Opportunities for good health services at doorsteps

Primary health centres (PHCs) and district hospitals (DHs) are the health facilities where most of the local and rural folk go for medical help. For rural folk the DHs are the secondary care centres where they are referred to, if PHCs are unable to help. DHs in turn refer difficult and complicated patients to tertiary care centres, usually located in the big cities. Unfortunately the services are not so clearly organised and people just opt to go which is the most suitable location for them at a point in time. For example a business trip to the city may include a quick consultation with a private doctor or to a tertiary centre as an outpatient. In an ideal situation, the patient should be seen in a PHC and if not manageable referred to DH and finally to tertiary hospital to be seen by specialist, as is the case in the UK where General Practitioner sees the patient and if required referred to DH or to a higher centre as the need may be. Accountability exists for each action on the part of the health care provider. One cannot jump the system and visit a DH without a referral. However, this system is rare and only works in those countries where well organised health care delivery systems exists. Other systems are controlled by the insurance policy and wherever the policy permits for the consultation and the treatment.

In MLICs the system is more erratic and works on the individual ability to buy the service. Those who cannot afford, generally the rural and remote populations, have to rely on inefficient government health services available from PHCs. The centres are poorly staffed and equipped and often lack medicines. Patients are often asked to buy from equally sparse pharmacies. This allows chemists or quacks to flourish in providing the services in exchange of cash. Yet another set of traditional practitioners also thrive because of consumer's ignorance and tradition. If the patient has some minor illness, recovery is spontaneous and time bound, treatment provided working as a placebo giving publicity to the skills of the practitioner. However, if the illness is a serious one like severe pneumonia or diarrhoea in an infant or obstructed labour can cost a life if not receiving proper treatment or referral. More often than not, the illnesses are complicated with underlying causes such as undernourished child or anaemic mother or simply delays caused in decision making and taking the patient to a suitable place for treatment. This is evident from the health indicators by stark differences in morbidity and mortality in urban (cities) and rural areas, developed and developing countries, rich and the poor countries.

To address these problems it was recommended, a very long time back in 1978 at the Primary Health Care conference in Alma-Ata**[1]** that a well organised primary health care would solve these problems. The recommendations were simple and workable but never got implemented to the level for them to be effective. To this day we still see the effect of poorly functioning PHCs largely dealing with the illness care model, so aptly ingrained by the medical and pharmaceutical professions, equally into the minds of public and health professional. Health care is a business to make money at the expense of ignorance of the public. Time and again**[2] [3] [4]** the Primary Health Care has been visited and revisited but the seriousness required for its implementation is still out of reach. It requires only improvements in one aspect of primary health care, the ***Maternal and Child Health,*** which will improve both the maternal and the infant mortality, changing the health status of the whole population.

It is a puzzle to my mind why proven measures are not applied to primary health care in the midst of big talks for "health for all" and "universal health coverage". Everyone knows that under nutrition and stunting is a major issue (more than one third of all children in the LMICs are stunted, malnourished or both) and is the main underlying cause of morbidity and mortality among children, even girls growing into adulthood with constant undernourished state and adding to the maternal and infant mortality, yet growth monitoring is still not a part of Universal Health Coverage. Poverty may be a

factor but it is the lack of knowledge and awareness which is the most important.
If governments and international agencies are genuinely concerned then following measures must be implemented without delay to strengthen the Primary Health Care to bring about required change:

1. Water and Sanitation: Safe water and adequate sanitation (functional toilets) alone improves the health of the communities. It is a fundamental right of every being to have access to these simple amenities;

2. Growth Monitoring: Simply making this service available at the health centre or district hospital in not enough. It must be provided to each child through regular monthly growth monitoring service, organised by village committees, with village health worker as in charge of the activity and the primary health care workers providing the technical aspect of this care. This would enable:
a. Optimal growth for each under-5 by helping mother to understand how best to feed the child soon after weaning from breast after six months. Weighing and length/height measurement conducted by VHW and village volunteers;
b. WHO Anthro package which is free of cost, should be used to enable accurate measuring and automatic reporting to monitor the service;
c. Growth monitoring also provides an ideal opportunity to vaccinate all children for common immunisable diseases;
d. An opportunity to deworm all children until such time that the safe water and sanitation is adequate, removing the need for periodical deworming;
e. Referral services by health centre staff for unresponsive children and possibility of other infections that may impede the growth;
f. Growth monitoring to be continued at school health under the school health programme using WHO Anthro Plus to continue to monitor growth for school children and adolescent, in particular the girls. Education and awareness on healthy life style being an important aspect of this service;
g. The service provides an opportunity to monitor the births and deaths to keep the populations register updated, so that it can serve as a credible denominator;

3. Maternal care: Growth monitoring combines education and awareness of mothers to learn and understand the optimal growth of their children. To help mothers in better care for their children, there are other factors:
a. Mother needs to be aware of the care during pregnancy and hence antenatal care (ANC) should be her priority when she decides to have a child. Availability of an accessible and adequate service cannot be compromised. A planned programme of where to deliver the baby and access to supervised child birth is mother's prerogative. Post natal care is often neglected, resulting in dangers of survival of both the mother and the new born, hence clear plan for it;
b. Education and awareness of mothers to take care of the new born by exclusive breast feeding and knowing when and how to wean the child. Most infants after six months begin to falter adequate weight gain because of poor weaning practices. The period of 6 to 36 months is the most crucial period in growth monitoring;
c. Next child – ensuring that the mother is aware of the chances of becoming pregnant again when she is required to address the needs of the existing infant is crucial. Family planning services, understanding and access to service are fundamental for how many, how soon and when to decide to stop having more children.

4. Training needs: Continued in service training for all health workers as they provide the essential services to the people they serve is the responsibility of the health care organisers, mainly the government health service providers
a. Village health workers are the first level of health care providers and must be well trained and supported under the primary health care programmes;

b. Health centre staff, mainly the midwives, needs support and continuous updating of their knowledge for augmenting the service provision;
c. Learning from their experience by reviewing the outcomes of the services they provide. Indicators of growth monitoring, antenatal, natal and postnatal care – stillbirths, maternal deaths or near misses, neonatal, infant and under-5 deaths are some of the indicators, an area totally neglected in primary health care. Review exercises are top down rather than bottom up. How often one hears of post-mortem or audits of maternal and infant deaths in a primary health centre. Responsibility and accountability are essential for learning and improvements is health service provision.

Social Development is the process of prioritizing human needs, in the growth and progression of society. This focuses on improving the lives of regular citizens, especially the poor, to make society a better place to live for everyone.**[5]**

References:

[1] Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978
[2] Mahler, Halfdan (1981) "The meaning of Health For All by the year 2000", World Health Forum, Vol. 2, No. 1
[3] World Health Organization (November 22, 2010). **"The world health report: health systems financing: the path to universal coverage"**. Geneva: World Health Organization. **ISBN 978-92-4-156402-1**.
[4] Astana Declaration. Astana 2018. Editorial. Lancet Vol. 392, October 2018
[5] Saravana Selvi and K.S.Pushpa. "Kudumbashree" - An Arm of Social Development. International Journal for Research & Development in Technology. Volume-11, Issue-6.June 2019. ISSN (O) :-2349-3585.

Please see illustrations below of Successful Implementation of PHC at Health Center Level