PNG Med J 1996;39:315-320

Primary health care in Melanesia: problems and potentials

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SUMMARY

Locally directed, decentralized health services offer opportunities for empowerment by defining priorities based on community-derived policies. These are the components of the Primary Health Care Approach still missing in Melanesia.

Introduction

We are soon approaching the twentieth anniversary of the Alma-Ata Primary Health Care Conference held in 1978 (1). Two years after that will Melanesia have obtained 'Health for All by the Year 2000'? It appears not.

Despite constraints due to political and budgetary instability, the independent Melanesian island nations of the South Pacific – Papua New Guinea (PNG), Solomon Islands and Vanuatu – have achieved notable successes in the delivery of health services to geographically scattered and linguistically and culturally diverse populations. But the primary health care approach defined 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" (1) has not yet come to fruition. The reasons for the failure of the Primary Health Care Approach (PHCA) in Melanesia can best be understood by a careful analysis of the successes and failures of its individual components and how they relate to the precepts outlined in the Declaration of Alma-Ata.

Hopes and aspirations

The introduction of Primary Health Care (PHC) in Melanesia predated the Declaration of Alma-Ata by many years. By the time of Independence, rural health services of Melanesia were well established under the auspices of the government and the missions (2). Essential health services were available to a majority, although not everyone, in the country. It appeared as though it was only a matter of time (and money) until there would be universal coverage and even the most remote island or bush hamlet would enjoy the presence of a government aid post orderly or at least a voluntary village health worker. Infant mortality had fallen precipitously and life expectancy had increased dramatically (although the relationship of these indicators to the provision of health services remained unclear). By 1994 the accessibility problem had been largely solved and the majority of the population lived within two hours' walk of a health facility. The unacceptability of a male health worker for the provision of women's health care had been surmounted by mobile maternal and child health (MCH) clinics staffed by female nursing sisters.

But most of the other critical elements of the PHC approach remain to be developed and implemented. Without a rational approach in resolving these deficiencies of self-reliance, self-determination and community participation, it appears that it will be impossible for Melanesia to move towards affordable health for all.

Concept of illness in the village

The aid post system was introduced into the

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village by western-trained colonial officials who had little knowledge of or interest in the traditional medical customs of the people. This promoted the development of a two-track system with government-paid male aid post workers specialized in symptom relief and infectious disease, while traditional healers dealt in psychosocial disequilibrium, and local midwives concerned themselves with obstetrics and gynaecology. A social distance was imposed between health providers and the traditional healers (3), an unnecessary separation that remains to this day although the two systems are not innately in conflict (4-6). Little effort has been made to identify and integrate traditional healers, and they remain marginalized from PHC.

In traditional society it appears that diagnosis and treatment decision-making occurs within the family prior to the patient visiting the aid post. The orderly is approached with a general treatment in mind and 'health education' is neither sought nor accepted (5).

The primary health worker is therefore isolated from the traditional medical system and unable to effectively influence health behaviour. Attempts at health education are limited to a few posters on an aid post's wall. It is clear that more innovative approaches are necessary to surmount the current cultural impasse. When the PNG Public Service Commission abolished health educator positions country-wide in the early 1980s, it was claimed that from then on all health workers could be health educators. Despite initial opposition at the time, it appears they had the right idea.

Community participation vs government responsibility

Government health services are 'samting bilong gavman' – a system of preventive and curative medicine available on demand, conveniently located, and free. Political expediency dictates that the patient's first contact with the medical system be free, although additional specialized or referral services may require a small family contribution.

A free service is viewed as of little value. Recognizing this fact and hampered by inadequate financial resources, some health providers have attempted to solicit voluntary cooperative support or required participation from the local population. But most locally sponsored health centre committees and fee-for-health-service schemes have been poorly supported and failed as the funds collected were never placed under the control of the committees. In some highland areas of Papua New Guinea, villagers had reversed the situation: they demanded payment from malaria teams before allowing the workers to spray residual DDT in their homes.

The islands of Melanesia are littered with the remains of PHC demonstration villages. We've all seen them: several cracked VIP (ventilated improved pit) toilet slabs under a palm, a leaking ferrocement tank, an old flip chart with drawings of mosquitoes and worms, and pig fences surrounding the model village gardens. Initiatives to train village aides in Madang Province, PNG (7) were judged as failures (8). A rural water supply project was unsuccessful in the highlands of PNG as villagers neglected to look after a system which was not seen as belonging to them (9). An endless series of PHC workshops are scheduled and later rescheduled with little hope for follow-up and support. Government health workers blame the villagers for not being ready for the primary health care approach. The villagers wonder why they should contribute to another government scheme that is unlikely to bring sustained development to their people. Besides, they already have adequate access to health care.

Causes of failures

The causes of the failure of PHC include lack of supervision and evaluation (10), incomplete understanding of the Primary Health Care Approach and Integral Community Development by health workers (11,12), lack of interest in the village stemming from different priorities (13), unsustainable projects, and the inappropriate selection and inadequate support of health workers, village development committee (VDC) members and voluntary health aides (8,14,15).

Primary health care workers in Melanesia are essentially unsupervised. The aid post worker or health centre nurse is rarely visited by their

supervisor. Without such input these front-line health workers suffer from poor morale and lose all sense of accountability. Once-effective interventions are forgotten or abandoned (16). Neither the government nor the villagers have many expectations. Health centres and aid posts are not adequately evaluated for their outputs (immunization coverage, clinics scheduled/clinics held, patients seen, or health talks delivered in the village) or the quality of care they provide (17).

The rural populace expects their health worker to distribute drugs and little else. The government is the provider and the people the recipients (18). Thus, once the sick have been seen, the aid post is closed for the day, for the health workers are neither inclined nor trained to engage in village mobilization or health promotion and education. This should come as no surprise as the priorities of the village often centre around economic progress. There is currently no shared vision of development between the village leaders and the health department (10).

Village development through PHC should not be limited to health matters. Integrated, intersectoral activities involving education, commerce and agriculture will, as Stephen Leeder writes, "promote maximum community and individual self-reliance" (19). This approach should also satisfy the priorities of the villagers. Although there have been attempts to involve other extension workers in specific PHC projects, there has been little day-to-day cooperation in overall village mobilization and planning.

Some village leaders are not ready for community development. Too often a convenient area is chosen for a PHC project by health headquarters based on an agenda set by a nongovernmental agency. After initial input, interest (for anything new to the village raises curiosity) and commitment fade as the cargo that arrives seems insufficient for the required dedication. Ownership of the project is seldom effectively transferred from the government to the people.

All village development and aid post workers should be chosen by the villagers themselves, directed by government guidelines. After an apprenticeship period under an experienced health, education, agriculture or women's development worker, those who prove to be truly motivated can be sent on for further advanced training. Only then will they be considered for employment or appointment to a position of leadership on a village development committee.

Successes

The list of problems above is not to imply that there have not been notable successes with the PHCA throughout Melanesia. Great strides have been made in vaccination coverage (20-22) and infant mortality is falling (20,21,23,24) due to the introduction of antibiotics, oral rehydration solution and immunizations by the health services (25). When villagers perceive a need for services, PHC interventions have been effective, as in the case of condom marketing along the Highlands Highway of PNG (26) and local support of village birth attendants (27,28). Some churches have successfully marketed prepaid health insurance schemes and promoted mass antifilariasis campaigns (29). Immunization clinic attendance has remained high even in areas where mobile clinics have ceased and mothers are forced to hire transport in order to attend. And yet few mothers can explain the purpose of immunizations.

Development of a comprehensive approach

Successful PHC interventions address the perceived needs of the population and cannot flourish if they remain the sole responsibility of the government. Involving more than the isolated health worker, they demand a system of village associations through group and individual relationships. When viewed as being in the interest of both health workers and the communities they serve, the PHCA answers the crucial question, "What is in this for me?" and provides a rationale for continuing commitment. In order to succeed, two strategic objectives need to be attained: health workers who are held accountable to the communities in which they serve and villagers who accept responsibility for their own health.

Accountability can be promoted through better supervision, but the villagers must be encouraged to demand acceptable standards of care from their PHC workers. If an MCH clinic is scheduled in a village, it is

unacceptable that no nursing sister shows up. Problems need to be identified and acted upon. A village leader who accuses a local aid post orderly (APO) of adultery is quick to demand his transfer but is unlikely to demand that the APO work a full day or carry out village inspections. The latter is government work, the former has become a village matter. Social transgressions are quickly remanded but a lazy health worker is ignored. How can the villagers be convinced that health care is more than 'samting bilong gavman'?

The answer is obvious. PHC and front-line health workers need to be accountable to the people. As noted above, they should be locally chosen and whenever possible paid, housed and supervised by a committee of villagers. Quality assurance and logistics would remain within the government's domain. Aid posts should be built by the villagers. Wages can be set by local government councils and councils of community leaders supplemented by financial grants from the government if need be. This would allow more flexibility; salaries could be linked to capitation and performance. An effective, busy health worker would earn more than one serving a smaller population. Careful thought would be given to the choice of whom to train as a community health worker when this worker will be returning to meet the health needs of the village. Candidates who are considered likely to use their training as a stepping stone and migrate to an urban area would not be chosen. Their move would leave the village unattended. As the majority of patients at the aid post are women and children, it would be logical to select females for the position, especially when one considers that women health workers are less likely to leave their village of birth, at least until marriage. Although politics and favouritism would undoubtedly be a factor in community-managed PHC, it is hoped that people and their leaders will ultimately look after their own welfare.

Local leaders also have the presence of power to direct their people to adopt practices that are in their own and the community's best interest. MCH clinic attendance doubled when the local council adopted and collected a fine from mothers who did not bring their children for immunization (30). In addition, the nurses turned up regularly and on time. None of them wanted to cancel a clinic and risk the anger of the council by denying them a source of income. Compensation claims for malpractice against village birth attendants are unusual as the services are perceived as necessary and therefore appreciated (28). Other legal or social interventions are possible; these include requiring the completion of immunizations before school entry, mandating supervised birth and a VIP toilet for every household.

If health care workers are to be accountable to the village, then villagers need to be educated to be responsible for their own well-being. How can ideas of health promotion and disease prevention best be marketed?

It is clear that health matters are most effectively approached in an integrated manner using all resources in the community. Linkages need to be forged between the schools, women's and church groups, traditional health providers and midwives, village leaders and agricultural extension workers before conducting a social diagnosis and planning community development projects. What better way to educate the villager than by utilizing existing and functioning organizations and their leaders? Primary health care should not be a "monopoly of the medical profession" (10), nor should it be ceded to nongovernmental organizations (NGOs) (31); its rightful owners remain the people.

To accomplish the goals of health education, people need to be made aware of the services available or of the danger to their health and then move towards action to obtain the assistance or to avoid the threat. Social marketing and health advocacy must be supported from above through the media and training of extension workers. However, the most effective work is done at the grass-roots level where it can be linked to local practices and customs. Community workers understand the barriers to optimal health. As respected opinion-leaders, their example can provide the cues to action necessary to initiate and sustain change (32). Development workers can be trained in adult education techniques, supplied with materials, assigned tasks and made accountable to inform existing village groups of good health practices. By the use of these

methods the PHCA can assist in mobilizing villagers into changing their social and physical environment to maximize their individual health and that of their community.

Conclusions

The health services of Melanesia have successfully delivered clinical health care to their people. But only through improving the accountability of their health workers and introducing the concept of responsibility for one's health, including individual, family and community well-being, can progress be made toward a self-sustaining comprehensive primary health care approach that promotes national development. This will provide the path to health for all.

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