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Primary Health Care System Development

Learning from the NGO Experience in Community Health

1. THE HEALTH POLICY EXHORTATION — RECOGNISING THE NGO

The National Health Policy 1982-84 is a comprehensive statement on the goals and intent of the Government on all aspects of health care delivery and manpower education in the light of the national commitment to Health For All by 2000 A.D.

One of the significant departures in this policy statement from the planning process and framework of previous decades is the recognition and importance given to the 'Voluntary Organisations'—a large network of health and development organisations working all over the country at the grass-roots level.

The policy emphasises this *'new partnership'* in at least four different paragraphs.

The recognition and the comprehensive dimensions of collaboration are unambigously worded (Ref. National Health Policy, 1983).

To reiterate, they include :

i) Utilising the services of NGOs

ii) Intermeshing NGO services with governmental efforts

iii) Encouraging increased investment by NGOs

iv) Offering financial, logistical and technical support to NGOs

v) Assist in enlargement of services by NGOs.

2. AN OVERVIEW OF THE NGOs IN HEALTH CARE

There are estimated to be over 5000 NGOs involved in Health Care all over the country (recent estimates are much higher). Quite a large percentage of these are situated in the six states of Gujarat, Maharashtra, Tamilnadu, Andhra, Kerala and Karnataka. A smaller number are available in most other states.

The hallmark of the Indian NGO Health Action Initiators are the diversity of approaches, structure, methodology and ideology. A special issue of Health Action (a magazine of HAFA Trust, Secunderabad) highlights some of this diversity and presents an overview of the situation in the NGO sector.

The NGO health project ranges from alternative service provider at micro level to alternative trainer, developer, issue raiser, awareness builder, social activist, networker, health educater and community organiser.

Due to the special nature and peculiar history of their development in the country, the NGO health project is marked by their diversity of approaches and flexibility of options at the micro level.

Most of them however provide a combination of two or more of the following types of services:

- ✯ Appropriate Technology for Health.
- ✯ Community Organisation and Participation in Health of Mahila Mandal, Youth and Farmer Clubs.
- ✯ Community Based Village Health Workers.
- ✯ Involvement of Traditional Healers, Dais and Indigenous Systems.
- ✯ Education for Health.
- ✯ Health with Integrated Development.
- ✯ Community Support to Health Care—financial resources.

While these describe the technical and managerial aspects of the NGO action they are increasingly characterised by their commitment to

exploring certain social dimensions of health work which are grossly neglected or unrecognised in governmental efforts. In fact it is this contribution that can be considered most significant to the Primary Health Care movement.

These dimensions are :

- ✯ The links with a socio-political process.
- ✯ The commitment to individual and community awareness building and generation of greater autonomy.
- ✯ The commitment to a participatory decision making process within the health team, and within the community & health team interactions.
- ✯ The process of 'community building', including increasing the participation of those who do not/cannot participate at present.
- ✯ The acceptance of conflicts of interests within the community.
- ✯ The confrontation of various factors in the 'medical model' of health care including the over medicalisation of health, over professionalisation of skill and knowledge, and the over emphasis on the 'physical dimension' of health.
- ✯ The quest for medical pluralism.
- ✯ The reorientation process required to modify the existing superstructure of health services and training institutions to meet the larger social goals of health care.
- ✯ The increasing commitment to accountability and medical audit.

The NGOs are brought together by various coordinating and networking organisations like Voluntary Health Association of India (New Delhi and state level branches), Catholic Hospital Association of India (Secunderabad), Christian Medical Association of India (New Delhi), All India Drug Action Network (New Delhi), Medico Friend Circle (Bombay) and so on. Through meetings and their bulletins/journals they maintain constant interaction and dialogue between these groups.

3. SOME CRITICAL ISSUES

The Community Health Cell is a study reflection action experiment that has been learning from the micro level NGO experience in India to evolve and explore macro level contributions to Health Policy and PHC System Development.

I would like to present seven key policy formulations that the macro health care delivery system, mostly under the Government of India, can consider adopting for the next decade so that Health for All becomes a much closer reality.

A. People as Participants and not as Beneficiaries

The NGO experience has shown time and again, that people can *participate* as planners in programme development and organisation and should not continue to be considered as beneficiaries of a top down, centrally planned and heirarchically, compartmentalised, health programme—be it from the national or state level.

People do not mean only the formal leaders but a host of other informal sections including women, youth, children, local healers, farmers, teachers and so on.

Care should be taken to focus on those marginalised, underprivileged groups who do not participate in decision making in the present social structure.

More than anything else, this attitudinal shift calls for a courageous shift in present day beaurocratic/technocratic planning.

B. Focus of Service on Enabling and Empowering rather than just Providing and Distributing

For too long health programmes have been seen as distribution programmes of food, vitamins, vaccines, contraceptives or drugs. The focus has been on providing, distributing, record keeping, accounting, supplying etc.

There has to be a shift in emphasis to enabling/empowering people to make decisions and carry them out in matters of health, be they at an individual or collective/community level.

Informal awareness building, discussions, non-formal education, community organisation and mobilisation, community building activities and mobilisation of local skills, resources, ideas and initiatives must take precedence over top-down centrally managed distribution systems.

In concrete terms this will mean a change in emphasis from e.g.,

— providing taps or tube wells to ensuring their maintenance;

— from providing vitamin supplements to encouraging vegetable gardens and low cost local nutrition mixes;

— from antidiarhoeals to home based ORT mixtures;

— from medical check ups to child to child, and child to home school based health programmes and so on.

Training 'tap turners off' and not 'floor moppers'

Much of present day focus and training of health manpower is on curative skills—drugs, dispensing and diagnosing and not on community awareness building or mobilisation.

The NGO community health trainers have made a significant contribution to preparing manuals and organising courses that shift emphasis so that health action begins to explore and support action at the deeper roots of ill health—at the community and societal level and not on a superficial, individual, physical level.

The shift in skills is not only from curative to preventive and promotive but from individual to collective, from providing to enabling and so on.

Case studies, field experiences, simulation games, small group discussions and alternative pedagogy have been developed to

bring this change in the trainee's attitudes and prepare him for more meaningful roles.

The overall pedagogical shift is from *working for people to working with and through people.*

D. Supervision — From Fault Finding to Problem Solving

Any meaningful action programme at the field level needs an effective supervision process. However, this has today become, especially in the government health system a target setting, fault finding system amounting to a sort of rigorous *policing* by superiors over their juniors, all the way down the ladder. The average monthly Primary Health Care meeting is typical of this situation.

Supervision can be a very creative exercise and from the NGO experience we know that to be effective it should be supportive and basically a problem solving exercise. Team members get together regularly to look at their actions and results in a mutually supportive way with the more senior members of the team exploring ways of getting over problems encountered by junior staff. The ethos is one of dialogue and the supervision process looks at strengths and weaknesses as well as identifies opportunities and threats.

This attitudinal change is an urgent necessity in the present system.

E. Management — From Authoritarianism to Participatory Management

Building a Primary Health Care System which is responsive to the needs of the large majority of people, with their participation, is basically a democratic process which needs patience, faith and enthusiasm. If health workers at all levels have to develop these basic attitudes, they need to function in a system that considers them as 'participants' and 'key components' and not just as 'cogs in a wheel'.

Most health care delivery systems today are hierarchical, authoritarian with lot of ideas, decisions, targets, going down the system but little feedback going upwards. Unless these top down authoritarian systems change to a more participatory management process, giving all team members due importance and share in decision making and credit, PHC systems will just not deliver the goods. The medicalised hospital system with the glorified role of the specialist is at the heart of this problem and since most health workers including doctors and nurses continue to be trained in this setting—team work concept at the community level has a long way to go. But change it must.

F. Monitoring and Evaluation — From Quantitative Project Indicators to Qualitative Process Indicators

There has been a preoccupation in all our education and monitoring programmes with quantitative indicators and measures of service distribution e.g. no. of vaccines given, no. of condoms or contraceptives distributed, etc.

Apart from the fact that these have been consistently subjected to inflation, and 'cooking up' due to the stresses and pressures of top down targets, these do not give any indication of the processes and qualitative changes that need to take place if the Health For All goal has to be reached.

There is a need to shift to qualitative and quality indicators as well as indications of equity and social processes e.g.

— From immunizations given *to* fully immunized children.

— From condoms distributed *to* couples seeking advice.

— From health talks given *to* the extent of ideas and suggestions given by the people in programme development.

— From numbers of materials distributed to numbers of people made aware or enabled to make decisions regarding health.

— From what the Primary Health Care doctors, statisticians

or professional programme evaluators feel about the programme *to* what people and grassroot level health workers feel about the programme and so on.

G. From Intracellular Research to Baloonist/Societal Research

The present focus of much of our research is at the intracellular, moleculor, biological level with the hope that we will discover new drugs or vaccines that will cure or prevent some of our health problems.

There is need to shift this emphasis to 'societal or community' research that will seek to determine, describe and understand the larger societal forces that make 'health' an impossible goal for most people.

What are these factors that prevent large majorities of our people from getting the knowledge, skills, attitudes, means, opportunities or services that make health possible?

We now know that inadequate water supply is at the root of the diarrhoea problem; inadequate land reform at the root of the malnutrition problem; caste and communal consideration prevent access of large numbers of people to health services; class determines access to education and wage income; indebtedness as well as government liquor policy at the root of the alcohol problem and so on.

As these deeper links are understood, action plans will emerge which will strike at the larger issues and not focus only on superficial programmes.

The Paradigm Shift

These seven dimensions represent a major paradigm shift in our understanding of Health and Primary Health Care and these are crucial to the goals of Health For All 2000.

THE PARADIGM SHIFT

PEOPLE	BENEFICIARIES →	PARTICIPANTS
SERVICES	PROVIDING →	ENABLING/EMPOWERING
HEALTH WORKER	FLOOR MOPPERS →	TAP TURNERS OFF
SUPERVISION	FAULT FINDING →	PROBLEM SOLVING
MANAGEMENT	AUTHORITARIAN →	PARTICIPATORY
EVALUATION/	QUANTITATIVE/ →	QUALITATIVE/
MONITORING	PROJECT	PROCESS
RESEARCH	INTRACELLULAR →	COMMUNITY/SOCIETAL

All health planners, policy makers, administrators, educators, service providers and evaluators need to appreciate this shift.

4. FROM SYSTEM DEVELOPMENT TO AWARENESS BUILDING (DEMAND/CREATION)

The entire group of regional review meetings and the previous meetings of the past decade have seen Primary Health Care System Development in a very myopic fashion.

They have focussed all along on infrastructure, manpower, materials, logistics and educational materials and rightly so because they are the basis of public health programmes.

But they have missed an important dimension of Primary Health Care System Development. Primary Health Care can never be a reality in this country if PHC is provided by professionals, technical/beaurocratic—from the top.

Primary Health Care has to be a demand from the grassroots—a demand from an aware and health conscious people. We have failed in our understanding of the need and necessity of planning for this dimension. *Unless health is seen as a right and a responsibility, unless people and*

communities begin to have a vested interest in Health and unless Health becomes a demand for the common people, all our efforts will fail.

It is therefore necessary to recognise that Primary Health Care System Development means both

Services Provision	Vs	Education for Health
(Supply)		(Demand)

This will mean that we will need to face up to some new questions:

i) Are we ready to discuss how to make health and health care important on this country's political agenda?

ii) Are we willing to discuss how to infiltrate the entire educational system of this country—formal and informal, professional, technical or vocational with the message of individual and community health?

iii) Are we willing to plan to generate health as a people's science movement involving science educators, teachers, youth groups media people, folk and modern communicators and so on?

iv) Are we willing to plan how to generate health as a mass movement from below, involving all sections of the people—their leaders, political parties, health, social & development activists, trade unions, women's groups, dalit and marginalised groups, workers and so on?

The 1990s call for a major shift in our efforts and deliberations to this important aspect of system development, otherwise our efforts will remain as unimportant, peripheral, anaemic and ineffective as they continue to be, inspite of all our efforts.

Health Education to Education for Health

Awareness building in Health or the term *Education for Health* used in this paper is very different from what we know as Health Education, which has become a euphemism for telling people the dos and don'ts of Health in a sort of passive, one way, top down process. *Education for Health* is a more creative, liberating process exploring the roots of ill health with people through informal group discussions and a host of two-way, interactive media like puppetry, street theatre, traditional folk arts and jathas so that, not only are people able to understand what causes or maintains their ill health, but what means, processes and initiatives are available or need to be sought to build health, both individually and collectively. For example, while teaching about water borne diseases, the stress on the need to have good personal hygiene and to drink boiled water is an example of orthodox health education. On the other hand, initiating a discovery process by which water availability and access are explored in a community and the group is motivated to take collective action to improve the situation in the community through village based action or pressure on the authorities is an example of the new emphasis.

More than any other action I think the NGOs in Health Care and Development have skills, resources, ideas and initiative in this direction. If only health planners and health policy makers are willing to see this need and more and more of the Health NGOs see this as an urgent necessity, a major break-through could be made.

Awareness building is not new. It has been mentioned differently in policy statements. (Ref. National Health Policy, 1982, and National Education Policy, 1986).

The emphasis has, however, unfortunately been on a passive, top down education process thrust on people rather than an active grass roots and upward extending process.

The purpose to highlight it here is to emphasise that this new emphasis on *education for health* must be given, and that this crucial area must receive concerted attention and action.

5. GOVERNMENT — NGO COLLABORATION IN THE 1990s

Having recognised the Health NGO as a potential partner in the health policy statement in 1982, the experience of the last 8 years has shown some important but disturbing trends in the area of Govt.—NGO collaboration in Health Care. I would like to highlight them, raise some points of caution and explore some alternative approaches.

Trends

1. Recognition as service providers only

The government continues to see NGOs as only alternative service providers and at best, alternative family planners or immunisers. Their skills in providing other aspects of the package of health programmes are still not seen. Their additional abilities as trainers, evaluators, issue raisers, awareness builders is still unrecognised. In many states, for planners, NGOs still mean Rotary or Lions Clubs or at best the Family Planning Association of India or a Mission Hospital. The Indian NGO today is a much more diverse and creative species and needs to be understood as such.

2. Pressures on scaling up

There is a tendency to expect NGOs who have shown their abilities at the micro level to scale up their efforts to larger and larger levels to make up for the deficiencies and inadequacies of government programmes at the periphery. The NGO's strength lies in its creative abilities at the micro level, allowing for qualitative inputs and processes. Pressures to expand will often make them as ineffective or bureaucratic as the larger system.

3. Glorifying NGO & denigrating Govt. sector

Due to the inadequacies and failures of the existing health care delivery system and *the large unmet needs*, there is a growing tendency to 'glorify' or 'romanticise' the NGO and have unrealistic expectations of this sector. This sector is small and primarily qualitative in its contribution. For a long time to come, the government service

will continue to be the main service in quantitative terms. This cannot and should not be ignored.

4. Privatisation under the garb of NGO involvement

Linked to the above, there is an increasing tendency to belittle or denigrate the government system and plead about its inabilities or built in problem or his resistance to change. This leads to two problems at the planning level. The first is, that reforming the government system is not adequately worked upon. The second is that under the garb of NGO involvement there is a definite move towards privatisation and involvement of the profit oriented corporate sector in health care.

Government systems can change if all those at the helm of affairs are committed and rightly oriented. There are innumerable examples all over the country and these need to be highlighted.

While the private sector may have its role in providing some aspects of health care—health services are basically a state responsibility and the tax payer must get basic health care for his contribution. Profit orientation of the private sector means that the consumer is always paying more than is necessary and this must be recognised. It is at least important not to confuse the NGO voluntary sector with the private sector to begin with, and to deal with them rather differently on policy issues.

5. Community participation and NGO involvement are not Synonyms

Finally, at all levels community participation is often seen as being equivalent to involving NGOs. This is neither synonymous nor realistic. NGOs are definitely closer to people, more responsive to the local situation and function under lesser, top down controls and are hence more creative. But they too are trying to explore real involvement of people in their own initiatives and processes and are meeting with varying degrees of success. Not all NGOs have succeeded in eliciting meaningful participation. If these terms are not confused, then we

will at least see community participation as a process that can be initiated in any system, Government or NGO.

What is most crucially required is the development of a new culture in health services and planning and this is highlighted by the following aspects:

i) Information transfer and awareness building programmes for the people.

ii) Reorientation programmes for government staff at all levels about the concept of people as 'participants' rather than as 'beneficiaries'.

iii) Monitoring and record keeping systems that are interactive and qualitative and build on feedback from people and grass roots level staff who are closer to them.

iv) Increasing involvement of voluntary agencies/NGOs in the role of monitors, evaluators, issue raisers, demand creators and trainers, not just as programme implementors.

v) Positive discrimination towards those groups who do not participate in local decision making processes.

vi) Health/Education efforts to strengthen the community building aspects.

vii) A move away from top down, centralised models to regional planning that reflects local socio-economic-political-cultural realities.

viii) Increasing acceptance of diversity of options and flexibility of approaches.

Many of these have been highlighted earlier. *Concerted political will and professional will is necessary in the 1990s to bring this major attitudinal change.*

CONCLUSION—THE CHALLENGES AHEAD

There are hardly 110 months ahead to reach the goal of HFA 2000, whether comprehensively or selectively.

Primary Health Care System Development is the backbone of this planning and management exercise.

The 1980s have seen a preoccupation with infrastructure development, logistics, supplies and manpower development and statistical exercises, both valid and invalid, interspersed with a large dose of populist rhetoric and policy statements.

The 1990s must see a paradigm shift in attitudes and efforts so that Primary Health Care is an enabling, empowering process and not just a mere provision of services and infrastructure. A new spirit and a qualitative change in all our efforts are required. The NGO experience in the country is diverse and creative. Major lessons can be learnt from studying this wealth of micro level experience. *There is need to incorporate these ideas and processes into all our efforts in Primary Health Care System Development—governmental or non-governmental. This is the challenge before us.*

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The original article has 6 pages of cartoons, references and appendices. All those interested could request these from the Community Health Cell, 326, V main, I Block, Koramangala, Bangalore-560034.