Concept of Primary Health Care in India

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Historical Perspective

The experience and concern in Health and Primary Health Care in India date back to the Vedic period. One finds evidence of well developed environmental sanitation programme such as underground drains, public baths in the cities, etc. Arogya or health was given high priority in daily life and this concept of health included physical, mental, social and spiritual well being. Much has also been mentioned in the Vedas about positive health. The life style was conducive to health promotion and daily routine emphasised health education, personal hygiene and habits, exercise, dietary discipline, civic and spiritual values, treatment of minor ailments and injuries. In Ayurveda, i.e., the science of life, emphasis on health promotion and health education are available.

Unfortunately due to various reasons particularly the invasions on India for centuries and the apathy of the British, the Government did not lay much emphasis on primary health. Health services were mainly meant for the Britishers and advocated medical components.

India gained independence in 1947 after a long colonial rule. Although the National Health Policy was framed only in 1983, the policy content and framework and the strategies were provided over the past three decades. We had the Constitution of India, the National Development Council, the Planning Commission, several Advisory Bodies and Consultative Committees, the Ministry of Health and Family Welfare and the Legislatures.

Keeping in view the constitutional obligations, the Government planned several approaches for the health care delivery. However, the basis for organisation of Health Services in India through the primary health care approach was laid by the recommendations and guidance provided by the 'Health Survey and Development Committee' (Bhore Committee) in 1946. The Committee recommended that the aims of progressive health service were (a) "that the service should be available to all citizens, irrespective of their ability to pay for it" and (b) "that it should be a complete medical service, domiciliary and institutional, in which all the facilities required for the treatment and prevention of disease as well as for the promotion of positive health care provided. Thus there should be provision for every patient if his condition requires it, to secure the consultant, laboratory and other special services, which may be necessary for diagnosis and treatment. There should also be provision for the periodical medical examination of every sick or healthy so as to ensure that his physical condition is appraised from time to time and that suitable advice and medical aid, wherever necessary, are given in order to enable him to maintain his health and the highest possible level." In the long-term programme the Committee had envisaged the eight objectives which are as follows :

1. The service should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;

2. These services should be placed as close to the people as possible in order to ensure their maximum use by the community which they are meant to serve;

3. The health organisation should provide for the widest possible basis of *cooperation between the health personnel and the people;*

4. In order to promote the development of the health programme on sound lines the support of the medical and ancillary professions, such as those of dentists, pharmacists, and nurses is essential; provision should, therefore, be made for enabling the representatives of these professions to influence health policy of the country;

5. In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute 'group practice, should be made available';

6. Special provision will be required for certain sections of the population, e.g., mothers, the mentally deficient, etc.; and;

7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it;

8. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement or recreation are essential."

These objectives of health services for people are followed by an infrastructure of the primary units consisting of 5 medical officers, 6 Public Health Nurses and 75 beds. Each of these units was aimed at providing preventive and curative services. Each

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primary unit was considered to be a link chain of community health service. The provision of ambulance and linkages with secondary units and further linkages with District Headquarters Organisation. A focal point of *Primary Health Centre* to be provided in each primary unit from where different types of activities would radiate. One can imagine the structure suggested 40 years back for providing primary health care.

India launched Community Development Programme in October 1952. This was the first step for all-round integrated rural development. The country was divided into blocks; each block had a population of 1 Lakh and the health coverage was provided through Primary Health Centres in each block. Eight functions of Primary Health Centres were identified, i.e. Medical Care, Control of Communicable Diseases, M.C.H., Nutrition, Health Education, School Health, Environmental sanitation and the collection of vital statistics. Each P.H.C. was further divided into sub-centres being looked after by trained midwife for providing M.C.H. services.

In Nursing Auxiliary Nursing Midwifery Training was started in 1952. Extensive changes and expansion are observed in the last 5 decades. Several expert committees, namely Mudaliar Committee (1961), Mukerjee Committee (1966), Kartar Singh Committee (1974) and Srivastava Committee (1975) were appionted. Progressive changes have been introduced into the programme over six five-year plan periods. Attempts have also been made to expand and reorient nursing education programme especially training of Auxiliary Nurse Midwives. The plans also aimed at extending health and family planning services to bring those increasingly within the reach of all the people for improving their health status. During the Fifth Plan (1974-80) removal of poverty and achievement of self-reliance on the part of the community were given emphasis. For preventing and correcting nutritional deficiencies, supplementary feeding programmes for the child and expectant mothers were initiated on a countrywide basis. The family planning programme was integrated with the M.C.H. and Nutrition programmes.

Then came the Alma Ata Declaration of 1978. India signed it and committed to attaining the goal of "Health For All" by the year 2000 through the Primary Healh Care approach. A critical view was taken while fourmulating the Sixth Five Year Plan (1980-85). Based on these a long term perspective plan was outlined for achieving "Health For All." Constant efforts were made to formulate a National Health Policy keeping in view the H.F.A. principles and strategies. The National Health Policy was officially adopted by the Parliament in 1983.

Basic Principles and Strategies of Health For All

Development:

1. The Health for All is to be attained in a spirit of social justice and as an integral part of social and economic development of the community.

2. An acceptable level of health cannot be attained through the health sector alone, but it would require the coordinated efforts of the health sector and relevant activities of other social and economic development sectors. Therefore, for achieving the ultimate social goals the strategies of the health and other developmental sectors should be mutually supportive.

3. There is a great need for a strong political will at all levels for promotion of health and health development must be considered a positive investment for socio-economic development.

4. There should be equitable distribution of health resource, and preferential allocation of resources to those in greatest social need. The health system should cover all segments of the population.

5. Health for All development is based on self-determination and self-reliance of the individual and the community. Active community participation, encouraging the people to assume greater responsibility for their own health, would be crucial for success.

6. Social orientation of different categories of health workers to serve the people properly would be important. They should also be properly reoriented to H.F.A. principles and strategies, and should receive adequate technical training.

7. The emphasis should be on preventive and promotive aspects of health well integrated with curative, rehabilitation and environmental measures.

8. The primary health care would be the key to the success of H.F.A. and it has to be an integral part of the country's health system, of which it should be a central function and the main agent for delivering health care. For attaining the desired level of health, every individual must have an access to primary health and through it to all levels of comprehensive health system. This concept should be the driving force for determininig all policies and plans.

Concepts of Primary Health Care

The Primary Health Care has been defined to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus and of the overall, social and economic development of the community. It is the first level of contact of individuals, the family and the community with the National Health System bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. The concept considers that there is close inter-relationship and interdependence of health and social and eonomic development, with health leading to and at the same time depending on a progressive improve-

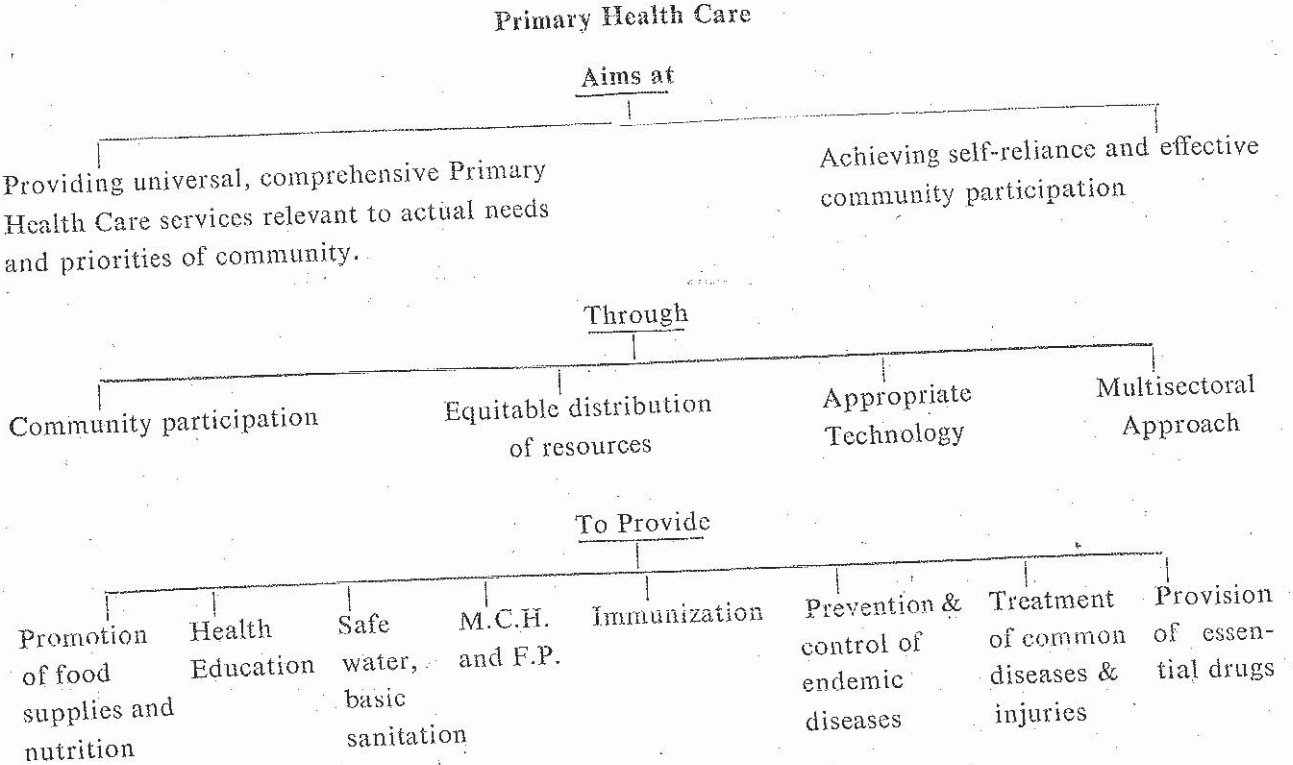
ment in condition and quality of life.

The primary health care is an integral part of the socio-economic development process. Hence, activities of the health sector must be coordinated at national, intermediate and community or local levels with those of other social and economic sectors, including education, agriculture, animal husbandary, household water, housing, public works, communication and industry. Health activities should be concurrently undertaken with measures for improvement of nutrition, particularly of children and mothers, increase in production and employment and a more equitable distribution of personal income, anti-poverty measures and protection and improvement of the environment. Full emphasis on community participation and ultimate self-reliance with individuals, families and community they assume more responsibility for their own health.

Hence if we see and make an analysis of what has been stated in the Bhore Committee report on Development of Health Service, what we are saying today is not new. Major difference is the impact and political support.

We, the nurses, teachers and administrators have to accept this challenge along with all other health professionals. I believe primary health care is the nurses' function. Nurses can take over the complete areas of health promotion and health education (education in community). M.C.H., family welfare, nutrition, education, prevention of locally endemic diseases, immunization. Nurses need to learn to work with people and the communities rather than working for the community. Help community to help themselves.

I may summarize now by saying that :



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