LEAD SPEECH

by

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The Challenge of Community Health Development

When I accepted the honour to give the lead address to this distinguished audience, I accepted also the obligation to point out at the very outset that I profess no special knowledge of community health practice; however, I share with everyone here a common interest in the community approach to the health and welfare of the individual.

We do not need to be experts to realise that the world community today is faced with major problems related to over-population, widespread starvation, dwindling natural resources, degradation of the environment, and economic and politico-social upheavals which threaten man's very existence on earth. It is also common knowledge that in one half of the world today poverty and disease take a heavy toll of the lives of infants, toddlers and children; while in the other half the hazards of affluence and the diseases of modern civilisation have already begun to curtail life expectancy.

Taken together, three-quarters of the world's population live in poverty – an all-pervading poverty of social, political, medical and material resources. For these unfortunate millions, life is an unending struggle in a web of poverty and disease and many of them succumb before they can clutch at the life-line that leads to better health and increased wealth.

Such stark realities have aroused the conscience of the world; everywhere there is a move to extend the benefits of health care to all citizens and to question established systems of health care delivery. The methods of community health or medicine as we know them today are now under scrutiny and the call to every nation is for new and revolutionary solutions to the old and well-known problems of community health development.

The oldest problem of them all and one which faces every nation, both rich and poor, is how to make the best possible use of limited and sometimes scarce resources to promote the health of the community as a whole. This is also the major challenge of community health development and in considering how we might mobilise resources to meet this challenge, I shall address my remarks mainly to the situation in developing countries.

The details will vary from one country to another; but the goal of community health development, the obstacles to its achievement, the human resources available and the manner in which they may be mobilised for community development will be similar in many countries. I shall discuss these aspects in a way that may invite dissent, but at the same time I hope will also provoke further discussion within the context of the theme of this Conference.

THE GOAL OF COMMUNITY HEALTH DEVELOPMENT

In all countries the communities in greatest need of health care are rural, and in developing countries this means more than 80 per cent of the population. Therefore, to put it very simply, community health development generally means rural development or reconstruction.

Several definitions have been given of rural development. Two are relevant to the points I want to make. The first considers rural development as a "strategy designed to improve the economic and social life of a specific group of people – the rural poor. It involves extending the benefits of development to the poorest among those who seek a livelihood in the rural areas". [1] The second defines rural development as a process of "improving the living standards of the mass of the low-income population residing in the rural areas and making the process of their development self-sustaining".[2]

These expert opinions from the World Bank and a renowned sociologist emphasise economic and social life and living standards. There is no specific mention of health and perhaps it is not

necessary to do so because poverty is inseparable from ill-health and indeed, at a certain level of deprivation, ill-health is inevitable and good health is impossible.

This relationship has been termed the absolute health hypothesis [3] and it has been suggested that "efforts to help the deprived must take cognizance of it (the hypothesis) and present solutions that will raise resources above the minimum for all". [3]

As members of the health professions and representatives of ministries of health, we are naturally tempted to assess community health needs in terms of disease prevalence and to advance technical arguments for giving high priority to formal preventive and curative measures. This, of course, may be justified, especially if a controllable disease can be identified as a major contributory cause of poverty and depressed productivity, but we must accept also that the mere provision of routine preventive and health promotive services does not by itself relieve really depressed rural areas of their poverty and therefore cannot be expected to provide the impetus required for self-sustaining development.

This same point has been made in another way – that "it is easy to say that food is what is needed by a malnourished child and that community development is a mechanism that can be used to supply it. It is hard to say that community development is the goal and that communities in the process of developing find a way of seeing that children get food". [4]

In other words, health professionals and administrators must make rural development or reconstruction in a general sense the primary goal of community health development.

I do not deny that for many communities with a relative rather than an absolute level of poverty, the primary need is to catalyse development through the provision of primary health care – by which I mean "measures aimed at providing answers to the fundamental human (health) needs which are expressed as: (a) where can I go and what can I do for the relief of pain and suffering? (b) what can I do to live a healthy life?". [5]

OBSTACLES TO COMMUNITY HEALTH DEVELOPMENT

A number of factors have been listed as major obstacles to health development programmes in developing countries: [6]

- Lack of a clear national health policy.
- Lack of a sound health manpower policy.
- Lack of an organisational concept in planning and developing the system.
- Lack of standards and criteria adapted to local conditions.
- Lack of community participation.

This combination of factors constitutes a general "lack syndrome" – a widespread deficiency disease of developing nations due to poverty of organisational and managerial skills which militates against the development of an effective health care programme.

No country represented here has a complete "lack syndrome", but many have a relative deficiency and in these countries there is frequently no paucity of ideas or decisions; but we know that even the best plans and decisions are of no avail if they are not acted upon and it is equally futile to take decisions that clearly cannot be implemented.

National health development policy

What is needed in many developing countries is a clearly stated national health policy and I believe that the health professions have a responsibility to guide governments and society itself in the formulation of such policies.

I am of course aware "that the health needs of the community as perceived by a responsive health profession do not always coincide with the felt needs and wants of the interested community. I know also that, in practice, health policies are subject to the political process, and therefore subject also to the vagaries of political expediency". [7]Such factors can sometimes be

blamed for failure to pursue a planned course of action; but the health professions may not be free from blame. Have we been too parochial in our recommendations; have we for example accepted the fact that the provision of formal or institutionalised health facilities does not in itself guarantee the availability of health care to those who most need it? Unless the seeds of poverty and deprivation are removed, the path to health is soon overgrown and never becomes well trodden.

Health manpower policy

Everywhere the cry today is to extend health care coverage to the total population; at the same time the needs and demands of individual health care continue to place an unyielding burden on the budgets of most governments. No country can completely ignore the implications of modern advances in health technology, and the developing countries in particular are faced with a dilemma, because "the same political, humanitarian and ethical forces that prescribe and ever-widening area of health care coverage to embrace the whole population also operate to demand an ever-increasing depth of application to the health needs of the single individuals who make up the community".[8]

Faced with this dilemma many countries seem to react by increasing their output of doctors in the hope that more and more doctors will achieve the desired end. Such a policy has repeatedly led to disillusionment and doctor/population ratios have quite rightly fallen into disrepute. A new philosophy has now emerged which urges the concept of the health team approach and the training of a balanced mix of health personnel for the provision of acceptable, accepted and accessible health care, in fulfilment of the promise of health care for the total population.

Admittedly these are high-sounding phrases, but the message is clear and requires an equally clear statement of national policy on the numbers and types of health personnel to be trained in a stated period of time and for a specified and coordinated range of health activities.

Organisational concept in planning and development

The inevitable facts of history and the example of the pattern of health services in developed countries have influenced the planning and development of health care systems in the developing world, but history and common experience have also shown that the established systems are not satisfactory even for the developed nations and are decidedly inappropriate for the developing countries. What is needed is courage to break away from conventional concepts and imagination to plan a system that is both realistic and relevant to the needs of developing countries.

Innovative ideas will require the support of organisational and managerial skills for their implementation. The reason why so many good intentions end up as sterile ideas is that the machinery for processing or re-cycling them into productive action is frequently lacking. Ideas for change must be matched with plans for their execution and this means that developing countries must place a premium on the training of staff at all levels to assume health planning management and supervisory roles.

Standards and criteria adapted to local conditions

Much of the criticism that has been levelled against medicine and doctors stems from failure to adapt standards and criteria to local conditions. Aggressive application of health technology, merely because it is new, has become fashionable, and yet in terms of health promotion much of such technology is purely palliative and sometimes achieves no more than placebo action.

The hazards of misapplied health technology are now well recognised as a potent cause of clinical iatrogenesis which can and must be avoided. What is needed is determination and courage to restrict the application of health technology to areas in which it is fundamental to health promotion or health care delivery and to levels that can be paid for without strangling other sectors of health development.

Similar comments apply to the current "pharmaceutical invasion" that has almost corrupted medical practice and in some countries now threatens society with a new and growing cult dependent on the needless consumption of useless and sometimes dangerous drugs. The need to establish criteria based on local conditions for restricting the importation and manufacture of pharmaceutical materials has become more pressing today than ever before.

There is no doubt that the advances in health technology and the "pharmaceutical invasion" have further entrenched the central role of the hospital in the health care system. This trend has led critics to observe that "when the intensity of bio-medical intervention crosses a certain critical threshold, clinical iatrogenesis turns from error, accident or fault into an incurable perversion of medical practice". [9] This is the stage that Ivan Illich has termed social iatrogenesis, "when health care is turned into a standardised item, a staple; when all suffering is 'hospitalised' and homes become inhospitable to birth, sickness and death". [9] Only timely and realistic reappraisal of the role and function of the hospital in relation to local conditions and needs can stem the insidious onslaught of this danger.

Community participation

It is inconceivable that behavioural change can be internalised and therefore sustained unless it involves the participation and co-operation of those whose behaviour pattern it is intended to change. And yet there are still instances of rural development programmes that have been planned and carried out without the active participation of the communities they are designed to help. Such development programmes usually take the form of sectoral projects. Experts from various sectors of development move in and pursue their allotted task with a singleness of purpose that is commendable in its own right but does not achieve lasting benefit.

The published reports of such projects frequently refer to the community as the "target population" and I often wonder if this is not a Freudian betrayal of the fact that the defined population was indeed bombarded from all sides. The reaction of such "target populations" to development projects often follows a predictable cycle – from initial inquisitive interest in the new activity, through resigned acceptance of it, to a third stage when the activity continues but is mainly passively ignored. Finally, when the experts pack up their bags and go their projects fold up with them.

THE HUMAN RESOURCE FOR COMMUNITY DEVELOPMENT

Obviously the success of community development programmes depends in large measures on the quality of the human material and on the leadership and direction provided at governmental, institutional and community levels.

At government level

I have already referred to the need for a clearly-stated national development policy to guide national health planning. In formulating such a policy, the concept of health development as a part of community development generally must receive constant attention.

The concept itself is not new, but it has received a new lease of life and is being championed as a recommendation for country health programming which emphasises "the national responsibility for a health development process that is intimately linked with social and economic development in general". [10]

In this connection the Director-General of the World Health Organisation has mentioned the creation of multi-disciplinary national health councils. The idea itself is sound; but whether you agree with it or not the important suggestion still remains that "we should recognise the need for social policy to promote health development and for health development to promote social progress, and that we should reach agreement on the approaches for attaining the goals of this policy". [11]

At the institutional level

Ministries of health and university medical schools are the two institutions most intimately involved in the development of health manpower policy and its fulfilment, and yet there is fre-

quently little or no consultation between the two institutions on the number and types of health personnel required to achieve stated objectives.

This is probably because in most instances there are no stated objectives, or where such objectives exist they have not been derived in a corporate manner and therefore do not command the support of those who are expected to implement them. The training of health personnel under such circumstances is invariably along conventional lines with piecemeal, ad hoc modifications based on assumed needs.

Everywhere, the intention is to train health personnel in a manner that is relevant to the needs of society. For this purpose medical schools in developing countries have expanded their teaching programmes in public health and have become more involved with the problems of health care delivery.

Departments of community health do their best in trying to train doctors who will function as effective leaders or members of a health team, but I know of no certain way of achieving this goal. Teachers and students sally forth into rural communities that have been carefully delineated for research and field learning experience; they do a good job while the project lasts, but there is no assurance that the intervention will become self-sustaining or that the lessons learned will influence health development policy or be incorporated in the health service system.

In spite of dedicated attention to detail, there is as yet no convincing evidence that the doctors trained in this way have an increased motivation for a career in community service in rural areas or that the planned sorties into rural communities with structured projects have made lasting or significant improvement on the health of the rural populations.

It has been said that "the death knell of community medicine (or health) as at present known in developing countries has already sounded for those with ears to hear", [12] but I cannot believe that community medicine has come to the end of the road. It has merely come to the crossroads and the question that must be asked is: will it continue along the self-defeating blind alley, or will it pause and change direction?

In my view, departments of community health have two basic responsibilities. Firstly, within the medical school, to infuse the principles and philosophy of the community approach to health into all departments. This is a missionary undertaking which will require much zeal and fervour and attract little or no reward. Secondly, within the university, the department of community health will have to catalyse the activities of many disciplines – sociologists, economists, anthropologists, agriculturists, educationists and others – in a direction that will help them come together intellectually to find the most practical way of achieving socio-economic and health development in a given cultural setting. When a critical mass of converts have been won in the relevant disciplines, the strategy to be adopted at the community level will become a joint and co-ordinated activity aimed at promoting health as an aspect of general community development.

At the community level

None of the factors I have mentioned so far will have any significant impact unless the community itself is receptive to innovation and change. Bringing about change in behaviour and attitudes through knowledge and the development of skills is a function of education – the type of education that is relevant to the total well-being of the community, its health needs as well as its social and economic viability.

The role of education in improving the quality of the human resource contribution to general community development is well known and requires no emphasis; but there is an urgent need at the present time to devise simple and effective techniques of verbal and non-verbal communication that can be adapted to the cultural needs and economic circumstances of rural communities.

It is of course possible to induce behavioural change by getting people merely to comply with the demands of authority; but behaviour based on compliance is short-lived and requires continued supervision or sanctions to sustain it.

Behavioural change may also occur by example – from a desire to identify or associate with someone who is liked or respected. Change by such indentification lasts only so long as the motivation for it continues.

The most permanent form of change is that which is the result of self-satisfying proof of the utility of the new behaviour and its relevance to important issues. Such behaviour change becomes internalised as an accepted and normal mode of behaviour and may be culturally absorbed and passed down to subsequent generations.

I have emphasised the need for community participation in development programmes, but, even more emphatically, it is only by such participation that new ideas and modes of behaviour can become internalised to provide the stimulus for self-sustaining community development.

MOBILISING COMMUNITY RESOURCES

It is now recognised that effective mobilisation of community resources for rural development should be based on an integrated approach, but what is meant by the integrated approach? Is it merely the putting together of a number of programmes into a package of inter-related projects? Or is it the co-ordination of various sectors into a comprehensive system?

The first or "package projects" approach tends to emphasise demonstration and pilot study aspects rather than the expected benefits to the rural people. The second or "intersectoral co-ordination" approach soon becomes preoccupied with the organisational means of co-ordination and fosters intersectoral tensions. Neither of these approaches incorporates effective community participation and therefore neither can be expected to provide reliable answers to long-term self-sustaining community development.

Real integrated development stresses self-reliance and requires the integration no only of programmes, but also of the rural people themselves into the planning, execution and evaluation of any project which directly affects them.

How may such an integrated approach to rural development be achieved? I believe the philosophy of rural reconstruction movements provides some useful lessons. The stated aim of these movements is to release the potential of the rural communities into a self-generating force for the solution of their own problems – defined as the problems of poverty, disease, ignorance and civic inertia.

I recently came across the following exhortation which sums up the method of operation of the Rural Reconstruction Movement:

"Go to the people;
Live among them;
Learn from them;
Serve them;
Plan with them;
Start with what they know;
Build on what they have." [13]

Admittedly, localised voluntary efforts of this type cannot be expected to transform the whole countryside, but they could heighten public awareness of alternative approaches to rural development and thereby influence national development policy.

HEALTH CARE DELIVERY AT THE GRASS ROOTS

It has become increasingly apparent that in developing countries the goal to provide health coverage for the whole population cannot be achieved solely by current conventional western methods. Consequently there is now a move to take a closer look at indigenous medical practices and to consider ways of utilising the services of traditional healers in the delivery of health care.

The role of traditional medicine

Traditional healers have delivered health care over the centuries and continue to do so, particularly in the rural areas where 80 per cent of the population in the developing countries live. In some countries the value of their contribution to health care is known and acknowledged; in

others it is unknown and questionable. In general, I believe the case for traditional medicine is frequently overstated.

Chinese experience in this field is often cited as a model worthy of emulation; but Chinese traditional medicine is well systemised and its modern version includes topics on basic medical subjects. The "barefoot" doctor receives instruction on the "two controls" – excreta and drinking water – and on "five reformations" – care of water, care of the cooking furnace, care of farm cattle, environmental refinement and latrine hygiene.

Obviously, Chinese experience cannot be transplated without modification; but the hygiene of excreta and drinking water is of universal concern and every culture has traditions that need to be reformed or updated. Is it possible to accept the traditional healers formally and to revolutionalise their training, so as to introduce new concepts of health promotion and disease prevention? And can knowledge of the "two controls" and an appropriate number of relevant "reformations", based on local culture and needs, be included in the training programme of a new breed of traditional healers?

In many countries it will not be easy to achieve formal integration of traditional healers into the official health care system. This fact must be faced and alternative solutions sought.

Village health workers

One possible alternative is to recruit villagers and to train them locally as health workers. A successful experiment of this type has recently been reported from south Java. [14]

As part of a self-help village health programme, local volunteers were accepted for training as "kaders". The criteria for selection were established by the villagers themselves. After six weeks of training each "kader" is assigned ten to fifteen families; his first task is to carry out a health survey of these families and to obtain information on felt needs and priorities. He then dicusses his findings with a supervisor before proceeding on a planned course of action. The "kader" is also responsible for village sanitation and for disseminating health information and advice.

The experience from this village self-help project has revealed that formal health activity may not rank high in village-determined priority lists; nevertheless, health activity forms a convenient and acceptable starting point for mobilising group action for community development.

The reaction of some people to the use of such minimally trained personnel in matters of so-called life and death is to dismiss it as an unwarranted and dangerous intrusion on the lives of unsuspecting rural folk. Those who think in this way need to divest themselves of certain fundamental misconceptions, for there is no mystery about the recognition and treatment or the prevention of the major health problems that afflict developing rural communities and "there appears to be no possible reason why the knowledge and skills of dealing with them should not go down the professional tree to every household at risk". [15] It has also been suggested that there should be a "demystification of medical technology", [15] and such a process of demystification I hope will include not merely removing the mystery surrounding medical technology, but also dispersing the mist of public ignorance concerning it, and discarding the myth of omniscience with which it is sometimes regarded.

What of the future?

The future is of course unpredictable, but today's challenge is the challenge of community health development and tomorrow's achievements will surely be measured in terms of the health and well-being of mankind as a whole. In this task no country can stand aloof in self-sufficient complacency, for no country can ever become completely self-sufficient. Mutual interdependence is inevitable and international co-operation is mandatory for the solution of the major problems of today.

In health matters such co-operation already exists in several regional groupings that the Commonwealth has fostered over the years. The viability of these regional associations, and indeed of the Commonwealth itself, is dependent on the concept of mutual self-help between member nations and this, far from conflicting with the need for national self-reliance, actually helps to promote it.

I know that a number of bilateral and multilateral technical assistance arrangements are available in certain specified areas of need. But given the challenge of today and the needs of the future, a number of pertinent questions may be posed:

- How can we help each other to identify the system of integrated rural development most appropriate to local needs?
- How can we motivate communities for continuing participation in activities to promote their own well-being?
- How can we integrate successful local programmes into the mainstream of the national development plan?

There are no simple answers to these and other questions that may be asked and only the willingness and courage to try out promising new approaches can hope to provide any concrete solutions.

CONCLUSION

It has been said that "no society can be complacent about its health". [15] In other words we are all in this together and health planners and administrators everywhere face similar frustrations and dilemmas in their efforts to provide health care with limited or scarce resources. But lack of funds is not the only obstacle to the achievement of community health development goals. In many countries a deficiency of organisational and managerial skills is a major obstacle which inhibits integrated planning and retards the implementation and evaluation of development programmes.

This situation demands a vigorous manpower development policy to fulfil expected needs in all areas of development, for health itself is only one aspect of community development generally and therefore only a part of the related activities that must proceed on a broad front.

In the health sector, ministries of health and medical schools have a joint responsibility: together to establish health personnel requirements and training objectives that are derived from the broad goals of national health development policy and are also relevant to the prevailing health needs of society.

New approaches based on a philosophy of integrated rural reconstruction, which emphasise active community participation at all levels for the achievement of self-sustaining development, must supersede outworn models which merely provide palliative relief from the selected or assumed requirements of the rural communities.

In any programme of integrated development, health has a unique role to play, for health care is a universal need and health action properly designed can demonstrate the effectiveness of group action and thereby promote community participation in other sectors of development.

Consequently, it is now necessary to re-examine the definition and scope of formal community medicine activities and to realign them to the goals of self-sustaining community development.

There is no longer any doubt that the goal to extend primary health care to the remotest communities cannot be achieved by conventional health service methods, and its fulfilment will continue to elude health planners unless they can define a new role for traditional healers or train new cadres of health personnel recruited from the rural communities themselves.

These problems are known to all of us and we all share a common hope for better world health in the years to come; but tradition dies hard and the wheels of change grind slowly on paths overgrown with tradition. What is required is courage:

- Courage to define the social goals of health development policy;
- Courage to break away from conventional methods of training health personnel and of delivering health care; and above all
- Courage to mobilise the political will to effect the necessary changes.

The task will not be easy and I have heard it said that "we must be prepared to raise hell to reach heaven".

Finally, in our time the gospel of self-reliance has been widely acclaimed and there is no conflict between it and interdependence for mutual self-help, for no one country can ever hope to be completely self-sufficient. The call today is for international co-operation and mutual assistance to wipe out the scourge of disease and the inequitable distribution of resources.

The aspiration to health and to wealth is common to all nations, rich and poor alike, and for us gathered here it must have a very special meaning – a worthy goal – for in "common health there is common wealth".

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