PRIMARY HEALTH CARE

NEW MUSIC - OLD HARMONY

COMMUNITY PARTICIPATION IN DECIDING ON AND SUPPORTING PREVENTATIVE HEALTH PLANS

The concept of primary health care now espoused by the World Health Organization (WHO) and the UN Children's Fund (UNICEF) has resulted from the conflict between the need to reach all the people with health care and the scarcity of resources available for health in most developing countries. Identified as a root cause of the inadequate care in less developed countries is the fact "that their patterns of medical care and education of health personnel are copied closely from the Western countries" (Health and the Developing World, J. Bryant).

With the entry of WHO into the arena, primary health care has received a new boost. A vast army of researches, health and development planners, with WHO, UNICEF and the World Bank in the vanguard, are seeking new formulae, new policies and approaches and new projects through which all people may achieve better health. The seven principles formulated and revised by WHO in 1975 have been accepted by most agencies and institutions as guidelines:

* Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.
* Primary health care should be an integral part of the national health system, and other echelons of services should be designed in support of the needs of the peripheral level for technical supply, supervisory and referral support.

* Primary health care activities should be fully integrated with agriculture, education, public works, housing and communications.

* The local population should be actively involved in health care activities to match health care with local needs and priorities. Community needs require a continuing dialogue between the people and the services.

* Health care should rely on available or untapped community resources.

* Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

* The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by suitably trained workers.

The overall goal is better health. Old patterns focusing on hospitals and advanced technology are largely irrelevant for developing countries and, in fact, often not very suitable for the countries where they originated. In its search for an appropriate health technology the WHO has made another discovery: Health is political! As Halfdan Mahler, WHO Director-General, declared in 1976 to the World Health Assembly: "For all the speed with which disease technology has been flourishing in recent years, it has been failing in its purpose because the social, economic and political contexts in which it is being applied have changed. The extension and refinement of this technology on the one hand and its increasing complexity and cost on the other, have led to a contradiction between the technical potential and the socio-economic ability to apply it to all who need it."

This, however, is not the only contradiction, and I would like here to examine a number of assumptions underlying present attempts at improving the

health of the underprivileged masses of our world.

The first assumption is that health care produces health. To contradict this there is evidence put forward by such sober organizations as the World Bank, that socio-economic conditions have a much more profound influence on the health of a population than the health service. In preparation for a WHO Conference on Recent Trends in Maternal and Child Health in Europe (Moscow 1974), a survey was conducted where European national programmes were given a score for quality of care, on the basis that the more varied the items which a service offered and the larger the number of people who use it, the higher the score. The scores were plotted against maternal and perinatal mortality statistics for the same European nations, but high scores on quality of service did not automatically correspond with low mortality, except in countries with a high standard of living.

Although most speeches, papers and projects now emphasize the importance of socio-economic conditions and stress the need for intersectoral integration, the political implications of this are seldom pursued. If unfavourable socio-economic conditions are seen as the fate of the losers in a competition for resources and power at the various levels (international, national and local); it may not be an easy task to persuade the winners to give up their privileges. Instead we find health planners taking upon themselves the task of developing health care which will compensate for the unfavourable political environment without creating any disturbance. We find institutes of development studies attempting to develop a set of indicators with which to assess the "quality" of health care, basing the evaluation on cost-benefit analyses of the relationship between services provided and measurable health changes resulting from them! It is a relief, then, to come across admissions such as the following from an address by Cvjetanovic to the Ciba Symposium Human Rights in Health, 1973: "I shall ignore the unquantifiable aspects of different socio-economic systems

and their respective merits and disadvantages for health. These are indeed of great importance, but at present we lack a methodological framework to do them justice."

I would like to argue that the methodological framework is lacking because we are afraid to face up to the challenge of the "unquantifiable". The result is that most health planners draw attention to the social, economic and political factors, and then go on to ignore them.

HEALTH CARE DOES NOT PRODUCE GOOD HEALTH.

Health care does not produce good health. The most we can expect from an effective health service is good care, while the need for care is determined by other factors, most important of which may be the extent of poverty and the ideology of the prevailing economic policy. But even effectiveness of care is a questionable concept where there is poverty. There is an unresolved conflict of interest between those who have power, money and knowledge and those who have none. In communities where disease is related to poverty and injustice, it is a mistake to believe that an "effective" health service can be neutral. If we hesitate to take sides, if we refuse to identify with any interest group within the community, we shall inevitably be co-opted by the strong necessity to serve their interests. The second assumption, that health care can be politically neutral, is not valid.

The reality of the conflict between the haves and the have-nots also contradicts another assumption, that a poor, rural village is a homogeneous, harmonious community. Unless profound political changes have been introduced on a national scale in order to counteract oppression of the weak by the strong, rural villages consist of several communities, divided by age, sex, status, religion, caste and class interests. The health sector has failed to transcend these divisions in the past, and every new project or policy which refuses to

accept the existence of such a conflict runs the risk of repeated failure. Again and again it has been found that communication across class divisions is not possible. The idea that the local population should be actively involved in the formulation as well as the implementation of health care activities through a continuing dialogue between the people and the services is unrealistic in a class-structured society.

Some 10 years ago, the response to projects which promised to lift the poor out of their poverty might have been enthusiastic co-operation, even competition among the poor, until it became clear who were the real proprietors, who were in fact benefiting. In all cases where the poor did not benefit, non-co-operation and apathy replaced the original enthusiasm. Repeatedly bitten, now shy, the spirit of self-help is hard to find.

DANGERS OF CO-OPTION.

A WHO/UNICEF study found that several successful health care programmes had developed a new type of health auxiliary, now known as village health workers or "barefoot" doctors (embodied in WHO principle No. 7). (See Development Forum, May 1978). Apart from the fact that they are cheap and easily trained in adequate numbers, this type of health worker has been seen as a tool to help overcome traditional barriers of communication. Some succeed and some fail. Evaluators assess basic qualifications, selection criteria, effectiveness of training and supervision, but the following example illustrates another aspect.

Since 1970 a type of village health worker, the *Family Welfare Educator (FWE) has been trained in* Botswana. For several years I was very closely associated with the programme in which I had considerable faith. We rejected the idea of recruiting volunteers, since we wanted workers to come from the poorest families, who would by definition need to be compensated for the loss of the economic activity of this member.

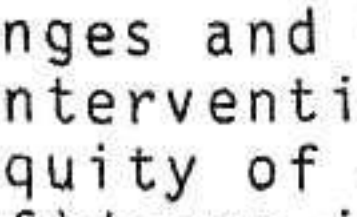
The problem then was how to pay them. As daily paid casual labourers they would have no guarantee of permanent employment, no rights to holidays or sick leave, they would receive no increments for experience, and at the end of their working life they would "retire" without any pension. In all these respects they would be no different from the majority of the rural population, but we felt that it would be unrealistic to expect FWEs to accept such conditions after training when no one else had to. The pre-service training lasted only 11 weeks, but experience and supervision over several years would mean indefinite on-the-job training.

On the other hand, the leap from payment as casual labourer to the lowest rung on the ladder in local government service involved multiplication of the monthly salary by a factor of three, as well as the introduction of a number of other privileges. Over the years the differentiation in rural incomes has increased, and FWEs are extremely well paid today. This means that FWEs identify with the bureaucratic class now, and no longer with the rural poor. There is also considerable competition to be selected for training as FWEs, which the better-educated daughters and nieces of the richer families often win. FWEs are now saying that the poor are extremely "difficult to understand", as well as unco-operative.

Lifted out of the context of poverty and co-opted into the bureaucratic structure, FWEs have lost their identification with the people they are serving, and therefore their effectiveness as a vehicle for change. The effect of the status promotion of the FWEs has been to depoliticize health once more, and render rural health care innocuous in political terms, but perhaps at the cost of decreasing effectiveness.

The invention of the village health workers is thus no guarantee that a project will have any relevance to the hitherto underprivileged. The language, socio-economic background, education and training of the village health workers are not decisive for their effectiveness in communica-

ting with the poor. The basic question is whether they are identified with the deepest aspirations of the underprivileged, and whether the political system in which they work will permit such identification.



co-operatives and workplaces

HEALTH IS POLITICAL.

My argument with the new policies for a more equitable distribution of health resources is that although the vocabulary and the technology have changed, it is not intended that anything else shall. Health is political. It has to do with the fair distribution of the basic requirements which make health possible, and it is unrealistic to expect that effective measures for change should be adopted by a class or a government which profits from the present bias in distribution. Or in the words of C. Elliott in his book "Patterns of Poverty": "Ruling groups have little incentive to undertake the structural changes and the budgetary cost of the kind of direct intervention that is usually required to secure equity of access for the excluded, as long as confidence in the (existing structure) is maintained. When it breaks down - there is an incentive to set in train no more than sufficient change to restore confidence in the system."

The world-wide concern about the inadequacy of the old system of health care is an indication of a certain amount of lack of condifence on the part of the consumers. The present level of ill health in the world is a threat to the groups in power whose prestige is being undermined, and whose own lives are at risk from potential epidemics.

The old kind of health service, which was almost exclusively curative, served to disguise the true nature of ill health. The new emphasis on preventive health care has revolutionary potential. Health education is eminently suitable for conscientization programmes to enable people to realise that they and their children are prey to preventable disease because they are poorly fed, lack good housing and adequate clothing, because

they are unskilled and unemployed.

EDUCATION FOR PARTICIPATION IN COMMUNITY AND POLITICAL LIFE

REAL HEALTH CARE.

Health education has revolutionary potential, if it leads to awareness, organization and action. But if people are to participate in a real and relevant way in their own health care, it means they also have to participate in the control and exercise of power.

At the moment most health workers, including the planners, are keeping themselves busy counting the casualties of the continuing conflict, developing appropriate technology and working hard to reduce the damage to a minimum. Naturally our duty is to relieve suffering, but our duty goes beyond curative and palliative care. If we are serious about preventive care we have to look at the evidence we are collecting to see what it means, and to use the information politically. A severe problem in this context is the larger percentage of expatriates in the health services of almost all countries. Expatriates are in a particularly weak position when it comes to political involvement. However, unless we find a way to work politically we shall be making ourselves accomplices in a confidence trick.

ADEQUATE WATER SUPPLY

METHODS OF INCREASING LAND PRODUCTIVITY

SKILLS RELATED TO EMPLOYMENT AND INCOME OPPORTUNITIES

LITERACY

IMMUNISATION AGAINST *MAJOR* DISEASES

SAFE SANITATION

NUTRITION, HEALTH, HYGIENE TRAINING

CHILD–CARE AND HOME RUNNING

If There Are No Side Effects,

DRUG	UNITED STATES	MEXICO
Tetracycline [ANTIBIOTIC USED AGAINST VARIOUS INFECTIONS; LEDERLE LABORATORIES.]	***Caution against use:*** By infants, children; during pregnancy, with liver or kidney impairment (latter can be fatal) or if overly sensitive to light. ***Adverse reactions publicized:*** Vomiting, diarrhea, nausea, upset stomach, rashes, kidney poisoning. Can poison fetus.	***Caution against use:*** By infants, children; during pregnancy or if overly sensitive to light. ***Adverse reactions publicized:*** Vomiting, diarrhea, nausea, upset stomach.
Ovulen [BIRTH CONTROL PILLS; G. D. SEARLE CO.] IN U.S., USED FOR CONTRACEPTION ONLY. IN SOME LATIN AMERICAN COUNTRIES, SEARLE RECOMMENDS IT ALSO FOR REGULATING MENSTRUAL CYCLES, PREMENSTRUAL TENSION, AND MENOPAUSAL PROBLEMS.	***Caution against use:*** If patient has tendency to blood clot, liver dysfunction, abnormal vaginal bleeding, epilepsy, migraine, asthma, heart trouble. ***Adverse reactions publicized:*** Nausea, loss of hair, nervousness, jaundice, high blood pressure, weight change, headaches.	***Caution against use:*** If patient has tendency to blood clot, liver dysfunction. ***Adverse reactions publicized:*** Nausea, weight change.
Imipramine [ANTI-DEPRESSANT; CIBA-GEIGY.] IN U.S., USED FOR DEPRESSION ONLY. IN SOME LATIN AMERICAN COUNTRIES, CIBA-GEIGY RECOMMENDS IT ALSO FOR SENILITY, CHRONIC PAIN AND ALCOHOLISM.	***Caution against use:*** If patient has heart disease, history of urinary retention, history of seizures, manic disorder, or is on typhoid medication. Not recommended for children or during pregnancy. ***Adverse reactions publicized:*** Hypertension, stroke, stumbling, delusions, insomnia, numbness, dry mouth, blurred vision, constipation, itching, nausea, vomiting, loss of appetite, diarrhea, sweating.	***Caution against use:*** During first trimester of pregnancy. ***Adverse reactions publicized:*** Dry mouth, constipation, itching, sweating.

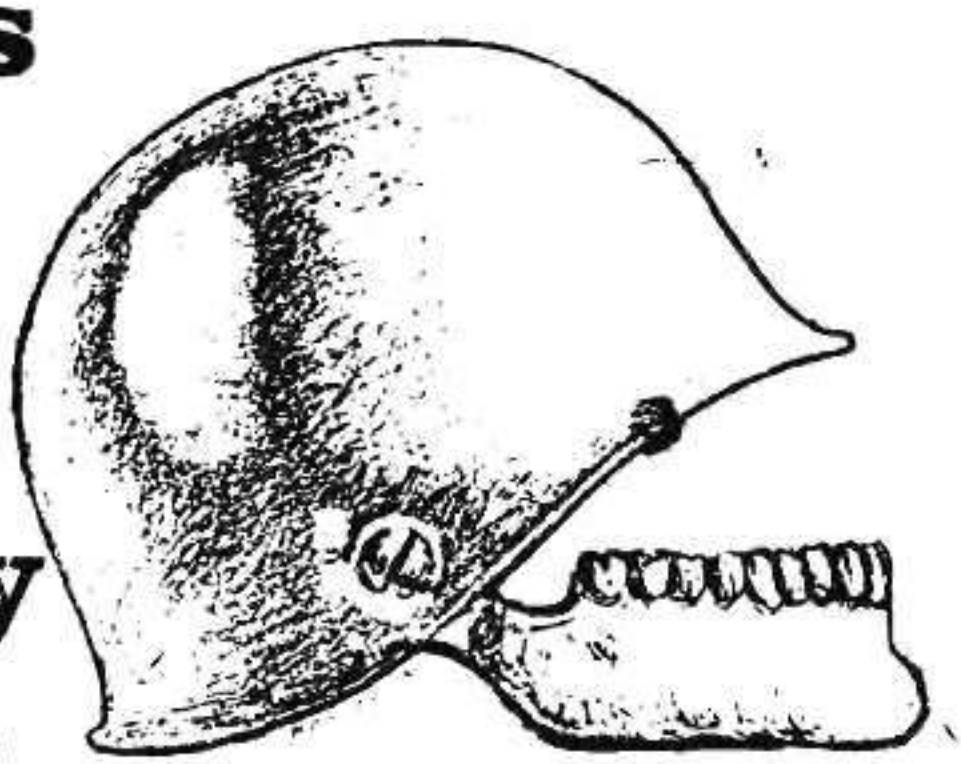
This Must Be Honduras

CENTRAL AMERICA	BRAZIL	ARGENTINA
Caution against use: None ***Adverse reactions publicized:*** None	***Caution against use:*** By infants, children, during pregnancy. ***Adverse reactions publicized:*** Vomiting, nausea, upset stomach, rashes.	***Caution against use:*** None ***Adverse reactions publicized:*** None
Caution against use: If patient has tendency to blood clot liver dysfunction ***Adverse reactions publicized:*** Nausea, weight change	***Caution against use:*** If patient has tendency to blood clot. ***Adverse reactions publicized:*** None	***Caution against use:*** If patient has tendency to blood clot ***Adverse reactions publicized:*** None
Caution against use: If patient has heart disease. ***Adverse reactions publicized:*** None	***Caution against use:*** If patient has heart disease. Not recommended for children or during pregnancy. ***Adverse reactions publicized:*** None	***Caution against use:*** May exaggerate response to alcohol. ***Adverse reactions publicized:*** None

Source: *Culled from* The Physician's Desk Reference—*the standard handbook for U.S. doctors, containing information drug companies supply about their products—and comparable foreign guidebooks.*

The money required to provide adequate food, water, education, health and housing for everyone in the world has been estimated at $17 billion a year. It is a huge sum of money

...about as much as the world spends on arms every two weeks.



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