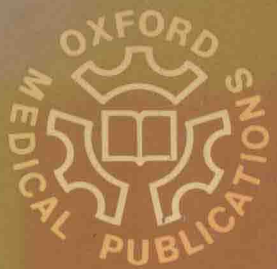

Basic Health Care in Developing Countries

An epidemiological perspective

EDITED BY
Basil S. Hetzel

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Basic health care in developing countries

An epidemiological perspective

Edited for the International Epidemiological Association and the World Health Organization by

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Foreword

FRANCISCO J. DY, MD.

Regional Director, Regional Office for the Western Pacific,
World Health Organization

A little over a year ago I had the pleasure of opening the first meeting of the Regional Working Group on Basic Health Services, which was held at the Regional Office for the Western Pacific of the World Health Organization, Manila, Philippines from 21 to 29 September 1976. This was also the first of such activities in the Western Pacific Region to be jointly sponsored by the International Epidemiological Association and the World Health Organization.

The objectives of the working group were to examine the developing trends and present status of basic health services in the Western Pacific Region, with particular reference to primary health care; to study means of applying the findings of operational research on basic health services; to prepare guidelines for the future development of such services; and to consider the role of international agencies in promotion and development in this sphere.

Working papers were prepared based on the objectives of the working group and have since been issued as a document of the Regional Office together with its final report. There have been many requests for copies of this document and it is now to be published by the World Health Organization as No. 1 in the 'Public Health in the Western Pacific' series.

When such activities are organized by the World Health Organization, it is expected that they will stimulate further activities; an expectation which is certainly being fulfilled by the working group on basic health services.

When Dr. B.S. Hetzel informed me of the intention of the International Epidemiological Association to publish a monograph on basic health care in developing countries, and expressed a desire to approach participants in the Working Group to ask them to prepare detailed contributions from a number of countries in the Region for inclusion in the monograph, I encouraged Dr Hetzel to do so. As a result of his efforts as editor and of those who complied with his request for contributions, this monograph is now being published by the International Epidemiological Association and the World Health Organization as one of a series of handbooks in the field of epidemiology and health care.

In addition to papers on basic health care in countries of the Western Pacific Region, there is also one from India. There are contributions on training and on health information systems together with an epidemiological perspective of aspects essential to the planning, programming, implementation, and evaluation of the delivery of health care at the peripheral level.

There is no need more pressing than the interchange of knowledge on the different approaches, strategies, and technologies being adopted and developed under varying economic, social, and political situations to achieve the goal of health for all by the year 2000. *Basic health care in developing countries: an epidemiological perspective* is a significant, factual, and stimulating contribution to this knowledge. The joint collaboration of contributors, the International Epidemiological Association, and the World Health Organization has resulted in a most useful publication. I am proud and honoured to have been asked to prepare this foreword.

Preface

This handbook arose out of a Working Group jointly sponsored by the International Epidemiological Association and the Western Pacific Regional Office of the World Health Organization held at the WHO Regional Office, Manila, from September 21 to 29 1976. The Working Group included as participants 16 Temporary Advisers from 9 countries–China, Laos People's Democratic Republic, Republic of Korea, Philippines, Malaysia, Papua New Guinea, Fiji, Solomon Islands, and Samoa. There were 4 consultants from the International Epidemiological Association.† It also included observers from three major international agencies, UNICEF, UNDP, and USAID.

The initiative from the International Epidemiological Association arose from a Council resolution in August 1974, to seek an active association with the World Health Organization at regional level in order to assist as far as possible with the application of the epidemiological approach to the definition, monitoring, and evaluation of health problems and the development of health services designed to meet these health problems. Since 1975 a series of joint meetings have been held in Copenhagen (European Region), Isfahan (Eastern Mediterranean Region) as well as the Western Pacific Region; while in 1977 the International Scientific Meeting of the IEA was held in Puerto Rico in conjunction with the American Regional Office of the WHO, Washington, the Pan American Health Organization.

The Working Group proved to be a very stimulating experience for all participants. It therefore seemed appropriate for a detailed monograph to be prepared, designed to include detailed contributions from a number of countries in the region and published in the IEA/WHO Handbooks series. I am grateful to all contributors, most of them members of the Working Group, who have so readily complied with a request for papers. The monograph includes in addition a contribution from India, and a general discussion of the epidemiological viewpoint, its concepts, and other aspects related to this topic.

The book reflects a new dynamism in thinking and action about basic health care in developing countries evident throughout the world. An outstanding example of this dynamism is the remarkable achievement of improvement of health by the People's Republic of

† Dr. K.L. White (Chairman); Dr. B.S. Hetzel (Australia); Dr. R. Sharma (India); and Dr. P. Campos (Philippines)

China. However, as indicated in Chapter 1, there is evidence of a world-wide movement involving Asia, Africa, and Latin America, along these lines.

The necessity of providing basic health care for all people and the development of a suitable strategy to achieve this is now becoming an urgent priority in developing countries. The relevance of epidemiology—the discipline concerned with the health and health care of populations—is obvious, but must be made explicit in order to facilitate the confrontation and solution of these problems. It is our hope that this book will be a significant help towards this end.

Adelaide, South Australia
June 1978

B. S. H.

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Contents

† Chapter written before reunification with the republic of South Vietnam and the creation of the Socialist Republic of Vietnam on 2 July 1976.

1. Basic health care and the people

B. S. HETZEL

There is a new dynamism evident in health care for developing countries. This new dynamism, typified by the expression 'health by the people', is characterized by a new thrust towards community participation and organization at the grass roots level in individual villages and municipalities. The term 'basic health care' is suggested to denote this new local community initiative towards health and health care.

Basic health care in this context seeks to meet the total health needs of the community and not simply the care of the individual patient. The overall aim of basic health care is to improve the health-level of the community as this is revealed by epidemiological data on health and disease as well as by relevant information concerning the environment and life-style.

The important features about the concept of basic health care are its breadth and its suitability for community action. Community initiative to improve health in developing countries must include housing as well as medical care, education as well as immunization, or, more broadly, community development as well as community health services. The health status of a community in developing countries will depend very much on agriculture, and on literacy and communication, as well as on the availability of personal health care.

In basic health care there is an emphasis on the provision of health care at 'grass roots' level—with an emphasis on benefits to the whole community. This contrasts with previous experience with public health services which usually reach only a minority of the community.

This limitation of so-called 'vertical' health services was recognized by the Executive Board of the World Health Organization in 1973. The Board considered that there was no ground for confidence that the continuation of such health services would significantly improve the delivery of health services to the majority. It therefore commissioned a joint WHO/UNICEF study to provide a reappraisal of the situation.

The report of the recommendations of this joint study were approved by the UNICEF/WHO Committee on Health Policy in February 1975. They were as follows:

(a) primary health care services should be recognized as forming part of overall development (of urban, rural, and other underserved groups), taking into account the interaction between development and health programmes;

(b) firm policies, priorities, and plans should be established for the proposed primary health services;
(c) all other levels of the health system should be reoriented to provide support (referral, training, advisory, supervisory, and logistic) to the primary health care level. Such an orientation of the health system would require active participation and training in the basic principles for all members of the health services;
(d) communities should be involved in the designing, staffing, and functioning of their local primary health care centres, and in other forms of support;
(e) primary health care workers who have undergone simple training should be utilized;
(f) the primary health care workers should be selected, when possible, by the community itself, or at least in consultation with the community—acceptability of such workers is in fact a crucial factor of success;
(g) there should be special emphasis on (i) preventive measures; (ii) health and nutrition; (iii) health care needs of mothers and children; (iv) utilization of simplified forms of medical and health technology; (v) association with some traditional forms of health care and use of traditional practitioners; and (vi) respect for the cultural patterns and felt needs in health and community development of the consumers.

1. PRIMARY HEALTH CARE

These recommendations include the term 'primary health care' as denoting the provision of comprehensive personal health services at village level. They do emphasize that primary health care is part of overall development, and stress the need for the use of traditional practitioners, or the selection of primary health care workers by the community itself.

These recommendations were adopted as a background document to serve as the basis for a world-wide action programme for primary health care which was approved by the World Health Assembly. This new emphasis on the relevance of the cultural aspect and the comprehensive provision of services by suitable personnel at village level is most important.

However, the term 'primary care' in English usage goes back to the 1920 report of Lord Dawson in England, concerned with the provision of 'primary health centres' which were to be mainly concerned with first contact medical care. Since 1960 many of these centres have now materialized in Britain under the National Health Service. They include general practitioners, public health nurses, and consulting rooms for visiting consultants, and they also have additional facilities for health promotion activities.

Subsequently, in 1962, the term was used in Great Britain to denote general practice, and has since achieved wide prominence in this connection (White 1963, 1964). However, the use of the term by the WHO is much broader than this. This is indicated by the Director

General of the WHO in his statement to the World Health Assembly in May 1975:

> Primary health care is taken to mean a health approach which integrates at the community level all the elements necessary to make an impact upon the health status of the people. Such an approach should be an integral part of the national health care system. It is an expression or response to the fundamental human needs of how can a person know of, and be assisted in the actions required to live a healthy life, and where can a person go if he/she needs relief from pain or suffering. A response to such needs must be a series of simple and effective measures in terms of cost, technique and organization, which are easily accessible to the people in need and which assist in improving the living conditions of individuals, families and communities. These include preventive, promotive, curative and rehabilitative health measures and community development activities.

It is clear that there is a considerable difference between primary health care as interpreted in these statements and the previous use of the term for first contact care. It is much more widely embracing in its current usage by the WHO in emphasizing community participation and promotional and organizational activities than in previous usage. It also contrasts with existing public health services by its emphasis on the periphery rather than central planning and organization of so-called 'vertical services', which have also been called 'institutional health services'.

The limitations of many existing institutionalized health services are seen to be their failure to enlist community participation and the fact that they are not linked to other services, such as education or social planning. At the same time existing curative or primary care services are characterized by urban concentration and quite inadequate rural coverage. This means that in countries where most of the population is rural, 65 to 80 per cent may not be covered at all.

The contrast between the new emphasis on participation and the existing institutional health services is exemplified by the village health worker, who is nominated and paid by the village, compared with the health professional 'parachuted in' from the city, who has an urban mind and a wife usually with a similar background.

The new concept places greatest emphasis on the village health worker as most likely to provide a nearly complete coverage of the population. Institutionalized services are expected to support primary health care at the community level by providing tehnical guidance, training for primary health care workers, and logistic, financial, and supervisory support for health measures such as immunization, sanitation, family health, and family planning.

These new concepts are clearly almost revolutionary in their thinking. They have been greatly influenced by experience in China

where a grass-roots emphasis has led to community participation on an unprecedented scale. Such a dynamic new concept should preferably be denoted by a new term rather than the current widely used term 'primary health care' which has a much more limited meaning. Indeed the usual meaning refers to the antithesis of the current concept in many countries with a bureaucratic structure.

It is for this reason that the term 'basic health care' has been preferred for the new 'health by the people' concept. It is different from the previously used 'basic health services' in that the latter term usually refers to the institutionalized or conventional public health services as originally enumerated by Winslow (1923)—'the sacred seven'. On the other hand, the term is different from 'primary health care' in that basic health care is seen as covering the whole health field of human biology, environment, life style, and health services.

A series of examples of basic health care has recently been cited by the UNICEF/WHO Joint Committee on Health Policy in Geneva at a meeting in Geneva early in 1977. This committee has already published an important monograph *Alternative approaches to meeting basic health needs in developing countries*, edited by V. Djukanovic and E.P. Mach (1975). In this study it was shown that the greater the participation of the community in the development of primary health care services, the greater was the motivation to accept and use these services; and with greater acceptance and use of such services there was less need for expensive curative care.

A further series of examples of community involvement in basic health care is now being studied to try to determine the factors responsible for community motivation and organization. These case studies include the following as cited in the *WHO Chronicle* for March 1977:

In Botswana, the case study was concerned with community participation, which began with the building of a primary school at Mochudi in the early 1920s, since when a pattern of community involvement in education, communications, and agriculture, has continued.

In Costa Rica, the case study was about community participation in development projects (including primary health care) in the canton of San Carlos.

In Indonesia, it was concerned with community participation through 'gotong royong' (the practice of mutual self-help) in developmental activities in two villages, Balongmasin (in East Java) and Nglebak (in Central Java).

In Mexico, the case study was about a program for stimulating and coordinating socioeconomic and health development in the Chiapas highlands, where road building, bringing piped water, and promoting primary health care are being carried out by the use of local volunteers.

In Senegal, the case study was concerned with activities in the region of Thies, where the people have constructed and are operating (on a self-help basis) c