THE NEW ORIENTATION OF HEALTH SERVICES WITH RESPECT TO PRIMARY HEALTH CARE WORK

THE PONTIFICAL COUNCIL COR UNUM
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The booklet entitled "Health Work for Human Development" contains the conclusions reached by a Working Group set up by the Pontifical Council COR UNUM in 1976 in order to examine Primary Health Care.

A second group was convened in Rome from 31 March to 2 April 1977, to examine the new orientations of health services to fit in with this Primary Health Care policy.

Experts drawn from many different areas of the medical and health care profession put forward their viewpoints based on their own experience and research in a very useful series of discussions. They looked at Christians' responsibilities and those of the religious congregations in the light of the new orientations. Being all too aware of the way in which situations can vary one from another, and of the complexity of the problems, they rejected the idea of prescribing formulae on methods to be used. Any comments made regarding structures at whatever level were only attempts to concretize the problems in order to be able to search for the most suitable solutions.

1. THE CHRISTIAN APPROACH

1.1. *The attitudes taken by Christ*

Christ took pity on people and came to their aid, whether they were spiritually ill as a result of sin or physically sick. His

attention was given to the sick person with whom he frequently talked, showing his preference for the poor, but without excluding anyone in need who appealed to him. Accounts of his miracles have been recorded where he restored people to health, teaching us that we also, with whatever means we have, must be concerned for those who suffer sickness, and do what we can to comfort and heal them.

1.2. *Populorum Progressio*

Jesus considered suffering and sickness as forming part of the "less human" situations which the Encyclical "Populorum Progressio" asks us to endeavour to make "more human" (cf. *Populorum Progressio*. 20). If we wish to be faithful to Christ and take up his attitudes with regard to our fellow-men, we must work for the overall development of each man, and focus on the sick person more than on his sickness. Since development also means solidarity, we must necessarily turn our attention towards the human community of the patient, his family first, but also his neighbourhood or village. This means we must practise community medicine.

The "quality of life" of his environment is important to ensure that the sick person will be restored to physical and psychological health, so that with the aid of his human community he can duly take charge of his own evolution towards a more human state, thereby becoming the craftsman of his own development.

The grassroots community responsibility for Primary Health Care work has the advantage of following the principle of subsidiarity. Health-care personal, following this principle, serve at the same time, their own personnel development.

Mastering their impatience, they listen and learn before they organize. They are more concerned with fostering action than undertaking it themselves.

1.3. *Evangelii Nuntiandi*

As Christians, we are evangelizers, as the apostolic exhortation "Evangelii Nuntiandi" reminds us. We are bearers

the Good News, of the whole and jointly responsible salvation of man in Christ. We proclaim this Good News through the witness of our lives, and by taking up the saving attitudes manifested by Christ towards each person, his environment and his traditions. Through us the Church evangelizes men and their communities. Through us and our commitment to health-care work, the Church proclaims evangelical liberation to the millions of human beings whose physical and spiritual health is affected.

1.4. *The need for conversion*

The mission that we have been given is a call for a true conversion of our hearts and also of our methods. Secularization is spreading in people's hearts from the industrialized and technological world to the developing world countries. We need to be converted all the time in order to bear witness as Christians to the sick who, through our work, will discover the love of Christ. The rapid development in the field of health service technology has often meant installing expensive equipment in the hospitals, requiring a large number of staff for a relatively low number of patients, while in many of the same countries in the world, up to 80% of the population are still without health-care services. Since Christians are the leaven, we must reach out towards the masses by providing simple, accessible and promotional health care according to our own possibilities, modest as they are, or in conjunction with the public services, where this is allowed.

Let us ever be mindful of the fact that service to the sick begins and continues to operate through the patient's human environment. Community health care is therefore part of the comprehensive pastoral work of the Church.

2. PRIMARY HEALTH CARE IN THE LOCAL COMMUNITY

2.1. *National health service policy*

Any primary health-care organization in local communities must take account of the health service policies laid down by

the authorities of the country in charge of the general running of health services.

2.2. *The basic principles of W.H.O.*

The organization of primary health care services must help each individual person in his own community. The true needs of this community must be taken into consideration and it must be encouraged and helped into contributing to its own development. Primary health care brings health services to the patient and is concerned with prevention of disease as well as early treatment where this is needed. In this respect, we follow the basic principles laid down by the Executive Council of the World Health Organization at the January 1975 meeting in Geneva, ratified subsequently by the various governments concerned.

1. Primary health care should be shaped around the life pattern of the population it should serve.

2 The local population should be actively involved in the formulation of health care activities, so that health care can be brought into line with local needs and priorities.

3. Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are often present.

4. Primary health care should be an integrated approach of preventive, curative and promotive services for both the community and the individual.

5. All health interventions should be undertaken, at the most peripheral practicable level of the health services by the worker most simply trained for this activity.

6. Other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervision and referral support.

7. Primary health care services should be fully integrated with the services of the other sectors involved in community

development (agriculture, education, public works, housing and communication.)

2.3. *The local community*

It is vitally important to be aware of the sociological situation of the community. This includes the composition and growth trend of the local population, its traditions and customary laws, the various social and economic problems and all the conditions on which the overall and balanced development of the community depends, including its health—an integrating factor which cannot be neglected.

The members of the community must be helped, where necessary, *to become aware of their own problems* and to express them so that, here again, they become the craftsmen of their own development. They alone are in a position, for example, to explain why they are afraid of the hospital, why they seek medical care late in the day, why the womenfolk prefer to give birth at home, what dying with dignity means to them, surrounded by their family, etc.

2.4. *The community health worker*

These profoundly human factors make it possible to share out the responsibilities for organizing primary health care. There is a wide variety of different things to be done, and some of them were brought to the attention of the Working Group. In the examples which follow, there is no desire to impose a specific pattern or model for the programmes which are to be implemented. They are simply a way of illustrating what a primary health care service in a local community can be. In some countries, a grassroot *Community Health Committee* is formed whose members are chosen by the community. They may be dignitaries in the community, government officers, etc., or simply persons whose personality or capability makes them suitable for such a task. This Committee makes known the health care needs of the people they represent and appoints the *community health worker.* Whatever be the title given to this

person, and this varies in different countries, he or she is the one selected by the community. He (or she) is given the basic training to be able to provide primary health care, usually on a part-time basis, while still continuing his/her normal daily work.

The health worker's tasks depend upon local conditions, but in general they may be summed up in the words of the WHO in "The Primary Health Worker" (Experimental edition, 1977, pp 4-5).

"1. care for the health of the inhabitants and look after community hygiene;

2. give care and advice, in accordance with the instructions written down in the guide or given by his supervisor, to anyone who consults him;

3. send patients to the nearest health centre or hospital in any case in which the guide instructs him to do so (evacuation or referral) and in any case not covered by the guide. The PHW should therefore confine his care and treatment to those cases, conditions and situations described in the guide;

4. with authorization from the local authorities, visit all dwellings and give those living in them advice on how to prevent disease and learn good habits of hygiene;

5. make regular reports to the local authorities on the health of the people and on conditions of hygiene in the community. Get the local authorities and the people to give him the help and support he needs for his work;

6. keep in as close contact as possible with his supervisor so as to be able to give of his best in his work and to obtain the equipment and supplies he needs;

7. promote community development activities and play an active part in them."

The training required, which may be graded in complexity, should initially be given on the spot by slow and gradual training process, given while actually "on the job". Unless the individual concerned is so talented that the training is going to be followed up at a later stage to "professional" level, the training should not be so advanced that the individual is pushed

beyond his capacity. Sometimes it is a good idea to train local healers or traditional "doctors" to become community health workers, if they are willing.

Although each community is called upon to look after its own health care problems with its own means as far as it is able, in accordance with the principle of subsidiarity, thereby enabling it to work out its own development, it should not be loaded with so many responsibilities that it finds it cannot cope with. The public authorities, who have drawn up an inventory of the *immediate resources* available (personnel, drugs and medical supplies etc.) must allocate them fairly for the benefit of the local communities as well.

3. QUALIFIED HEALTH SERVICE PERSONNEL

Each individual country has the task of determining *the type of personnel* required, and their respective role, in the light of the training to be given. A great many experiences and ventures undertaken in the past have shown that a unified *terminology* would be very helpful and in this, assistance of WHO would be appreciated.

We simply wish to mention *certain constants* that our own experiences and generally recognized requirements have shown to exist in the various types of personnel required, and their respective tasks. These constants will enable us to see in what direction we should be moving in order to play our part, especially since we are often numbered amongst the promoters.

3.1. *Health care auxiliaries*

One of the first levels of health service personnel is that of auxiliaries, whose responsibilities, recruitment, training and motivation need to be examined. These are people who should be able to undertake tasks on their own. They also have to assist the doctor to perform many tasks in preventive and curative medicine. They work both in medical centres and with the community health workers. The latter's training may be given by certain auxiliaries, whose supervision they will accept. This

supervision not only gives them security but also provides them with on-going training, since it is not so much a question of controlling them, as counselling them as they carry out their work. The auxiliaries are *recruited* both from those who apply for the work directly, or who are nominated by the local community, as well as from among those community health workers who show the right sort of ability and know their human environment sufficiently well. It must not be forgotten, however, that they do not always continue their work on a long-term basis, and this is a cause for concern.

Their training, which should be also given on an ongoing, continual basis including the period they are actually performing their health care work, can be at various different levels of skills and responsibilities. It should be provided by professional personnel such as the medical team that supervises them. The responsibilities which are entrusted to the auxiliaries under this new primary health care policy demand *serious motivation*. They must consider their function not so much as a form of personal development as a service to the community. It is a service which demands the highest moral conscience if dangerous deviations are to be averted. The auxiliaries must never lose sight of their own limitations in terms of medical skills, and of their need to be in continual training. Their professional conscientiousness must constantly keep their spirit of service alive in their minds.

3.2. *The nursing staff*

On account of their qualification and skills, nurses frequently have to aid the local people to grasp the fact that their health is in need of attention, and to encourage them to aspire to improved health and a changed way of living. Since they will give top priority to prevention and health education, they will also devote their efforts to training community health workers and auxiliaries. They can be helped by the qualified midwives who can undertake some of the same tasks, and they also assist the doctor in organizing primary health care services. This new role for nursing staff of both sexes, and of qualified midwives, demands the right training on a continuous basis, as well as deep motivation. This is a need of all the health care personnel.

3.3. *The doctor*

This new health care policy alters the role of the doctor, but does not make it any the less essential. The doctor needs not only new motivation, but a training that will enable him to respond to all the demands that will be made on him as a member of a health care team. He must be capable of coping both with the challenges of sickness and those of under-development. He must learn to consider his *vocation* as a doctor as a call to be of service to the community rather than a means of personal development. The reluctance to go out and serve in rural areas, which is far too widespread, has to be overcome.

3.4. *The health care team*

Since the health care is entrusted with the task of promoting health in a context of true community development, and it is not merely a means for accomplishing routine work such as distributing medicine, there should be a genuine team spirit among them.

This health care team usually comprises the following *members* : the doctor, the nurses and the auxiliaries, and also the community health workers and traditional midwives. The fact that they have different educational background and training, different tasks to perform and different degrees of commitment to the service of the sick and their communities, sometimes inevitably leads to tensions or psychological conflict within the health team. It is the leader's responsibility to restore harmony, if he is unable to prevent them occurring in the first instance.

The responsibilities of this health care team include planning the various tasks the team has to carry out. The team must also provide medical treatment, nursing care, hygiene education and be sensitive to the psychological problems and comprehensive needs of their fellow-men. This shows how important it is for the members of the team to have a comprehensive training and background.

4. THE THINKING UNDERLYING THE CHURCH'S NEW APPROACH TO HEALTH CARE

The emphasis given to the new primary health care policy has shown the vital importance of a whole motivational approach on the part of those who work in the health field or for health improvement. Unless this new approach on the part of the personnel is inculcated through special courses that need thorough planning and implementation by highly qualified staff, the new orientation to be followed by the various health services will simply not come about. The "Christian approach" outlined above looked at the motivation underlying the Church's particular interest in this new approach to health services for which the Church and its personnel take on direct responsibility.

4.1. *The health care centre*

The health care centre stands midway between the village and the hospital, and must have a dispensary with a few beds for emergency admissions. The number of emergency beds will depend on the population served by the centre and the distance from the nearest hospital. The team must look after a certain number of villages which will be using their services for more complicated cases ; the centre is in charge of preventive, curative and development work.

The team must also help the community health workers in the various communities by providing them with continuous advice, supervision and supplies.

A team motivated and oriented in this way will really participate in the implementation of the new health care policy.

4.2. *The hospital*

The rural hospital is the point of reference for a number of health centres which refer the patients they cannot handle to it, or those in need of surgery.

The hospital team is most important. It must look after all the hospital's needs, as well as provide continuous training and

supervision to its health care centres. It may be called upon to make up mobile health teams. Eventually these may be nucleus of a new health care centre.

Where the team includes a *pharmacist*, he or she can help in the training of personnel and, where appropriate, can help educate the local people in basic public health, hygiene and simple nutrition, though this latter is more usually done by a nutritionist.

The category of personnel known as *health inspectors* can be very valuable members of the team and provide aid both to the health centres and the community health workers.

To the hospital team falls the responsibility of handling the hospital *administration* problems. Where the hospital falls under the responsibility of a *Board of Governors or Directors*, a Management Board or a similar kind of body, the local communities must be represented on it.

The doctor and one paramedical staff representative are habitually *ex officio* members of such a board.

In a larger town there is usually *a regional hospital* to which the rural hospitals in its catchment area refer the patients whom they are unable to treat themselves. The medical team in these hospitals needs to be larger and more highly qualified to be able to meet all of its responsibilities. In order to avoid overburdening this hospital with the basic needs of the local population, it may have an annexed dispensary, either adjacent to it or even in another part of the town.

4.3. *Childbirth*

A new orientation could also be introduced in the case of maternity units which would only be used for the difficult births. Very serious difficulties would of course be referred to the hospital. Childbirth could normally be organized in the mother's home once the health care services really do cover the whole of the local population, particularly through careful training given to the traditional midwives. Maternity units can be independent units or wards attached to the health centre.

The maternity units also have the task of training the midwives. Part of their instruction should include the teaching

methods by which they can help their patients toward *responsible parenthood* using natural methods for child spacing in the general context of the promotion of the family.

5. CHRISTIANS' RESPONSIBILITIES

5.1. *Evangelical motivation*

Christians are citizens just like anyone else, and must be committed to the struggle against under-development. The example and the teaching of Christ and the exhortations of the Popes shed light on this commitment and serve as a guide and encouragement to them in their work which they undertake for the love of God and their fellow-men. If they work in the field of medicine and nursing, the evangelical reflections mentioned at the beginning will lead them to ongoing conversion of heart, to provide a better service on behalf of the suffering members of Christ and to awaken the communities of men to their responsibilities in this area.

5.2. *Relations with the government*

In the past, the laity or members of the religious congregations have often pioneered health care work in many countries. In some instances today, their work is being taken over by the government which sees health work as a part of its duty towards its citizens and for which it accepts responsibility. Far from feeling discouraged or useless as a result of this new state of affairs, they must see it as a golden opportunity to play an active part in the national endeavour to bring about integral and mutually responsible human development.

The *religious congregations* are called to reinforce their basic attitudes of cooperation with all organizations at whatever level, and in particular with the governments. This cooperation, respecting the specific role of all concerned (for example, the vocation and constitutions of the religious) should always be offered with the one concern of attending to the true needs of the sick and their communities.

The hospitals and health care centres for which the congregations are responsible and where they provide a Christian spirit of service, are there for the benefit of the whole population without any racial or religious discrimination. They must be ready to provide their services in those areas out of reach of the public health network, insofar as their personnel and financial resources permit.

Where they run *schools* for nursing or auxiliary staff, the training curriculum, animated by the Christian spirit, must conform to the requirements laid down by the government, so that the personnel trained there will have a state-recognized qualification and can, one day, join the public health service if they wish. Wherever religious personnel undertake tasks alongside professional people in the public sector, they must demonstrate their constant concern to be fully integrated into the medical teams running the areas in which they work.

5.3. *The current situation*

While this new primary health care policy is taking shape, members of the religious congregations must take a good hard look at the current conditions under which they are working in order—where necessary—to re-direct them. It sometimes happens that as a result of changes which not everyone is necessarily aware of, too many of them work in hospitals and health centres that have become too expensive for the majority of the population, and are only within reach of the pockets of a certain "elite" who can afford them. In this case the leaven is too far removed from the loaf.

5.4. *New orientation*

The religious congregations are by no means ill-equipped to take part in the necessary new orientation process. Although it may happen that in some cases some of their hospital workers are somewhat distant from the masses, so many others are working closely with local communities and are in close contact with the people in rural areas or poor urban areas.

Their experience can be profitably used by everyone, since they really know the true needs and deep-seated aspirations of the local people. Before they take part in this new health care policy, those in charge of religious congregations must see if they have *the necessary means* to do so, especially in terms of manpower, trained and suitable for the work, and with the right motivation.

Having *the right kind of training* for the personnel will be valuable to the country. Special care must be devoted to training foreign[1] personnel so that they have a good knowledge of the environment and the psychology of the people with whom they will work. Local and foreign[1] personnel must be spread over the various services in the local community and the hospital according to their skills and qualifications so that the population everywhere may have increasingly free access to health care services. They must never forget that they have the duty to aid everyone to develop wholly, bearing in mind that all development is a community matter, in a spirit of mutual respect and brotherhood.

Religious congregations, therefore, have a chance here to play a role of *promoters* and pioneers in the health field by educating some of their members for the important tasks in the primary health care field, such as public health specialists trained to implement this new health approach as well as skilled in planning and running staff training courses.

CONCLUSION

By setting up a hierachy of values and a policy regarding the means to be used on behalf of the sick people requiring care and the human communities needing to be helped to reach their full development, the Church has already provided a substantial contribution. It is ready to do even more in order to bring health to the sick and to awaken the conscience of the people. Working on behalf of the very poorest, the Church is enabling them to know their essential needs and to undertake the responsibility for their own development in a healthier existence.

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[1] (*The word "foreign" here refers to non-local personnel*)

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