Primary Health Care System Development

Lessons from the NGO Experience in Community Health

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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 policy in the light of the National Commitment to HFA 2000.

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 organizations working all over the country at the grass-roots level.

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

The recognition and the comprehensive dimensions of collaboration are unambiguously worded:

To reiterate, they include:

i) Utilizing the services

ii) Intermeshing services with governmental efforts.

iii) Encouraging increased investment

iv) Offering financial, logistical and technical support.

v) Assist in enlargement of services.

2. **AN OVERVIEW OF THE NGO’s IN HEALTH CARE**

There are estimated to be over 5000 NGO’s 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, Andra, Kerala and Karnataka. A smaller number are available in most other States.

The hallmark of the Indian NGO Health Action Initiator is the Diversity of approaches, structure, methodology and ideology. A special issue of Health Action (a magazine of HAFA Trust, Secunderabad) distributed with this paper 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 educator and community organizer.

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 organization and participation in Health of Mahila Mandal Youth and Farmer Clubs.
- Community based 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.
While these describes the technical and managerial aspects of the NGO action they are increasingly characterized by their commitment to exposing certain social dimensions of health work which are grossly neglected or unrecognized in the governmental efforts. In fact it is this contribution that can be considered most significant to the PHC 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 emphasis on a demystifying decision making process within the health team, and within the community and 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 overmedicalisation of health, overprofessionalisation of skill and knowledge, overemphasis 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 NGO’s are brought together by various coordinating and networking organizations like Voluntary Health Association of India (New Delhi & 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 the 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 contributions to Health Policy and PHC System development.

For this meeting 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 HFA becomes a much closer reality.

**A. People as participants and not Beneficiaries**

The NGO experience has shown time again that people can participate as planners in programme development and organization and should not continue to be considered as beneficiaries of a top down, centrally planned and hierarchically compartmentalised health programme be it from National or State level.

The people do not mean only the formal leaders but a host of other informal sectors including women, youth, children, local healers, farmers, teachers.

Care should be taken to focus on those marginalized. Underprivileged groups who do not participate in decision making in the present social structure.
More than anything 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

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 individual or collective / community level.

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

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.

C. 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 mobilization.

The NGO community health framers have made a significant contribution to preparing manuals and organizing courses that shift emphasis so that health action begins to explore and support addition 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, filed experiences, simulation games, small group discussions and alternative pedagogy have been developed to bring this change in the trainees attitudes and prepare him for more meaningful roles.

The overall pedagogical shift is form 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 PHC 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, weaknesses and 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 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 programme with quantitative indication and measures of service distribution eg. 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 and so on these do not give any indication of the processes and qualitative changes that need to take place if the HFA readily has to be reached. There is a need to shift to qualitative and quality indication as well as indication of equity and social processes eg.

- From immunizations given to fully immunized children
- From condoms distributed to couples seeking advise
- 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 re-health
- From what the PHC doctors statisticians or professional programme evaluation feel about the programme to what people and grass root level health workers feel about the programme and so on.

G. From Intracellular Research to Baloonist/Societal Research (see Cartoon)
The present focus of much of our research is at the intracellular, molecular, 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 ‘social 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 diarrhea 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 govt. 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 issue not focus 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 HFA 2000.

**THE PARADIGM SHIFT**

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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 regional review meetings and the previous meetings of the past decade have seen Primary Health Care Systems development in a very myopic fashion.

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

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

PHC has to be a demand from the grassroots – a demand from an aware and health conscious people; we have failed I 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
began to have a vested interest in Health and unless Health become a demand of the common people all our efforts will fail

It is therefore necessary to recognize that PHC system development means both

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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 how to generate health as a people’s youth groups, media people, folk and modern communication 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, womens groups, dalit and marginalized groups, workers and so on.

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

**Health Education to Education for Health**

Awareness building in Health on 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 dos and don’ts of Health is 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 recked to build health both individually or collectively e.g. while sharing about water borne diseases and the need to have good personal hygiene and drink boiled water is an example of orthodox health education, 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 village based action or pressure on the authorities is an example of the new emphasis.

More than any other action I think the NGO’s in Health care 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 urgent necessity.

Awareness building is not new. It has been mentioned differently in policy statements.

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 emphasis 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 recognized the Health NGO as a potential partners 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 and I would like to highlight them, raise some points of caution and explore some alternative approach in this final section of my paper.

**Trends**

1. **Recognition as service providers only**

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

2. **Resources on Scaling up**

There is a tendency to expect NGOs who have shown their abilities at 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 his creative abilities at the micro level allowing for qualitative inputs and processes. Pressures to expand often will 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............ needs there is a growing tendency to ‘glorify’ or romanticize 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 quantities terms. This cannot and should not ignored.

4. **Privatization under the gap of NGO involvement**

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

Government system 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— the services are basically a state responsibility and the tax payer must get back basic care for his contribution. Profit orientation of private sector means that the consumer is always paying more than is necessary and this must be recognized. 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. NGO are definitely closer to people, more responsive to the local situations and function under lesser top down controls and hence more creative. But they too are trying to explore real involvement of people in their own initiatives and processes and meeting with varying degrees of successes. Not all NGO’s have succeeded in eliciting meaningful participation. If these terms are not confused than at least we will 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 beneficiaries.

iii) Monitoring and record keeping system 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 Volgas/NGO’s 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 , centralized 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.

**The Karnataka Experience**

Before I conclude, I would like to highlight that Govt. NGO collaboration need not remain a philosophical entity in the 1990s. Our experience in Karnataka in the last 5 years has shown that with adequate openness and enthusiasm on both sides. This is a creative possibility and can be operationalised. Even though this may not have brought any miracles in Karnataka as yet the stage is set for a close and meaningful collaborative effort in the decade ahead. Some aspects of this collaboration are:

1. The Formation of a Consultative Committee by the Ministry of Rural Development and Social Welfare comprising of secretaries of all key government departments and representatives of NGOs in Community Development, Education and Health. This was formed at the initiative of the planning commission and has been sustained by the
The Consultative Committee has sub committees including one on Health in which
NGO’s dialogue with the Director of Health Services and his colleagues on programme.
2. Dialogue of NGO’s with perspective planning Committee of Govt. of Karnataka on
Health, Welfare and Educational Programme.
3. Dialogue with NGO’s by Director of Health Services at various levels.
   a) Sub Committee of consultative committee
   b) 8th Plan document preparation
   c) Dialogue on government programmes organized by voluntary health association of
      Karnataka.
4. Steps to prepare a comprehensive directory.
5. There are steps to increase such dialogue at the district level.
6. Exploration of collaborative efforts are also under way.

The Key process in all this is frank discussion, feedback from grassroots and mutual
consultation in a non-threatening interactive ethos and a general commitment to exploring the
idea of working together.

6. CONCLUSION- THE CHALLENGES AHEAD

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

PHC 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 PHC 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 effort
in PHC Development- Governmental or non-governmental. This is the challenge before us.
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   health in India.

5. Perspectives in Health Policy & strategies for the State of Karnataka-  
   A response from the Community Health Cell, Bangalore.  
   (Document 1)

6. Beyond policy rhetoric, Statistics and Infrastructural Development:  
   The Tasks for the 1990s-  
   A working paper from Community Health Cell for the Regional  
   Review meeting on Primary Health Care System Development  
   for Southern Zone (Document 4)

Copies of all these papers 2-6 are available on request from C H C, Bangalore
5..... ‘that the planning and implementation of the various health programmes is through the organized involvement and participation of the community, adequately utilizing the services being rendered by private voluntary organisations active in the Health Sector’.

8.1..... “There are a large number of private voluntary organizations active in the health field all over the country. Their services and support would require to be utilized and intermeshed with the governmental efforts in an integrated manner:.

8.7...“With a view to reducing governmental expenditure and fully utilizing untapped resources planned programmes may be devised, related to local requirements and patients….. to encourage increased investment by non-governmental agencies in establishing curative centers and by offering organized logistical financial and technical support to voluntary agencies active in the health field”.

8.12....”Organised efforts would require to be made to fully utilize and assist in the enlargement of services being provided by private voluntary organizations active in the health field. In this context, planning, encouragement and support would also require to be afforded to fresh voluntary efforts, specially those which seek to serve the needs of the rural areas and the urban slums.
APPENDIX-‘B’

POLICY STATEMENTS ON EDUCATION FOR HEALTH

1. “The attainment of the goal: Health for All by 2000 AD depends above all on three things:

i) The extent to which it is possible to reduce poverty and inequality and to spread education;

ii) The extent to which it will be possible to organize the poor and the under-privileged groups so that they are able to fight for their basic rights;

iii) And the extent to which we are able to move away from the counter-productive consumerist western model of Health Care and to replace it by the alternative model based in the Community”.

-‘Health For All- an alternative strategy’
ICSSR/ICMR Report, 1981

2. “The recommended efforts, on various fronts, would bear only marginal results unless nation-wide health education programmes, backed by appropriate communication strategies are launched to provide health information in easily understandable form, to motivate the development of an attitude for healthy living. The public health education programmes should be supplemented by Health nutrition and population education programmes in all educational institutions, at various levels. Simultaneously efforts would require to be made to promote universal education, specially adult and family education, without which the various efforts to organize preventive and promotive health activities, family planning and improved maternal and child health cannot bear fruit.

NATIONAL HEALTH POLICY, 1982.

3. 4.1…..The new Policy will lay special emphasis on the removal of disparities and to equalize educational opportunity by attending to the specific needs of those who have been denied equality so far.

5.4…..A full integration of child care and pre-primary education will be brought about, both as a feeder and a strengthening factor for primary education and for human resource development in general. In continuation of this stage, the School Health Programme will be strengthened.

5.18….Health planning and health service management should optimally interlock with the education and training of appropriate categories of health manpower through health-related vocational courses. Health education at the primary and middle levels will ensure the commitment of the individual to family and community health, and lead to health-related vocational courses at the +2 stage of higher secondary education.

NATIONAL EDUCATION POLICY, 1986
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