HEALTH POLICY

REFLECTIONS

COMMUNITY HEALTH CELL

1984-1990

1565.

Some Policy Reflections

in the context

of

a) Health Policy for Karnataka

b) Perspective Planning for Health Services

c) Approach Document for 8th Plan.

-

Presented at a Dialogue of NGOs including Community Health Cell Team, with Director of Health and Family Welfare Services and Joint Director(Planning), Directorate of Health and Family Welfare Services, Government of Karnataka, Bangalore.

July 1990
Bangalore

C O N T E N T S

A P P E N D I C E S

INTRODUCTION

The National Health Policy of 1982 strongly recommends a collaboration of Government with non-governmental Voluntary agencies in the Health sector to achieve the goals of the Health Policy.

The NGO/Volag in Health is often seen by the government, Planning Commission, and international health agencies as an alternative service provider and at best an alternative health team trainer. However a time has come for them to also be recognised as awareness builders, issue raisers and alternative planners.

The Community Health Cell, an informal study-Reflection-Action experiment in Bangalore (1984-1989) has been studying the experiences of NGO's/Voluntary Agencies at micro level with a view to build up perspectives that are relevant for macro planning. The Cell has tried to share these reflections with health planners, policy makers, health administrators and health service providers at various levels and at different forums (see Appendix A, Appendix B).

In July 1988 at the invitation of Sri.L.C.Jain, Chairman of the Expert Group on Perspective Plan for Karnataka, (Appendix C) we participated in a discussion on 'Perspectives in Health Policy and Strategy'(Document 6). Following this meeting we sent our comments (Document 5) on a Perspective Plan, submitted to the Committee from the Health and Planning section of the Department of Health and Family Welfare Services of the Government of Karnataka. Later on further request we also submitted an additional paper on Perspectives in Health Policy and Strategies for the State of Karnataka (Document 1 & 2).

..2

In October 1989, the Planning Commission initiated a dialogue on 'People's involvement in Planning and Implementation Process' to which we sent a paper responding to the various questions (Appendix D) sent by the Adviser to the Commission (Document 3). At the request of the Assistant Director General, Health Administration, DGHS, New Delhi, we also presented a working paper entitled 'Beyond Policy Rhetoric Statistics and Infrastructural Development - the tasks for the 1990s at a Regional Review Meeting on Primary Health Care Systems Development for Southern Zone organised by Government of India and World Health Organisation (Document 4).

Dr.Prasanna Kumar (Additional Director of Health and Family Welfare Services, DHS Karnataka) wrote to the Cell after persuing these papers and requested for an informal dialogue with him and the Joint Director(Planning). The matter was also brought up at a meeting of the sub committee on Health of the Consultative Committee on Rural Development held in Dr.Prasanna Kumar's Chamber on 21st June 1990.

This compilation of papers is a background for this Dialogue.

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road,
Bangalore - 560 001.

"PERSPECTIVES IN HEALTH POLICY AND STRATEGIES"
FOR THE STATE OF KARNATAKA

--a response from the Community Health Cell, Bangalore

A. GENERAL PERSPECTIVE

1. As a background it is important to keep in mind that the health of people and populations is largely determined by broader factors such as:

employment;
adequate income and purchasing power;
adequate food, housing and clothing;
availability of sanitation facilities and safe water;
education and opportunity for skill development;
accessible and effective health care services.

This is exemplified by the documented experience of several developed countries where major public health problems like tuberculosis, leprosy, cholera and other diseases were on the decline prior to the medical era of antibiotics and vaccines. It is accepted that this change was due to general socio-economic development.

2. At an operational level, acceptance of the above ideas call for effective intersectoral linkages in terms of planning and coordination between the Departments of Health, Education, Water Supply and Sanitation, Housing, Town and Country Planning, Agriculture and Industries.

....2

Keeping in mind the decentralised system adopted by the State, this planning and coordination could be done at the Zilla Parishad level.

3. Regional Health Planning

At present, in the health sector, we have national health policies, programmes and targets for the country as a whole. While overall policies and thrusts are important, keeping in mind the vastness and diversity of the country and even within single States, health programmes and plans need to be evolved at a more local level--at District level to start with. Two important factors to consider in this are:

a. the special needs of certain groups, who are socially and economically marginalised--dalits, tribals, slum dwellers, women and children, the handicapped;

b. the dynamic nature of the health status of populations which keeps changing in response to factors in society--eg., environmental, economic, cultural changes, life style changes etc. We are faced simultaneously with the diseases of poverty for large sections of the population, viz., malnutrition, tuberculosis, leprosy, water related diseases etc., and diseases resulting from industrialisation and modernisation--eg., cancers, cardio-vascular diseases and ill-defined new symptom complexes that are presenting in areas of environmental pollution.

Health planning needs to move from a rather adhoc, centralised, top down method to a more scientific basis. For this, it is necessary to have good quality health information, collected on an ongoing basis from different geographical, social and economic strata of society. Presently health statistics are largely compilations from various administrative reports. Greater emphasis needs to be given to quality of information, its validity and analytical interpretation of the data. Quantitative or hard data reflect some of the physical factors but an interactive, participatory approach with people would indicate the live social/human processes taking place.

There are presently more than 400 voluntary agencies working in the field of health in the State. Involving them in planning exercises would provide a 'window' to what is happening at the grass root level. Involving members of gram sabhas, mandal panchayats and zilla parishads would play the same role--they would in the process get better equipped to monitor the functioning of the health care services.

4. The budgetary allocation for health, education and welfare services needs to be critically analysed in the context of the health needs of the people. This could also be the subject of wider debate at various levels--State, District, Zilla Parishad, Mandal Panchayat, Gram Sabha etc.

Broadly there could be--

a. a larger allocation to health - eg., 6-8%

.....4

b. a reducation in the present urban/rural bias in health expenditure--eg., Rs.30000 spent on drug purchases per annum, per primary health centre presently covering a population of 60-80000 (or even the prescribed 30000 population) is grossly inadequate. In contrast the annual budgets of specialised, elite institutions at State and District head quarters is excessive.

5. The Indian Systems of Medicine (Aurveda, Siddha, Unani, Yoga etc.,) and other systems like homeopathy are widely prevalent throughout the country. They are culturally more acceptable and economically and geographically more accessible. Though official recognition has now been given to them, they are very marginalised in terms of State financial resources and in involvement with health planning. By recognising them as partners, we would increase the health infrastructure many fold.

6. During the past decade and particularly so in the past 4-5 years, there is a very rapidly increasing trend towards privitization of medical services. Corporate sector business houses are getting involved with the running of diagnostic centres, hospitals and even with medical education. Though conducted under the name of increasing accessibility to the latest in medical care and of self-reliance etc., the basic logic is one of making profits. Unfortunately, they are also receiving State

.....5

encouragement. It is resulting in the commercialization of medicine with the 'selling' of high technology diagnostic and therapeutic services not all of which are beneficial and some of which are positively hazardous and harmful to health.

B. SPECIFIC ISSUES/STRATEGIES

1. Public health approach/training

Over the years, there has been a gradual erosion in the role played by public health specialists in the sphere of health planning. The discipline itself has unfortunately slid into disrepute and has not been attractingthe best. This is in contrast to the increasing role being played by such trained specialists in health planning and organization and evaluation of health services in several other countries to their benefit. This situation needs to be rectified by providing better training facilities and job opportunities.

It would be beneficial if all Govt. Medical Officers could undergo some basic training in practical public health (more than that in the undergraduate course), management, team work etc., as in their future role, they are also expected to function as team leaders and planners. In the absence of such a "staff college" type training, they in effect offer only curative services to those who manage to reach their clinics.

....6

At the primary health centre level, 'team training', orienting all members as one group to the overall objectives of the work, programmes, team functioning itself could be given. This could be followed by regular meetings for sharing and feed back of experiences, problem solving, team building and continuing education. At present these exercises are more of a beaurocratic, policing nature, mainly checking out on target coverages.

2. As mentioned earlier, regional planning for health based on a knowledge of the regional patterns of health indicators is necessary.

3. There is a great need for continuing education for doctors, nurses and paramedical staff on an organized basis. Teaching and research institutes from different disciplines including sociology, management, economics etc., could be involved. This should be a two-way dialogue--much feed back from the field level is necessary to suitably modify teaching curriculum and research priorities.

These experiments are also going on in teaching institutions and coordinating bodies among voluntary agencies involved with health, teaching, service and research.

4. Recently, there is a trend emphasising vertical health programmes - eg., immunization, oral rehydration, child survival, leprosy etc., as time bound, targetted efforts. This is going full circle back to the days of malaria eradication and unipurpose

.....7

workers. India, infact has historically contributed the concept of an integrated community based health care approach and the wisdom of this should not be lost sight of in spite of professional and other pressures from national and international bodies.

5. There is an urgent necessity to evolve a rational drug policy. This would ensure an adequate supply of essential drugs to meet the health needs of people and in fact would also help conserve scarce resources.

6. The system of medical education itself needs critical reappraisal. Several governmental committees have given very relevant recommendations regarding this aspect of health personnel training. But as yet no major dent has been made on the system.

In Karnataka, private enterprise in medical education is playing a questionable role. These money oriented practices are detrimental to a profession which is so closely associated with life and health of people.

7. Studies (some in Karnataka as well) have reported poor utilization of government health services. In the face of this a mere expansion of structures and numbers will not yield results. There is a need to consolidate and strengthen the qualitative aspects of the service.

8. As in many other spheres, there is corruption at many levels of the health service. This factor has to be addressed seriously by all concerned if the goal of public service is to be realized.

——xx——

"PERSPECTIVES IN HEALTH POLICY AND STRATEGIES" FOR THE STATE OF KARNATAKA

A SUMMARY

A. Perspective Planning in Karnataka for health services must keep in mind the goal for 'HEALTH FOR ALL BY 2000 A.D.' and in this context reorient its focus:

   a. From HEALTH as a medicalized PROVISION of curative Services to Health as an enabling/ empowering process in the community increasing individual, family and community's autonomy over health related means, opportunities, knowledge and structure.

   b. From Health Policy as infrastructural development to Health Policy as 'quality of life' and 'quality of care' development.

   c. From Health Planning as a top down bureaucratized procedure to a participatory, community based, bottoms up exercise. This is particularly relevant in the context of the decentralised system of Panchayat Raj ushered into the State.

B. In keeping with the overall perspectives of the Ministry of Health & Family Welfare Services outlined in their March 1988 Perspective Plan and the discussions with Sri.L.C.Jain, we wish to highlight the following key issues:

   1. Health Policy must be closely interlinked with policy of socio-economic development.

   2. Health Policy must explore multi-sectoral linkages.

   3. Health Policy must evolve regionally from local level upwards taking into account--

      a. Special needs of certain groups - dalits, tribals and slum dwellers;

      b. Changing status of health, environment, socio-economic status;

      c. Reliable and good quality health information

      d. Interaction with community perceptions and needs.

   4. Health budgets should be increased substantially and rural urban disparity tackled seriously.

..2

5. All systems of Medicines and existing alternatives and options available to the community must be involved and included in an attempt to create an integrated Indian System of Medicine and Health Policy.

6. Privatization and commercialisation of medicine must be curbed and the State must continue to bear the major responsibility to providing people with affordable and accessible services, NGO, Volags and the private sector must be welcomed to complement the services but not replace it.

7a. Public Health reorientation of all medical staff is an important strategy organized through a staff college process and oriented to team training and participatory approaches.

7b. Continuing Education programmes for doctors, nurses and para-medicals based on multi-disciplinary and participatory approaches are crucial investments for the future. A community/social reorientation of medical education and all existing health manpower training programme is important.

8. Stress on integrated community based health care approaches and movement away from vertical unipurpose health programmes is necessary.

9. A Rational Drug and Technology Policy needs to be outlined and implemented.

10. Health Practice Research geared to important basic issues such as:

a. Poor utilisation of government health services;

b. Corruption in health services; and

c. Participatory approaches in planning/management should be organised.

PEOPLE'S INVOLVEMENT IN PLANNING AND IMPLEMENTATION PROCESS (PIP)

(This response to a Planning Commission, Initiative from the Community Health Cell (CHC) Team in Bangalore is based primarily on the experience of the Health Sector which is the main focus of CHC's activities. However our conviction, that 'Health action' is an important and integral part of development has led us to interact with a large number of development groups, who may or may not have 'health' as an important focus of their activity and the general comments and wider issues raised arise out of this larger interaction)

1. People' involvement in Planning and Implementation Process (PIP) is not really a new concept.

Firstly by participating in a democratic process of electing the Government, (which then plans a development strategy) the people have indirectly participated in PIP from the time of independence.

Secondly the 'Community Development' plans of the 1950s did stress the involvemtnt of people particularly at implementation level and village based consultation committees and involvement of community based organisations was accepted in the programme as relevant strategy. However this process was often controlled and dominated by the bureaucrats and technocrats and quite a large extent by the leadership ofthe dominant and priviliged sectors of the community. So 'People's participation' got a skewed orientation and often degenerated into a concept that was paid lipservice to, only in documents and important occasions.

..2

The concept of Decentralised Panchayat Raj has also been all along discussed though no action, till very recently, was taken at the political decision making level, and where it was attempted it soon became neutralised by the wider socio-political dynamics.

2. The new interest in People' involvement in PIP apart from being part ofthe growing populist rhetoric also stems from

   a) The evaluated experience of the last few decades where official programmes failed inspite of technological and managerial innovations because of lack of involvement/participation of the people; and

   b) From the increasing number of reports of micro-level voluntary agency/NGO initiative where this dimension was seriously attempted in diverse ways and programme implementation met with relatively greater success. In the NGO sector 'people's participation' was made an important part of decision making by many projects and taken beyond the level ofimplementation.

This explains why 'people's involvement' or community participation is often used synonymously in government policy papers as involvement of voluntary agencies though these are related but different concepts.

3. While studying/evaluating these micro-level positive experiences there is a trend in official policy documents to concentrate on <u>What was done</u> - 'action', 'programmes', 'projects' and these are then integrated into policy options and some operational guidelines and financial sanctions enunciated. However very little emphasis is given to <u>How it was done</u> and the 'process' dimensions or innovations are ignored. If the planners interested in <u>People's involvement</u> in PIP have to learn from the rich and diverse experience of Voluntarism/NGO action in the country, they have to seriously

..3

study, adapt, integrate and accept a new 'Development culture' where people are not seen as 'benificiaries' or 'targets of programmes' but are seen as 'participants' as well.

4. If 'people' have to participate in the planning and implementation process as 'participants' in the true sense then planners and decision makers as well as implementors at all levels of the government's planning and implementation heirarchy have to reorient their understanding of the dynamics and culture of Development in many other dimensions as well. e.g.,

A Social Analysis And crossectional feedback

a) 'People' are not a homogenous/amorphous mass who can be represented by a few formal leaders but are a heterogenous group stratified by income land ownership, education, caste, culture, gender and other factors. The stratified groups dominate and participate and utilise services more than others. People's representatives for dialogue must be sought from all strata and groups and positive discrimination towards those groups who do not benefit from existing programmes must be a clearly indicated policy option.

b) People's perception/experience given weightage

The People's perception of the working of projects and programmes or their own responses to problems must be seen as equally important as statistical/professional/ technical situation analysis. This perception must be sought by informal focus group discussions rather than formal surveys. This calls for an attitude of learning from the people and a growing confidence that people who experience problems evolve their own responses that need to be evaluated and literacy or technical skill/ knowledge is not necessarily a pre-condition for local innovation.

..4

c) Feedback from those closer to people

Feedback from lower level functionaries within the government system, who are closer to the people and who can more easily identify with their culture and aspirations must be given greater importance by higher level supervisors and decision makers.

d) Promotion of integrated/holistic problem analysis

Integration, inter-sectoral coordination and holistic view of a situation or problem must be stressed and the 'orthodox' governmental classification into sectors/departments/ministries, projects/programmes must be countered at the peripheral level especially since people experience life in a holistic way and find bureaucratic compartmentalisation hard to comprehend.

e) Evaluation - interactive and qualitative as well

Evaluation and Monitoring has to be seen as a 'problem solving' or solution finding exercise and not 'policing' or 'blame fixing' procedure. Rather than basing it on a routinised form/register filing exercise which is not used at the level it is collected but basically collected for someone else at a higher, more remote level-the exercise should be moreinteractive both within the team of funcationaries and with the formal/informal leadership among the people and qualitative aspects given as much importance as quantitative indicators.

f) Diversity of options and flexibility of approaches

Finally since people are in different situations and each village, tribal area, slum, region or district is so diverse in its historical experience, socio-cultural reality and development experience, people's involvement in PIP presupposes the acceptance of Diversity of responses and flexibility of approaches in the evolving nature of

projects/programmes. Models thrust top-down through centre/state sponsorship which do not allow diversity or flexibility are counter-productive to the whole concept.

While this may sound theoretical to the macro planner preoccupied with measurable goals and targets and macro-programme and project guidelines - they arise out of a deeper understanding ofthe realities at the grassroots and of the problems in the interphase between government development efforts and the people. It is at this interphase the present system has been constantly breaking down.

Managerial innovation in planning has to be beyond orthodox project formulation and management to the crucial process formulation i.e. not only what to do but how to do it? If we are serious about making a change in the situation, we cannot overlook or ignore these dimensions any longer.

Moving on to the more specific questions outlined in the letter-our response would be as follows:-

5. The Lessons from 7th Plan experience

The positive lessons are:

a. The involvement of an increasingly wider cross section of 'development experience' in PIP has been a positive development. This not only means greater involvement of Volags/NGOs who are considered closer to the people but also the acceptance of wider consultations of formulation stage with people at all levels outside the 'government' including at the grassroots and the training of village based cadres.

b. This interaction between the Government and NGO system and between the system and the people has opened up the closed Government System of earlier years to ideas generated outside the system and the increasing feedback

..6

to government often negative has led to some introspection and concern for accountability.

c. In areas or sectors where NGO/Volag partners are not available certain ministries and departments particularly Human Resource Development, Social Welfare and Education have experimented with Government sponsored semi-autonomous units, e.g., the Samakhya programme of Women's education which have tried to emulate 'Volag' organisational structured and styles of functioning. This experience is new and needs a serious evaluation.

The negative experiences are:

a. There is a growing misunderstanding among decision makers and administrators that involving people in PIP through
   i. the involvement of NGO/Volags among the people, or
   ii. the trained village selected health/development animators means that those who have been hither-to considered outside the system, will now become government sponsored functionaries. Due to this development bureaucratic red-tape and other problems of the existing systems are beginning to make inroads into this new 'interphase'.

b. NGOs/Volags or people's representatives on committees or community based workers are also seen only as associates for implementation of programmes. Their role as issue raisers, monitors, evaluators, demand creators and even trainers has been mostly ignored.

c. Top-down planning, model generation and operation guidelines still continue to stifle innovation and creativity and still refuse to accept adequately the differences in local social reality, past development experience and diversity of approaches.

d. There is a growing tendency to 'lionise' the NGO/Volags or the people's representatives sometimes putting demands

..7

and pressures on them beyond their own capabilities or resources. The number, outreach and availability of NGOs/Volags is also somewhat over-estimated. They still form a very small part of the total system inspite of their apparently increasing numbers.

The need to tone up, the existing government system and to bring greater accountability as well as qualitative improvement in services is then ignored. Corruption, inefficiency, political interference and mismanagement continue to hold sway in the established infrastructure while the NGOs, the people and now more surprisingly the Private Sector are supposed to deliver/takeover/ provide better services to the people.

e. The bureaucracy and official technocracy still refuse to discuss process levels of the established infrastructure but continue to be preoccupied by somehow getting things done. Scaling up of action is seen as more important than seriously studying structural constraints and deficiencies or facing squarely the socio-political-cultural realities. The people's organisations and NGOs/ Volags are seen as 'alternatives' and there is the constant pressure on NGOs to scale up their operations and spread over larger areas often at the cost of quality.

f. There has been no dialogue/education process down the line in the existing infrastructure about change in the planners/ decision makers/ government's perception about people working outside the system (NGOs¼Volags) or about 'people's participation' in planning and implementation of programmes. The changed perception if at all is at the IAS cadre levels on the top and among some of the DCs at the periphery. The rest of the existing functionaries continue to perceive the situation as they have in the last few decades. <u>Such a reorientation is long overdue</u>.

g. The key to success in involving people in PIP is the ability to keep them adequately informed about:

i. the evolving programmes and guidelines
ii. expert recommendations;
iii. alternate possibilities

on the one hand while on the other hand constantly interacting with them to ascertain their own responses and experiences of problems etc. This is the weakest link ofthe present system, there is heardly any information available to people about the whys and hows of each programme, much less a discussion with them to explore ideas of how to do them better. This is an area where NGOs have something to offer not only in ways of 'interaction with the community' but in 'creative low cost communication' as well. Both of which have been ignored. Information to people would probably be the most important/credible step for the 8th plan.

6. The Health Sector:

The Health Sector planning efforts need serious reconsideration if the concept of people's involvement in planning and implementation process is to be supported.

i. Inspite of all the populist rhetoric and the empirical holism outlined in the Health Policy especially since the 80s, Health continues to be a top-down, target oriented vertical programme concentrating on Family Planning excessively, to the point of ignoring the other health needs and programmes. Of late immunization programmes are being thrust with the same orientation. It is not at all surprising that our gains in Family Planning are so meagre compared to the investments and probably the highly advertised technology missions in immunization will meet the same fate, failing miserably at the interphase between the programme and the people.

ii. There is a growing concern that this exclusive base-level orientation towards family planning and immunization (selective, top-down Primary Health Care) at the cost of more comprehensive Primary Health Care, responses to regional and situational diversity is becoming counter-productive to 'Health' itself. If the bureaucrats and technocrats in the Health Ministry and directorates would care to listen to the feedback from the PHC doctors, the PHC health staff and the people, this would have been obvious. They are waiting to be asked but the coercive,

..9

disincentive oriented top-down targetted pressure disallows negative feedback and ignores the statistical adjustment and mis-information that is taking place at all levels of the record keeping procedures.

iii. If people's involvement is seen as necessary than the health sector needs a major change in orientation. The thousands of village health workers trained are no longer health animators or educators of the people but 'lackeys' of the system demanding more salaries etc., and getting pre-occupied with the local politics.

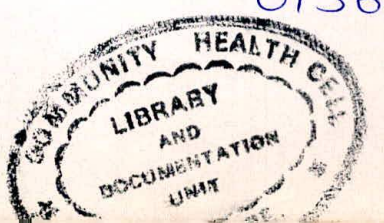
The levels of motivation of health staff is at a very low ebb. The levels of institutionalised corruption in drugs and supplies and their diversion to private practice of government staff is high. There is no concept of problem 'solving' training or continuing education.

Health planners are busy with infrastructural development and analysing and quoting statistics from a record-keeping system which is highly questionable and invalid.

iv. At the people's level the image of the PHC and the government health staff is very very poor. People are unhappy with the functioning/attitudes and quality of services of PHC staff. Accountability is a major need in the health services but any change in orientation towards involving NGO/Volags and people's representatives in health care planning/implementation would be seen as very threatening to the existing staff,. Already in Karnataka this accountability factor is beginning to result in Panchayat Raj institutions raising issues about PHC service quality, corruption of doctors etc.,

v. If people's involvement in planning and implementation process has to have an increasing role then the health sector, more than any other sector has to accept a radical departure from old styles of functioning and acceptance of new forms of planning processes. At the level of the Health Secretaries in the Ministries and

..10



among some top technocrats the realities of the situation and the challenges ahead are not unknown. But a very concerted effort is required to move from the existing style to a new approach and it will need more than rhetoric.

vi. In this context the Health Sector needs to dialogue with the NGO/Volag sector in a whole host of common areas of interest - Community Health approaches, village level training, health education, health awareness building, community participation. The efforts begun early in January 1988 to set up an expert committee for dialogue within NGOs and Health Sector at the Central level has has not taken off as yet due to various bureaucratic reasons. In other sectors through such dialogue forums and consultative committees much headway has already been made. The Health Sector has had dialogue with NGOs in the past for family planning efforts and now for immunization but the NGOs have always been seen as alternative implementors. True dialogue will require that alternative policies, grassroot level feedback, accountability and alternative pedagogy for training is also explored together. The NGOs role as an issue raiser, community educator, organiser and mobiliser has also to be recognised. Otherwise this interaction will lead to counterproductive confrontation.

vii. In the last two plans there has been a massive preoccupation with infrastructural development. The number of PHCs and subcentres have been increased substantially. Apart from the fact that this exercise may have succeeded moreon paper rather than in 'brick and mortar' terms, what is irrefutable is the fact that the quality of health care which was not very good to begin with ~~the~~ has deteriorated rapidly. This is a serious development. The 8th plan should predominantly concentrate on quality development of the existing infrastructure-focussing on quality of

... 11

supplies, manpower and training. If this urgent matter is ignored, by the end of the 8th plan we will have a concrete shell ofhealth care, promoting a coercive family planning programme supplemented by a top-down immunization programme with impotent vaccines and the whole concept of 'Health for All' will degenerate into a farce inspite of all the UNICEF and Technology Mission supported rhetoric. The situation is serious because we have the pedagogocal/technological/ managerial expertise in the country to provide a meaningful health care but what is lacking is the socio-political will to tackle the realities at the grass roots.

viii. For too long the Health Sector has ignored the local health culture and traditional system of medicine and health care because of its western allopathic origins. Integrated policy for this plural situation is an urgent necessity not only from the economical point of view but also in the context ofinvolving people in their health care. In recent years there is a upsurge in the interest but this seems to be tinted with romanticism and nationalism rather than 'level headed policy research'. The 8th plan should earmark definite policy research funds andmake a serious study of the existing situation to evolve a more comprehensive integration policy for the future.

Some General Issues

7. Political interference at various levels of the infrastructure and corruption involving diversion of resources for private use are two hallmarks of the present system. Even planning Commission documents and reports accept this reality though couched in 'acceptable jargon'. At the level of the people this is a daily experience and any involvement of people in PIP will have to accept this feedback and be ready to modify the situation. The people are ready to provide the feedback but the system is not yet ready. These issues should

more objectively studied and the role more clearly documented. The ICSSR could undertake investigative research in these areas. Preventive programmes can be planned only if the problem analysis is thorough.

8. While co-operative efforts have been promoted by Government primarily as an income generating/economic activity, the co-operative culture has not yet taken adequate roots because of the politicisation of the process. This needs to be strengthened and diversified.

   Serious attempts should be made to link/or involve existing functioning co-operatives to 'health' and 'education' programmes. Not only is a link between economic development and human resource development (health and education) thus established, but health and education activities give time and space, for co-operative culture to be accepted. The needs in health and education are also relatively more homogenous and thus conflicting interests within rural, urban slum or tribal situations is less. There is also need to build up the culture of 'cooperative benefits' rather than individualised benefits and here again Health and education lend themselves to promoting this dimension.

9. In Tribal areas there is a serious need to restructure many of the development programmes to 'cooperative ownership'and 'cooperative benefits'. The individual 'farmer' or 'villager' oriented programme which may be realistic in a caste/class stratified culture ofthe villages, is not always relevant to tribal societies. Development workers are becoming increasingly concerned about the destruction of the pre-existing cooperative culture in tribal areas through the development process. Sub plans for tribal area development must take into account this reality and allow flexibility for 'group ownership' and 'group beneficiary' orientation.

10. With the phenomenal degree of urbanisation and rapid industrial development - a group that needs immediate and urgent focus is the '<u>construction worker</u>'. Migrancy, exploitation by

..13

contractors, unjust wages and inadequate basic facilities are making life inhuman for a larger and larger population of migrants to city. The 8th Plan needs to focus on them more substantially. The NGO sector has a lot of experience to share in this area.

To Summarise therefore

If people's involvement in PIP has to move beyong 'populist rhetoric' to the 'core' of national planning then the 8th plan document must include 'processes& that enhance

a. Information transfer and awareness building programme for for the people.
b. Reorientation programmes for staff at all levels of the existing infrastructure about this alternate concept of people as participants and not beneficiaries.
c. Monitoring and record keeping systems that are not only quantitative but also qualitative and allow feedback from people and from lower level functionaries of the system who are in closer w contact with the people.
d. Increasing involvement of Volags/NGO sector in the role of monitors, evaluators, issue raisers, demand creators and trainers and not just 'programme implementors'
e. Positive discrimination towards those groups who do not participate in local decision making processes supplemented by Health / Education efforts that could strengthen the overall community building aspects.
f. Move away from top-down, centralised, models to development planning that reflects local socio-economic-political-cultural realities and allows diversity of options and flexibility of a approaches learning from the existing positive and negative experiences of both government/NGO development efforts especially since the 1970s.

-xxxxxxxxxxxxxxxxxxx-

BEYOND POLICY RHETORIC, STATISTICS AND INFRASTRUCTURAL DEVELOPMENT:

The Tasks For The 1990s

(A working paper from Community Health Cell, Bangalore, for the Regional Review Meeting on Primary Health Care System Development for Southern Zone. (Government of India))

22-23 February 1990.

CONTENTS:

Note: This background paper responds to the aims of the meeting as well as the tentative agenda outlined in the letter circulated by Assistant Director General (HA) D.D.No. 3/RRM/89-90 dated 6th February 1990.

It brings together a 'grass roots' public health perspective developed from

i. A Study-Reflection-Action experiment with voluntary efforts in Community Health in Southern India;

ii. A decades experience of community oriented health manpower development from a medical college;

iii. Participation in the evolving perspectives of networks like medico friend circle, Voluntary Health Association of India, Catholic Hospital Association of India, All India Drug Action Network and Asian Community Health Action Network.

---

1. INTRODUCTION

The Alma Ata Declaration, 1978 established Primary Health Care as:

> "Essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost the community and country can afford"

The four principles stressed in the declaration were:

i. Equitable distribution
ii. Community Participation
iii. Multi-sectoral approach
iv. Appropriate Technology.

The most important development was the recognition of a 'Social Process' dimension in health care including community organisation, Community participation and a move towards social equity.

India has been an enthusiastic signatory and promoter of the Declaration and Primary Health Care policy.

In the decade following Alma Ata, we in India concentrated on infrastructural development and manpower training to operationalise this concept building further on the established Primary Health Centre concept with its three tier structure of Doctors and health supervisors, Multipurpose workers and CHW and TBAs. The Primary Health Care(PHC) approach supplanted the Basic Health Services approach, and the National Health Policy statements of the 1980s saw a 'conscious shift from hospital-based urban medical care to 'community oriented rural health care'.

We are now at the threshhold of the 1990s - the final decade before the goal of Health For All - 2000 AD. This Regional Review Meeting will consider reports by the seven Southern States on 'infrastructural developments, health manpower,

....2

training facilities, community participation, self-care, coverage of areas of health education, awareness, immunization and so on.

This working paper would like to move the discussion beyond Policy Rhetoric, Statistics and Infrastructural Development.

First it would like to list out the distortions that are emerging in the comprehensive community oriented exhortations of Alma Ata on Primary Health Care. Does our own National, Regional, State or District level experience symbolise those distortions?

Secondly it would like to list out some of the problems that are emerging in the policy and delivery system of Primary Health Care in India.

Thirdly it would list out creative approaches to be explored in the 1990s towards surmounting the distortions and problems mentioned ment above.

Finally it would list out the dimensions of a new development culture which have to be developed if PHC policy has to move towards Health For All - 2000 AD. Infact this is the most crucial test of our commitment to PHC.

2. DISTORTIONS IN PRIMARY HEALTH CARE

In the recent years we have been gradually witnessing a shift of emphasis and a multi-dimensional distortion of the concept of PHC. Is our experience similar?

* PHC was meant to be a bottoms-up community evolved programme. It has become a top-down community imposed programme.
* PHC was meant to be a comprehensive programme of locally evolved activities. It has become a selective package of distribution services.
* PHC was meant to be a social process stressing community empowerment and demystification of health. It has become an over-technologised, over-managed, over-professionalised service.
* PHC was meant to be a locally created programme appreciative of regional diversity. It has become a monotonous medel thrust from the Centre.

....3

* PHC was meant to be a socially promoted programme, proposed by community involvement in a participatory managed programme. It has become a 'socially marketed plan' by health ministries coerced by National and International health resources agencies.

* PHC was meant to be a process stressing educational, organisational, awareness building and empowering approaches. It has become a medicalised programme selling or distributing industrially produced short-term alternatives and options.

* PHC began by learning from creative experiences of voluntary agencies and health ministries committed to social justice in health care. It now draws sustenances from top-down, managed, health research projects that stress targets, quantifiable indicators and measurable objectives, overlooking the process factor and the qualitative dimension.

* PHC had a vision that was even relevant ultimately to secondary and tertiary health care. This dimension has been blunted by the co-option of the concept and principles by the Medical System which has a vested interest in the 'abundance of ill-health'. The medical system has internalised the rhetoric but lost the spirit.

3. SOME PROBLEMS OF PRIMARY HEALTH CARE IN INDIA

In reality in India this has meant that the comprehensive health care concept and vision of the Bhore Committee and the numerous committees thereafter has now been watered down in spite of the impetous of 'Alma Ata Declaration' to top-down vertical programmes of sterilization, contraceptive distribution, immunization, ORT package distribution and/some focussed TB and leprosy control. Converting some of these to technology missions or placing them on the Prime Minister's 20 point programme has not necessarily meant a move towards greater efficiency.

* Apart from the selectivisation of the package (comprehensive to selective PHC) a host of inter-related problems in the existing PHC delivery system further reflect the growing distortions.

....4

* There is a growing concern at all levels that the over-preoccupation with Family Planning and Immunization is at the cost of basic and comprehensive health care.
* The coercive disincentive oriented top-down targetted pressures disallows relevant feedback and ignores statistical adjustment and mis-information that is taking place at all levels.
* Staff motivation is at low ebb with monitoring processes being fault-finding oriented rather than problem solving oriented, hence morale is low and insecurity level is high.
* Levels of institutionalised corruption in drugs and supplies and diversion to private pockets or private practice is high, but fails to be taken seriously by planners or administrators.
* The PHC process still ignores the local health culture and traditional systems of medicine and health care, where it is accepted it is mostly 'lip-service' or at best rather paternalistic support. No attempt at a meaningful integration has been made.
* Training programmes are inadequate and both basic training and continuing education faculty in its pedagogical orientation. So that manpower still work 'for people' not 'with people'.
* Awareness building and demand creation processes are the most badly neglected because of 'telling people' or 'talking down to them' rather than exploring health issues with them and empowering them through informal/non-formal education approaches.

4. BEYOND PROBLEMS: TOWARDS CREATIVE SOLUTIONS

Though the above features outlined may seem mostly critical of the existing system, this criticism stems from a close touch with grass-roots reality.

However this paper would not like to stop at critical introspection. There is today at both micro-level NGO/voluntary agency health project experience as well as in many district level government programme experience all over India - the experience of meaningful alternative options in handling the above problems and moving towards making the PHC movement a more creative and 'equitous' response in the 1990s.

....5

While it is not possible in this paper to highlight the project/process experiences all over India, the key issues/alternatives are listed out for consideration by planners in the years to come. A reference list at the end of the paper gives details of larger papers/reports where further substantiation is available.

* PHC Policy must be interlinked with socio-economic development.
* PHC Policy must explore multi-sectoral linkages actively.
* PHC Policy must evolve regionally from local level upwards taking into account:
    a. special needs of certain groups - dalits, tribals and slum-dwellers.
    b. changing local health environment and socio-economic status.
    c. reliable and good quality health information.
    d. interaction with community perceptions and needs.
* Budgets for operationalising PHC must be increased substantially and rural-urban disparity tackled seriously.
* All systems of medicine and existing alternatives and options available to the community must be involved and included in an attempt to create an integrated Indian System of Medicine and Health Policy.
* Privatization and commercialisation of medicine must be curbed and the State must continue to bear the major responsibility to providing people with affordable and accessible services, NGO, Volags and the private sector must be welcomed to complement the service but not replace it.
* PHC re-orientation of all medical staff is an important strategy organised through a staff college process and oriented to team training and participatory approaches.
* Continuing Education programme for doctors, nurses and para-medicals based on multi-disciplinary and participatory approaches are crucial investments for the future. A PHC/Community/Social reorientation of medical education and all existing health manpower training programme is important.

....6

* Stress on integrated community based PHC approaches and movement away from vertical unipurpose health programmes is necessary.
* A Rational Drug and Technology Policy needs to be outlined and implemented to support the PHC Policy.
* Health Practice Research geared to important basic issues in PHC:

  a. poor utilisation of government health services;
  b. corruption in health services; and
  c. participatory approaches in planning/management should be organised.
  d. Appropriate Technology for community based response.

5. ATTITUDINAL CHANGE IN THE HEALTH DELIVERY SYSTEM

The above creative solutions can emerge and be supported by the Health Delivery System only if there is a complete change in attitude among planners, decision makers and health service providers. This attitudinal change is the most crucial task of the 1990s.

At all levels of the system a new 'culture' has to be actively promoted and developed. The six dimensions of this culture are:

a. A Social Analysis and Cross-sectional Feedback

'People' are not a homogenous/amorphous mass who can be represented by a few formal leaders but are a heterogenous group stratified by income, land ownership, education, caste, culture, gender and other factors. The stratified groups have conflicting/competing interests. Some groups dominate and participate and utilise services more than others. People's representatives for dialogue must be sought from all strata and groups and positive discrimination towards those groups who do not benefit from existing programmes must be clearly indicated policy option.

b. People's perception/experience given weightage

The People's perception of the working of projects and programmes or their own responses to problems must be seen as equally

....7

important as statistical/professional/technical situation analysis. This perception must be sought by informal focus group discussions rather than formal surveys. This calls for an attitude of learning from the people and a growing confidence that people who experience problems evolve their own responses that need to be evaluated and literacy or technical skill/knowledge is not necessarily a pre-condition for local innovation.

c. Feedback from those closer to people

Feedback from lower level functionaries within the government system, who are closer to the people and who can more easily identify with their culture and aspirations must be given greater importance by higher level supervisors and decision makers.

d. Promotion of integrated/holistic problem analysis

Integration, inter-sectoral coordination and holistic view of a situation or problem must be stressed and the 'orthodox' governmental classification into sectors/departments/ministries, projects/programmes must be countered at the peripheral level especially since people experience life in a holistic way and find bureaucratic compartmentalisation hard to comprehend.

e. Evaluation - interactive and qualitative as well

Evaluation and Monitoring has to be seen as a 'problem solving' or solution finding exercise and not 'policing' or 'blame fixing' procedure. Rather than basing it on a routinised form/register filling exercise which is not used at the level it is collected but basically collected for someone else at a higher, more remote level - the exercise should be more interactive both within the team or functionaries and with the formal/informal leadership among the people and qualitative aspects given as much

....8

importance as quantitative indicators.

f. Diversity of options and flexibility of approaches

Finally since people are in different situations and each village, tribal area, slum, region or district is so diverse in its historical experience, socio-cultural reality and development experience, people's involvement in Planning and Implementation process pre-supposes the acceptance of Diversity of responses and flexibility of approaches in the evolving nature of projects/programmes. Models thrust top-down through centre/state sponsorship which do not allow diversity or flexibility are counter-productive to the whole concept.

While this may sound theoretical to the macro planner preoccupied with measurable goals and targets and macro-programmes and project guidelines - they arise out of a deeper understanding of the realities at the grass roots and of the problems in the interphase between government development efforts and the people. It is at this interphase the present system has been constantly breaking down.

Managerial innovation in planning has to go beyond orthodox project formulation and management to the crucial process formulation i.e not only what to do but how to do it. If we are serious about making a change in the situation, we cannot overlook or ignore these dimensions any longer.

6. ADDITIONAL READING

This working paper is based on five key papers of Community Health Cell which are available on request for all those who wish to explore these ideas further.

1. Community Health in India (Cover Story)
'Health Action' Vol 2, No 7, July 1989 (18)

....9

2. Towards a Paradigm Shift
   'LINK' (Newsletter of ACHAN)
   Vol 7, No 2, Aug-Sept 1988 (4)

3. Perspectives in Health Policy and Strategies for the State of Karnataka

   A Community Health Cell response 1988 (10)

4. People's Involvement in Planning and Implementation Process

   A response to a Planning Commission process by Community Health Cell, 1989 (14)

5. Towards a People Oriented Alternative Health Care System.

   Social Action, Vol 39, July-Sept 1989 (14)

(Numbers in brackets indicate pages)

Please write to author
C/o Community Health Cell
No 47/1 St Mark's Road
Bangalore 560 001

SPECIFIC COMMENTS ON PERSPECTIVE PLAN FOR KARNATAKA (Dept of Health and Family Welfare Services), March 1988.

In keeping with the main points raised earlier the following specific additional comments are offered in the context of specific recommendations of the Government Department.

(Paragraph numbers correspond to specific numbers in the departmental document)

1. "Encouraging dependence" is very different from exploring complementarity and partnership. Government should never depend on sources outside government but explore links, support, mutual dialogue etc. Government should remain main provider/enabler supplementing its services with other non-governmental initiatives. Undue dependence will fuel 'privatization'.

1.3 We fully endorse the need for simplifying procedures and reduction in red-tape.

1.4 Volags/NGOs are operating on a no profit no loss basis. Since it is the government's responsibility to provide health infrastructure they should provide genuine volags/NGOs with mobile units and volags could bear running costs.

.....2

1.5 This Committee's orientation must be built on mutual dialogue, flexibility and appreciation of diversity in approaches. Otherwise the suggestion to 'devise plans', 'supervise', 'direct' or 'implement' could be the starting of an equally bureaucratic procedure. Supervision should be supportive not 'policing'.

2.1-2.4 While infrastructural development is important it should not become an end by itself and a play with numbers on paper. PHC/PHUs are not functioning due to a host of reasons including rampant corruption in the services. It is accountability of the health team and structures to the local community that is most important.

2.5 The drug budget of Rs.30000 per annum for a PHC is inadequate (less than 40p. per person), while the suggestion to base it on population norm is most welcome the rural/urban disparity must be severely reversed and higher and more realistic estimates should be made.

3.1--3.8 The focus is too much on curative services/ referral services/specialist services. While a good referral services link is a must and needs to be well established the main effort should be on reorienting all PHC staff including specialists towards Public Health/Community Health orientation in their knowledge, attitudes and practices. Public Health/Primary

.....3

Health Care and Community Health are primarily attitudes of mind and basic skills not specialization. A staff college training for all grades particularly medical officers is more important than focussing on 'Specialist presence'.

4.2 Resource Mobilization

It is important to remember that in a socialist democracy, it is the government's primary responsibility to provide basic health services to people irrespective of their ability to pay. Mobilization of resources to supplement tax payers money is a good idea only if it is supplementary and through a process of accountability; otherwise 'charging patients' as a policy would lead to keeping out the majority of the poor who need the services the most.

4.3 Government knows that there is a hike in construction materials, pay scales etc. Therefore 30-40 lacs for construction of a CHC is not "luxury". The problem is more of the siphoning of resources from the existing budgets by corrupt contracting practices. In addition, Appropriate Technology efforts in identifying suitable low cost building materials and building plans should be explored with Science/ Technology institutions.

....4

4.4 Strengthening of existing health institutions alone will not solve the problem of under-utilization of health services. The causes for this under-utilization must be explored through health practice research.

4.6 Why should the community take the burden of paying incentives to the staff? The amount mobilised should solely be used for the improvement of services inside the health centre--for eg., purchase of drugs, health education materials etc.

.....

PERSPECTIVE PLANNING IN HEALTH

- A Report -

At the invitation of Sri L C Jain, Chairman of the Expert Group of Perspective Planning set up by the Govt of Karnataka, a meeting was held at 'Krishna', the home office of the Chief Minister on 18/7/88 for a discussion on the 'perspectives in health policy and strategy'. Members present at the meeting were:

1. Sri L C Jain
2. Smt Vatsala Watsa, Registrar of Co-operative Societies & Member-Secretary Expert Group on Perspective Plan
3. Dr H Sudharshan, VGKK, B R Hills
4. Dr Dara S Amar, Prof & Head of Community Medicine St John's Medical College
5. Dr Gopal Dabade, Convenor, Drug Action Forum-Karnataka
6. Dr Ravi Narayan, Community Health Cell
7. Dr Thelma Narayan, Community Health Cell
8. Dr Vanaja Ramprasad.

The following points arose as a result of the group discussion.

Sri Jain explained the objective of this discussion and highlighted the fact that due to the process of decentralisation, greater decision making powers now lie in the hands of the people through the Gramsabha, the Mandal Panchayat and the Zilla Parishad system in Karnataka. In order to utilise the full benefit of this decentralised system to bring about greater accountability in the functioning of the

Govt health services the resources available at the community must be tapped. In this process, it is important to pay attention particularly to Human Resources available in the community. Two major means of approach to creating greater awareness and in mobilising community resources are -

a) through health services

b) through education

The Infant Mortality Rate is a parameter which indicates the health status of the community and thereby the progress made in health activities. While attempting to reduce the Infant Mortality Rate, literally every aspect of health education and development will have to be covered. Based on a study in Kerala, it was recalled that female literacy by itself constituted an important parameter for measuring the health status of the community.

The ensuing discussion brought up the fact that in order to initiate any form of Community Action or even to identify priorities in health needs and approaches, a "Health Map" of the state would be of prime importance. It is important to identify regional differences in health status as well as differences in class, caste, age and sex groups. An important aspect of creating such a "Health Map" for the state would be the fact that the Govt health statistics would have to be relied upon to a major extent. The members however, felt that the availability of and access to these Govt statistics is not an easy task

and perhaps the NGOs would have to be aided in this matter in order to strengthen the verasity of such a "Health Map". The validity and reliability of such statistics was also in question. It would be very important that all health organisations would have to provide factual data of their own communities which they serve. However, this throws up the fact that there is a disparity in the distribution of health services coverage by voluntary agencies in the state. It was opined by the members that whereas Bangalore, Mysore and Dakshina Karnataka areas were adequately covered by various voluntary health organisations, the northern districts of Bidar, Bijapur etc. were inadequately covered. Yet the major health needs are in these northern zones. In order to collect any form of information in these health service deficit areas of the north, it is imperative that the present Govt machinery be geared to supply the information as they alone have a uniform distribution of geographically placed services in the state.

In terms of any form of Community Action, it was felt that the untapped resources in the community were the rural women. This is especially so when we consider the fact that atleast 25% of the representatives at the Zilla Parishad levels are women. Keeping in

view, the health and education approach to motivate human resources, it was felt that the rural women had an instinctive realisation of the importance of children's education and children's health. Therefore, women representatives can constitute an extremely powerful lobby for pursuing better health care and educational services for the community.

It is obvious that the present planning for health is budget-oriented and not objective-oriented. This has created a culture which stresses importance on expending the allotted budget within a given time period irrespective of the quality of work done. Perhaps the biggest lacuna here is the need to evolve measurable parameters for quality of health care. This has also resulted in the use of targets for measuring health service progress. However, the use of the target method of evolving health services has resulted in the target being central to all other activities. Fulfillment of targets becomes the prime functions of health projects. This maintains the vicious chain of target setting and achievement of the same by any means including manipulation of records. Experience of the members suggested that questioning the people themselves regarding health performance, elicited a qualitative type of assessment for health services. Although the judgement was qualitative, it reflected the truth regarding need-fulfillment which was in contrast to the target oriented

results in the same area. In short, the use of targets has reached a point of abuse.

Planning at central levels may be convenient. However, central planning always leads to mathematical equality of resources versus population. Aspects of geographic distribution, physical accessibility, social norms, cultural and traditional barriers, new prioritisations and actual community needs are not considered. In this form of central planning, all resources are distributed irrespective of the need for the same. The group felt that local/regional planning at Zilla Parishad level would reverse this procedure and give practical relevance to the process of planning. In this manner, accountability for performance will also be at the local Zilla Parishad level.

It was felt that an inter active type of planning was called for wherein community level leaders would have to atleast express their felt needs which could then be given a final shape at the central level. This would prevent the projection of centrally perceived needs on the community by the planning authorities. This fact is often overlooked due to the inbuilt bias that such an inter active type of planning with the community would be very chaotic and unmanagable. Yet, the strength of the NGO activities always lies in the community level inter active micro planning which has resulted in yielding better and more meaningful results rather than mere target fulfillments.

As a measure of understanding the manner in which many of the NGOs have brought about localised changes in the field of community health, it was felt that an audio visual aid be prepared to highlight certain selected and important projects in health adopted by the NGOs. This envisages that members of the Voluntary Health Association of Karnataka, to begin with, would formulate an itinery for the visit of a video taping team to each of their project areas. Certain processes and inter active behaviour with the community as also innovative approaches in health would then be filmed for each of the health centres. It was suggested that a number of Governmental health centres were also doing excellent inter active planning and community level quality work. The work of these Governmental agencies would also be included in this audio visual aid project. A final software would be used to edit the various sequences filmed. Copies of this film could then be circulated and distributed through the Govt publicity net work. The idea is not to highlight any particular organisation's achievements, but to share ideas visually in order to stimulate and modify further innovation in community health approaches.

The role in health care played by the Indian or traditional systems of medicine was highlighted. These ranged from home remedies and folk healers like bone setters, dais etc. to practitioners of Ayurveda, Siddha, Unani, Homeopathy etc. At present, though they do have official recognition and have their own councils etc. the

importance given to them in health planning and resource allocation is still marginal. This situation needs to be rectified.

- In the planning and implementation of health programmes, there is a trend of going back to the "vertical programme" approach as against the integrated community based approach. Recent examples of these are theimmunization programme, Oral Rehydration Therapy programme, etc. These are detrimental to the general health services and also in terms of financial input, time spent by health personnel and most especially from the point of view of the community in whose daily experience, health problems cannot be dissected one from another. The change of hands in decision making from public health physicians to clinicians and professional managers could be partly responsible for this.

- The immense potential (as yet largely untapped) of school health programmes, health education and child to child programmes was discussed. There is also a need to reach children who do not attend schools or drop out of school. These often come from families who are the most in need. Innovative and nonformal methods would be needed to reach them.

- There is a need to understand and respond adequately to the special needs of the tribal population in Karnataka, who constitute about 4% of the total population of the State. This was to be done in a separate session.

- It was expressed that there was a need to evolve a

rational drug policy. The example of the Govt of Andhra Pradesh was referred to. They have recently drawn up a list of essential drugs to be used in Govt health institutions and have banned the use of certain hazardous drugs.

During the afternoon, the discussion was confined to discussing the perspectives in the family planning programme of India.

It was felt that, to begin with, the entire family planning programme has been viewed from mainly a demographic point of view. The planning has been geared mainly to reduce the birth rate. In this manner, the various other facets of family planning, namely maternal amd child health aspects, have been given second priority.

Further, the aim of family planning was again target oriented in terms of the number of birth limitation operatioas done. Thus, "Human" aspects of the decision to adopt family ~~pxix~~ planning has been ignored. Rather than involve the family as a unit, individuals appear to matter more for the family planning officials. Even among the individuals, the target group are women rather than men.

In the race to limit the number of births, legalisation of abortion has been resorted to in a very indirect manner under the MTP Act by suggesting that one of the provision of that act is "failure of contraceptive". Thus the aspect of respecting life has also been neglected. The members further felt that there has been a vulgarisation of the family planning programme through the use of crude

incentives for people accepting sterilisation. Thus, the respect fo "Family" in the family planning is grossly missing.

It should be explained that child survival is more important than birth limitations. It is common knowledge that if couples are given a guarantee regarding the survival of their children, the couple themselves decide on a small family norm without further motivation. Therefore, the stress should be on child health and prevention of infant mortality rather than birth limitations. The priority that family planning enjoys in terms of budget allotment must be used for promoting child health schemes and maternal health schemes. This will ensure that the quality of the surviving population will be of a high order rather than merely have managable quantities of population as per cold demographic norms.

As regards the interest of developed countries in Family Planning in India, it was clearly brought out that the developed countries are more interested in protecting their own resources which they do not wish to share with an expanding population from the third world countries. It should also be noted that these resources of developed countries had also been built up by exploiting developing countries through an unjust economic order and trade-aid relations. In addition developed countries population used more of the world's resources than those in developing countries. Therefore, it is

imperative that decisions regarding family welfare projects be taken irrespective of the western countries norms and dictation.

In order to achieve the above, Family Planning must be made as an integral part of health care delivery rather than give it any form of separate priority. The provision of primary health care to the people should gain more importance than family limitation$. There should be a realisation that a lot of progress needs to be achieved on the economic front in order to ensure child survival. The important factor to actively promote is the need to raise female literacy which in itself will ensure small families.

There is a need to create parameters for measuring the progress in family planning measures. These parameters should not be merely the number of sterilisations or the number of users of family limitation devices. In fact, greatest stress should be laid to measure the parameters relating to the progress made in child health as a measure of the quality of the present family planning programmes. Health education for family health should be more important than propaganda for family planning devices. For more effective planning, it is imperative that the family planning field workers themselves be involved in the planning of the health strategy as they have a rich knowledge of grass-root experience. The involvement of peripheral workers in any planning process is central to its success and this holds good for family planning as well.

The whole day's session has been conducted in the form of a "brain storming" for ideas rather than any form of recommending solutions. It is a collection of ideas of the perspectives in health and family planning and not a collection of solutions.

/////

APPENDIX 'A'

HEALTH POLICY REFLECTIONS - CHC INVOLVEMENT

The National Health Policy of 1982 strongly recommends a collaboration of Government with Non-Governmental Voluntary Agencies in the Health sector to achieve the goals of the health policy.

The Community Health Cell, an informal study-Reflection-Action experiment in Bangalore (1984-1989) has been studying the experiences of NGOs/Voluntary Agencies at micro level with a view to build up perspectives that are relevant for macro-planning and which can be shared with health planners, policy makers, health administrators and health service providers at various levels and at different forums.

Since 1984 many such opportunities have been utilised for such a continuing dialogue. The key among them have been:

* A Dialogue with the Director and other officials of the Health Directorate in Karnataka, as part of the Annual Meeting of the Voluntary Health Association of Karnataka on the theme 'Government - Voluntary Agency Collaboration' in March 1984.

* A two week consultancy with UNICEF, New Delhi, to explore approaches to enhancing Government - Voluntary Agency Collaboration in child survival programmes in 1984-1989 phase in September 1984.

* A Two-day seminar on Involving Voluntary Agencies in the implementation of Government Programme, organised by the Consultative Committee on Rural Development in July 1985.

* A meeting with Sri.L.C.Jain, Member, Perspective Plan Committee of Karnataka Government to discuss perspectives on Health and Family Welfare in July 1988.

* A response from Community Health Cell on Perspectives

..2

in Health Policy and Strategies for the State of Karnataka' submitted to the above Committee in July 1988.

* Some comments on the Perspective Plan for Karnataka drawn up by Department of Health and Family Welfare, Karnataka, was also sent in July 1988.

*, A paper on 'People's Involvement in Planning and Implementation Process' which was a response from the Community Health Cell to a dialogue initiated by Sri.Bunker Roy Adviser, Planning Commission on evolving concrete policy guidelines on this issue for the 8th Plan in November 1989.

* Participation in the Regional Review Meeting on Primary Health Care Systems Development for Southern Zone organised by Government of India and World Health Organisation held in Bangalore (February 1990). A working paper entitled 'Beyond Policy Rhetoric, Statistics And Infrastructural Development - The Tasks for the 1990s, was also circulated.

* Participation in a Dialogue with NGOs, on Health Policy - issues and perspectives at the Planning Commission, New Delhi, in March 1990.

-xxxxxxxxxxxxxxxxxxxxxxxxx-

BUILDING THE NEW PARADIGM

- A Study-Reflection-Action experiment on Community Health In India

Community Health Cell
47/1 St Mark's Road
Bangalore 560 001

The Community Health Cell (CHC) is a Study-Reflection-Action experiment drawing upon the rich and varied experience in Community Health Care from all over our country. In the initial phase, two members of the existing team travelled all over the country interacting with Health and Development projects. The team now continues interactions from its base at Bangalore, Karnataka.

The Study-Reflection-Action experiment has been based on interactions which are open-ended, non-formal, non-threatening and a reflective exploration of past experiences and future plans.

The purpose of the CHC experiment has been to build a framework for an alternative approach to health care, based on a diversity of micro-level experiences. The attempt has been to look at philosophical assumptions, goals, methodologies, successes and failures, strengths and weaknesses, opportunities and threats in order to build the components of a new paradigm.

A necessary first step of this approach has been the experimentation within the team with a non-hierarchical, participatory, mutually supportive effort in its working. This has led to democratic decision making which has a team-sustaining effect and smoother function. The team has a few full timers, while the part-timers contribute at

....2

their convenience, such that their participation has a flexibility ranging from half-a-day contribution, through alternate day work, to even alternate week contributions to the team. In addition, there are a number of associates on the CHC network, coming together off and on.

The catalyst process has generated activity for the CHC team, ranging from participatory reflections, perspective planning, exploration, issue-raising, networking, documentation, inputs into training programmes, workshops, seminars and Action research on Community Health related issues.

The CHC team participates with individuals, whether health professionals or otherwise, field based project groups, Resource and Co-ordinating groups and Government agencies interested in exploring Community Health Action in its various dimension.

The topic range spans Rational Drug Therapy, Alternative medical education, community health training, Environmental health issues, Health Policy matters, Medical Pluralism and Integration of Traditional Systems of Medicine in Health Care and so on. In short, anything of relevance to Community Health.

The definition that is emerging from our interactions over six years is that

> "Community Health is a process of enabling people to exercise collectively their responsibility to their own health and to demand health as their right. It involves the increasing of the individual, family and community autonomy over health and over organisations, means, opportunities, knowledge, skills and supportive structure that make health possible"

....3

To make Community Health a reality, the present health superstructure has to be:

* more 'people oriented'
* more 'community' oriented
* more socio-epidemiologically oriented
* more democratic and participatory, and
* more accountable.

The paradigm shift is to be in our thinking of health and health care from the orthodox medical model of health to understanding, appreciating and practicing a social model that will tackle health problems at its deeper roots. This shift of emphasis should take place at all levels and at all dimensions of existing health care planning and management.

The Technological/Managerial components of the new Paradigm include:

* Appropriate Technology for Health
* Community organisation and participation in Health
* Community/Village Health Workers
* Involvement of Traditional Healers, Dais and indigenous system
* Education for Health
* Health with Integrated Development
* Community support to Health Care -- financial/ resources.

....4

References

This working paper is based on five key papers of Community Health Cell which are available on request for all those who wish to explore these ideas further.

1. Community Health in India (cover story)
'Health Action', Vol 2, No 7, July 1989 (18)

2. Towards a Paradigm Shift
'LINK' (Newsletter of ACHAN)
Vol 7, No 2, Aug-Sept 1988 (4)

3. Perspective in Health Policy and Strategies for the State of Karnataka

A Community Health Cell response, 1988 (10)

4. People's Involvement in Planning and Implementation Process

A response to a Planning Commission process by Community Health Cell, 1989 (14)

5. Towards a People Oriented Alternative Health Care System.

Social Action, Vol 39, July-Sept 1989 (14)

Numbers in brackets indicate pages.

Please write to author

C/o:Community Health Cell
No 47/1 St Mark's Road
Bangalore 560 001.

Towards a People-oriented Alternative Health Care System

Ravi Narayan

A 'People-oriented' alternative health care system cannot be just a new package of actions, or a new technology fix. It has to be a new vision of health care, a new attitude of mind, a new value orientation in health action intertwined closely with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people.

It has been the field experience of many that the existing health care system in India does not meet the needs of the large majority of the people in the country. There are many reasons for this situation.

Firstly, the present model based on the 'western-technological-institutional model' of health care is too costly and efforts to duplicate it have meant that we can develop much less of it with our constraints on resources.

Secondly, the present model relies too heavily on expensively trained doctors and nurses and other para-professional workers, who by the very nature and culture of their training are the least likely to work in disadvantaged areas, be they rural, urban slums, or tribal regions where most of the people reside. Hence there is a continued shortage of humanpower in situations which need them the most.

Thirdly, the system is too closely linked to a rapidly growing medical industry of drugs, equipment, technology which, because of its preoccupation with growth and profits, has developed a vested interest in 'the abundance of ill health' and in the medicalisation of health itself. The proliferation of drugs, capitation fees—medical colleges, high technology, private diagnostic centres, corporate sector hospitals are all indications of this trend.

Dr. Ravi Narayan is Coordinator of the Community Health Cell, Bangalore.

Fourthly, the system, having developed in a different historical and socio-cultural milieu, is cut off from the health culture of the people. It looks upon traditional healers and birth attendants, herbal and home remedies, indigenous systems of medicines and their practitioners and the folk medical culture of the people, as superstitious remnants of an earlier era, waiting to be replaced by the so-called 'rational scientific western system'.

Fifthly, the system looks at health in a very myopic way, concentrating on the physical and biological dimensions, paying lip service to the mental/psychological dimension and mostly ignoring the social, cultural, political, economic and ecological dimensions. The focus is on 'diseases' and 'syndromes' rather than on the way of life or social processes in the community that cause ill health. The system also has a built-in prejudice of looking at problems in an individualistic sense rather than analysing them in a community and collective context.

Sixthly, the system is highly professionalised and mystified with its knowledge being compartmentalised in specialities and fully under the control of professionals. There is a built-in resistance to transfer of knowledge and skills down the line within the hierarchy of the health team itself.

Seventhly, the medical system undermines the autonomy of individuals, groups and communities by not increasing the common knowledge of health and by promoting an 'economy of created needs'. In addition, the planners of the system thrust top-down, vertical package of services, be they curative, preventive or promotive in nature, on the community.

Finally, the people who use the system are seen primarily as beneficiaries and consumers rather than as participants of a joint effort (by professionals and patients) to build health.

When such a 'health system' with the built-in contradictions outlined above is transplanted and developed in an inequitous social system such as ours, in which class, caste, money and power determine accessibility, availability and affordability of services, then it is not surprising that the large majority of the people who are either marginalised or disadvantaged, live below the poverty line—*dalit* or tribal groups—are left out of it. Not having control over the means, opportunities, knowledge, organisations and supportive services that make health possible, the large majority of the people do not utilise or participate in such a system. It is in this sense that the existing system is not people-oriented. What then is an alternative?

Towards an alternative: The Search

Since the late 1960s a large number of initiatives and projects have emerged outside the governmental system by individuals and groups keen to adapt 'orthodox health care' to our very different social realities. Doctors, nurses, health and development activists, social workers and others pioneered micro-level community-based projects that gradually moved beyond medical care to a host of activities and programmes that were geared to making health care more relevant to people's needs. These individuals and groups, in fact this whole 'movement' if it can be called such, is marked by its diversity in ideology, background social analysis and perception of the developmental process, funding, conceptions of their individual roles and their knowledge of medicine/health itself. However there were many common perceptions as well engendered by the situation in India:

—All of them were aware of the inadequate reach of the existing services, so they reached out their offorts to more peripheral areas.

—All of them moved beyond the 'orthodoxy' of pill distribution by doctors and nurses to a wide range of health actions in which para-medicals, health auxiliaries and community-based health workers were involved.

—In all these projects much of the health action was invariably planned at the community level involving existing leadership and community organisations of the village and most sections of the people.

—Invariably most of them added preventive and promotive dimensions to their health work and some went further on to integrate health with developmental programmes focusing on agriculture, income generation, water supply and formal and non-formal education.

—However, since each of them were creatively responding to the special situation and issues relevant to their area be it a caste village, a tribal region or an urban slum, they also developed and explored other components of health action.

Towards an Alternative: The Evolving Perspectives

Some of us have been spending the last few years informally studying these experiences, programmes and approaches, trying to understand their dynamics and trying to build a new perspective, emerging from the collectivity of the experience and basing it on the successes and failures of these, numerous, micro-level health action

projects. Our study reflections have led to the identification of the following 'action' components of the emerging alternative.

Integrating health action with developmental welfare and educational activities: some examples

Banwasi Seva Ashram (Govindpur, Uttar Pradesh) had a health and family planning programme which is integrated with its other programmes which include agricultural extension, dairy, village industries, education, *gram kosh* (revolving village fund) and social justice programmes.

RUHSA Project (Kavanur, Tamilnadu) has developed a comprehensive health and family welfare project along with adult education, vocational training, community organisation, income generation, agricultural development and agro-support services.

VGKK Project (B.R. Hills, Karnataka) evolved a programme of health care along with programmes of community organisation, education, cottage industries, vocational training and adult education for the Soliga tribals of that region.

Streehitakarini (Bombay, Maharashtra) working in the slums of Bombay included among its activities maternal and child health and family welfare, non-formal education, female literacy programme, income generation programmes, creches for under fives and small savings schemes.

Integrating curative with preventive, promotive and rehabilitative activities in health action: some examples

The VHS Project (Adyar, Tamilnadu) evolved the mini-health centre scheme which included maternity services, child welfare, nutrition, family welfare, minor ailment treatment, communicable disease control and health records and data system.

AWARE (Telengana, Andhra Pradesh) has a health programme which includes maternal and child health and nutrition, health education, environmental sanitation, disease control and a floating health centre catering to 300 villages along the banks of the Godavari.

Rangbelia Health Project (24 Parganas, West Bengal) has a maternal and child health care programme along with minor ailment treatment, and programmes for family welfare, housing, safe drinking water, sanitation, communicable disease control and health education.

Though most projects developed a 'health package' not very different from the Primary Health Centre package of the Government of India, the main difference was that, in these projects there was activity in all the components and they were not pre-occupied with the

Family Planning component as the government health centres are doing today. There was also a qualitative difference in the type of services.

Experimentation and development of low-cost appropriate technology

—Many projects evolved simple kits for traditional birth attendants to ensure that they were able to conduct hygienic home deliveries.

—Many projects evolved simple, locally produced health education materials using local ideas and art skills. Others evolved simple record keeping materials that could be used even by illiterate village workers using simple diagrams and signs.

—The promotion and incorporation of herbal and home remedies was a common response.

—Preparation of local food mixes and home-based oral rehydration solutions are additional examples of this search for 'technological appropriateness'.

Recognition, promotion and utilisation of local health resources: some examples

Miraj Project (Maharashtra) trained indigenous *dais*, village health aides and established liaison with untrained practitioners of *Ayurvedic* medicine, bone setters and registered medical practitioners without formal training working in the area.

VGKK (BR Hills, Karnataka) worked not only with *dais* but explored the use of traditional herbal medicines as well.

Tilonia Project (Rajasthan) involved indigenous medical practitioners and *dais* in implementing their programme along with village health workers.

Deenabandhu Project (Tamilnadu) incorporated the use of herbal remedies, acupressure and massage in their health care programme and have been one of the enthusiastic proponents of this dimension.

Training of village based health cadres

Jamkhed Project (Maharashtra) pioneered the training of village health workers—local, illiterate, middle aged women—who became the front liners of their programmes which included maternal and child health, nutrition, immunisation, family welfare services, control of communicable diseases, safe water and health education.

The Rehbar-I-Sehat Programme (Korbhalwal, Jammu & Kashmir) trained teachers of village schools as primary health care guides.

Local workers were trained in most projects and they took several interesting names e.g.,

Swasthya Mithras (Banawasi Sewa Ashram, UP)
Link Workers (CLWS Scheme, UPASI, Coonoor)
Lay first aiders (VHS, Adyar, Tamilnadu)
Community Health Volunteers (SEWA-Rural, Gujarat)
Gram Svasthikas (Indo-Dutch project, Somajiguda, Andhra)
Family Care Volunteers (RUHSA, Tamilnadu)

Organising and involving community organisations like Mahila Mandals and Farmers' Associations

Child-in-Need Institute (Daulatpur, West Bengal) organised its maternal and child health programmes and balwadis by involving *Mahila Mandals* (women's associations) in the slums and villages of Calcutta.

Kottar Community Health Project (Kottar, Tamilnadu) initiated the whole health programme in conjunction with the evolution of *Mahila Manrams* (women's organisations) which have taken gradual charge through an ongoing programme of decentralisation. Over a hundred registered village women's organisations pay and support over two hundred village health guides and animators.

Jamkhed (Maharashtra) evolved and involved young farmers' clubs in the planning and organisation of services.

Bodokhoni Project (Orissa) evolved its programmes of health, adult education, grain bank, savings scheme, goat rearing, non-formal school for children etc. with the participation of *Gramya Sangha* (men's organisation) and *Mahila Sangha* (women's organisation)

Community participation in decision making

Most of the projects involved existing and or newly evolved community organisations or representative health/development committees in their organisation and planning exercises. The village health committee was an important component.

The ongoing process was difficult since involving all sections of the community, especially the marginalised elements, was not easily possible. Also project staff had to learn to treat community members as equals and learn from their local culture and experience and not impose ideas from outside. Different projects have evolved this dimension to different extents depending on their ability to handle the above two problems.

While many of them have involved the community at various levels of the planning cycle, decisions about funding and evaluation are two dimensions still not generally decentralised.

Tapping local financial, manpower and other resources

The Mallur Dairy Cooperative (Karnataka) supported its health project through a health cess on production of milk, generating adequate resources to pay for the health team and most of the health care supplies. Over the years the cooperative established a health endowment scheme which paid for the basic services.

The RAHA Projects (Madhya Pradesh) developed a medical insurance scheme which provided medical cover through a network of three base haspitals and 47 rural health centres.

The Kottar Project (Tamilnadu) built up a local contribution from the beneficiaries to support village health guides scheme. Other forms of local support apart from direct payment for services included health savings scheme, festival donations, grain banks, accommodation for clinics and programmes, voluntary labour and building materials, services by volunteers, village health fund and so on.

Would these Eight 'Action Components' Taken Together Constitute a People-oriented Health Care System?

Many alternative health care enthusiasts and activists would have us think so? The ICMR organised two meetings on alternative health care approaches, to identify new perspectives from the Indian experience. The list of components that emerged in these meetings were not dissimilar.

The 'Social Process' Dimension

Our study reflections show however that these are important components of the alternative people-oriented health care system but are basically in the category of technical and managerial innovations. There is another whole set of issues and dimensions which can be called 'social process' components which help the above approach to become more people-oriented. Often these issues are neglected or ill understood by health action initiators so that even though the goal of the initiated process is to build a health system with the participation of all, this objective gets somewhat derailed in the ongoing process. To understand these process components, one has to first understand some important characteristics of our social reality as well as of the health care system that is existing and dominant.

An unequal society

Firstly in the present inequitous and stratified social system there is no community in the real sense of the word. The community is divided by factors of caste, class, religion, land ownership, power, education and status. Even the so-called 'community of the poor' has internalised these divisions. The 'haves' consisting of the landed, rich, educated, upper caste groups dominate decision making processes and invariably participate, utilise and monopolise any services—health or otherwise—or development in the community. The poor do not participate at all or marginally in the process. Building a people-oriented health system in such a situation would invariably require two added components:

(1) Increasing the organisation, involvement and participation of large sections of the community who do not participate adequately in any development process today. Such attempts will invariably be opposed by the '*status quo*' forces and all who draw greater advantage from the present system.

(2) Efforts to imbibe and improve the concept and spirit of community and to improve group dymamics and group interrelationships by enhancing the collective dimension of action and the cooperative spirit.

New value system

Secondly the existing health care system is overmedicalised and characterised by certain values which are inherent components of the organisational ethos as well as of the professional and para-professional teams working in them. These values described in the beginning reflect our social system and have been internalised even by those who set out to build a more people-oriented system. Therefore, health action initiators have to constantly

(1) Confront these values in their action and approaches and try and evolve new attitudes, skills and approaches that are more people and community-oriented and place medicine, professional skills and technology in their right and limited context.

(2) They need to empower the people to counter these trends in the health superstructure to make it more democractic, accountable and relevant to people's life.

If we wish to build a health system with the partnership of all people including the illiterate and dispossessed, then health team members need to have experienced some features of this new ethos in their own team functioning itself. Building democratic, decentralised, participatory and non-hierarchical decision-making processes within the health team become as important as introducing these elements in the interaction between the health team and the people.

Learning from local knowledge

Thirdly, there is need to recognise that there are numerous cross-cultural conflicts inherent in transplanting a western medical model on a non-western culture and hence exploring integration of medical traditions and cultures in a spirit of dialogue is very important. This means often; more than involving the local *dai* or healer in the health programme. It means learning from their knowledge and experience and cross fertilising it with what is already known in the more dominant and rational medicine. In this process, however, one should also not allow a sense of romanticism about traditional or indigenous systems of medicine making us uncritical of some of their inherent values which may be similar to those of the dominant allopathic system. The relevance to the life of the poor must be an important criterion in the dialogue and integration process. It also means looking at the dominant western model with a more critical focus rejecting all that is non-science and or anti-people in it.

Understanding societal processes

Finally, a people-oriented health system would help the people to understand and appreciate the deeper links that ill health has with societal processes so that health action could move towards wider social issues and movements to enable people to demand health as their right as well as to increase their autonomy—both individual and collective—over health and organisations, means, opportunities, skills, knowledge and supportive structures that make health possible. A people-oriented health system would therefore have a strong dimension of empowerment.

Is this Social Process Dimension and Value Orientation in Health Action being Taken Seriously Today?

Our study-reflections show that this awareness is gradually evolving as serious groups and committed project initiators subject their action to a critical evaluation in the context of an ongoing social analysis. For example,

**The Deenabandhu Project* (Tamilnadu) reports two emerging policy changes in their project which symbolise the recognition of these dimensions.

(i) A shift of the programme from its initial focus on total community—rich and poor alike to a focus on the target group of the powerless—the landless and the *dalits*.

(ii) Introduction of a comprehensive account of the nature of poverty and its relationship to ill health, the unjust distribution of land, oppression in the name of religion and other factors in the women village health workers' training programme to instill in their mind the class nature of ill health.

**ARCH Mangrol* (Gujarat) records its experience of working among the marginalised poor in the eastern belt of Gujarat and the movement of their efforts from health of women and poor children to organising the poor tribal villagers to challenge the unjust rehabilitation programme for villagers losing their homelands due to the Narmada dam project.

**The Bodokhoni Project* (Ganjam, Orissa) records the journey of its health animators in helping the people to move from a magical understanding of their problems to a critical one so that they can strike at the root causes. Diarrhoea is not treated only with ORT but the villagers marched to the block development office to demand a well as a right of the citizens of India and then, when materials and resources were made available, dug collectively their own well as a symbol of their unity and mutual concern.

**Community Health Programme* (Pachod, Maharashtra) records its efforts in participatory management which emplies a redistribution of power to take decisions and is convinced that this process can increase health awareness, effect community reflection and increase demand on health services apart from contributing to social change.

**Miraj Project* (Maharashtra) records that due to its efforts in training all health workers of various religions and castes together and with taking their meals together, the age-old caste system is breaking down and the *dais* from the *dalits* (low caste) are called upon by upper caste Hindu women to conduct deliveries.

**The Medico-Friends Circle*, a national network of doctors and health activists stands for the demystification of medicine, democratic decentralised team functioning, active community participation, medical practice built on humane values and equality and firmly opposes the negative unhealthy values of our society whidh include glorification of

money and power, division of labour into manual and intellectual workers, domination of men over women, urban over rural, foreign over Indian.

**The Community Health Training Team* of the Catholic Hospital Association of India (Secunderabad) defines community health as 'a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right'. Thus it goes beyond mere distribution of medicines, prevention of sickness and income generating programmes. Its training programmes for middle-level workers are therefore based on this perspective.

**The 'Mandwa Project'* (Maharashtra) recounts that its experiment of training semi-literate village women as health workers was opposed by local powerful rich leaders and the government health personnel since they demonstrated results superior to those of the professionals, demystified health and reduced people's dependency. This resulted in loss of practice in the private sector, created surveillance and brought accountability in a normally unaccountable public sector. The powerful leaders were fearful of an alternative power structure developing through the project.

All these examples taken together show that this social process dimension is beginning to be taken seriously by many groups and there is a move away from developing isolated models to locating the initiative in a local socio-political cultural context.

It mus be recognised at this stage that most of the health-action initiators in the NGO/Voluntary sector do not set out in their exploration of an alternative health care process after a thorough societal analysis or a critical analysis of the political economy of existing health and health care services. Much of the innovation and creativity is therefore of an *ad hoc* nature, action and ideas evolving by trial and error. There is, on the other nand, a lot of aberrations as well due to this initial lack of understanding of 'health in society'. This aberration manifests itself in many ways.

(1) A gradual conversion from focus on the poor and indigent to a preferential option for the well-to-do and paying patient.

(2) A promotion of a distribution service and not the evolution of an enabling empowering service.

(3) Increase in size, bureaucracy, compartmentalisation, over-professionalisation and hierarchical decision-making cut off from the lives of the poor.

(4) A preoccupation with targets and records, numbers, efficiency and cost effectiveness rather than a focus on indices of equity, participation, quality of services and health abilities of the local people.

This is inevitable when health action is not located in a wider socio-political-economic-cultural analysis of society and is a great danger faced by all those who begin this exploration today. Moreover, all those who begin this search today invariably emerge out of the educational and health system which are themselves not geared to a people's orientation. Therefore an attitudinal change and a value re-orientation become pre-requisites though not always easy.

Conclusion

This short exploration highlights some of the action dimensions of the search for a people-oriented health system in India. It also highlights some of the social process dimensions that need to be recognised by health action initiators to ensure that the project/process that evolves through their effort does not lose its people-orientation somewhere along the way.

The examples given are a small selection from the wealth of experience and reflections emerging in the country in the last two decades. The main plea of this paper is that the quest for a people-oriented health system must not become a quest for a new package of actions or a new technology fix.

It has to be a new vision, a new attitude of mind and a new value-orientation in health action intertwined closely with efforts to build an alternative socio-political-economic-cultural system in which health can become a reality for all people.

A MOVEMENT NOT A PROJECT
A MEANS NOT AN END

REFERENCES

Though no references have been given in the paper, apart from our field experience, following readings have influenced our analysis. These additional readings can be of use also to the reader.

Antia, Noshir H. "The Mandwa Project: An Experiment in Community Participation." *International Journal of Health Services* 18 (n.1, 1988), pp. 153-164.

Arole, Rajanikant. "Comprehensive Rural Health Project, Jamked, India," *Contact* 10 (August 1972).

Banerji, D. *Formulating an Alternative Rural Health Care System in India: Issues and Perspectives* (New Delhi: Centre of Social Medicine and Community Health, Jawaharlal Nehru University, 1976).

Bang, Abhay and Ashvin J.Patel (eds.). *Health Care: Which Way to Go? Examination of Issues and Alternatives* (Pune: Medico-Friends Circle, 1982).

CHC. *Community Health: The Search for an Altereative Process—Report of a Study-Reflection-Action Experiment* (Bangalore: Community Health Cell, 1987).

ICMR. *Alternative Approaches to Health Care* (New Delhi: Indian Council of Medical Research, 1976).

———. *Evaluation of Primary Health Care Programmes* (New Delhi: Indian Council of Medical Research, 1980).

———. *Health for All: An Alternative Strategy—Report of a Study Group Set Up Jointly by Indian Council of Social Sciences Research and Indian Council of Medical Research* (Pune: Indian Institute of Education, 1981).

———. "Health and Power to People: Theory and Practice of Community Health," *Medical Service* 43 (n.2, Feb.-March 1986).

John, Hari and Prem Chandran. "We Learn through Our Failures: The Evolution of a Community-Based Programme in Deenabandhu," *Contact* 82 (December 1984).

Kukreja, Neera (ed.). *Anubhav: Experience in Community Health—Anubhav Series* (No. 1-12) (New Delhi: The Ford Foundation, 1987-1988).

Medico Friends, Circle Pamphlets (Pratapgarh, Rajasthan).

Narayan, Ravi. "Community Health: The Quest for an Alternative" in Walter Fernandes (ed), *Development with People: Experiments with Participation and Non-Formal Education* (New Delhi: Indian Social Institute, 1985), pp. 67-82.

———. "Towards a Paradigm Shift—A Viewpoint from Community Health Cell," *Link* 7 (n. 2, August-Sept., 1988), pp. 22-25.

Patel, Ashvin J. (ed). *In Search of Diagnosis: Analysis of the Present System of Health Care* (Pune: Medico-Friends Circle, 1977).

Ram, Eric R. "Realisation of an Integrated Health Services Programme in Rural India," *Contact* 44 (April 1978).

Rao, Jaia, S. Kamla and Ashvin J. Patel (eds). *Under the Lens—Health and Medicine* (Pune: Medico-Friends Circle, 1986).

Satyamala, C., Nirmala Sundaram and Nalini Bhanot. *Taking Sides: The Choices Before the Health Worker* (Madras: Asian Network for Innovative Training Trust, 1986).

Volken, Henry, Ajoy Kumar and Sara Kaithathara. *Learning from the Rural Poor: Shared Experience of the Mobile Orientation and Training Team* (New Delhi: Indian Social Institute, 1982).