

THE SECONDARY IMPORTANCE OF PRIMARY HEALTH CARE IN SOUTH CAMEROON

ABSTRACT. Primary health care in Cameroon meets with serious obstacles. The state gives it a low priority in its budget and over-all policy. The health institutions are rarely active in this field. Institutions which do practice some primary health care are usually foreign. The villagers, finally, are little interested. They insist only on improvement of curative services and material life conditions. The conclusion is that primary health care is regarded as something of secondary importance. First comes a better life. The research for this paper was conducted in 1980 in the South of Cameroon.

1. INTRODUCTION

In the Declaration of Alma-Ata the word 'primary' in 'primary health care' has a double meaning. It refers to the fact that this type of health care is the first that people come across in their search for health, because it is found right at their doorstep. The second meaning is that this form of health care is of primary importance because it covers the fundamental conditions for 'health' in the widest sense of the word: 'a state of complete physical, psychological and social well-being'.

In this contribution I suggest that the philosophy of the WHO conference in Alma-Ata may be too optimistic, perhaps even unrealistic, for the people for whom it is meant in the first place. In theory these ideas, which have been hatched by an intellectual advance guard, may be more or less correct. In actual practice, however, they meet with insuperable problems. Impressions gathered during research into the distribution of medicines in South Cameroon suggest that only secondary importance is attached to what is called 'primary health care'. The Ministry of Health, as well as health institutions and the villagers themselves show only lukewarm interest in this approach.

In this paper 'primary health care' and 'community based health care' are used as synonyms. They are defined as fundamental health care based upon active cooperation between a community and the existing health services. Usually the emphasis lies on prevention and on how people themselves can improve their health conditions.

2. THE RESEARCH

The research on which this paper is based was carried out during the year 1980, mainly in the Division (in French: Département) of Ntem. Ntem is located in

South Cameroon, on the borders with Equatorial Guinea and Gabon. The research dealt primarily with the distribution and use of Western medicines. The original focus was on the proliferation of the illegal trafficking of medicines by petty traders, a phenomenon which can be observed in many developing countries. At a later stage I decided to broaden the subject to all existing channels of medicine distribution. This was done mainly because I thought it necessary to study the informal sector in relation with the sector of official institutions of medicine distribution. It was in the context of this research that I studied conditions of health and health care in the villages and came across various attempts to organize primary health care. I want to emphasize that primary health care was not in the center of my attention but provided much of the context of the main subject of my research.

The research area was chosen mainly because valuable anthropological studies about the region were available, and could be used as a starting-point for the research. Among these were studies of a general anthropological character (e.g., Alexandre and Binet 1958; Laburthe-Tolra 1977), studies of traditional medicine (e.g., Cousteix 1961-63; Mallart Guimera 1977) and an excellent medical sociological case study of one particular village (Amat and Cortadellas 1972).

The actual research consisted of a kaleidoscopic array of methods and techniques. Because the purpose was to describe and understand the problems of medicine distribution in the widest possible context, the research dealt with kinship, politics, financial issues, religious beliefs, ethnomedical cognition, traditional medicine and other fields of life. Research was carried out in ministerial offices, hospitals, health centers, pharmacies, medicine shops, and in people's homes. Techniques included open interviews, use of key informants, structured interviews, collection of case histories, in particular illness episodes, and scrutinizing reports, files and financial accounts.

One of the most striking outcomes of the research was that the distribution of medicines was most defective where medicines were free of charge. Public health services, as a consequence, suffered greatly from chronic shortages in their medicine stock. A preliminary report (Van der Geest 1981) discusses the various problems in detail and offers suggestions as to how the situation could be improved.

3. HEALTH CONDITIONS IN NTEM

Ntem is located in the forest zone. Nearly 100% of the rural population is, at least partially, engaged in agriculture; the great majority of the men occupy themselves with the only significant cash crop, cocoa; women are almost exclusively engaged in the cultivation of food crops (see Table I). The most common food crops are cassava, cocoayam and plantain.

TABLE I

Sexual division of agricultural activities in the Division of Ntem (percentages in parentheses; derived from population census 1976).

	Men	Women	Total
Food crops	3,044 (13)	20,981 (87)	24,025 (100)
Cash crops	16,920 (98)	349 (2)	17,269 (100)
Total	19,964 (48)	21,330 (52)	41,294 (100)

Ntem, with an area of 16,000 km² (almost half the size of the Netherlands), has a population of about 140,000 (1976 census). The average population density is 9 per km². Most of the villages consist of two long-drawn-out rows of houses on both sides of the road ('la piste'). A narrow strip, about two or three km deep, on both sides of the road is used for farming. Behind the strip the forest begins. Apart from the cocoa plantations, agriculture is practiced following the slash and burn system.

The predominant ethnic group in Ntem is the Bulu. Other groups such as the Ntounou, Mvae, Fong, Bane, and Ewondo belong to the same language group, sometimes indicated as 'Bëti-speaking'. In the larger population centers such as the divisional capital Ebolowa (20,000 inhabitants), Ambam, Ngoulemakong and Mengong one also finds migrants from other parts of Cameroon. Most numerous among them are the Bamileke, who have practically monopolized trade in Ntem, the neighbouring Basa and the islamized Hausa and Bamoun.

Health statistics, which are based only on medical activities in modern ('Western') health institutions, suggest that malaria and intestinal worms are the most frequent diseases in Ntem (both constitute about 20% of cares reported in health centers). Other frequently reported diseases are skin diseases (10%), throat-inflammation/cold/influenza (9%), rheumatism (8%), bronchitis (4%) and gonorrhoea (4%). (See Table II which also shows the main diseases for the whole country.)

According to the same statistics measles is by far the most frequent cause of death among infants and children, but in actual fact these deaths are always caused by additional complications such as pneumonia, malaria and encephalitis. The child mortality rate is reported as 86, the infant mortality rate as 150.

Sanitary conditions in the villages leave much to be desired. The greatest health hazards are brought about by the poor quality of the water, the absence or non-use of latrines, the presence of domestic animals such as pigs and goats which can move about freely, the neglect of a proper disposal of refuse, and the bad conditions of houses (cf. Amat and Cortadellas 1972:342-56). An additional risk for children lies in nutrition. Eating habits, which reserve the best

TABLE II

The nine most frequently reported diseases in hospitals and health centers in Cameroon and the Division of Ntem (percentages only).

	Cameroon	Ntem
Malaria	16.1	20.3
Intestinal worms	10.4	20.0
Skin diseases	7.0	9.7
Angina – cold – influenza	6.6	8.9
Rheumatism	4.9	7.7
Gonococcal infections	3.9	3.6
Bronchitis	2.7	3.7
Dysentery (Amebiasis excluded)	2.6	2.8
Pneumonia	2.3	2.9

food for adults, particularly the men, often deprive children of the necessary protein.

Medical services in Ntem are provided by three hospitals (together 450 beds), 44 health centers, about 2000 traditional health practitioners and an unknown number of illegal and non-qualified practitioners of modern medicine. Medicines are distributed through these hospitals and health centers, through one pharmacy in the capital Ebolowa, and by an estimated 300 unofficial medicine vendors, varying from established shopkeepers to itinerant peddlers (see Van der Geest 1981:9–46). The large size of the clandestine market indicates that self-medication with modern medicines has become a common phenomenon in the region, as it has in many parts of the third world. In most villages of Ntem people do not rely on trained health workers and official health institutions for their 'primary health care'. First aid is given by members of the family or neighbours. This aid may be based on traditional therapy with herbs or on treatment with modern pharmaceutical products. Each family has some home remedies against the most common medical complaints and in each village one finds a few people who have learned how to give injections. Then, if these forms of self-medication bring no quick result, one may resort to a specialist in herbal medicines. Such specialists can be found in nearly every village. A nearby rural health center may also be visited, but since many of these centers are often without medicines, people sometimes prefer to travel straight to a distant hospital or private dispensary where medicines will be available. People may have to wait half a day, or longer, before they find transport to take them there.

Health education and preventive measures are rarely organized in the rural communities of Ntem, as will be shown in the course of this paper.

4. THE NATIONAL HEALTH POLICY

Several statements of the Ministry of Health emphasize the great importance of community health care. Personnel in rural health centers are told that they should devote much time to health education and the improvement of sanitary conditions in the villages. Official documents emphasize the importance which the government attaches to primary health care. In the *Sixth Report on the World Health Situation* the following information is given about Cameroon (WHO 1980:39):

Priority is given to preventive medicine, strengthening of maternal and child health activities, communicable disease control, and expanded programme of immunization; promotion of environmental health; and strengthening of community health education.

In actual fact, however, the Ministry itself seems to give this type of health care very low priority. In the 1979–1980 budget of the Ministry of Health only 7% of the operating expenses was given to rural and preventive medicine, whereas 30% went to the central administration and 59% to the central and regional hospitals. This unequal distribution clearly demonstrates that the real emphasis still lies with curative hospital-based medicine. A similar picture arises when we look at the budget for drugs and technical materials: 60% is reserved for urban hospitals, 10% for preventive medicine and 18% for rural health centers. According to the 1976 census however only 28.5% of the population of Cameroon lives in towns. Boutrais and others (1979) calculated that in 1975 23% of all medical personnel served 82% of the population and that one quarter of all medicines in the country went to Douala and Yaoundé, the two largest cities.

There may be a political reason for this unequal distribution. The national policy of the last decade has been geared toward centralization at all levels. This policy was without doubt related to the enormous diversity of the population together with the centrifugal forces operating within it. Of these factors the most prominent are ethnic diversity, competition between two exogenous religions, Islam and Christianity, and a heterogeneous colonial history which has resulted in there now being both an English and a French speaking population. This policy of centralization has created a less favorable climate for initiatives and activities outside the administrative centers. Most initiatives by foreign bodies (missionaries or organizations for development aid) directed to setting up primary health care programs in rural areas do not receive government support. Internal evaluation reports of these programs show that they were never integrated into the government's health policy. They remained islands, 'foreign affairs'.

As far as we have been able to investigate, child welfare programs undertaken

by state institutions (in French: "Protection Maternelle et Infantile" or PMI), which allow also for some preventive medical activities, are only organized within the bounds of urban hospitals. In Ntem there is no public institution which organizes child (and maternal) welfare in the villages.

Officially, rural health centers are intended not only to perform a curative role but also to mobilize the local population so as to improve the sanitary condition of their environment. Our observations in Ntem taught us that public health centers hardly ever fulfil this role. Public health centers in rural areas tend to be neglected. This neglect is expressed not only in the very limited size of the Ministry's budget for them (only 18% of the medicines, as we have seen above), but also in the fact that they receive only about 65% of the medicines which they are supposed to receive (see Van der Geest 1981:73). As a result rural centers have to contend with serious shortages of medicines and other materials during a great deal of the year. These shortages directly impede normal curative functions, and indirectly also preventive functions. When villagers do not receive efficient medical treatment (due to the lack of medicines), they are also not prepared to listen to health workers who want to educate them on health problems. Conversely, rural health workers in public institutions are often discouraged and demoralized by the chronic shortage of medicines and forced passivity, and thereby lose the interest and energy indispensable for setting up community based health care.

An exception must probably be made for the Ministry's policy regarding the so-called DASP zones (Zones de Démonstration d'Action de Santé Publique). Between 1967 and 1970 six areas were selected for experiments with new approaches to rural preventive health care. In four of these areas the experiments still continue. One of them is located in the forest zone of South Cameroon. A convenient survey of these projects is provided by Anonymous (1978).

5. THE HEALTH INSTITUTIONS

There are mainly four reasons why health institutions engage so little in primary health care. One reason is the lack of government support for carrying out this work. Other reasons are: primary health care is not commercially attractive; health workers, who have not had appropriate training in community medicine, are not interested in it; and, finally, most of them prefer the town to the village.

The lack of government support, as we have seen in the previous section, affects the *public* health institutions. Rural centers are even hampered in the performance of ordinary curative activities. Public health workers are not able to mobilize villagers for preventive measures, because the people are not prepared to listen to those who cannot provide adequate curative service.

The *private* health institutions in Ntem, nearly all of which are church-related,

are more oriented toward primary health care. In the whole division five mobile teams visit villages and organize various health activities. They give vaccinations, offer maternal and child care, educate people on health issues, organize the digging of garbage pits, the construction of latrines, and the improvement of the water supply, and try in other ways to improve hygiene in the villages. It is no coincidence that all five teams involved in these projects belong to private, church-related, health institutions. If missionary societies tend to be better motivated to provide medical care for remote villages, the most important reason why they in fact do provide these services is probably that they have the means. Preventive medicine in villages is expensive (for example it requires a vehicle and refrigerators for the vaccines) and has few, short term, returns. Missionary personnel usually retain contacts with foreign organizations which may provide the means for carrying out primary health care.

The implication is that primary health care is kept alive 'artificially', by foreign funds, foreign personnel and foreign inspiration. Primary health care, as we have said before, is largely a 'foreign affair'. This view is corroborated by the fact that primary health care often breaks down in the process of Cameroonization of missionary institutions.

Church-related health institutions receive hardly any subsidy from the state. They depend on fees paid by patients and receive foreign grants for extraordinary expenses such as buildings, expensive equipment, vehicles and also primary health care activities. After Cameroonization foreign funds gradually dry up as a result of the absence of a *foreign* contact person and because of misunderstandings which tend to arise about the spending of previous grants. The financial problems which follow force these non-profit institutions (which is what mission hospitals and dispensaries really are) to offer their services on a commercial basis in order to survive. Hospital fees and the prices of medicines are raised and unprofitable activities are abandoned. Primary health care is one such unprofitable activity. Villagers, as we shall see in the next section, are willing to pay for medicines and personal medical treatment. They are, however, reluctant to pay for preventive measures, because they perceive no clear and direct effect from them.

It is also possible that exactly the opposite takes place, that 'primary health care' is encouraged to escape from such financial dilemmas. Primary health care is fashionable, and is favorably received by the rich, fund-giving countries. Institutions which draw up a primary health care project can be fairly confident that they will find funds for it. It reminds one of the ease with which family planning programs in the third world are financed by rich countries. A shrewd person may be able to plug the holes in his hospital accounts with parts of primary health care funds. Vehicles (and the fuel they use!) which are meant for primary health care are often used for other purposes. The same applies for

certain equipment. Medicines, vaccines and materials which should be given out freely or very cheaply, may be sold for a high price in the hospital pharmacy. One hospital, for example, which had a subsidy for its primary health care project, tried to use part of this grant to order curative anti-tetanus serum together with a number of prophylactic serums. The order suggested that all the serums were to be used in its free vaccination program, which of course was not true for the curative serum. It was clear that the hospital had hoped to get the anti-tetanus serum free of charge to sell it later, at a substantial profit, to its own patients. The examples we have quoted show that attempts to overcome financial problems by pushing 'primary health care' fail to establish a really efficient service. In either case, therefore, financial difficulties seem to result in deterioration of primary health care.

The training of doctors and other health workers usually does little to interest them in problems of prevention and primary care. Doctors are not interested in health but in disease. Diseases, particularly when they are grave or rare, pose a challenge to them. Attempts to improve water and food, on the other hand, do not touch their medical imagination. Such issues are regarded as boring and 'unheroic'. Without doubt, the medical school in Cameroon contrasts favorably with training institutions in most other third world countries, but it would be an illusion to think that its graduates are not affected by the world-wide preference of the medical profession for curative medicine.

There is still another explanation for the fact that existing health centers undertake so few activities in the field of primary health care. The large majority of health workers (and, for that matter, of people in general) prefer to live in urban centers with facilities such as water, electricity and entertainment. Primary health care often presupposes living or lodging in what is disparagingly called 'la brousse'. Health workers, therefore, are little attracted by primary health care. Those who are supposed to make outside visits in the course of their work often fail to do so and stick to their urban base. Life in a city or town has also economic advantages. Most health workers, particularly those in public institutions, carry out private practices alongside their official tasks. These practices constitute a substantial extra income if they take place in towns where the buying power of clients is the greatest. Appointment to a rural place, therefore, has considerable financial consequence; and it is understandable that health workers mobilize their social relationships to acquire an appointment in a town. This tendency is found at all administrative levels: national, provincial, divisional and sub-divisional.

6. THE VILLAGERS

Opposition to primary health care is not only found among central administrators

and personnel in health institutions, but even among those who would benefit most by it: the people living in the villages. The two main factors which obstruct the setting-up of primary health care in the villages are the absence of strong village solidarity and reluctance to spend money on *preventive* health measures.

Primary health care or community based health care, as we have defined it in the introduction, presupposes the active cooperation of the population. The most common method of mobilizing the community is through a 'village committee' or 'village health committee'. The success of this committee depends a great deal on the presence of accepted leaders and the degree of solidarity among those represented in the committee. The problem is that both conditions are rarely fulfilled in the Bulu villages of Ntem and, more generally, in most villages of South Cameroon.

Traditional Bulu society is characterized by an egalitarian ideology. It can be best described as a segmentary society in which, to use Balandier's (1972:64) words, "the diffused political life is revealed more by situations than by political institutions". A Bulu village is composed of several lineages (*mvog*) each of which has an elder (*ntôl môt*), in French indicated as 'chef de famille'. The position of 'chef de village' did not exist formerly but was invented and imposed by the German and French colonizers (cf., Bertaut 1935:166). Bertaut (1935: 164-5) reports that the Bulu even presented people without any authority as their leaders to the white invaders because they did not trust their intentions. These people were often made 'village chief' even though lacking all prestige. A man with real prestige in his village is, significantly, called *nkukuma* ('rich man'). Such a person derives his prestige not from an inherited function but from personal achievement. At the same time this person is subject to all kinds of levelling actions which force him to redistribute his properties (cf., Alexandre and Binet 1958:60-1; Laburthe-Tolra 1977:817-48; Quinn 1980:299). The effect is a reduction of his wealth combined with an increase of his prestige and social power. Geschiere (1978), who observed a similar situation among the Maka, another society in South Cameroon, speaks of a tension between personal ambitions and egalitarian community norms.

Still today, in Bulu villages, there is seldom any real authority. Those chiefs who do exercise true power at the village level, derive their position from their personal qualities rather than from their office. Most villages are split up into patrilineages, the most effective social unit, in which elders play a leading role (cf., Quinn 1980). For the rest, Bulu villages are characterized by what some observers have termed 'anarchy' – individuals competing for power and prestige. This 'anarchy' has certainly increased in recent times now that rapid socio-economic mobility has become a real possibility for individual members.

This situation renders the setting-up of a lasting village committee extremely difficult. Usually there is no chief who can function as a binding force within

the committee. Instead there are individuals and lineages, often with conflicting interests. Since the lineage and not the village is the effective social unit, members think in terms of personal or at most of lineage interests. Common village interests are hardly perceived. These private interests undermine the communal role of the village committee.

Huijts (1979) studied community health projects in two Ewondo villages of South Cameroon. Ewondo and Bulu society have much in common. She remarks that people who cooperated with the project did so because they expected *personal* advantages from it, such as gifts, employment, free medicines and useful contacts with civil servants outside the village (p. 32). The sanitation of the *entire village* did not really interest them. In one village it was the lineage of the village chief which had benefitted most from the project (p. 30). She concludes (p. 36) that it is practically impossible to speak of an identification of the whole community with the objectives of the project, because villages do not constitute real social units. She wonders if an approach based on the lineage as 'community' would not be more successful.

A similar reaction comes from a community health nurse who works among the related Ntoumou, who live south of the Bulu. In an internal report she writes:

In fact, villages exist only administratively, not socially/culturally. Therefore village committees too can only exist administratively. Because of this we judged the village committee approach inappropriate for those aspects of the project that do not necessarily require community efforts, aspects that can be achieved individually, such as improvement in hygiene of the compounds, food production, nutrition. So we chose for family approach, each family being a community by itself . . . In the local language the word 'village' is used for the compound where a family lives. There is no special word for a group of compounds that we consider a village.

The second obstacle to effective primary health care is that people are unwilling to spend time, money and energy on health measures which do not have a short term effect. Participation in preventive health activities is often 'bought' by giving them other things which do have such a short term effect. For example, community nurses distribute medicines or perform other curative services which attract people. The prevention is then taken into the bargain. This explains why nurses in public health centers, who do *not* have medicines, are not able to mobilize villagers for preventive health activities. We have observed that nurses involved in primary health care always give their instructions about preventive health just before the distribution of medicines; this ensures the greatest possible audience. Huijts (1979:29) saw how in one village people who had worked for the (i.e., their) project received free medicines.

The emphasis on curative medicine, to the detriment of prevention, is not only a preoccupation of the medical profession, but also of the villagers. The

latter have an almost unlimited confidence in modern medicines and are prepared to spend large sums to procure them, but they are not willing to pay for preventive health measures.

This problem has been foreseen in the report prepared for the WHO conference on primary health care in Alma-Ata:

Individual payment on a fee-for-service basis is certainly not a solution that can be widely applied . . . Private methods of payment may be totally inapplicable to some vital components of primary health care that are not concerned with direct service to individuals, such as the provision of potable water, the protection of houses against insects and rodents, or health education in all its aspects (WHO 1978:42).

As we have seen in the preceding section, health institutions which depend on patient fees often have no other choice than complying with the wishes of their clients by providing only curative services.

Another short term effect which people expect from health projects is material and social progress. Amelioration of living conditions, writes Huijts (1979:33), is understood by them in a socioeconomic rather than in a medical sense. This viewpoint, which is considered by primary health planners as a wrong attitude and lack of understanding, is probably more enlightened than one might think at first sight. We shall return to it below.

7. AN EXAMPLE OF A PRIMARY HEALTH CARE PROJECT

To illustrate my argument I shall now present a brief history of one primary health care project in South Cameroon, organized by a church-related private hospital. Most of the data derive from an internal report and from interviews.

In 1972 the expatriate directors of the hospital started a PMI program ('Protection Maternelle et Infantile') in view of the fact that the highest mortality rates were among children between 0 and 5 years of age and among women in their pre- and post-natal period. A midwife from the United States was appointed to head the program. The midwife formed a team and they occupied themselves with consultations with mothers and children, vaccinations and health education. The program was financed with gifts from the U.S.A. and support from the hospital which at that time was doing very well financially. The Cameroon government provided many of the vaccines free of charge. By 1974 the PMI team visited 15 villages regularly, each with about 300 inhabitants.

To meet growing demands from numerous other villages it was decided to set up a second team and also to train a Cameroon nurse for this type of work. A subsidy was asked for and obtained from the U.S.A. to pay for two vehicles, vaccines, refrigerators and the training of the above mentioned nurse. The total amount was about 7 million francs CFA (at present \$35,000).

The first midwife was replaced by another one in 1975 and the range of activities of the two teams expanded. In the year 1976–1977, 23 villages were visited at regular intervals. The two teams travelled 17,000 km. In that year 112 latrines were built, 49 carbage pits dug and 120 drying frames constructed for kitchen utensils. The following year these figures grew considerably: 244 latrines, 145 garbage pits and 491 drying frames were built. The teams also visited villages in the evenings because that was the best time to meet the villagers. In each village a village health committee was inaugurated. The project continued to receive gifts from the U.S.A., consisting mainly of church donations. The hospital paid the salaries of the personnel.

In 1978 the management of the hospital was transferred from foreign to Cameroon hands. In the same year the American midwife in charge of the project gradually withdrew. A new vehicle for the project, paid by a foreign organization, was acquired. In 1979 the American nurse left. The number of teams was reduced to one, and the new director of the hospital was not much in favour of its activities. He forbade the team to visit the villages during the evening and tried to annex the project's vehicle for private and hospital purposes.

Conflicts among the medical staff in the hospital led to a decrease in the number of patients which resulted in a worsening of the hospital's financial position. A financial scandal involving the director, who had appropriated a foreign grant for private use, caused irritation among the overseas churches, leading to a reduction in foreign donations, thereby exacerbating the financial problems. The director left to start a private clinic in Douala. The number of patients decreased further. The hospital accumulated large debts with the pharmaceutical wholesaler and the supply of medicines was blocked for some time.

In this situation the hospital was no longer able to render primary health care services, for these only cost money. A member of the hospital board was quoted as saying precisely this, that the hospital is not interested in services which yield no profits. Moreover, after the departure of the American midwife foreign grants diminished. The new hospital director stipulated that the primary health care team could only continue their work if it paid for itself.

From that moment onward non-profitable activities such as the improvement of environmental health conditions were abandoned and emphasis was placed on services for which the people were willing to *pay*, such as ordinary consultations and the provision of medicines. The sale of membership cards was also stressed. The primary health care project had become a predominantly curative business. Prevention and community participation had drastically declined. The responsible nurse characterizes his present work as driving a 'mobile medicine shop'.

The irony is that the majority of the villagers are quite content with this, for them unfavorable, development.

8. SECOND THOUGHTS ABOUT PRIMARY HEALTH CARE

Primary health care in the rural south of Cameroon does not make people more autonomous with respect to their health. Projects are not successful because of lack of support from the central administration, from the health institutions and from the people themselves. In those cases where some tangible results are achieved these results are more likely to come from above and from outside than from the people themselves.

The three sets of factors we have mentioned up to now may prevent a solution to the problem of ill health, but the basic cause of ill health is poverty. The inability to remove inequality in the use of resources poses the real reason for the failure of community based medicine. It seems, we have been too naïve with respect to the feasibility of primary health care. The 1978 WHO Conference on Primary Health Care emphasizes the links between health and socioeconomic factors. Its basic philosophy is summarized in the following quotation:

Health cannot be obtained by the health sector alone. In developing countries in particular, economic development, anti-poverty measures, food production, water, sanitation, housing, environmental protection and education, all contribute to health and have the same goal of human development. Primary health care, as an integral part of the health system and of overall social and economic development, will of necessity rest on proper coordination at all levels between the health and all other sectors concerned (WHO 1978:10).

Two other quotations, which follow below, further explain what is meant by 'primary health care as an integral part of overall social and economic development'.

The healthier people are, the more likely they are to be able to contribute to social and economic development, and such development, in turn provides the additional resources and social energy that can facilitate health development (WHO 1978:9).

The WHO report clearly rejects the view that economic development is a condition which should be fulfilled, *before* primary health care can be attempted.

Reservations may be voiced by certain schools of economic planning based on the common belief that economic growth alone will bring in its wake the solution of health problems. In answer to this it should be explained that, whereas real social and economic development can undoubtedly bring about improvements in health, there is also a need to apply direct health measures to improve health situations and that, as mentioned above, efforts from all the sectors concerned are mutually supportive (WHO 1978:12).

Although the WHO report cannot be accused of overlooking the problems faced by primary health care, it seems at the same time too light-hearted and optimistic with regard to the possibility of overcoming these problems. If the WHO expects a general worsening of the food situation in poor countries (see for example WHO 1975:15; cited also by Doyal 1979:99), how can it at the

same time hope for "an acceptable level of health throughout the world in the foreseeable future" (WHO 1978:7)? This is the main contradiction in the report. It would have been more in line with the arguments brought forward if the authors had concluded that primary health care in poor countries will almost certainly fail to succeed. The final optimism after the summing up of such fundamental obstacles looks like a *deus ex machina*.

Much more pessimistic is England (1978) who sharply criticizes some misconceptions of the present time, which he calls 'myths'. One myth refers to 'simple prevention and easy treatment' of diseases in third world countries:

The vast majority of illness in poor countries is so deeply rooted in poverty and culture as to be virtually unpreventable without revolutionary changes in the life-styles of millions. Solution to the kind of disease pattern faced is hardly within the province of the medical profession at all unless we are prepared to significantly widen the range of our knowledge, skills and commitments . . . In the poverty cycle linking ill health with environmental conditions and access to education and employment opportunities, what kind of interventions are effective and what are the appropriate organizational and institutional forms by which even present technologies can be made accessible? (England 1978:155).

Primary health care has been regarded by many as a 'short cut' to health. It need not follow the long, and probably never ending, road of socioeconomic development, but can intervene directly in the processes of ill health by having people improve their own sanitary conditions. Is such a short cut possible?

Werner (1980) distinguishes two (ideal) types of primary health care: community-supportive and community-oppressive. Community-supportive are those programmes "which favorably influence the long-range welfare of the community, that help it stand on its own feet." Community-oppressive are those programmes "which while invariably giving lip service to the above aspects of community input, are fundamentally authoritarian, paternalistic or are structured in such a way that they actually encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions; those which in the long run are crippling to the dynamics of the community." (p. 5).

The Cameroon situation as described in this paper cannot be clearly earmarked as either community-supportive or -oppressive. As far as projects are sincere attempts to build up health within the community through the members themselves, they are supportive. But the fact that the projects rely to such a large extent on foreign capital and personnel makes them oppressive. It is not unlikely that certain projects which clearly have a community-supportive aim have after all an oppressive effect.

The easiest way to distinguish an oppressive program from a supportive one is probably to ask about its political character. A primary health care project that is said to be purely techno-medical and politically neutral is likely to be

oppressive. Being 'a-political' implies usually accepting and reproducing the existing political situation, which in most third world countries implies exploitation of the rural population.

Primary health care as a technical short cut reminds one of another 'short cut to better living' in poor countries: family planning. The debates which evolved around this subject are enlightening with regard to primary health care. One group of writers, branded as 'neo-Malthusianists' by their opponents, argued that limiting fertility was a necessary condition for economic growth. Another, 'Marxist' group held the opposite view: fertility is a dependent variable; a decline in fertility follows economic growth. The political implication of the debate was that the 'neo-Malthusianists' were accused of trying to solve the 'population problem' at the least possible cost to themselves. Moreover, it was said that their perception of the 'population problem' did not include the problems faced by poor countries but was based on the view that 'overpopulation' in those countries would cause political unrest and constitute a threat to their own privileged economic position. The 'Marxist' view held that only structural changes putting an end to economic exploitation can prevent this 'political unrest'. According to them the 'population problem' does not exist but is a cloak to cover the much more painful problem of poverty, which is caused by the unequal distribution of resources, in other words, by the exploitation of the poor by the rich.

Although the 'neo-Malthusianists' may not have been so simple-minded and/or depraved as their opponents sometimes suggested, and although some of their ideas contained valuable insights, the 'Marxist' view is now generally regarded as more correct, certainly when it is tested in actual processes. The account by Ratcliffe (1978) of developments with family planning in the Indian state of Kerala is a case in point.

This debate about the feasibility and objectives of family planning seems to fit the problem of primary health care in a remarkable way. If we accept that poverty is the main cause of ill health in third world society, then primary health care to improve living conditions is 'putting the cart before the horse'. The same expression was used by Wertheim (1974:276) to denote the attempt to promote economic development through birth control.

There is yet another resemblance between family planning and primary health care. Like family planning, primary health care can be regarded as the easiest and least costly solution for rich countries wishing to solve the health problems of the third world. More exactly, it is not a real solution; it is a pseudo-solution which may satisfy poor countries for a certain length of time, but not definitively. If we analyze primary health care very carefully, it will probably prove to be a policy "to prevent a development which, in the long run, would appear to make a revolutionary course inescapable" (Wertheim 1974:269). The provision

of primary health care does not seem to be effective in the first place against ill health but against political instability. Primary health care has much in common with other 'sops' which have been mentioned by Wertheim (1974: 267-82): community development, agrarian reforms, birth control, foreign aid and improved varieties of food crops.

Our conclusion has to be pessimistic. A technical solution for the problems of ill health in poor countries does not seem to exist. If we accept that ill health is rooted in poverty, we must admit that it can never be removed without changing socioeconomic conditions. But how can poverty be removed from this earth? The Alma-Ata Declaration does not provide the answer. The only agreement among authors seems to be that it will take a very long time. Primary health care without changing the economic structure may be unrealistic, but it seems even more unrealistic to postpone primary health care until an equitable distribution of resources has been realised. Especially those who are actively involved in health care will reject the latter solution as impracticable and inhuman.

It seems that one has to choose between two near impossibilities. It should be taken into account, however, that such a pessimistic judgement is typically an outsider's view, a reaction by a social scientist who is not directly involved in finding concrete solutions for existing problems. Medical and political decision-makers cannot afford such a 'defeatist' standpoint but have to come up with practical recommendations. In their eyes, they can choose between two possibilities. Their most likely choice then is primary health care, because its feasibility and wholesomeness is testified in numerous documents all over the world.

Although we do not believe in primary health care as a technical short cut to better health for all we do not rule out that it may have some effect among those who are in a relatively sound economic position and can afford improvements in their diet, housing and other living conditions. The overwhelming impression is that people do not choose for a healthier life but for a 'better life'. As Western societies have experienced, a fortunate coincidence is that an increase of comfort has the side-effect of an increase of hygiene and health, at least to a certain standard. Cameroon villagers who try to pick material benefits from a primary health care project are after all doing the right thing: they attempt to improve their standard of living. Primary health care itself has only secondary importance for them.

9. CONCLUSION

Primary health care has had a lukewarm reception in Cameroon. Its implementation has been kept back by the lack of support from the central administration, from the personnel in health institutions and from the people themselves. But

the greatest obstacle lies in the contradictory character of primary health care itself. Its aim is to enable people to become more independent in health matters, but in practice it rather tends to create greater dependency. Where primary health care has produced tangible results it has often done so through 'foreign intervention'. Moreover many of these results have nothing to do with preventing ill health but exist merely in an extension of curative services. We are not suggesting that such an extension does not benefit the rural population but we do emphasize that a one-sided strengthening of the curative services is not the purpose of primary health care.

The question as to why primary health care seems to have so little success can be answered by referring to failures met in family planning programs and community development projects. It is surprising that the promoters of primary health care have not learned from those lessons. By now we have firm evidence that community development or comparable programs yield results only if some advancement has been made in the people's socioeconomic condition. Where poverty continues to exist primary health care has little chance to succeed.

It will be clear that primary health care is not a community-supported movement which will lead to health for all in a relatively short period. It is more likely to remain an advantageous affair for some families, usually those which are better off. For the rest it will play the role of ordinary medical care all over the world: consolidating the structure of the existing society.

If rural people in Cameroon regard primary health care as something of secondary importance and give priority to raising their standard of living, they do a sensible thing. Better health follows in the wake of better living.

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The author wants to make clear that the critical tone of this paper is meant as a constructive contribution to the solution of health problems in Cameroon.

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