MEDICAL NEEDS IN DEVELOPING COUNTRIES

Even though health services have been considerably increased in many of the developing countries, medical and hygienic conditions for the people are still not satisfactory. It is possible to accomplish a great deal, and a variety of programmes are under way, ranging from the installation of completely new infrastructures to the institution of pioneer projects in limited areas. Both WHO and Unicef have looked into these initiatives with a view to providing information and suggestions which might benefit other nations. A joint study, with the participation of many experts from both institutions was published by WHO.[1] *We have chosen several passages demonstrating the vital need of meeting, as fully as possible and as quickly as possible, the basic health needs of the developing countries.*

The health services are only one factor contributing to the health of a population. Economic and social development activities often have a positive influence on a community's health status. Sanitation, housing, nutrition, education and communications are all important factors contributing to good health by improving the quality of life. In their absence, the gains obtainable with the disease-centred machinery of health services cannot go beyond a certain point.

The essence of a successful development programme is that it should be properly balanced. Health services should neither be too sophisticated nor lag behind other sectors in development. Good health must surely be a basic component of economic development; in turn, social and economic development contributes to good health. The relationship is not completely understood, but even partial knowledge can prevent grossly inappropriate sectoral programmes being set up.

[1] V. Djukanovic and E.P. Mach: *Alternative approaches to meeting basic health needs in developing countries. Geneva, 1976.*

In some of the cases studied, the health programme has been integrated into a general development programme. In others, it is associated with more limited measures aimed at improving the quality of life.

However, a complete change in the economic and social structure of a country is not the only path to follow. Regional programmes, as in Niger and Venezuela, have shown that less ambitious endeavours can meet basic health needs.

Adequate coverage and use of preventive and curative health services at the village level have been achieved when the population takes major responsibility for primary health care in collaboration with the health services. The principle of local self-reliance implies that local contributions play an important part in providing the necessary manpower and facilities and in bringing the health services into line with needs, wants and priorities of the population they serve. Community involvement also means that the population participate in decision-making about its health services. Participation usually guarantees that community's motivation to accept and use the services, and feeds information on its felt needs and aspirations back to the decision-makers...

...Forms of funding range from almost complete financing by the central government to payment of a considerable share by the community itself. In countries where it is possible, the national government has been able to fund primary health care directly. In all other cases, irrespective of the political and economic system, the community has shared this responsibility to a varying degree.

As the shortage of health personnel is one of the main factors preventing the health services from increasing their coverage of the rural areas, the possibility of training health manpower in a different way must be considered seriously. Moreover, if health staff are to be used properly, at the lowest cost, the tasks in the country's various health installations should be defined and the training geared to them. Here the case studies clearly demonstrate certain innovative features.

Primary health workers, locally recruited and supported by their communities, form the front line of the health system and the entry point into it for the population. They are effective, acceptable and inexpensive, and they require only brief initial training. In many of the countries studied, primary health workers are assigned to such priority areas as communicable diseases, maternal and child health (including family planning), nutrition, sanitation, and curative services for minor illness.

Indigenous healers can be trained and integrated in the general health system. Indigenous systems of health care function among large popula-

tions in the developing world, and in some countries, such as India, the system is well established although unrecognized. Further integration of these indigenous practitioners—professionals, nonprofessionals, faith healers, magic healers—into the state system calls for more research and information.

The development of a decentralized system is undoubtedly one of the most difficult undertakings facing a country trying to improve its people's health. It can be reasonably argued that the result is not worth the effort and that a completely centralized system is more efficient. The best answer to the argument, though a limited one, is to be found in the case studies, which show that the most impressive gains have been made in countries where a strong central policy has been implemented by a decentralized executive organization. The degree of decentralization differs from one case to another, varying from complete managerial devolution to the community (China) to a redistribution of responsibilities within the health system accompanied by consultation with communities (Venezuela).

Examples of community participation are found in different political settings. Participation makes communities more readily mobilized, increases their health awareness, and provides health authorities with the information they need for a better and more sensitive administration.

A firm national policy of providing health care for the underprivileged will involve a virtual revolution in most health service systems. It will bring about changes in the distribution of power, in the pattern of political decision-making, in the attitude and commitment of the health professionals and administrators in ministries of health and universities, and in people's awareness of what they are entitled to. To achieve such far-reaching changes, political leaders will have to shoulder the responsibility of overcoming the inertia or opposition of the health professions and other well-entrenched vested interests.

Fundamental changes in health care of this kind in the developing countries will require correspondingly far-reaching changes in the organizational structure and management practices of the health services. For illustrative purposes three different types of health delivery systems, appropiate to the differing stages of a country's development and relying heavily on primary health workers, are outlined in Annex 2. Although many variations of these three types are possible, such services need to be manned by a new brand of health professional with a wider social outlook, trained to respond to the actual requirements of the population. The basis and the strength of such services lie in a cadre of suitably trained primary health workers chosen by the people from among themselves and

controlled by them, rather than in a reluctant, alienated, frustrated group of bureaucrats "parachuted" into the community. The entire health service system will need to be mobilized to strengthen and support these primary health workers by providing them with training, supervision, referral facilities and logistic support, including a simplified national health technology appropriate to their needs. Primary health services of this kind will also function in close coordination with other segments of the health services and with other services that have a bearing on the health status of the masses, such as education, agriculture, public works and social welfare.

The innovations and successes described in this study are sufficiently promising to warrant a major change in policy and direction enabling such programmes to be fostered, extended, adapted and used as examples for a large-scale global programme.
