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Rural Health Care Delivery Systems and the Social Development Task*

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In September 1978, the World Health Organisation sponsored the International Conference on Primary Health Care. The conclusions of this conference resulted in what has become known as the Declaration of Alma-Ata. This declaration concludes with the following solemn exhortation:

“The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical co-operation and in keeping with a New International Economic order. It urges governments, WHO and UNICEF and other international organisations, as well as multilateral and bilateral agencies, non-governmental organisations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration” (WHO, 1978).

It is therefore the principle of primary health care that directs the policies of all progressive health services in the present age, and particularly in developing countries. I therefore propose to start by looking at the principles of primary health care, and to see how these principles are incorporated into health policies in Zimbabwe. I shall then see how far, and in what concrete ways, we have tried to put these policies into practice in this country. Finally, in the light of the problems encountered, I shall propose some suggestions on how we can get closer to the realisation of primary health care and its result — Health for All (by the year 2000?)

Principles of Primary Health Care

The Alma-Ata Declaration draws up the following seven principles of primary

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health care:

1. It is realistically related to the economic conditions of the country.
2. It addresses the main health problems in the country providing promotive, preventive, curative, and rehabilitative services accordingly.
3. It includes education, food supply, nutrition, water and sanitation, maternal and child health care, family planning, immunisation, prevention and treatment, and provision of essential drugs.
4. It involves co-ordination and co-operation with other sectors: agriculture, food, industry, education, housing, public works, communications.
5. Self-reliance and participation are important at all levels.
6. Referral systems from village health worker right through to specialist consultant should be effective.
7. All health workers at every level should work together as a health team: physicians, nurses, midwives, auxiliaries, community workers, traditional practitioners. (Alma-Ata, Section VII).

These seven principles are summarised in the WHO definition of primary health care as:

essential health 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 community with the national health system bringing health care as close as possible to where people live and work, and contributes the first element of a continuing health care process.

Health Policy in Zimbabwe

The principle of primary health care has been fully adopted as the basis of the health policy of the Government of Zimbabwe. The health sector contributed to the Transitional National Development Plan of 1983 by saying that "The main health problems are located in the rural areas, and are to be most effectively addressed by a preventive approach, that is, a health programme which de-emphasises curative care, focusses on preventive care and the promotion of healthful life styles, with the main thrust in the rural areas, improves nutrition, limits the incidence of preventable disease, and reduces the rate of mortality — particularly infant mortality" (Ministry of Health, 1983).

Other elements of the Alma-Ata declaration are incorporated into the government development plan by speaking of the need for integration of rural health programmes with other rural development programmes such as involvement in rural infrastructure, education, housing, food production, water supply and disposal of sanitation. The plan further says that universal accessibility is to be achieved physically by building clinics so that no one has

to walk more than 10 km to a clinic; economically by providing free health to all earning under \$150 a month; psychologically through community involvement.

At the same time the Ministry of Health is conscious of the constraints and limitations in terms of funds and man-power which they face when implementing this programme. As a result of this awareness, a workshop was held in 1983 (the National Health Manpower Planning and Projections Workshop), attended by representatives of WHO, Ministry of Health, other government ministries, government hospitals, mission hospitals and the University. One of the purposes of this workshop was to "look into the extent to which we can get maximum benefit from our present limited resources in pursuit of the stated goals" (Ministry of Health, 1983).

It was noted in the report which emerged from the workshop that, in order to put into effect the proposed plan, a significant increase in the budget of the Ministry of Health would be required. In fact, the budget has decreased since then. It was also noted that with present training facilities, it would be impossible to reach required staffing levels of medical assistants (the backbone of the present rural health service) even by the year 2000, while village health workers would not reach sufficient numbers until 1993. (Ministry of Health, 1983). The urban bias in the distribution of qualified nursing and administrative staff was also pointed out, and was recognised as caused by the poorer conditions of service in the rural areas, especially as regards the missions which are responsible for 63 percent of all rural beds.

Being aware of the aims of our health care delivery systems, and conscious of these two major constraints — funds and personnel — we can now move on to see how they relate to the social development task.

Rural Health Care Delivery Systems

Nutrition

There is general agreement among all health workers with any experience of rural areas that under-nutrition is a major factor in rural ill-health, especially with the young and the old. But there is less agreement on the major cause of under-nutrition: economic, climatic, ignorance, traditional practices or destruction of traditional practices, absentee husbands or other social factors. Accordingly there have been as many different attempts to combat under-nutrition. The two traditional methods are emergency food aid, and education. Emergency aid in terms of food imported to a rural area either from the city or from outside the country is certainly effective and will continue to be provided as crises occur. This year, practically all the rural hospitals in drought stricken areas are involved in supplementary feeding schemes. Tshelanyemba hospital (Matabeleland South) has 60 groups over 1200 sq. km comprising 4544

children — 90% of the pre-school population. (Dunster, 1984). But no one would claim it to be anything other than a short-term and last resort measure. However, it must be pointed out that there is a difference between emergency supplies of maize for Mutoko coming from USA, or from Malawi, or from Karoi commercial farms, or from the Mangwende communal area. We are progressing on the self-reliance road the shorter the distance emergency food has to be transported. In this country we should be at least nationally self-sufficient in food, and progressing towards regional self-sufficiency. Communal area deliveries of surplus maize to the Grain Marketing Board have increased dramatically since independence.

Ignorance has long been considered an important factor in under-nutrition. But we must not naively think that Western education is the solution, because it is the very fact of Western food that has largely brought about the problem. If you see the mother of an under-nourished child and ask her what she feeds the child, she will give one of two replies. Either she gives the child oil, nuts, vegetables, eggs, soup and occasional meat — in which case she is lying but clearly the problem is not ignorance. Or she will say tea, coca-cola and white bread and jam. In this case she is ignorant; she is ignorant of the fact that these Western-style foods are nutritionally useless. So the “educated” person who hopes to remedy this ignorance must first acknowledge that it is himself, as representative of the “educated West” who first provoked the ignorance. For many years all clinics and hospitals have been giving education talks to mothers at baby clinics, ante-natal clinics and in the wards, but education alone cannot win the battle against the advertisers and suppliers of such nutritionally valueless products. There is ample evidence to show that, prior to colonisation, famine was not a permanent feature of Africa. Apart from occasional seasonal climatic disasters, the people had enough land and sufficient variety of crops to provide an adequate balanced diet and frequently a surplus. It was primarily the taking of vast areas of land for cash crops, and the subsequent introduction of high yield (high in carbohydrate) maize and cassava crops, to get the most out of the limited amount of land that brought under-nutrition to Africa. The failure of the Green revolution in the 1960s is a further example of the fallacy of this approach. Also significant was the migration of men to the towns, leaving only the women to work on the land (Loyal, 1979: 129-130).

Nutrition villages have been established at several hospitals. These are basically educational centres, where the mother of the undernourished child sees her child recovering and gaining weight simply by being given the appropriate foods, at the right time and not over-cooked. This experience should be more effective as an education than simply listening to the lesson at the baby clinic. Nutrition villages can also be used as demonstration centres for Blair toilets, appropriate technology and new ideas about agriculture and animal husbandry. But the results of nutrition villages can sometimes be

disappointing. While a mother may be willing to stay with her child in hospital because the child is receiving medicines or other medical treatment from doctors and nurses in white uniforms, she is often unwilling to stay for the required time at a nutrition village simply for feeding. And, while people are interested in the innovations they see at such demonstration centres, few seem to consider following such innovations at their own home. We must ask ourselves why. I would say that nutrition villages are a useful educational aid at a hospital, especially if they can also be used as a farm to provide food for the hospital, a demonstration centre, and meeting place for creches, women's groups, etc. But they cannot be expected to provide the magic solution to the nutrition problem.

A more recent approach to the problem has been the concept of *nutrition centres*. Unlike the nutrition village built at and run by a hospital, the nutrition centres are smaller and located anywhere where a local community has sufficient initiative, organisation and cohesion to establish one. But the idea behind these community-based centres is completely different to that behind the hospital-based village. Rather than the basic problem being identified as ignorance, to be remedied by education, the basic problem is identified as the destruction of traditional communal life and nutrition, to be remedied by the development of an acceptable modern community life and the restoration of a more diverse agriculture. With colonisation, vast numbers of people were moved away from their traditional homes, with consequent disruption of community life, overcrowding on poorer land, and change of diet from a variety of cereals and pulses to a universal diet of maize alone. A few years ago, kwashiorkor was considered to be a protein deficiency disease. But more recently it has been recognised to be as much a calorie deficiency disease. The most concentrated source of calories is in fats and oils. The groundnut contains an abundance of oil along with high levels of protein. The idea of the nutrition centre is that a local community obtain a plot of land on which they grow groundnuts. They fence their plot, work on it together, maybe build a kitchen, store-room and meeting place, and select their pre-school teacher. Several days a week they send their children to the pre-school group at a site adjoining the plot where, apart from the normal activities of the group organised by the teacher, the children are weighed, fed with the groundnuts and receive their immunisations by a visiting team from the local hospital. This scheme has been operating at 40 centres in the Mangwende communal area around St Paul's hospital, Musami, for four years now, not without numerous difficulties, but also with some successes.

The most significant feature of this approach to nutrition is the local community involvement. The fifth principle of primary health care mentioned above is "self-reliance and participation at all levels". Although this is a principle which applies to many other areas of rural life, it has special possibilities with regard to health. This is because the health promoting

activities which have the greatest effect require little specialised skill or knowledge. People may at first prefer to have their doctor in the hospital 50 km away than a village health worker in their own village. But the *village health worker* will probably save more lives, and for the salary of one doctor we can pay for fifty village health workers. The good village health worker is so important because she is selected by her own people; she knows their problems; she thinks with them and talks with them; she can work through the local structures, traditional and political. In combination with the mothers running a really local pre-school group and nutrition centre, the village health worker can make the biggest impact on nutritional problems.

One of the specific tasks given to village health workers, along with health assistants, is the promotion of sanitation, particularly encouraging the construction of wells and Blair ventilated latrines. In areas where funds have been made available to supply cement and hand pumps, usually through the local hospital, a lot of rural communities will be enthusiastic about constructing protected wells. A good example of this for several years now has been the area around St Theresa's hospital, Chilimanzi. People are less interested in latrines than wells, which is probably an indication that the interest in wells is not so much with regard to health aspects as with convenience of shorter distances to walk in search for water. Even so, there is still a steady increase in the number of latrines in rural areas, but the building of properly effective Blair ventilated latrines can often fail because the builder does not understand the principles of the design.

Immunisation

The immunisation of under-fives against the common childhood diseases is the most effectively carried out of the preventive health measures. All hospitals and clinics provide immunisation. Most rural hospitals have a mobile team reaching centres not accessible to a clinic; some mobile teams (medical assistants and experienced unqualified nurse-aids) go out to as many as fifty centres.

Over the past two years the coverage has increased considerably, following the launching of the expanded programme of immunisation (EPI) in all provinces of Zimbabwe. This programme, sponsored by WHO and organised through provincial and district medical officers, involved courses for planners and nursing staff, and provision of more funds for transport and refrigeration. Most mothers seem to be enthusiastic about having their children immunised, the big exception being the children of independent African churches. The coverage of childhood immunisations is not 100 percent, but it is certainly the most widely accepted and accessible aspect of health care at present.

Childhood diarrhoea and malaria

These two diseases are taken together because they are common and frequently lethal if untreated. They are not prevented by immunisation, but early simple treatment can cure them easily and cheaply. Again, it is the village

health workers who are most effective in achieving this. In many areas where the mothers have seen their children cured of diarrhoea with salt and sugar mixture alone, this remedy is now widely known and effectively used, and the admissions to hospital have been reduced considerably. Also, if the village health worker can be supplied with chloroquine tablets from her nearest clinic, she can effectively treat most early cases of malaria.

Family Planning

Although nearly all rural clinics and hospitals offer family planning, only relatively few women take advantage of it. Those who do are often those who have a profession of their own, teaching, nursing, etc, or are more emancipated from male dominance in some other way.

Ante-natal

All rural clinics and hospitals have busy ante-natal clinics and labour wards. But there are many mothers who are attended entirely at home by traditional mid-wives. Because most births are uncomplicated, usually no problems occur. But traditional mid-wives are not so good at identifying those pregnancies which are likely to have a difficult labour, and they have little knowledge of aseptis. So all rural hospitals and clinics receive a number of emergency obstructed labours, post-natal infections and infant tetanus.

Following the WHO understanding primary health care is supposed to be socially acceptable and scientifically sound, but for a lot of mothers the scientifically sound techniques of their local clinic are not socially acceptable. Howard Hospital in Chiweshe has for some time been offering short basic training courses to traditional mid-wives to teach them appropriate aseptis techniques for the village, and how to screen the more difficult pregnancies. This is an appropriate and realistic example of bringing together the scientifically sound with the socially acceptable.

The Disabled

There are many disabled people, including the aged, in rural areas, but there is almost no special health care available for them. They may be brought to hospital for treatment, but hardly any of the rural hospitals have anyone with any physiotherapy training. And, even where some progress is made while the patient is in hospital, the condition invariably deteriorates at home. This may be because of lack of interest, or the sheer difficulty of life in the rural village, or traditional attitudes towards chronic illness. The disabled, whether old or young, often seem to be kept almost hidden at home. I have come across an old man with a stroke, who can easily be helped to walk and sit outside with the others, and who is very pleased and lively when this is organised. But, unless an outsider comes and initiates this, the family will simply keep him in bed twenty four hours a day. Another case has been reported to me of a blind boy who, whenever visitors come, has to get under the blankets and the visitors are told he is asleep. But there is little chance of improvement in this situation until there are trained personnel available for home visiting. It is a pity that the WHO

rehabilitation programme for developing countries has not been made more use of. It is full of appropriate technology and physiotherapy ideal for our rural areas.

Mental Health

Rural hospitals and clinics have very little to offer to those with emotionally disturbed behaviour. The violent can be quietened down for a few hours with largactil and the anxious can be calmed with valium but it does not go much beyond that. Generally speaking the 'nangas are far better equipped to deal with these problems by invoking the forces of the traditional spiritual realm. The non-violent socially maladjusted person is more easily accommodated in rural areas than in towns. They can come and go as they please; no excessive demands of conformity are made on them; they are occasionally a nuisance, but often manage to find their place in society.

The proportion of mentally handicapped children in rural areas is much the same as in the cities. It usually results from peri-natal brain damage, or high fevers with convulsions in childhood. These children are often picked up by village health workers. They can be sent to the city (ZIMCARE or St. Giles) for assessment and the mothers trained to provide stimulation to the children. There are also a number of special classes available in rural areas for these children.

Curative

The curative services in the rural areas are good, although many more clinics are needed if everyone is to have a clinic 10 km from their home and, along with this, many more staff are needed. The supply of essential drugs is adequate most of the time. Referral services from village health worker to clinic to rural hospital to specialist consultant is adequate, transport being the major problem.

Problems Encountered

Financial

Since independence the Ministry of Health has directed a very much greater proportion of its funds away from the cities to the rural areas. In the case of mission hospitals the amount doubled in the first three years of independence. And this has had a significant effect on the staffing and supplies at rural hospitals and clinics, government, council and mission. However, a national health manpower planning and projections workshop last year concluded that the health budget would have to increase if the government was to succeed in its policy of improving health care in rural areas. Last year, the mission hospitals received \$10 million for salaries and recurrent expenditure from the Ministry of Health. This year the missions have been allocated \$7 million, a cut of 40 percent allowing for inflation. And this is not enough even to pay all the

present salaries. Similar cuts have been made in government hospitals, especially with regard to transport. The problem with financial cuts is that the easiest thing to save money on is the preventive and promotive aspects of health. Although, in the long run, this is the most economic side of a health service. It is, in practice, easier to cut down on your outreach immunisation programme than to cut down on your curative programme.

Qualified staff

Given the choice, virtually no qualified person will choose to work in a rural area. This is made worse when, with no grading and no pensions, mission hospital staff are effectively paid less than government hospital staff. The result is that rural hospitals, and especially the missions, are largely run by unqualified staff. Many of those staff have been working like this for years and are extremely competent and dedicated. They have to be; life is harder, they work harder and they get paid less than city nurses. With the present government freeze on filling posts, and cut in budget, posts which fall vacant will stay vacant. So the rural staff will be called on to work even harder. No doubt the same problem is at present facing every ministry in Zimbabwe, but it is not possible for the government to carry out the present health, education and social services policies unless more funds are available.

Community Involvement

With the economic problems and the limitations in skilled personnel outlined above, we are not going to manage to achieve the aim of "health for all" simply by following the health care delivery systems developed in industrialised countries. We do not have the resources, in the foreseeable future, to be able to do this. But what we do have in the rural areas is another under-utilised resource. That is large numbers of intelligent, resourceful, but not very highly formally-educated women. I specify women because the majority of men with initiative have managed to escape from the rural areas to find work in towns. Another very significant group will be emerging at the end of this year, and that is the vast number of form four leavers coming from the rural secondary schools. These young people, boys and girls, cannot be absorbed in the towns and will not find the salaried employment which they are hoping for. Therefore the large numbers of women will be joined by even larger numbers of more educated young men and women. The pessimist sees an enormous pool of frustration building up. But let us try to be more positive. But it must be remembered that school-leavers are less reliable in rural areas than mature married women because they have no commitment there and will get away at the first opportunity.

There are three successful developments I mentioned above which can be expanded at minimum cost, and using the personnel available: village health workers, community based nutrition centres, and training traditional midwives. These can be expanded and, I am sure that with imagination and initiative, other projects could be started. Such projects are sometimes difficult

to get started and to maintain, and what is successful in one place will frequently be a disaster at another place. The problems to be overcome are the basic ones of community development.

a) Lack of competent leadership: Leaders must be honest, able to communicate and trusted by the local people. They must have vision, be willing to work hard for the success of the project, be able to persevere in the project and be competent to do the job required. In all this the process of selection of the leaders is important. This has been made easier in the past four years with the emergence of party structures in rural areas. But, while party structures are invariably dominated by men, most successful health projects are led by women in rural areas; women seem to have more of the leadership qualities outlined above.

b) Co-operation and jealousy: Any leader, but especially in rural areas, needs to be a diplomat. She must be able to get the widest co-operation possible. She must be able to deal with the male local political and traditional leaders. She must not be a person who is going to arouse too widespread jealousy — although it seems to me that jealousy is the inevitable burden of anyone with initiative in a rural area. This is why the selection process must be carefully worked out. But I do not consider myself competent to define what this process should be.

c) Corruption: Community fencing, seeds, implements and fertilizer can be found in the private fields of leaders and committee members. Bicycles can be used for personal business while the community duties are left undone. And this is more likely to happen the more remote the donor agency, be it government or voluntary, and the less the recipient community is involved in the whole project from its earliest days of planning. But the donor agencies are partly to blame for this. People get extremely disheartened in the early stages of an application to an agency, filling up forms, getting more impossible questions to answer, not knowing whether it is going to be successful or not. Only a few of the leaders persevere in enthusiasm; the majority of the community give up hope and forget all about it. Then, suddenly, a truck arrives from nowhere full of fencing, ploughs, seeds and fertilizer. When someone comes from the city some months later they are then surprised to see that the project has not worked out exactly as it was on paper two years previously. There must be accountability and checks on the use of funds, but some system must be worked out which relies less on a centralised and remote bureaucracy and administration. The problem is to find competent and trustful administrators in the rural areas.

d) Long term v. short term gains: Rural people know as well as anyone that at the present rate there will be no more trees left in their area after a few years, and everyone will suffer. But, if I need to cook my meal tonight, and I know that if I don't cut down the last tree then someone else will, then I'll cut the tree and enjoy my dinner. Through years of being deprived, rural people have learnt to

disturb the hope of a long term gain, and to grab what can be got for the present. This largely explains the frequency of corrupt practices mentioned above, and points even more to the need for leaders of vision, hope and perseverance.

e) Transport and communications: Roads are bad and transport unreliable and expensive. Any programme which depends on petrol or diesel vehicles is going to have its own special difficulties. The mobile immunisation vehicle breaks down; the people at the immunisation point cannot be informed; they wait all day; they lose interest and another immunisation centre collapses until confidence is restored. Rural bicycles very quickly get shaken apart. If there is no skill, funds or parts to repair them, they can be out of action within a year. Only buses and ox-drawn carts keep going.

f) Remuneration: In her television address on October 1st this year, the Minister of Community Development pointed the problem of pre-school teachers receiving no allowance, while the village health workers receive \$36 a month. This is a source of frustration to these women, not so much because they only do the job for the money, but because it gives them a sense of being under-valued, and again the result is loss of interest.

g) Individualism: One recurrent problem with communal fields is that, despite having an element of traditional practice to make them acceptable, they suffer from belonging to everyone and therefore to no one. The result is that work on these fields gets left until the fields at home are planted and weeded; especially weeded, since that job is never finished at home. So there has been a move to have a larger number of smaller and more local nutrition centres, where the people are able to identify more with the project. This initiative has come entirely from the local people, which is an indication that it is a sound move.

h) 'Nangas: There is a lot of confused talk about 'nangas. This is because, depending on whether you support or oppose them, you stress their herbal or spiritual role. Few people object to herbal remedies although, as in Western medicine, mistakes are sometimes made. The 'nangas can also help what Western medicine call emotionally disturbed people. But it must not be forgotten that a great deal of the 'nanga's practice concerns diagnosis of witchcraft and, although carefully avoiding transgressions of the letter of the law, helping to identify the most suitable witch. All rural people fear witchcraft and would be quite lost without the 'nangas to confirm this fear and then provide the remedy. It hampers community development at every stage and frustrates any attempt rural people may make at social analysis. But I do not foresee the witches leaving us alone until well after the year 2000.

Conclusion

I have pointed out two facts of life with regard to rural health care delivery systems: they must be less costly and be based on less qualified personnel. The personnel are there in the rural women. And at \$36 a month the cost could not be lower. What we must do is give basic, appropriate training to these women so that they can realise their full potential in the local community, and subsequently the community can achieve its full potential. I have outlined some of the problems we encounter in rural health care delivery systems. Many of these are common to other areas of rural development. And many of them fall under the category of social problems. Consequently I would see the specific task of social workers to apply themselves to the solution of these problems, and to assist in the training of the rural women.

Footnote

1 Other figures given for the sixty groups for 1983: immunisations 18 633, food distributed 10 973kg mealie meal, 998l oil, 1 200kg beans, 1 309 pkts soup, 325kg pwd milk, 625kg Mahewu, 1 000kg other foods.

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