BEYOND POLICY RHETORIC, STATISTICS AND INFRASTRUCTURAL DEVELOPMENT: The Tasks for the 1990s

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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.O. No 3/RRM/89-90 dated 6th February 1990.

It brings together a “great 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 friends circlem, 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 supplant ed the Basic Health Services approach, and the National Health Policy statements of the 1980’s saw a “conscious shift from hospital based urban medical care to community oriented rural health care”.

We are now at the threshold of the 1990’s - the final decade before the goal of Health for All – 2000AD. This Regional Review Meeting will consider reports by the seven Southern States on
infrastructural developments, health manpower, 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 exhortation of Alma Ata on Primary Health Care. Does our own National, Regional, State or District level experience symbolises these distortions?

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

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

Finally it would list our the dimensions of a new development culture which have to be development culture which have to be developed in PHC policy has to move towards Health for All – 2000AD. 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 multidimensional 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 model thrust from the Centre.
- 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 ministeries coerced by National and International health resource 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 sustanous 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 committee thereafter has now been watered down inspite of the impetus of “Alma Ata Declaration” to top-down vertical programmes of sterilization, contraceptive distribution, immunization, DRT 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.
- 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 healthcare.
- 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 practice is high, but fails to be taken seriously by planners and 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 programme 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

Through 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 1990’s.
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 year 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 environmental 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 or 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.
- 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. ATTITUINAL 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 compete change in attitude among planners, decision makers and health service providers. This attitudinal change is the most crucial task of the 1990’s. 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 staata 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 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 ust 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 compartmentlisation 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 routine 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 importance as quantative 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-programme 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 situationm 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)  

2. Towards a Paradigm Shift  
   “Link” (News letter of ACHAN)  
   Vol. 7, No2, 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-Sep 1989 (14)

(Numbers in brackets indicate pages)

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