MARCH OF AN IDEA

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The primary health care approach reflects the experiences in public health and social medicine over the past several decades, and a reaction to the disappointment felt by many countries at the proven inefficacy of the concentional health services.

At the World Health Assembly in May 1977, Member nations of WHO gave the call of "Health for All by the Year 2000" and declared their main social target for the coming two decades to be: "The attainment by all the citizens of the world of a level of health that will permit them to lead a socially and economically productive life".

What they were, in effect, asking for was: a radical change in the health systems now serving the majority of mankind; re-distribution of health resources to permit health care to reach the poorest sections of society; curbs on the wasteful expenditures and high-cost medical technology serving only the privileged urban minorities; de-mystification of medicine and medical education to give village communities the confidence to be responsible for their own health and to use lay people with short-term training to provide health care as the vanguard of a new health system.

Brave sentiments, said the sceptics, but is the goal realistic? Will human nature change and the privileged minorities give up their special advantages? Will there be sufficient resources to cover entire populations? Will not physicians and other health professionals object to standards being "lowered" by laymen providing health care? In any case, some of them said, "Health for All" is only a slogan and needs further definition. In other words, most of these critics—all belonging to those fortunate minorities in every country who receive adequate health care—tried to shoot down the idea even before it had received a full hearing in national and international forums.

Strong endorsement

But the idea caught on. At the WHO/UNICEF International Conference on Primary Health Care at Alma-Ata, USSR, in 1978, the goal of "Health for All" was endorsed by an international gathering to which the governments had sent not only their spokesmen for health, but also experts from such fields as: economics, finance, planning and development.

The Declaration of Alma-Ata, issued at the conclusion of the Conference gave strong endorsement to the Assembly's call, and went a step further in spelling out in finer detail the Primary Health Care (PHC) approach as the key to achieving the social target adopted by the governments. The approach reflects the experience in public health and social medicine over the past several decades, and a reaction to the disappoinment felt by many countries at the proven inefficacy of the conventional health systems. PHC offers an alternative that is practical and pragmatic, and takes into account not only the bleak reality of widespread disease, poverty and maldistribution of wealth, but also the resources that mankind possesses today to change it all, provided political will can be galvanized to this end. It regards health not as an objective to be pursued in isolation but as one of the interacting forces of the development process, a desirable goal of development, and, at the same time, a lever to raise social and economic standards. Above all, PHC lays strong emphasis on the community's role in promoting its own health, and that of the health services in providing support that would enable the people to exercise their responsibility and not remain passive recipients of health measures devised in some far off city and introduced without their involvement.

The United Nations General Assembly endorsed the Declaration of Alma-Ata in 1979 by a resolution which welcomed the efforts of WHO and UNICEF to attain "Health for All by the Year 2000", and called upon the relevant United Nations bodies to support the efforts of WHO by appropriate action within their respective spheres of competence.

The new ideology, while it caused eyebrows to be raised in the citadels of traditional medical learning and the medical establishment, was welcomed enthusiastically by the developing countries who were beginning to realize the futility of trying to improve the health conditions of their people by importing expensive technologies and spending the best part of their health budget on hospital-based services.

National strategies

In keeping with their goal of "Health for All", These countries have been formulating their national health strategies. The task involves evaluation of the present programmes and the existing potential resources, a re-ordering priorities

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where necessary, and development of PHC programmes suited to the specific socio-economic conditions of the country and its communities to ensure the best possible use of the available resources and manpower. These strategies propose primary health care programmes focussing on safe water and sanitation, nutrition, care of mothers and children, immunization against childhood diseases, control of local endemic diseases, and provision of essential drugs and vaccines. Health education forms an integral part of the programmes.

Major topic

"Health for All" strategies formed a major topic for discussion at the meetings of WHO Regional Committees held in September and October 1980. As may be expected, the strategies vary from country to country, and the regional strategies, based on the national priorities, also have their own emphases and priorities. In the African Region, for instance, 21 countries reported having set up multisectoral health councils of similar mechanism representing, in addition to government ministries, the leading political, trade union and religious organizations, and women's and youth groups. The main functions of the councils are to identify health priorities, to formulate appropriate health policies, to promote continuous dialogue among development sectors and to formulate intersectoral strategies, to identity the resources required and to encourage technical cooperation from abroad, including other developing countries.

From the Region of the Americas, it was reported that 22 countries had formulated national strategies for "Health/2000". In addition, 24 governments had evaluated their national efforts to implement the Ten-Year Health Plan for the Americas, 1971-1980. To all countries, the goal of "Health for All" meant health care for the entire population with emphasis on the deprived urban and rural groups, particularly the high-risk families, children under five and mothers. Within the overall objective of increasing life expectancy at birth, the country strategies emphasized the control of communicable diseases, malnutrition and chronic and degenerative diseases.

Europe's concern

The regional strategy for Europe called for a fundamental reorientation of health efforts towards intersectoral coordination, preventive primary health care and self-help. It was noted that simply pouring more resources into the existing health care systems in the hope that current gaps will be filled was neither economically feasible nor the real solution to the problem. A complete reorientation of health programmes was proposed with activities covering three main programme areas: promotion of life-styles conducive to health; reduction of preventable conditions; and provision care which is adequate, accessible and acceptable to all.

In the Eastern Mediterranean, three subregional meetings discussed strategies aimed at supporting countries to reach their targets. They imply a marked redirection of WHO's priorities in the Region towards "Health/2000". It was reported that Member countries were giving considerable attention to the rationalization of community health services and to the development and expansion of primary health care. However, provision of health care in peripheral areas and to special groups such as nomads was still a serious problem in some countries where hospital-based, curative services in urban areas absorbed most resources, and village health centres suffered neglect.

The regional strategy of the South-East Asia Region, it was reported to the Regional Committee, had been derived from a synthesis of national strategies and from WHO's perceptions for collective action in support of national strategies. Health policies of the governments in the Region reflected a growing commitment to health development as an integral part of overall socio-economic development. Nine countries had signed the Charter for Health Development, a unique instrument for health improvement, at the highest decision-making level. Systematic planning exercises had been held in most countries to translate the policy mandate into action. At the core of national strategies was the basic minimum package of services envisaged in the Alma-Ata Declaration.

Three basic actions

In the Western Pacific Region, the regional strategy called for three basic courses of action with PHC as the principal approach: provision of adequate food, water and shelter, so as to lay the foundation for health; developing individual and community reliance in health; and provision of appropriate and affordable health technology for the sick, the disabled, the chronically ill and the socially maladjusted.

A report to the Regional Committee underlined the trend in the Region towards viewing health promotion as an integral part of national, social and economic development. Health leaders were in the process of reinterpreting the concept of health and broadening their mission to include development of the people's ability to lead a socially and economically productive life, thereby achieving community self-reliance in health.

Hope with caution

Despite the enthusiasm created by the idea of "Health for All", no one is making wildly optimis-

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them, and to avail itself of their services. If, for some reason the community feels that the CHV is not delivering the goods, it can 'de-recognize' him, and once this is done, all facilities provided to him as a CHV, would automatically be withdrawn. Even though such instances are rare, they have taken place. The reason they are not frequent is that normally people selected by the community live up to the trust placed in them."

In the case of Charan Singh, he is already a member of the local **panchayat** (village council), vice-president of the school society, and secretary of the youth club. After taking over as the CHV, he says, his status in the community has further gone up.

A real asset

How has the scheme benefited the community? According to the wizened old "Baba"—"grandfather" to the entire village, who claims to be 80, but could be more—Charan Singh in his CHV role is a real asset to the village. "People do not have to travel to the PHC to seek relief for minor cuts and bruises, aches and pains", Baba says. "Since Charan Singh is our man, it is easier for us, including our womenfolk, to go to him without any hesitation . Ever since he started working, you do not find as many children as before with running noses."

With the community's involvement in their own health, there has been another noticeable change in attitude. According to Ajit, who had recently been treated successfully for malaria, "Earlier, when health officials used to come here and urge us to do this or that, the advice was forgotten as soon as the visitors left. Now, with Charan Singh, we are able to do much more collectively." Pointing to a freshly filled-up area, he said that until a year ago it used to be a stagnant pool of water, ideal for mosquito breeding. At Charan Singh's suggestion, the villagers got together and filled it up. Now there are plans to construct soakage pits for every house to replace the use of open drains for sewage disposal.

It will be some time before proper excreta disposal facilities become available, or the dream of a piped water supply is realized, but the village people are already talking about these needs. Charan Singh has told them that more than half their health problems could be solved if they had easy access to potable water. As it is, the village has only two wells with an acceptable quality of water. For irrigation, the village relies almost wholly on seasonal rain.

On Charan Singh's suggestion, some community social workers have started knitting and sewing classes for women. A few houses down the road from Charan Singh's, a voluntary organization is running a nursery, which takes care of over fifty children. While the children are kept busy with their crayons and other educational aids, their mothers are given information on nutrition and immunization. Within the compound of the building which houses the nursery, Charan Singh points out to the model of a dry latrine, which the people are encouraged to study and construct in their homes.

These are small beginnings of things yet to come. But there is a mood of hope in Hasanpur based on what the community has already achieved by taking the initiative to be something for themselves, and not waiting for the authorities to do everything for them.

(Courtesy — WHO)

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tic forecasts of success. Notes of hope are always muted with caution. As Dr. V. T. Herat Gunaratne, the then Regional Director for South-East Asia, said: " 'Health for All by the Year 2000' are no empty words or a slogan. For the South-East Asia Region, the most populous and perhaps the poorest in resources, with a heavy burden of disease and ill health, the stakes are high in the attachment of this goal. It is against this background that I view with satisfaction the growing political will, earnest commitment and the intensive efforts by our Member States to achieve 'Health for All'."

Dr. A. H. Taba, WHO Regional Director for the Eastern Mediterranean, sees solutions to the health problems of today to be "complex and long-term and inextricably linked to some of the most perplexing and persistent problems in the world—poverty, injustice, and social conflict". Referring to the health situation in his Region, he warns, "unless bold and imaginative steps are taken by countries of the Region, working individual and together, the world must expect a painful delivery into the 21st Century".

(Courtesy — WHO)