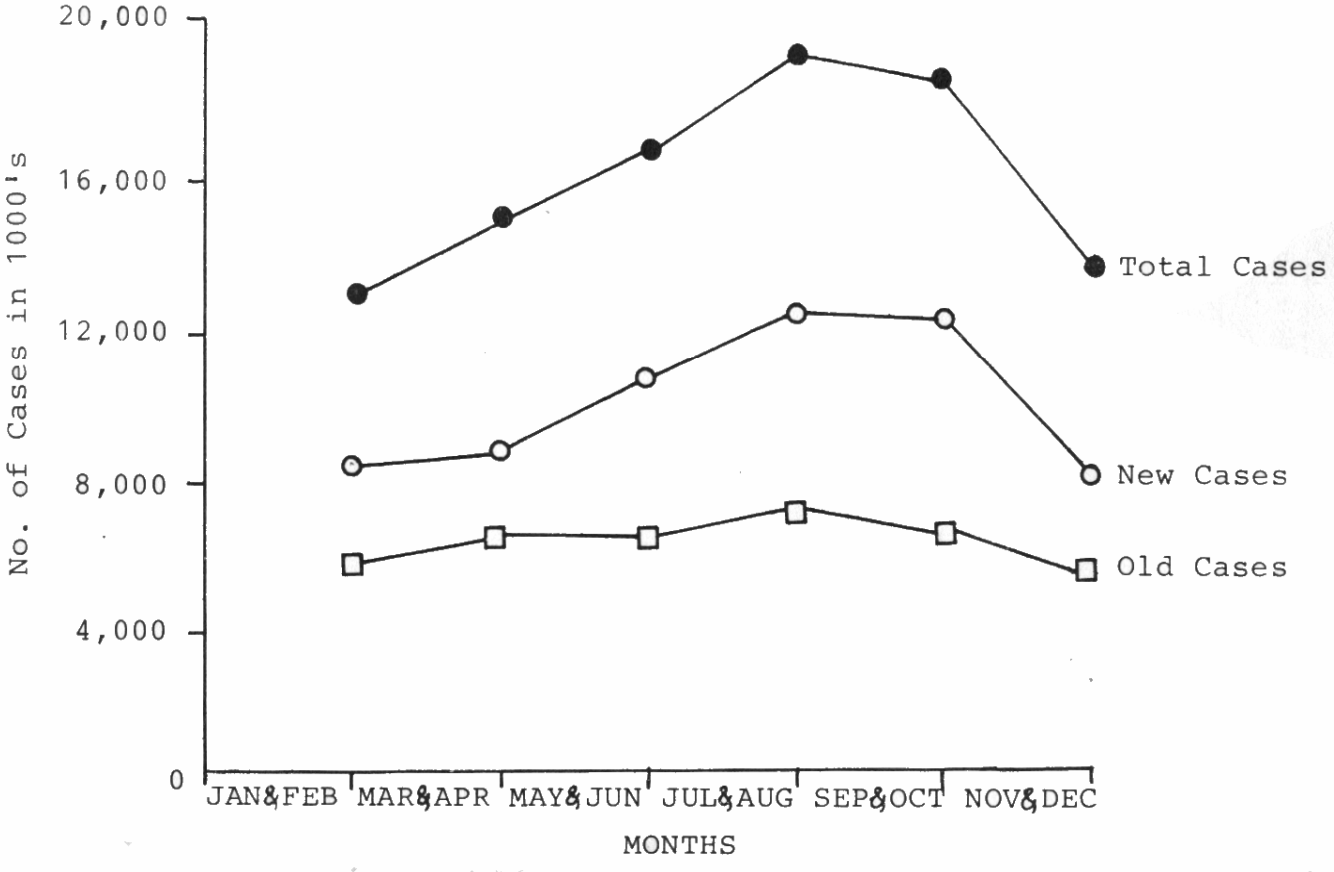
Average Total Cases - 96,094

Months	New Cases	Old Cases	Total Cases
January	4059 (61)	2631 (39)	6690
February	4222 (59)	2892 (41)	7114
March	3979 (56)	3084 (44)	7063
April	4581 (59)	3172 (41)	7753
May	5081 (63)	2966 (37)	8047
June	5362 (63)	3144 (37)	8506
July	6079 (63)	3536 (37)	9615
August	6079 (65)	3319 (35)	9398
September	6538 (67)	3256 (33)	9794
October	5596 (64)	3083 (36)	8679
November	3944 (60)	2634 (40)	6578
December	4035 (59)	2822 (41)	6857
Average	4963 (62)	3045 (38)	8008

Note: 1. All decimals were rounded to the nearest figures.

2. Percentages are indicated in brackets.

GRAPH SHOWING SEASONAL TRENDS IN OPD ATTENDANCE



months have been clubbed together. While for the old cases the trend is not sharp, for the new cases however, it is clearly displayed. The same trend is reflected for the total number of cases too. The peak months for the new cases were from July to September while the lean months were from November to April. The daily average for the lean and peak periods were 262 and 392 cases respectively.

Daily average basic information on the total medical OPD attendance (new and old) was collected during the period September, 1985 to March, 1986 with 32,171 new cases and 22,033 old cases. Data for a given specific day in a week were added together for the same day for the entire period. The daily averages were derived based on thirty observations during the period which can be treated as a representative sample for the whole year. The results so derived are given in Table 3.

The maximum attendance was found on the first day of the week and the daily average was nearly 316 cases. The average observed timings were calculated by the disease group in a seven point classification which roughly corresponds to the broad groupings of International Classification of Diseases. The time taken per patient for each one of the disease groups were recorded. The total number of cases for which the observations taken were 263 in all and for each disease groups it was not less than 16 in number. The findings on these aspects are presented in Table 4.

Results of average observed timings and the standard timings are given in Table 4. The average time taken for the patient was the highest for genito-urinary disease 9 minutes and forty seconds followed by cardiovascular diseases-8 minutes and 33 seconds and respiratory diseases 6 minutes 28 seconds. The average time taken in Medical OPD per patient was 6 minutes and 41 seconds. It may be seen from the table that the time allowed for contingency allowance (CA) and relaxation allowance (RA) vary from 1 to 2.80 minutes depending upon the group of diseases. The CA would obviously be more for the genito-urinary group of patients whose examination require strict privacy, scrutiny, use of gloves removing gloves and hand washing after examining each patient. The time allowed against CA and RA together in other category of patients does not exceed 20 to 30 per cent of the total standard time. The CA and RA have been calculated[1].

The average standard time for medical out-patients was 8 minutes and 54 seconds. Genito-urinary diseases and miscellaneous groups had standard timings more than the average value to the extent of nearly 50 per cent in two cases and 25 per cent in case of one disease group. The remaining five disease groups accounted for less than the average value. The average standard timings were more than the observed average timings by 33 per cent. This can be compared favorably with the standard elsewhere abroad. These were used to calculate the number of doctors required in the medical out-patient department utilising the percentage distribution of the disease groups on an average day, the average number of cases in each disease grouos. Summing up these results the total time that would be equired on an average day in OPD has been derived and the number of doctors that

TABLE 3

DAILY AVERAGES WERE DERIVED BASED ON THIRTY OBSERVATIONS DURING THE PERIOD WHICH CAN BE TREATED AS A REPRESENTATIVE SAMPLE FOR THE WHOLE YEAR

Week Days	New Cases	Old Cases	Total Cases	Percentage distribution of outpatients each day in a week
Monday	224.10	136.63	360.73	19.00
Tuesday	179.39	124.38	303.77	16.00
Wednesday	193.44	119.80	313.23	16.50
Thursday	195.86	131.41	327.27	17.24
Friday	158.57	120.31	278.88	14.70
Saturday	175.25	139.03	314.28	16.56
Average	187.77	128.59	316.36	100.00

TABLE 4
AVERAGE OBSERVED AND STANDARD TIME BY SYSTEM CLASSIFICATION

System	No. of Cases	Percentage Distribution	Average observed time in minutes	Standard time in minutes
Respiratory system disease	90	34.22	6.28	8.19
Fever of all origin	43	16.35	4.35	5.32
Gastro-intestinal diseases	39	14.83	5.52	7.14
Nutritional diseases	30	11.41	3.56	4.59
Genito-urinary disease	21	7.98	9.40	12.11
Cardio-vascular disease	16	608	8 33	10.36
Miscellaneous group	24	9.13	9.34	12.05
Total and Mean	263	100	6.41	8 minutes 54 seconds

could be required is obtained by the total time available in a medical out-patient departments.

This procedure led to the calculations umber of doctors. In the present situation at Safdarjang Hohere the average daily workload in medical OPD is as high as 316. Therefore, 14 doctors in all would be required as against 11 doctors presently available. The results are given in Table 5.

DISCUSSION

The total out-patient attendance in the whole hospital does not show any appreciable increase over the three year period of 1983-85. Past experience, however, indicates that every year the number of patients tends to increase. This phenomenon cannot be ruled oure. Number of doctors required is correlated with the number of patients and the available time. Thus, arises the need for periodical application of the methodology at least once in every five years. Seasonal trend exists both in new and old cases. The peak period of attendance correspondainy seasons and the lean period to winter and spring seasons. Although this trend technically affects the total number of doctors required its variation in an year would, however, be not amenable for administrative application. Apart from the influence which the total workload will have on the

TABLE 5

THE AVERAGE NUMBER OF DOCTORS REQUIRED IN MEDICAL OUTPATIENT DEPARTMENT

Disease Groups	Total time spent in examining OPD cases in minutes	
Respiratory system disease	= 90/263 x 316 x 8.19	= T_1 = 885.38
Fever of all origin	= 43/263 x 316 x 5.32	= T_2 = 274.52
Gastro-intestinal diseases	= 39/263 x 316 x 7.14	= T_3 = 334.35
Nutritional diseases	= 30/263 x 316 x 4.59	= T_4 = 165.27
Genito-urinary tract diseases	= 21 /263 x 316 x 12.18	= T_5 = 307.20
Miscellaneous group	= 24/263 x 316 x 12.05	= T_6 = 347.29
Cardiovascular, disease	= 16/263 x 316 x 10.36	= T_7 = 199.10
		$\sum$ T 2513.11

$$\frac{\text{That is } 2513.11}{60 \times 3} = 13.84 \text{ say } 14 \text{ doctors}$$

results, the disease group with varying standard timings will have to be taken into account. Based on the observations of 263 cases, the diagnostic spectrum of cases at the medical OPD has been determined. These have been grouped into meaningful seven point classification. The miscellaneous group therein consists of a small number of different disease entities. The total cases are not accounting for more than ten per cent.

The average observed timings has a good deal of range varying from 9 minutes 40 seconds to 3 minutes 56 seconds. This wide variation and small percentage itself indicates the appropriateness of the classification. Justified on these two grounds this classification would be applicable in any of the medical OPD situation of a large or small hospital. This classification is also suitable on another account that is the number of observations on each of these groups, the least number of cardiovascular diseases, while the largest number was found in respiratory system diseases. Empirical investigations in respect of the appropriateness of the classification could not be ruled out. Such investigations may be directed to an increase in the sample size of the cases observed and the resulting percentage distribution of the disease groups in relation to the sample size.

The standard timings derived from the average observed timing would have the same range as that of the observed timings. The calculation of the total number of doctors based on the standard timings for all the disease groups would add the sensitivity and to the estimation of the total number of doctors. The average time can be further reduced by introducing improvement in job methods such as using the rubber investigation stamps in place of writing and filling up separate investigation forms.

The development of methodology for estimation of standard timings enumerated above was in the setting of large hospitals and total monthly medical OPD attendance of about 8000 cases. These cases are essentially drawn from different groups of disease entities which may roughly correspond to the morbidity distribution in the community. The sample size that have been adopted in the present study may be correlated with the percentage distribution of morbidity itself. The present method of estimation should be applicable to all settings of varying sizes of hospitals. The usefulness of this method is established not only on account of the soundness of classification of disease groups and large sample size for calculation of observed timings but also on account of the standards of allowances recommended by the ILO.

In view of the likely changes in out-patient attendance, the repetition of this methodology periodically say once in every five years would be most desirable so as to lay down certain standards to modulate the strength of the working staff as doctors in OPD department, subject to any administrative conveniences. These standards can be adopted to add to the efficiency and effectiveness of the medical out-patient care programmes.

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स्वास्थ्य एक राज्य विषय है। इसका तात्पर्य यह है कि इस देश में विभिन्न राज्य स्वास्थ्य रक्षा प्रदाने करने के लिए अपने नियम, प्राविधान, तौर–तरीके और प्रक्रिया निर्धारित करते हैं इसका अर्थ यह है कि इस देश में चिकित्सा रक्षा के कानून बनाने, उसका पालन व कार्यान्वयन करने में शायद ही समानता हो और ऐसा ही अस्पतालों व स्वास्थ्य केन्द्रों में कार्यरत चिकित्सकीय और अर्द्धचिकित्सकीय कार्यकर्ताओं के स्टाफ पद्धति के विषय में सत्यता है। इस पेपर में एक अस्पताल में बाह्य रोगी विभाग के चिकित्सा अधिकारी की आवश्यकता के पैमाने का आकलन किया गया है। इस पैमाने का निर्धारण आई. एल. ओ. द्वारा निर्धारित मार्गदर्शिकाओं व कार्य–अध्ययन तकनीकों के आधार पर किया गया है। इस प्रकार निर्धारित किये गये आधार देश के स्वास्थ्य एवं चिकित्सा प्रशासकों के लिए एक अस्पताल में बाह्य रोगी विभाग की चिकित्सकीय मानव संसाधन जरूरतों के नियोजन में लाभप्रद होंगे।

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HOSPITAL PUBLIC RELATION

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ABSTRACT

In this paper public relation in a hospital has been discussed. The role of public relation in general and its need and applicability in a hospital situation has been highlighted. Organization of public relation activities in a hospital has been presented and the steps needed to have an effective public relation programme in a hospital have also been discussed. The sensitive areas which need more emphasis of public relation activities have been identified.

Hospital as a community institution is no more a simple and a small organization. With time not only the size of the hospital has increased but also more complexities have grown up because of various factors. The most important factor which has made the hospital a complex entity is the rapid development in the science of diagnosis and treatment of diseases. The diagnostic and therapeutic infrastructure of the modern hospital attracts a large number of patients seeking relief from diseases and injury. Introduction of modern biomedical equipment, advanced specialization in medical disciplines and the changing role of the hospital have all led to the creation of a dynamic and complex institution. The hospital clientele has also changed radically and today the hospital is utilized by educated and affluent class of society. This clientele is demanding and puts lot of pressures on hospital operations. More often than not the people are dissatisfied and unhappy with the services that a hospital provides. This is, in spite of the fact that more sophisticated machinery as well as highly trained manpower is deployed in the hospital. There is thus a great need to have free communication with the society which uses hospital services. Hospital public relations, therefore, has assumed great significance in today's hospital management.

DEFINITION

Various terms like publicity, propaganda and advertising are used frequently. These are not the same as public relations.

PUBLICITY

Publicity is concerned with dissemination of information about an organisation to attract attention or to publicise products of activities. The objective of publicity is

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to gain recognition, build image and win the approval of the target audiences.

PROPAGANDA

Propaganda is an organized effort to propagate a doctrine, an idea or a cause. Propaganda may not have an ethical content. It is based solely on self-interest.

ADVERTISING

Advertising is buying of space in print or time on air to promote the sales of products, acceptance of ideas or to earn goodwill.

Public relations are the management function which evaluates public attitudes, identifies the policies and procedures of an individual or an organization with the public interest and executes a programme of action to earn public understanding and acceptance. Implicit in the definition is the threefold functions of the professional practitioner:

i. to ascertain and evaluate public opionion;
ii. to counsel management in ways of dealing with public opinion as it exists; and
iii. to use communication to influence public opinion.

Hospital public relations is therefore a deliberate, planned and sustained effort to establish and maintain mutual understanding and relationship between the hospital and the community which uses it with the sole objective of promoting goodwill between these parties.

ROLE OF PUBLIC RELATIONS IN HOSPITAL

Good public relations is no substitute for good performance or services. False image cannot be sustained for a long time but at the same time right policy and good performance do not get automatically appreciated or even known without effective public relations. Good public relations would provide:

i. the recognition that in administering a public services an obligation exists for the service to account not only for what is done but also for what is not done;

ii. recruitment of staff and good staff relations are more easily obtained if the organization enjoys a sound reputation and public confidence;

iii. a hospital can play a more effective part within the community while contributing towards its general health and by preventive measures if it has the goodwill of other bodies with whom it is brought into contact, there by obtaining their cooperation and general support; and

iv. a sound reputation will more readily inspire confidence and hope in those who seek its aid.

In attempting to implement a sound public relations programme it must be

appreciated that the process is based upon two way communication. It is important for the hospital to know what the public is thinking /expecting as it is for the public to know what it is that the hospital wishes to communicate. Thus, it is a continuous process.

ORGANISATION OF PUBLIC RELATIONS

It is only through an organized planned programme which considers the total relationship of an organization with the people that a sound two way partnership with the public can be established. A few hospitals have appointed Public Relation Officers (PROs) to give them sound technical advice regarding hospital public relations-organizational programmes. A Public Relation Officer works directly under hospital administration. He is responsible to chalk out the planned programme of public relations. Depending on the requirement, a few more staff is assigned to PRO for his assistance. Public relation is a fulltime job. Programme is not only made by the PRO but he is also responsible to see that it is implemented. For programme implementation only public relations staff are not just adequate but all the hospital departments and staff are involved.

In some hospital, a public relations committee is made which supervises, evaluates and monitors the public relations programme. Public relations in a hospital are established by two elements of good services to patients and free communication to the people.

While organising public relation programmes it should be remembered that the patient's needs are of paramount importance in the hospital. A patient has the right to have the best treatment a hospital is able to give him. He has the right to be treated as quickly as possible whether in the ward or in outpatient department. He has the right to have adequate information about his condition and his progress. He has the right to expect that details of the treatment are given to him on his discharge so that his care can be continued by his local doctor. He has the right to be properly fed, supplied with drugs and surgical appliances to enable him to be effectively treated for the illness or injury from which he is suffering.

In addition hospital environment should be such that sympathy and compassion can be extended to the patients.

SERVICE TO HOSPITAL EMPLOYEES

Good public relation also depends upon the way the hospital looks after its employees who are providing the services. The contribution which can be made by all members of hospital staff towards sound public relations is often overlooked. A good relationship among the staff would raise morale, improves efficiency and reduce turnover.

It is also of positive assistance in improving and establishing a hospital's relations with the public, as they get mixed and communicate with them and their opinion of the hospital for which they work necessarily bears the stamp of authority.

COMMUNICATION TO THE PEOPLE

There are many methods of communicating with the public. Some of them are:

Hospital Reports

The annual report provides one of the best ways in which the quantity and cost of service provided can be given to the community. It is very important for public relations.

Press Relations

Newspapers require information about patients either as individuals, patients, events or items of human interest occurring within the hospital or concerning hospital staff or about developments in medicine or surgery or any other discipline. Information on these points may be conveyed to the press by answering direct enquiries made by reporters, holding a press conference and the handout or press releases.

Radio and Television

Radio and television programmes about hospital services should be promoted. Local groups should be informed, notices should be sent to the press and people may be asked to send in their reactions. Hospitals should use their means to educate/communicate with the people.

Public Functions

Annual day celebrations, baby show, nursing school's lamp lighting ceremony, prize distribution function etc. should be organised by the PRO and people in the community invited. Hospital can come closer to the public in these functions. The people of the community feel the hospital belongs to them.

Relations with the Police

Harmonious relations between the police and the hospital are highly desirable and the staff - medical, nursing and general should be encouraged to maintain this relationship. The hospital administrator is well advised to make himself known to the police authorities of the locality, as frequently problems arise which can be solved out by mutual understanding at their level.

Relation with Local Health Authorities

Close association between the hospital and the local government/authority is essential particularly in outbreaks of infections, maternity patients, geriatric patients, paediatric patients, mentally ill and mentally abnormal patients, reporting of births and deaths, morbidity study, assistance in mortality rate of the area and general coordination in planning of services, referral services, etc.

ANALYSIS OF THE COMPLAINTS

All complaints received in the hospital should be thoroughly analyzed and quick response to the complaints would go a long way in removing the irritants.

Prompt action on complaints would reduce the number and variety of complaints from different areas of the hospital.

SENSITIVE AREAS IN THE HOSPITAL FOR PUBLIC RELATIONS

The following areas are sensitive and important from public relations point of view. Extra care, therefore, should be taken to organize public relation activities with respect to the enquiry and information services, the telephone service, the admission office of the hospital, the outpatient department, the accident and emergency services, operation theatres, labor rooms, intensive care units, laboratory, radiology services, pharmacy, ambulance and hearse van services. The visiting time in the hospital should also be regulated according to the needs of the community and the hospital.

It is, thus, important that organized effort to develop good relation would go a long way in improving the hospital environment and minimizing the complaints which are frequently made by the public using the hospital. The image of the hospital in the eyes of the society would also improve considerably through these efforts.

Lkkjk'k

इस पेपर में एक अस्पताल में जन सम्पर्क पर चर्चा की गई है। सामान्य रूप में जनसम्पर्क की भूमिका और अस्पताल स्थिति में इसकी आवश्यकता व उपयुक्तता पर ध्यान केन्द्रित किया गया है। एक अस्पताल में जनसम्पर्क गतिविधियों के आयोजन को प्रस्तुत किया गया है और एक अस्पताल में प्रभावी जनसम्पर्क के उन संवेदनशील क्षेत्रों की पहचान की गई है जिन पर अधिक जोर दिये जाने की आवश्यकता है।