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TOWARDS A PARADIGM SHIFT

– A Viewpoint from COMMUNITY HEALTH CELL, Bangalore

Dr. Ravi Narayan

(These reflections on the theme of the workshop draw upon a study-reflection-action experiment with a large number of community health action initiators in India, particularly in the state of Karnataka, since 1984. Its perspectives are rooted in "grassroots" involvement in India, which may or may not always be relevant to the situation in other countries of Asia or other parts of the world. However, its "inspiration" is derived from a growing conviction that there is an urgent need for a paradigm shift from medicine as a "providing process to Health as an "enabling process". Its basic plea is that the real issue facing us today is not Primary versus Secondary/Tertiary Health Care; Vertical versus Horizontal Programs; Selective versus Comprehensive Health Care;

but

Medical model versus a Social model of Health, be it individual, community or international.)

INTRODUCTION

"Primary Health Care is 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."

– Alma Ata Declaration, 1978

Primary Health Care (PHC) emerged in the Alma Ata Declaration as an alternative view of health and health care, which included locating health in the wider context of socio-economic development and exploring actions beyond orthodox medical care, that would be pre-requisites and/or supportive of the health of communities. The four principles stressed in the Declaration were:

1) Equitable distribution
2) Community participation
3) Multisectoral approach
4) Appropriate technology

Apart from a series of technological and managerial innovations that were considered in the view of Health Action that emerged at Alma Ata, probably the most significant development was the recognition of a "social-process" dimension in health care including community organisation, community participation, and a move towards equity. Health service providers would be willing now to appreciate social stratification in society, conflicts of interests among different strata and to explore conflict management. These were not explicitly delineated but were inherent to the issues raised in the Declaration. An equally important fact was that these perspectives emerged from the pioneering experience of a large number of voluntary agencies and some health ministers committed to the development of a more just and equitable health care system.

DISTORTIONS IN PHC:

In recent years, however, we have been gradually witnessing, the world over, a shift of emphasis from the comprehensive community oriented exhortations of Alma Ata, to a narrowing down of the scope and focus of primary health care. Some of the distinct trends noticed are:

a) Primary health care is becoming a top-down, community-imposed program not a bottom-up community derived program that it was meant to be.

b) Primary health care is becoming a selective package of services not a comprehensive program of locally evolved activities.

c) Primary health care is getting over-technologised, over-managed and over-professionalised at the cost of the social process dimension including community empowerment and demystification.

d) Primary health care is being promoted as a monotonously similar "model" rather than as a locally created process appreciative of local diversity.

e) Primary health care is being "socially marketed" by Health Ministries, coerced by international health and resource agencies and not socially promoted or proposed by community involvement in a participatory management.

f) Primary health care concepts have a growing relevance for secondary and tertiary levels of health care as well. However, they are still being strictly focussed on primary levels.

g) Primary health care is getting medicalised, and industrially produced alternatives that can be sold or distributed are being promoted, at the cost of educational, organisational, awareness-building and empowering approaches.

h) Primary health care concepts and principles (even words) are being coopted by the existing medical system which has a vested interest in ill-health. The deeper meanings of the principles are lost in this process.

i) Primary health care has been hijacked by teaching and research institutions and international NGOs in the developed world who are now promoting "PHC courses" and "PHC research" as stepping stones to a lucrative career in International Public Health and not as a challenging commitment towards a movement for social justice in health care. This distortion and promotion of myopia also stems from the fact that most staff of such institutions have little or only peripheral, remote and second-hand experience of community based health care in the developing-world situation. In addition, their own personal experience of the high-technology, institutionalised and professionally managed health services of their own countries is of little relevance to the task.

j) Primary health care has not continued to learn from the creative experience of voluntary agencies and health ministries committed to social justice in health care, which was its initial inspiration. It now draws sustenance more and more from top-down, "management by objectives" oriented health research projects thrust on health ministries of developing countries by international NGOs. These stress targets, quantifiable indicators and measurable objectives, overlooking process indicators which may be qualitative, and all the emerging participatory management, training and research skills.

k) In short, Primary Health Care in 1988 is fast becoming a caricature of its original philosophy, a captive of an over-medicalised health care system, a rhetorical slogan coopted by an inequitous social and economic order, both at the national and international levels.

Forty years after the comprehensive definition of health by WHO and ten years after Alma Ata, is our understanding of health care - comprehensive or otherwise - still where it was before?

COMMUNITY HEALTH
Is there an Emerging Alternative?

1. Community oriented health action has been an important dimension of Indian health planning since independance. The Primary Health Centre concept, the national programs, the concept of the multipurpose health worker and community health workers, all were in principle geared to the planners' and health professionals' perceptions of community needs. However, all the tinkering and attempted reforms were hampered by the fact that we had uncritically adopted a technology-intensive, institutional model of health care from western industrialised nations, that was proving to be more and more inadequate to meet the social realities of a predominantly rural and agricultural population. By 1975, the group on Medical Education and Support Manpower, a high-powered committee set up by the Government of India was constrained to record:

"It is desirable that we take a conscious and deliberate decision to abandon this model and strive to create instead a viable and economic alternative suited to our conditions, needs and aspirations"

- Shrivastava Report 1975

2. In the meanwhile since the

late sixties, a large number of initiatives and projects outside the Government system were established by individuals and groups keen to adapt health care to our social realities. Broadly classified as voluntary agencies, (now NGOs), all of them started with illness care, but moved on to a whole range of activities in health and development. Soon, ongoing community development projects and community education experiments also began to add health dimensions to their actions. As the number increased, networking and training efforts were also initiated. Soon health issues began to feature on the agenda of people-based movements - be they environmental or around women's, dalit's or trade union issues. This upsurge was a spontaneous development and not an organised pre-planned movement.

3. From 1984, a team of us have been studying this process through participatory reflections and presently a much more detailed report is in circulation among health action initiators in India for participatory and collective comment. From these reflections, however, we have begun to evolve a series of principles and issues that are emerging from the successes and failures, strengths and weaknesses of all these community health action initiators, and we list some of them out here:

4. The broad definition that has emerged of community health itself, initially, is

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

5. The next set of issues are components of community health action which are very similar to those outlined in the Alma Ata declaration. These being attempts to:

Integrate Health with development programs,

Integrate curative with preventive, promotive and rehabilitative activities,

Experiment with low-cost, effective, appropriate technology,

Involve local, indigenous health knowledge, resources and personnel,

Train village-based health workers,

Initiate, support community organisations like youth clubs, farmers clubs and mothers clubs,

Increase community participation in all aspects of health planning and management,

Generate community support by mobilising financial, labour, skills and manpower resources.

These above dimensions could broadly be described as technological and managerial innovations, which, in principle could also become part of top-down vertical programs, though they reach their full potential in community based and evolved programs.

6. However, in our reflections we discovered another whole set of issues and actions which could be broadly classified as "social process dimensions" which were beginning to be seriously taken up by a growing number of programs. These were:

i) Organisation of non-formal, informal, demystifying and conscientising 'education for health' programs;

ii) Initiating a democratic, decentralised, participatory and non-hierarchical value-system in the interactions within the health team and in the health team-community interactions;

iii) Recognising conflicts of interests and social tensions in the existing inequitous society and initiating action to organise, involve all those who do not/cannot participate at present;

iv) Questioning the over-medicalised value system of health care and training institutions and challenging these within the health team; learning new health oriented values;

v) Recognising that community health needs community-building efforts through group work, promoting cooperative efforts and celebrating collectively;

vi) Confronting the superstructure of medicalised health delivery system to become

- more poor people oriented,
- more community oriented,
- more socio-epidemiologically oriented
- more democratic,
- more accountable

vii) Recognising the cross-cultural conflicts inherent in transplanting a Western Medical model on a non-western culture and hence exploring integration with other medical cultures and systems in a spirit of dialogue.

viii) Recognising that community health efforts with the above principles and philosophy cannot be just
a speciality;
a professional discipline;
a technology fix;
a package of actions;
a project of measurable activities;

but has to transform itself to

a new vision of health care;
a new value-orientation in action and learning;
a movement, not a project;
a means, not an end

Are these the axioms of an alternative?

THE PARADIGM SHIFT

We have suggested a 'paradigm shift' from a Medical model of health to a social model of health as the basic plea of this paper. From all the perceptions that have evolved in the action-reflections in these past years, we see this as the crucial and probably the key perceptual change that has begun to take place in our own perceptions, values, definitions, indicators, methodologies and plans of action.

In table I we propose a short list of the differences between these two models.

TABLE I
PARADIGM SHIFT
HEALTH

Medical Model	to	Social Model
Individual	to	Community
Patient	to	Persons/people
Disease	to	Positive living
Providing	to	Enabling/empowering
Drugs & Technology	to	Knowledge & social processes
Predominantly physical & mental	to	Physical/Mental/Social Ecological/Political
Professional control over skills and knowledge	to	Transfer of skills & knowledge to lay people
Intracellular research	to	Social Research
Patient as beneficiary and consumer	to	Patient as participant in process
Mystifying knowledge	to	Demystifying knowledge and promoting autonomy

Recently we received a letter of concern from David Werner and his colleagues at the Hesperian Foundation. They were distressed at the top-down approach being used to promote ORT as part of PHC. They were keen to help evolve a more integrated, decentralised, effective people-oriented approach to ORT. David sent a chart comparing the two strategies to us. It was a further indication of the growing awareness of the two approaches to health care, of the tendency of technology to be equally people-debilitating as it can be people-empowering.

We believe that the same dichotomy/divergence exists in approaches to training, management and research in emerging health care.

AN APPROACH TO DIALOGUE

Management, training, evaluation and research approaches in our health care system as they exist today reflect most often the dominant, orthodox, medical viewpoint. This medical orientation is built into their assumptions, interpretation of facts, understanding of community realities, priority and methodologies.

How justified would we be in imposing these approaches to study/learn/understand the new alternative 'social model' of health care that is emerging today out of the experience of numerous community based health care programs in Asia.

How justified would we be if orthodox indicators such as mortality and morbidity were the only ones used as the criteria for evaluation of CBHC especially when we are increasingly recognising it as a social process at base.

To do justice to the new community health approach we would have to explore process indicators which may be qualitative, to measure enabling and empowerment dimensions. Do we have an understanding of such indicators yet?

These will be some of the issues that are going to emerge in any discussion that seeks to explore the issue "vertical interventions vs CBHC".

TWO STRATEGIES FOR ORT PROGRAMS

Strategy of health ministries and big international agencies (top down)	Strategy of non-governmental (NGO) programs, popular organizations and community-based programs
Programming: Implemented as a separate program, or as part of 'selective primary health care'	Integrated into comprehensive primary health care (includes the social causes of poor health)
Main type of ORT promoted --packets of ORS salts (glucose based) --standardized formula	--home mix (sugar or cereal based) --formula adapted to local resources, conditions and beliefs
Main focus and investment --on products, (manufacture and distribution) --social marketing --social mobilization (getting politicians and celebrities to promote it)	--on education (through many channels: health posts, schools, etc) --awareness raising --community participation (mothers, popular organizations, healers, teachers, children)
Management: --centralized --controlled by health sector	--decentralized --collaboration from other sectors: health, education, communication, popular organizations
Main implementing body: Health ministry, health posts, health workers	Multisectorial, school system, health system, women's organizations
How it is presented: as a medicine (to facilitate acceptance and use)	as a food or drink (to demystify and promote understanding of concept)
Annual cost: --increases every year due to growing demand (for packets) --or transferred to consumers through commercial sale of packets	fairly constant for first few years, then rapidly declines as educational investment "pays off" and sound CAT practices become "common knowledge"
Evaluation --safety of ORS method based mainly on content of formula and accuracy of preparing solution --indicators of success: -number of packets distributed -number of people who know how to mix ORS correctly -reduction in child mortality --reliance on hard data, statistics, controlled studies	--safety of methods based more on social factors: availability and constraints of supply, peoples habits and attitudes --indicators of success -how many people understand concept and process -how many people use ORT in a way that seems to work -impact on children's, families' and community's well-being --reliance of peoples impressions and observations.
Main goal emphasized child survival	improved quality of life
Political Strategy: win government support by using methods that strengthen and legitimize government and make people dependent on its provisions (government-oriented)	win popular support using methods that organize and empower people, helping them to become more self-reliant

References:

1. The Alma Ata Declaration
2. Community Health: The Search for an Alternative Process (Report of the Study-Reflection-Action Experiment of Community Health Cell, Bangalore.