Primary Health Care Revisited: A Review of the October 2018 *Contact* Issue

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Introduction

In this 70th anniversary of both the World Health Organization and the World Council of Churches, the 50th anniversary of the Christian Medical Commission, the 40th anniversary of the Alma-Ata Declaration, and the start of the Ecumenical Global Health Strategy, this commemorative special issue of Contact Magazine was a timely contribution to re-invigorate Primary Health Care (PHC) from a Christian perspective. A compilation from multiple authors, it revisits some of the seminal articles written in the years leading to Alma-Ata, explores areas of advocacy and programming, visits case studies, introduces the WCC Ecumenical Global Health Strategy, and looks to the challenges and opportunities in the future.[1]

Content

Concerning Primary Health Care: Are We Faithful to Our Foundations?

The first author, Mwai Makoka, addresses issues that were of seminal importance to PHC as envisaged by the Alma-Ata Declaration. We are duly informed that in the past, health care was regressively distributed, with the result that the great majority of mankind were and are still allowed to suffer from diseases, disabilities, and deprivations, which the world community as a whole has the skill and resources to relieve. No doubt, as amplified by this contribution, when attention is paid to the 1970s, health historians would place a premium on primary healthcare (PHC) or community care. Of seminal importance to this review is the fact that there is a growing awareness of the interdependence of prevention and cure, both technical interdependence and in terms of acceptability. This involves, firstly, integrated programs with the prime emphasis on prevention rather than detection and cure and, secondly, integrating the specifically medical service with programs integrated with rural development. This integration notwithstanding, the author does well by drawing the attention of the reader to that which needs much emphasis. Health is an important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. As can be found in the theoretical literature, the existing gross inequality in health status in the world is unacceptable.[2,3,4] The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace. It is therefore essential to note that governments have a responsibility to ensure the health of their people which can be fulfilled only by the provision of adequate health and social measures. Of equal importance, the author encourages all governments to formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a

comprehensive national health system and in coordination with other sectors.

However, it has been found that communities adjust to diseases differently, based on cultural, social, and, sometimes, prevailing physical conditions in the environment and in the country. One drawback is that health care has been considered a rather low priority in the demands on community resources as compared to education and other social needs. The argument is not that we must wait until a "high" quality of care can be guaranteed and distributed equitably before we invest any resources at all in PHC. Rather, the argument is that we at least need to ask whether an equivalent amount of resources invested in traditional types of health care, *e.g.*, upgrading "village midwives," is consistently provided to support the communities that need them. In Africa, structural adjustment led to several reforms which led to the issues concerning full-cost recovery in several sectors of their economy, including healthcare. However, the new millennium has witnessed the introduction of health insurance to aid citizens of countries in Africa in particular to have equitable healthcare.[5,6,7]

Building on a long tradition of engagement in education and care for the sick and destitute, churches and religious charities accelerated the establishment of schools and hospitals, applying new knowledge that became more available from the middle of the nineteenth century. These are some of the Christian answers that must be supported or encouraged to suffice. Looking again at global health, we have to understand the enormity of the potential for the future. Technology and innovations have helped to elevate hundreds of millions of people out of poverty and have contributed significantly to the recent progress in global health. But they are by no means sufficient to achieve the great convergence of health and development. Progress of that magnitude in one generation will require many factors to come together, and this is exactly why a renewed partnership between faith and development will be so critical. The question of closer collaboration between the faith and the development communities has been amplified by the theorizing literature. It will be one of the key factors to allow us to move more quickly towards these common goals of health and development.[8,9,10,11]

The Alma-Ata Declaration 40 Years Later

In the second article, Odile Frank ties in a very essential argument. We are in agreement with the author concerning the conference strongly reaffirming that health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity. We are equally encouraged by the persistent argument on the attainment of the highest possible level of health, which is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. With no equivocation, the theorizing literature emphasizes the argument that to achieve health for all, inequities have to be overcome, powerful interests are to be challenged, and political and economic priorities should also be transformed.[12] Therefore, it is imperative to emphasize with no contradiction as echoed by this section of the contribution: health is not only a matter of human rights, it is a matter of justice and requires a redistribution of wealth and significant changes in the global economic order. Equity in health and social justice must be the basis for all decision making. To ensure access to health services to all, service provision through public and not-for-profit providers must be given the primacy in health system planning and implementation. This is clearly a novel way to go even in the globalized world that continuously seeks to achieve Universal Primary Health Care.

It recognized health as a human right, and to attain the same, several social and economic sectors in addition to the health sector need to be actively involved and show results. Health as subject of human rights has been reported by Farmer who discusses pathologies of power: health, human

rights, and the new war on the poor.[13] Mann also highlighted the critical issues in health and human rights.[14] Similarly, Leary discussed the right to health in international human rights law.[15] However, one needs to look beyond the four walls of the hospitals where the real causes of ill-health lurk. They could be unemployment, underemployment, poor housing with overcrowding, and lack of access to nutritious food and safe water, illiteracy, and gender inequalities. To overcome all of this, people will need to be involved in planning health programs. And for that, a minimum understanding of health is essential as well as the requirement of a multi-sectoral approach to deal with the issues. A multi-sectorial approach was a strong pillar of Alma Ata Declaration. The critical question to be re-echoed is whether affordability remains the over-riding and universal challenge.

Revisiting, "Is PHC the New Priority? Yes, but..."

The ardent issue raised by Makoka for further discussion is the need to keep the ball rolling. Significantly, it has become imperative especially due to the fact that geographic and financial inaccessibility, limited resources, erratic drug supply, and shortages of equipment and staff have left many countries' primary care services disappointingly limited in their range, coverage, and impact. There is therefore the increasing consensus that stronger health systems are key to achieving improved health outcomes. There is plenty of evidence for cost effective interventions that could vastly improve maternal and child health, for example, but less evidence on how to ensure that these services reach the most vulnerable populations to have lasting effect. Though the question of PHC is important in the contemporary discourse, there still remain some gaps in community-oriented initiatives that would clearly ensure PHC. Emphasis on evaluations of new ways of organizing primary healthcare services in specific settings are required. Affordability remains the over-riding and universal challenge. What services can realistically be provided free at the first point of contact and what mix of financing mechanisms should be promoted to do so continue to be remaining essential questions both in this contribution and shall remain significant in others in the foreseeable future. All things being equal, it can be envisaged in this contribution that commitments toward health care financing as explicated in earlier literature on health financing and social insurance among others cannot be gainsaid. Also, public sector general practitioners are required to concentrate on preventive programs that tackle a few well-defined diseases and tend to be dominated by quantitative objectives at the expense of individually tailored prevention and treatment.

Revisiting "Health Care and Justice"

Gisela Schneider reifies the role of the Christian Medical Commission (CMC) which was formed in 1968 and whose first major activity was to evaluate the existing patterns of relationship between church medical institutions and the people they served. It was also a place that was deeply conscious of the tremendous dedication and selfless service that have made church-related hospitals unique symbols of the proclamation of Christian love in action. In seeking to address health care and justice, core issues are the use of curative and preventive strategies or services which are effective and accessible. We believe that this will accentuate the gains made towards the issue of healthcare and justice.

A concern for effectiveness will require a better balance of preventive activities. Also, because of archaic medical prejudices about clinical care being the doctor's preserve, we do not turn routine treatment over to auxiliary personnel, although it has been abundantly demonstrated that they can care for 90 per cent of illnesses as effectively as physicians. Patients invest inordinate amounts of wasted time in waiting while nothing is done — both as inpatients and outpatients. Certainly, in seeking for healthcare and justice this should not be the way to go. The

definition of injustice here starts with the conviction that basic morality requires equitable distribution. The greatest moral dilemma of medical care is to find the least unjust way to allocate scarce resources. We cannot just open facilities and wait for the centripetal and spontaneous inflow of patients. The concern is centrifugal in reaching out to all those in need. The CMC has shared with others increasing attempts to publicize these areas of concern.

First, instead of spending all our precious resources on those who come spontaneously, we must work out new ways of defining and providing a basic minimum of services for all. The definition of this basic minimum must be locally derived and strictly limited to ensure coverage. The second part of providing equitable distribution is to set and follow priorities in care. The purpose is to focus on the measures that will do the most for particularly vulnerable groups. As concluded in this contribution, an important element in the effort to reduce injustice through better health care is to relate health deliberately to the total development of the whole person. It is only right to give attention to the needs of individuals, families, and communities.

"Five Challenges to the Churches in Health Work": Still Relevant?

Bimal Charles emphasizes the contribution of faith-based organizations and churches in mitigating the health challenges to communities and nations at large with their concomitant challenges. He analyses the fact that the church has yet to understand the magnitude of problem faced by the poor. Concerning "The history," he writes, among other things, that the intersection of religion and medicine does not provide us with ready-made solutions to contemporary problems. Rather, it provides a broader context for understanding the complexity of illness and suffering. Harmony between humanity and the gods was paramount, with sickness being an intrusion of maleficent spirits or cosmic forces rather than a symptomatic, treatable disease. While he first outlines the general practices and beliefs of these ancient peoples, he then provides a more detailed panorama, starting with basic history. He then moves to the development of healing methods and the societal roles of healers who often dealt with both the treatment of physical symptoms and the cosmic force that was believed to have caused the illness. This is consistent with the social causative theories espoused by authors like Twumasi, Adu-Gyamfi, and Oware that emphasize the need to appreciate the non-medicinal aspects of healthcare delivery that are equally important in ensuring health care.[16,17]

As Christians, we can try to compensate by being loving and seeking appropriate practical and useful strategies to support people. However, the institutional environment itself often discriminates against the families most in need of support. An important element in the effort to reduce injustice through better health care is to relate health deliberately to the total development of the whole person. Attention must be given to the needs of individuals, families, and communities. This requires real collaboration of health workers with those working in the economic and political sectors of community life. As clearly seen, this contribution dovetails into the contribution in the previous section. It has been emphasized that the Church Health Center created a model of health care that integrates wellness and medical care while addressing the spiritual needs of those it serves. A similar philosophy is shared by Adu-Gyamfi and Oware when they discuss the contribution of the Wesleyan Missionaries among the Asante people of Ghana.[17] A wellness mentality includes thinking beyond the illnesses doctors typically address in a clinical setting to other parts of physical and emotional health that affect an individual's quality of life. From the beginning, the Church Health Center has focused not only on treating illness but also on helping people experience greater whole-person wellness.

Review: "Primary Health Care and the Village Health Worker"

Closely linked to the broader discourse concerning PHC is the contribution by Dan Irvine. He suggests that community health worker (CHW) programs thrive in mobilized communities. Community health workers as a rule and by their very nature provide services in environments where formal health services are inaccessible and people are poor. India has a long and rich history of small and large community health worker programs. A large national scheme was established in the late 1970s that aimed to provide one CHW for every 1000 population in order to provide health care to rural people and to educate them in preventive health care. Similarly, in Ghana, there has been efforts to get community action in place, but there is still more to be done to further decentralize health to allow effective participation at the local level.

Health-Promoting Churches: A Case for Congregation-Based Health Promotion Programs

Makoka argues that congregations have an opportunity to reclaim their historic status. Although some of the major causes of sickness and early death are due to sanitation, nutrition, and lifestyle, many of the societal variables we face today, violence, drugs, racism, poverty, youth gangs, divorce, single parenting, lie outside the medical care system. To reclaim the full ministry of teaching, preaching, and healing, we need to be intentional and committed to that mission. Developing a congregationally based health ministry changes the paradigm of health. The future in health will be to focus on working together in integrated ways, sharing resources, and meeting one another in community. Schools, hospitals, health agencies, and churches must come together with a common mission empowered by the community itself.

The Historical Involvement of the Christian Medical Commission and Churches on the Politics of Breastfeeding

In this section, Senturias and Makoka argue that one of the early justice issues is the politics of breastfeeding. Historically, the WCC through the CMC and other faith-based organizations has showed keen interest in the politics of breastfeeding. However, this is a follow-up on the early 1970s warning about the dangers of not breastfeeding, the rising tide of public opinion favoring it, and the boycott of Nestle in the United States. Under the sub-theme "advocating internationally and at the grassroots," the authors argue that in observance of "International year of the Child" (p.33), the CMC published an article which emphasized the superiority of mother's milk. It provides the best nourishment for the baby, protects from infections, ensures biological child spacing, and enables emotional bonding between mother and child. The CMC collaborated with the WHO to draft the International Code of marketing for breast-milk substitutes. The literature continues to highlight the significance of breastfeeding to the mother, the baby, and the larger human community. Kornides and Kitsantas have argued that clinicians who supported breastfeeding also increased the odds of a woman initiating breastfeeding. In addition, interventions to increase maternal knowledge about the benefits of breastfeeding and family and clinician support for breastfeeding in the prenatal period may help increase breastfeeding rates. They concluded that encouragement to breastfeed needs to be a priority among health care providers.[18] Lawrence has also emphasized that the benefits of breastfeeding include savings in health care costs.[19] The reference to Rubenson, the program secretary of CMC, and his contribution to this discourse cannot be gainsaid. The authors of this section remind us that on Feb 14, 1989, Rubenson reminded the world that the struggle for health for the infants and children of the world continues especially when breast milk substitutes

were found to be routinely available. We learn from the pages of this section that, if any successes have been gained, it has come about as a result of collaborations with NGOs the WHO and UNICEF. However, what is of greater consequence is the need to mount continuous pressure on stakeholders to ensure that the issue of breastfeeding remains at the heart of global health discourse.

From Disability to New Abilities: Case Studies in Disability Care

Through two case studies, Gift Norman and Raji Thomas address significant issues of disability. The authors argue that despite progress in science, technology, and advocacy, disabilities of all kinds are still equated — incorrectly and by too many people — with ill health, incapacity, and dependence. Admittedly, the authors seem to thread a narrow path by trying to disconnect disability from ill health or physical challenges that would require some form of support from society. This notwithstanding, the authors opine that the misperception remains that only a person who is physically agile and neurologically intact can be considered healthy. Similarly, with regard to individuals with mobility difficulties, several people in the society are believed to still hold persons with mobility difficulties individually responsible for their challenges. Only with accessible, comprehensive healthcare and wellness promotion services can all persons with disabilities enjoy full, engaged, and productive lives in their communities. He has also identified four main misconceptions that continue to plague how disability status has been perceived: (1) disability is equated with poor health status; (2) public health should focus only on preventing disabling conditions; (3) no standard definition of disability is needed for public health purposes; and (4) the environment is not a factor in the genesis of disability. When not specifically mentioned, disability was rarely identified as a concern by persons without disabilities. It became a concern only when it was posed as an issue on which to voice an opinion. One of the challenges, then, is to identify ways in which the health and wellness of persons with disabilities can be brought to the consciousness of the public as an issue warranting effective action and ongoing attention.

Faith in Health: Why It Still Matters

Gillian Paterson points out that the technological advances of the past century tended to change the focus of medicine from a caring, service-oriented model to a technological, cure-oriented model. Technology has led to phenomenal advances in medicine and has given us the ability to prolong life. However, in the past few decades physicians have attempted to balance their care by reclaiming medicine's more spiritual roots, recognizing that until modern times spirituality was often linked with health care. The emphasis of the fact that people think about health and illness in multifaceted ways, evidencing a conceptual complexity that corresponds to equally complex behaviors in relation to a diversity of healing practices.

The understanding of the goal of good medical care is attention to the whole patient, not just the specific illness; courses that are taught holistically, rather than by symptoms only, emphasize whole patient care. So, when learning about a patient with diabetes, students learn not only about the pathophysiology of diabetes but also about the psychosocial and spiritual issues that patients with diabetes may face. Thus, when learning to take a history, students learn all aspects of the history — physical, social, emotional, and spiritual. Spirituality can be an important element in the way patients face chronic illness, suffering, and loss. Physicians need to address and be attentive to all suffering of their patients—physical, emotional, and spiritual. Doing so is part of delivery of compassionate care. This argument is largely anchored in the literature concerning spirituality and medical care [20]

A New Health Impetus for WCC: The Ecumenical Global Health Strategy

In the final paper, Lyn van Rooyen adds to the non-material discourse to health specifically laying emphasis on the theological traditions of the church. Health is more than physical and/or mental well-being, and healing is not primarily medical. This understanding of health coheres with the biblical-theological tradition of the church, which sees a human being as a multidimensional unity and the body, soul, and mind as interrelated and interdependent. It thus affirms the social, political, and ecological dimensions of personhood and wholeness. Health, in the sense of wholeness, is a condition related to God's promise for the end of time, as well as a real possibility in the present. The Author concludes that as a community of imperfect people, and as part of a creation groaning in pain and longing for its liberation, the Christian community can be a sign of hope and an expression of the kingdom of God here on earth (Romans 8:22-24). The Holy Spirit works for justice and healing in many ways and is pleased to indwell the particular community that is called to embody Christ's mission.

Conclusion

The Contact issue has drawn our attention to the fundamental role of institutions like the church in ensuring global healthcare. It has been reported that global health builds on national public health efforts and institutions. Global health is concerned with all strategies for health improvement, whether population-wide or individually based health care actions, and across all sectors, not just the health sector.[21] It is clear, however, that the commitment towards attainment of Primary Health Care goals within the global health construct could be achieved through multi-dimensional approaches that are practical enough but do not reject the holistic approach contributed by faith based organizations and churches.

Again, as stated elsewhere in the *Contact* issue, the church can play an important role by encouraging young church members to consider a career in health care. Regional/Provincial/Metropolitan/Districts Departments of Health can give bursaries to bright young people to train as nurses, clinical associates, allied health care workers, or doctors and also offer counseling, healing, and support services for those who need it. The saving hands of their Messiah works through a well-trained church force that is willing to support humanity in countries and regions to meet significant global health demands. This is amply surmised in Christ's solemn word recorded in Matthew 25: 35-40 (ESV):

> For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me . . . as you did it to one of the least of these my brothers, you did it to me.

As recorded elsewhere in the *Contact* issue, to reiterate, the value of the human being from the Christian perspective calls us all to build a society where every individual is cared for according to his or her needs and not according to his or her assets.

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