International Health and Primary Health Care 600

International Health and Primary Health Care 600 is a core unit in the Master of International Health. The course coordinator is Dr Mohammed Ali.
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MODULE ONE

Introduction: The Context of International Health and Primary Health Care

Introduction to international health and primary health care and the disciplines involved in its study.

OBJECTIVES

At the end of the module you should be able to:

• Gain an understanding and appreciation of the concepts of international health and primary health care.

• Compare and contrast the approaches of community health with those of clinical medicine.

• How globalisation has impacted on health of peoples around the world.

• Indicate how social and attitudinal factors influence health and health care.

• Appreciate the rationale for engagement in international health work.

INTRODUCTION

In this course it is hoped that you will develop an understanding of some of the different concepts of health that exist. Furthermore, you will gain an understanding of how the context of both carers and people experiencing illness or injury influences these concepts. Those understandings will enable you to look with a broad view at health issues and to articulate and apply that knowledge in both individual and community settings.

In recent decades, the world and its health have changed. Waters (2001) has commented on these changes, which can be conflated into three related areas. The first is “globalisation”, which
incorporates a number of changes including the reduction of distance between people and communities, and the increasing commercialisation of their interactions. Second is the emergence of new and more complex patterns of morbidity and mortality. Third, societies are grappling with profound changes in the way people live their lives as a result of a historical shift in the patterns of production and consumption among families and communities throughout the world, along with their attendant environmental consequences. Walt’s paper provides an informative and systematic look at the health challenges confronting the globalised world.

**ESSENTIAL READING 1.1**


Some of the central tenets of primary health care as enunciated when the term was first coined more than a quarter century ago, are as important now as they ever were. Here we choose two fundamental components of primary health care, and highlight them for their topicality and modernity.

First, primary health care is about health, not disease; it places social and political equality as not only central causes of improved health indices, but also as contributors to “wellbeing”, to healthy and rewarding living. Paradoxically this lesson is as important at the beginning of the 21st century, and as much for the developed world, as the developing countries.

Second, while health services are not the whole answer, they are important to primary health care. Increasingly, they are becoming beyond the reach of the disenfranchised poor, as “privatisation” and “user pays” are favoured ‘buzz’ words. The course examines these issues in the light of communities, societies, and peoples.

We consider ‘international health’ to be a term that examines health from both a global perspective and at the local community or national level. It highlights how influences related to communication or capital can affect other groups, whose health in turn, can both suffer and harm the health of other groups. For example, we could see how the poor communities of North-east India and Myanmar can suffer directly through the development of groups of injecting drug users and their resulting HIV infection. In turn, we could also see how economic and political factors in Afghanistan have led to an increase in production of opium there, and ultimately to the availability of cheaper heroin in the streets of Europe, North America and Australia.
CONCEPTS OF HEALTH AND DEFINITIONS

When considering the concept of health it is useful to consider in what context that consideration is being undertaken. For example, if one assesses the needs of someone who has fallen and broken their leg, it may seem appropriate to assume that what they need is medical care.

This form of intervention might involve the taking of a history, an examination, ordering of special tests (an x-ray in this situation) and prescribing some treatment (reduction of the fracture, applying a splint or plaster cast and providing analgesics). It may be tempting to think that the health needs of that person have now been met.

However, if one is to consider the definition of health adopted by the World Health Organisation in 1948, and reiterated in its literature since, then it is possible to see that only the immediate and obvious health needs of this person can be met by the above-described process.

The World Health Organisation defines health as:

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity; it is a fundamental right...


This definition implies that the health of a person may be broader than solely physical needs. Further, the value of this definition may be that it ensures that the person’s experience of health or illness is not isolated from the particular health problem currently of concern. For example, there may be many issues of relevance other than the fact that the person has a broken leg. Some of these could include:

- How did they come to be injured?
- What impact does that injury have on them?
- Do they have adequate shelter, food, water, supports, income, etc. to enable them to recuperate successfully?
• Do they have responsibilities to others regarding income generation, food preparation, water collection, firewood collection, health care and support?

• Do they have access to health care?
• Is the health care offered appropriate?

• Can they afford the direct and indirect costs involved in such care?

• Do they believe that the care provided will be effective?

The definition of health used by the WHO incorporates an understanding that not just physical wellbeing but also mental and social wellbeing are important. This can be contrasted with the biomedical model which focuses on disease as dysfunction at a biochemical, cellular or organ level. Briefly, the biomedical model is ‘reductionist’¹ and views the human body as a machine which can be repaired once a part of it becomes dysfunctional.

Whilst caring for the sick is of importance once an illness develops, it must be remembered that there are much broader influences than care of disease and illness that determine the health status of individuals within a community or population. It is therefore important to develop an understanding of those influences and to know the difference between primary health care, primary medical care and primary, secondary and tertiary prevention.

Wood, Vaughan & deGlanville (1981) provide a simple framework for understanding the difference between community health and individual clinical medicine. They articulate the difference between health needs, wants and demands and offer definitions of three levels of prevention. They also include some discussion on the way primary health care may be implemented in some settings.

Primary care is about medical care at first contact, and usually refers to doctors. General practice in Australia is primary medical care.

Primary health care is a much broader term that encompasses not only primary care but also the broader activities of government and other sectors of the society.

¹ Reductionism means reducing a complex phenomenon to lesser parts, which can be controlled when so separated. Reductionism can be contrasted with holism.
PRIMARY HEALTH CARE AND THE DECLARATION OF ALMA ATA

In 1978, health ministers and delegates from around the world met in Alma Ata, the capital of what is now Kazakhstan, to formulate a historic consensus on the provision of universal health care based on the principles of social justice and equity. The concept of Primary Health Care (PHC) was crystallised at the conference. The Declaration of Alma Ata defines primary health care as:

… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing the health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

WHO & UNICEF, 1978: 15

The Declaration incorporates an understanding that health is determined by issues of equity, access, acceptability, affordability, appropriateness, participation, prevention, socio-political and economic development, peace, intersectoral action, and the availability of essential health care.

Though daunting in its scope, the Declaration provides a framework for effective primary health care in many settings.

As will be considered in module 2, this framework has engendered considerable international discussion about what is the most effective method of addressing health issues in the face of, what some would argue to be infinite need, with very limited resources. You may want to review the final report of the Alma
Ata conference with its historic Declaration which is available both online and on the Curtin library e-reserve, it has been a beacon of inspiration and guidance in health and social development for the last three decades.


Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

In the essential reading below, Lawn et al reviews the progress and evolution of Primary Health Care since the Alma Ata conference. The paper revisits the core principles and affirmations of the Declaration, and reviews its failures, successes and applications worldwide.

ESSENTIAL READING 1.3

LEARNING ACTIVITY 1

Briefly describe how someone you know perceives the concepts of health and illness. Can you generalise some of those perceptions to the wider community in which you live?

HEALTH INEQUITY

The issues raised by the landmark report of the Commission on Health Research in Development in 1990 are equally relevant today. It describes the initial optimism for change following the Declaration of Alma Ata. However, the increasingly obvious inequity in health status that was evident in the late 1980s led to a questioning of why the progress towards improved health status had failed to materialise or at least had seemed to stall. These gross inequities in global health are discussed in greater detail in the excellent report below by Marmot which reiterates the important distinction that the major determinants of health in people are social in nature or origin, and therefore the remedies must also be social in nature.

ESSENTIAL READING 1.4


CONCLUSION

While international health is a relatively new term, it has developed suddenly and dramatically as a consequence of the rapid developments in global communications, and the intensification of “commercialisation” of health. There have been winners and losers, just as there were when the western world started a similar process of reaching out to distant communities, and to use the links for gold and souls four centuries ago. Then, it was called colonialism. Now, there are consequences, of which some, such as marginalisation of those who cannot “join the business”, are to be expected.

What was not expected, was that the process is endangering the life processes of the planet, and it is these on which all of us
depend. The way national and international issues inter-relate, and how health and disease arise from these interactions, and what health services can do to limit disease and foster health are all further explored in this and the subsequent modules.

The paper below by Gostin makes a compelling argument for why rich countries should take greater interest and involvement in trying to better the health of poor nations. While reading the paper, think about your own reasons for wanting to study and work in international health. Have any of the reasons in the Gostin paper made you think about international health work in a different way?

ESSENTIAL READING 1.5


Web Resource

For information on international health matters, the WHO’s website is arguably the best! [http://www.who.int/](http://www.who.int/)

ESSENTIAL READINGS


Additional Bibliography


