Integrating maternal and child health services with primary health care

PRACTICAL CONSIDERATIONS

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INTEGRATING MATERNAL AND CHILD HEALTH SERVICES WITH PRIMARY HEALTH CARE

Practical considerations

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Chapter 1

INTRODUCTION

Since the formulation of the goal of "Health for all by the year 2000", countries throughout the world have made efforts to strengthen and expand their systems of primary health care. The Declaration of Alma-Ata in 1978 identified eight essential elements of primary health care—education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water, and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

Historically, services that furnish the different components of health care have often developed in parallel but separately; now, however, it is widely accepted that the provision of a fully comprehensive health service requires their efficient integration. This book deals specifically with the integration of maternal and child health care—including family planning services—with the other components of primary health care, addressing the organizational and other problems raised. These problems include identifying the best system of integration, the necessary extension of technical skills and expansion of the workforce, supervision and referral logistics, the need for additional equipment and supplies, and the organization, services and monitoring of clinics.

Many of the basic concepts of primary health care are derived from maternal and child health care practices, and existing infrastructure should be utilized in the integration process wherever feasible. Integration of the two services should take place on several fronts, notably "horizontal" and "vertical". Horizontal integration aims to link together and coordinate the broad range of developmental services, including health, education, agriculture, water supply and sanitation, transport, communications, etc. If integration is to be achieved with maximum efficiency and have maximum impact, the interdependence of all these facets of development must be fully recognized.

Vertical integration is concerned with ensuring the vital linkage between different levels of care, from the national level down

through the district and health centre levels to the community and the individual. This vertical linkage should be used for planning and implementing services, for monitoring their impact, and to keep health and development systems responsive to, and directed by, the needs of the people.

INTEGRATION IN PRIMARY HEALTH CARE HAS BOTH A HORIZONTAL AND A VERTICAL COMPONENT

The timing of particular events in the field of maternal and child health can also be valuably exploited for purposes of integration with primary health care. For instance, passive immunity to measles wanes when infants reach about 9 months of age; at this time weaning is generally well advanced and ovulation is therefore likely to have been re-established in breast-feeding mothers. Thus, the ideal time for immunizing infants against measles usually coincides with the time when mothers may be seeking family planning advice. Moreover, with the introduction of normal family food into infants' diets, this is also a valuable time to educate mothers in the prevention and management of diarrhoea and in food safety generally.

This book examines in some detail the objectives of integrating maternal and child health care into primary health care services, identifies barriers to realizing that integration, clarifies the issues involved and gives examples of innovation already achieved in some countries. As part of an overall effort to strengthen primary health care, it provides an overview of the organization, management, implementation and evaluation of maternal and child health, including family planning services, and should enable readers to understand the different components of maternal and child health programmes and the links between them. It should also help them to identify the most appropriate circumstances and methods for improving the social acceptability, effectiveness and efficiency of maternal and child health and family planning programmes in their own communities.

Because of the broad implications of the relationship between maternal and child health and family planning, it is vital for health personnel at all levels to understand the importance of integrating maternal and child health/family planning into primary health care and to support efforts to achieve this integration. This will entail the appropriate education of existing staff and possible modifications to the curricula of some training programmes. It may well be impossible to effect a complete reorganization and offer all

components of primary health care at one time; a phased process is then in order, with appropriate changes in staffing, equipment, supplies and organizational patterns proceeding concurrently. Community and family self-reliance should be given high priority during the reorganization phase.

This publication is aimed at programme managers, from district to national level, who are concerned with primary health care and with maternal and child health, including family planning. It may also be used at several levels in relevant training programmes, or equally well as a framework for the analysis and evaluation of activities in these areas. Those who provide primary training for community health workers and for auxiliary and other nonprofessional staff could use it as a basis for the development of locally suitable training materials. It should also be helpful to programme managers responsible for developing and designing national curricula for different levels of health worker, providing them with a framework for an integrated curriculum.

Chapter 2

BACKGROUND

When organizational changes are proposed, it is important to understand the background of existing services and why they have evolved as they have. This is helpful in dealing with concerns on the part of the staff and the community about the proposed changes and for planning the timing and phasing of measures for the integration of services. It is most important to ensure that no useful elements of an old system are lost in the plan for a new one.

Maternal and child health

History of maternal and child health care

One of the oldest components of health care is certainly midwifery; assistance at delivery, whether performed by a relative or by a village matriarch, is a feature of practically every culture. More importantly, a recent WHO review of traditional birth practices shows that many are physiologically sound and beneficial, including the use of traditional delivery positions (squatting, kneeling, standing), allowing delivery of the placenta before cutting the cord, delivery in special huts with a source of heat, etc. It is also true, however, that other birth rituals are at best harmless and on occasions dangerous.

MANY TRADITIONAL BIRTH PRACTICES ARE GOOD

"Professionalization" of the delivery process began in the late nineteenth and early twentieth centuries. The importance of antenatal care emerged with the recognition of risk factors such as pre-eclampsia and anaemia, and the desire for an aseptic environment and more specialized care gradually moved deliveries away from the home or village to the clinic or hospital. While enhancing the technological aspects of delivery and making it easier for the professional health worker, this began the long process of removing many of the personal and familial aspects of childbirth. Only in recent years has the important concept of family bonding, with its sociocultural implications, been "rediscovered" and reintroduced in developed countries. It is to be hoped that this aspect of the uncomplicated delivery can be maintained where it is still common, while other improvements are introduced.

Fig. 1. Many traditional birth practices are good and should be encouraged, such as delivery in a sitting or squatting position

RETAIN FAMILY BONDING AS AN ASPECT OF DELIVERY

Family planning is another aspect of maternal care with a long cultural history. The health benefits of family planning, though not necessarily explicitly recognized, have been implicitly acknowledged in many societies. For instance, sexual abstinence after pregnancy, combined with breast-feeding, has served to lengthen the time between pregnancies in many countries, even when not directly identified with the goal of limiting fertility. In other areas, however, breast-feeding has declined as a result of greater involvement of women in the workforce, and this has led to an increase in fertility. It is important to counteract this latter trend by encouragement of breast-feeding and by development of culturally acceptable methods of birth control.

Equally important, though sometimes less apparent, is the development by traditional societies of their own child-rearing and feeding practices. The types of food used and the timing of feeding during weaning have had a profound impact on infant health. Infections caused by poor hygiene and unclean water have been

major causes of infant mortality. Only in the past half-century, with the development of modern medicines, especially antibiotics and vaccines, has child care improved dramatically.

Current patterns

In the more recent history of maternal and child health services, the impact of technological development and increased health manpower has been considerable. The recognition and treatment of diarrhoeal diseases, the identification of risk factors in both pregnancy and childhood, improved nutritional programmes with appropriate food supplementation, better delivery techniques, and more sophisticated referral options are all part of the improving picture.

Because of their relatively long history, antenatal services are often the best-established clinic-based maternal health programmes, although persuading pregnant women to attend early and regularly can be something of a challenge. Problems routinely monitored in clinics include anaemia and pre-eclampsia. Iron tablets and multivitamins are often used, when in stock, and tetanus toxoid immunization is given in areas where neonatal tetanus is common. However, the difficulty of detecting complications and providing specialized care when required remains a major problem at the primary health care level.

GOOD CHILD CARE BEGINS DURING PREGNANCY

In primary care programmes, the nurses or midwives who provide antenatal care in the clinics often handle deliveries as well. Because of this, they may already know the mothers and be acquainted with their medical and obstetric histories. Some women do not attend antenatal clinics, yet come to the health centre or hospital for deliveries. Others attend antenatal clinics but, for one reason or another, are delivered at home under the care of a traditional birth attendant or family member. Improved delivery techniques, both in the home and in health facilities, are still a goal. Failure to make timely referrals in difficult cases is a major barrier to reducing maternal and perinatal mortality in many countries.

Family planning services are another part of maternal and child health care. In some countries they are well organized; in others, where both cultural and organizational barriers have limited their expansion, they are nonexistent or merely a weak adjunct to other services. Occasionally, a separate administration, either within or

distinct from the ministry of health, has been developed to promote family planning; while this may help services to get started more quickly, it has made it difficult to integrate family planning into maternal and child health services. A further problem is that of the political implications and confusion in social policy associated with attempts to reconcile the needs of individual couples with national growth. Some people have questioned the wisdom of limiting increases in their country's population, and this has occasionally left health workers uncertain of how actively they should promote family planning. In other parts of the world, family planning has been culturally acceptable and actively promoted for a number of years. It is generally felt that the best approach is to let family planning become a fully integrated and accepted part of primary health care, through which the health aspects of family size and child-spacing can best be dealt with. Only by keeping family planning a health issue can health workers effectively promote the best plans for mother and child.

CHILD-SPACING IS A HEALTH ISSUE

The last of the established features of maternal and child health services is child care, typically provided in the form of clinics for the under-fives. These clinics usually cover health education, growth monitoring, nutritional evaluation, immunizations, oral rehydration, and the treatment of simple diseases. The services provided have done much to lower infant mortality in many countries, although there are still shortcomings in the care and follow-up of complicated cases. They have traditionally been separate from antenatal care and other services for women, and in some countries this has reduced their effectiveness and coverage.

Primary health care

The concept of primary health care and its components has been refined in the past decade. To understand the central role it plays in health care, it is essential to look at its historical evolution.

History of health services

For centuries, health care was based primarily on a one-to-one relationship between a health practitioner of some type and an ailing patient. This usually resulted in some type of "treatment" or instruction that was believed to be beneficial to the patient. While knowledge and techniques are now vastly superior, this basic

relationship is still at the core of most health systems. Its efficacy depends on health workers having the knowledge, skills and resources required to help someone with a particular problem.

The advent of modern epidemiology allowed a better understanding of disease and disease transmission, and more effective measures to protect or improve public health became possible. These measures often centred on water and sanitation projects and were most successful in controlling many communicable diseases. New types of health worker (e.g. sanitarians) appeared on the scene, who were concerned with community projects rather than individual patients. This development was the beginning of modern public health. The new programmes were usually developed and administered separately from clinical health services, and it was initially felt that there was little need for the two spheres of activity to interrelate to any significant extent.

Continued advances in medicine have now led to personal preventive practices being considered an integral part of effective health care. Many diseases can best be prevented by activities or procedures practised or initiated at the level of the individual, such as immunization or healthier nutritional habits. Even in areas such as the safety of water supplies, which are traditionally the concern of the community, supplementary efforts of a personal kind may be required. In recognition of this, health care systems have increasingly integrated curative and personal preventive activities in order to achieve better results.

PRIMARY HEALTH CARE INTEGRATES CURATIVE AND PREVENTIVE SERVICES

The training and orientation of health workers through the years have followed the same pattern of development. The need to relieve pain and suffering and the relative immediacy of results have oriented most health workers towards the treatment of disease or the practice of curative medicine. This is particularly true of the past 50 years during which modern medicine has had a record of greater success than before. Long-term projects, such as preventive and educational activities, often have less immediate impact, but are equally important and effective in improving the health of the community.

As health care has become more sophisticated, a greater diversity has been required in the workforce. This has resulted in the development of different types of health discipline, as well as several

levels of training within each discipline. It has become important to define with some care the relationships, both vertical and horizontal, between the different types of health worker concerned. Their morale and effectiveness are significantly influenced by their perceived status and the fairness with which they are treated.

The technological advances of modern medicine are well known. The fact that so few of them are available to most of the world is less appreciated. Social inequities, socioeconomic barriers, lack of logistic support, the difficulty of maintaining a trained workforce, and various other factors combine to reduce considerably the benefits of twentieth-century medicine in many areas of the world. Equally unfortunate are the attempts made to introduce inappropriate technology into the health care system. The "inappropriateness" of the technology may be due to a lack of the technical and staffing infrastructure needed to support it, or to the fact that its level of sophistication is too high for the circumstances in which it is being used. This results in a waste of financial and other resources, and in frustration for those involved. The concept of appropriate technology points the way towards more workable approaches.

Principles of primary health care

Increasing pressure for social justice and the growing acceptance of health care as a right of all people are causing radical changes in health care systems. As much a political statement as a health plan, primary health care rests on the three fundamental pillars of *equity for all, community involvement,* and *intersectoral coordination.*

The concept of health for all by the year 2000 was forcefully expressed by the World Health Assembly in 1977. The Alma-Ata Conference endorsed it in 1978 and decided that primary health care should be the principal means employed to realize it. The Conference emphasized that this meant appropriate health care, not second-rate care, which should cover at least the following:

- education concerning prevailing health problems and methods of preventing and controlling them
- promotion of food supply and proper nutrition
- adequate supply of safe water and basic sanitation
- maternal and child health, including family planning
- immunization against the major infectious diseases

- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries
- provision of essential drugs.

Equity in health care

Primary health care is particularly concerned with ensuring that essential care is available to all. A variety of political and socioeconomic forces have traditionally encouraged a concentration of health resources in the larger cities, leaving rural populations with little organized care. Other inequities exist in health care allocation, notably between rich and poor urban areas, between certain population groups, and between the sexes. To redress these inequities, specific measures for the more even-handed distribution of resources will be necessary. To some extent, these will involve the preferential allocation of resources to underserved areas—a task that may be feasible with new resources but comparatively difficult with established ones.

EQUITY IN HEALTH CARE REQUIRES REDISTRIBUTION OF RESOURCES

The unit cost of primary health care, i.e. the cost per person of a specific intervention, is small, but the tremendous expansion that will be required to cover underserved areas will call for significantly increased input from government and community resources. Effective primary health care demands centralized support and political commitment from the top levels of government. While the utilization of community resources is important, inherent inequities in the amounts of these resources should not be allowed to influence the quality of the care provided. In other words, poorer communities will need preferential help if the cycle of poverty and poor health is to be broken.

Most governments have now accepted the above requirements and committed themselves to providing health care for all their people. This commitment has been incorporated in the definition of primary health care. Because of the enormous increase in health units that will be needed and the underdeveloped nature of the areas they will serve, primary health care will have to be relatively simple in most countries and rely heavily on community resources, though even this will not make it any easier to provide. Nevertheless, the basic goal of making health care available to everybody must be realized.

Community involvement

Another basic principle of primary health care is community involvement. Close contact between health services and the community is essential and should be a two-way process. Health workers and the services they provide must remain responsive to the perceived and real health needs of the people they serve. Similarly, the community must understand the objectives and constraints of the health system and seek ways of making its task easier and increasing its effectiveness. In solving some of the sociocultural and economic problems that are so important to good health, community leaders can be particularly valuable in mobilizing resources and assisting health workers to understand needs and take appropriate action.

MEMBERS OF THE COMMUNITY ARE AN INVALUABLE HEALTH RESOURCE

It is important to make a distinction between genuine community involvement and mere passive participation. In true involvement, the community can be influential in such areas as the setting of priorities, the selection and dismissal of health staff, the organization of clinics and services, including opening hours, and the kinds of technology that are appropriate. In no situation is there any substitute for open dialogue and trust. Various community organizations and social networks, such as village development committees, young people's, women's, religious, or family associations or clubs, can serve as the mechanism for participation. Properly utilized, the community usually constitutes the most valuable resource available for improving health.

Intersectoral coordination

The third pillar of primary health care is intersectoral coordination. As health services have grown more diversified, and awareness of the impact on health of other sectors, such as agriculture, education, and transport, has increased, it has become clear that such coordination is of vital importance.

INTERSECTORAL COORDINATION IS A MUST IN PRIMARY HEALTH CARE

Development is such a complex process that it is difficult for any particular aspect, like education or health, to make much headway

without reference to others. There are many examples of this, such as agricultural policies that have given cash crops preference over food crops and thus led to increased malnutrition. Even within the health field, it is important for programmes in such areas as water and sanitation, clinical services, and development of the workforce to proceed in a coordinated fashion. Because of the need for frequent dialogue between the different people involved, an intersectoral committee can be extremely helpful in this connection. Such a committee could include representatives of the following sectors and groups:

- water/sanitation
- education
- agriculture
- transport/communication
- unions/employee groups
- religious groups
- women's groups
- social clubs
- local politicians
- local employers/merchants.

ENCOURAGE ADULT LITERACY

One particular aspect of development—the literacy of women—deserves special mention because of its influence on maternal and child welfare and primary health care. Women who are able to read and understand about health and development are open to new ideas for protecting their own health and that of their families. As a result they may change their ways of preparing food, their attitudes towards pregnancy, childbirth and contraception, and their sanitary practices and working habits. Health workers may accordingly want to encourage literacy programmes.

Fig. 2. Adult literacy is a critical part of integrated development

Barriers to change

It is part of human nature for people to seek to maintain what they know and feel comfortable with. Consequently everybody resists change to some degree, and those with relatively little exposure to new ideas through reading and other forms of communication tend to resist change more than others. This must be accepted as a normal response and not viewed primarily as being negative or as a conscious attempt to stop progress. People often advance a number of reasons for clinging to old and comfortable ways and solicit support from others in their resistance to change. Their objections must be dealt with patiently.

ANALYSIS OF BARRIERS TO CHANGE HELPS IDENTIFY SOLUTIONS

The social or group process used to resist change can also be used to endorse it. By carefully obtaining the understanding and support of one or several group leaders, it is possible to initiate the process of acceptance. Credit should be given to those with new ideas or