

PRIMARY HEALTH CARE IN A MULTI-LEVEL PERSPECTIVE: TOWARDS A RESEARCH AGENDA

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Abstract—The authors propose to view primary health care (PHC) from a multi-level perspective. Studying how PHC is conceived and implemented at different levels of social organization (e.g. in international agencies, national governments, regional centres of health care and local communities) will reveal which interests may be competing in the planning and execution of what broadly and conveniently is called 'PHC'. Mapping out these conflicting views and interests will contribute towards a better understanding of how PHC works or why it does not work and provide suggestions for a more effective and equitable PHC. Five themes are proposed for a multi-level research approach: (1) vertical versus horizontal organization of PHC; (2) the role of medical personnel in PHC; (3) the distribution of pharmaceuticals; (4) the integration of traditional medicine in PHC; and (5) family planning.

Key words—primary health care, multi-level perspective, research

INTRODUCTION

The idea of primary health care (PHC) as a strategy to attain 'health for all by the year 2000' was received enthusiastically at Alma Ata at the time. However the critics started raising their voices almost from the very beginning [1]. One of the main complaints, and the most threatening to PHC's existence, was that the PHC concept was unrealistic. The comprehensive and community-based health care approach was believed to be too idealistic and not feasible. Tangible decreases in morbidity and mortality rates were seldom reported. A PHC success story, comparable to the eradication of smallpox for example, has not yet been written.

Most of the criticisms were heard in the debates on selective versus comprehensive, and vertical versus horizontal PHC [2]. Today, more than 10 years after Alma Ata, PHC is in real danger. Some of the WHO's paymasters and donors of public health programmes are chafing at PHC's slow pace and its revolutionary rhetoric. They seem to favour a vertical, 'no-nonsense' approach going after quick results. At the same time, important shifts have taken place at the WHO and the consequences these will have for the organization's policy are still being awaited.

In this paper we investigate the possible sources of problems surrounding PHC by looking at PHC from a 'multi-level perspective' (see next section). The immediate reason for undertaking this exploration was the contrast between the unanimous approval of PHC at the Alma Ata conference and the following confusion about its meaning. Countless reports and publications on PHC programmes in many countries have made it clear that PHC can mean all sorts of things to different people in different positions in the political hierarchy. Consequently, Alma Ata has generated a great variety of programmes and activities on all of which the 'PHC' label has been pinned,

but which in fact may even prove to be in conflict with one another.

The confusion about the concept's meaning and the contradictions in the PHC policy are, however, not formless. They seem to have a logic of their own. It is our intention to give a rough sketch of the different forms and meanings of PHC by departing from a multi-level perspective; that is, we will examine how PHC is perceived and implemented at different levels of social integration. Our contention is that 'PHC' could not succeed because it never really existed as a concrete strategy agreed to by its supposed supporters. PHC as a global movement systematically avoided the different views and interests of the participants—in fact, needed to ignore them so that a global movement could take place. The multi-level perspective enables us to illuminate and analyse the underlying processes that led to the present state of 'PHC'. This paper provides suggestions for interdisciplinary and comparative research into problems in PHC policy.

MULTI-LEVEL PERSPECTIVE

Social research has often been confined to a single level of social organization. For anthropologists this level was usually that of the village community. Influences from beyond this level were generally excluded from the researcher's area of attention. With growing state intervention in rural societies and the increase of global economic interdependence, this one-sided interest became more and more problematic and prevented a deeper insight into the social developments in local communities. Conversely, researchers studying processes of state formation and other macrosocial themes often did not consider sufficiently the influence of developments at lower levels. In order to simplify the research,

social reality was often made, as it were, one-dimensional.

The multi-level perspective, which is a reaction against this one-sidedness, insists that the object of research should not be isolated but rather seen as linked to 'higher' and 'lower' levels of social organization. It could, therefore, also be called 'linkages perspective'. The assumption is that developments at the various levels are linked to one another and that the nature of these linkages has to be studied in order to understand properly what takes place at a specific level. The word 'level', a metaphor, refers in particular to the international, national, regional and local tiers of social organization [3]. The term 'linkage', it should be noted, does not refer to political power alone. Of equal importance are aspects of 'descending cultural values': opinions and customs held by elites, and which are gradually becoming part of the social code of larger groups in society. For that matter, it is not only a question of 'linkages' extending from 'the top' to 'the bottom'. Influence spreading from one level to another can also start from the bottom.

What we call 'linkage' will almost always be some form of communication transmitted by man or by material means and moving from one level to another. Information, in its widest sense, is distributed over the various levels of society by people and objects, particularly by commodities. Underlying the multi-level perspective is the assumption that *what* is carried around does not remain the same thing during its journey. The meanings of concepts and objects, of words and institutions change as they move from one level to another. So the main concern of those applying a multi-level perspective is to reveal the different meanings of phenomena carrying the same name at different levels of social organization.

In the multi-level perspective we are particularly concerned with vertical linkages. But there is also an interest in horizontal linkages. This interest presents itself in a multi-sectoral approach breaking with the tradition of dividing reality into fields of scientific disciplines such as economy, politics, religion, language and health. Finally, interest in the historical context is growing, phenomena are being considered in their development through time. One could therefore speak of vertical, horizontal and time linkages. Here we shall mainly focus our attention on vertical linkages [4].

The subject of this paper, PHC, lends itself particularly well to a multi-level perspective. PHC is, after all, a subject which occupies people at all levels. Furthermore, it seems to be a 'vehicle', as we shall see later, with which governments try to exert influence on lower levels. One could say that PHC material and personnel themselves constitute linkages between the various levels in the health care system.

PHC AT DIFFERENT LEVELS

A general assessment of PHC at different levels of social integration is not really possible. The differences between countries are too great. Therefore the following exposition can only be exploratory and fragmentary. The examples quoted come mainly from

a few countries in which the authors have conducted research: Nepal, Cameroon and Somalia. Examples from The Netherlands are sometimes used to compare experiences in developing countries with those in a highly industrialized society.

International organizations

PHC is not a new concept. However in 1978 it began to receive more attention as a response to the immense health problems, in Third World countries in particular. For the WHO, PHC was in the first place a correction of the old model of hospital-based and urban-centred curative health care. The PHC plan was an attempt to adjust the achievements of medicine to the economic reality of the countries concerned. It was hoped that this objective would be attained by emphasizing the importance of disease prevention and by drawing the attention of local communities to their own possibilities of preventing illness. Furthermore, it was pointed out in the document that certain outside curative services could be provided much more cheaply than had been the case so far. Much of this care could also be provided by low-skilled health workers instead of highly qualified doctors. PHC should be an integration of two approaches: first, community-based health care, that is by and for the community, provided to the greatest possible extent with the community's own means and, therefore, including traditional health care; second, basic health services, that is the lowest level of health care organized, financed and controlled by the government or by private institutions. In broad outline the PHC document was a plea for prevention and for the greatest possible self-reliance in the field of health care. The principal components of PHC were summed up as follows:

... promotion of proper nutrition and an adequate supply of safe water: basic sanitation, maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries [5, p. 2].

Apart from the WHO and UNICEF, many other organizations are involved in implementing PHC policy, bilaterally or multilaterally, by financing or carrying out projects. They include public as well as private organizations. The latter sometimes have a religious affiliation.

The emphasis on community participation is significant. Stone [6] has suggested that the way this concept is (was?) promoted by international donor organizations reflects Western notions of self-reliance and equality. Community participation is understood as the people's "adoption of an attitude of self-reliance and faith in their own powers to better their lives through 'self-help' and 'taking initiatives'" [6, p. 212]. Indeed, Western cultural values of individualism seem to dominate these organizations which may be 'international' but are not yet 'inter-cultural'. Stone shows that rural people in Nepal have quite different ideas about 'community participation'. For them it means: obeying orders from above to contribute land, money or labour to a specific develop-

ment project. In their situation, a Western-type of self-reliance would amount to social and economic suicide. In the Nepalese village community *inter-dependence* seems the best strategy for survival. Stone remarks: "Rather than seeking self-reliance and a sense of 'mastery over their own destiny', perhaps villagers would welcome a greater sense of meaningful interdependence and exchange with outside development agencies and institutions" [6, p. 211]. In addition, as we shall see in the next section, national authorities may apply yet another definition of 'community participation'. Many governments will probably favour political and socio-economic dependence for their population rather than the Western ideal of self-reliance. It seems likely, therefore, that one of the basic concepts of the Alma Ata strategy is a Western cultural value that may not be shared at all by those involved in the PHC enterprise at lower levels of social organization.

In a survey of the failures of community participation in PHC throughout the Latin American continent, Ugalde [7] criticizes the political objectives behind the international—mainly U.S.A.—support for these programmes. He summarizes his argument as follows: "... through symbolic participation, international agencies had two purposes in mind: (1) the legitimization of low quality care for the poor, also known as primary health; and (2) the generation of much needed support from the masses for the liberal democracies and authoritarian regimes of the region" [7, p. 41]. In his view, PHC is not only a political tool in the hands of national governments (as we shall argue in the next section) but also in those of organizations at the international level, where certain countries may be able to sway the policy.

To make things still more complex, the PHC policy of the international organizations has not remained unchanged in the past years. The emphasis, which was at first placed on the population's participation and self-reliance, has been shifted here and there towards a more marketing-like strategy; the original comprehensive approach is now faced with competition from more selective approaches. Examples of this development are the GOBI approach (Growth monitoring, Oral rehydration, Breastfeeding and Immunization), 'FFF' (Family spacing, Food supplements and Female education) and a growing emphasis on water and sanitation. Another development that should be mentioned is the cautious but increasing value accorded to traditional healers. It can perhaps be stated that the following characteristics still broadly determine the policy of the WHO, of UNICEF and of other supranational organizations and donors:

- a. PHC is based on considerations of medical rationality and efficiency. It is hoped that via PHC, Third World health statistics will improve. The principal objective is to reduce morbidity and mortality rates.
- b. At the same time the very limited resources of the governments of Third World countries are taken into account. Therefore, the second characteristic is that PHC is based on economic

considerations. After all, medical rationality is dependent on material possibilities.

- c. Furthermore, it is of importance that the WHO and UNICEF are bound to abstain from making political statements openly criticizing a particular government. Yet the concept of PHC is political because emphasizing general improvement of health conditions has immediate political implications. However, these implications are not mentioned. The PHC document is openly apolitical, as most other WHO and UNICEF publications are. As a matter of fact, most aid organizations avoid political pronouncements, usually for tactical reasons, exceptions being a few private organizations.
- d. It seems contradictory that, on the one hand, PHC is offered and promoted from the top and, on the other, community participation at the bottom is urged.
- e. The plea for community participation carries another contradiction, for is it not the case that the most urgent problems of local communities and the solutions to the same problems have been defined at the top? As we have seen, the PHC document recommends self-reliance and more attention to prevention as a solution. However, it is odd that the plea for self-reliance does not come from those who should become self-reliant but from the international health planners.

The state

The most important transformation PHC is undergoing at national government level is that it is becoming a political topic. Many Third World countries are young nations in which it is difficult to propagate the ideal of unification among the whole population. This applies mostly to African nations, but even in these countries where the concept of a unified nation is already understood by the population, local governments are still confronted with large cultural, ethnic and linguistic variations, which are difficult to unify [8]. Another obstacle in the process of state formation is the poor economic situation of many countries. Consequently, a large part of the population often lives in poverty. If, as Rousseau states, the *raison d'être* of the state is "the salvation and the prosperity of its members", then many young states risk contradicting themselves. After all, they are not always in a position to guarantee an acceptable subsistence level for their populations. For national governments encountering so many problems in their efforts to introduce the concept of one nation and to establish the authority of the state in the local communities, health care seems an attractive vehicle to spread state influence. Western biomedical care, which has proved its popular appeal in most non-Western societies, undermines self-reliance. Almost everywhere Western medicine seems to succeed in displacing local medical traditions based on self-help and to make people dependent on highly specialized knowledge [9]. At the same time Western medicine tends to be so expensive that it cannot be applied by local groups trying to restore their autonomy. By supplying the villages with medical care, the state appears in its most favourable light as a

bringer of provisions which the community cannot itself provide. Advanced technology and high costs are the reasons that this type of health care can only be organized by very wealthy professional institutions such as the state itself.

However, in practice it is quite a different matter. Many national governments do not succeed or are not interested in taking advantage of the political opportunities of health care. The costs appear to be too high and the physicians, whose training they have financed, often disappear abroad or remain in the big cities where the financial situation is more attractive. In addition, in many countries the position of the Ministry of Health in the governmental bureaucracy seems to be rather weak. And frequently, governments are not even interested in using PHC as a political tool. Salim [10, p. 308] points out that PHC is not attractive to politicians, "... because it takes a long time to show results and because the benefits are not easily calculated. Consequently, primary health care is among the first activities to be cut when government revenues decline." Generally politicians who want to build up a clientele by promising rewards to their supporters, prefer to give impressive evidence of something that can be realized within their period of office, which is usually about 5 years. PHC does not suit that purpose. The fact that most PHC activities are especially directed towards rural communities can be another reason for their low priority; the rural population does not usually pose a threat to the government nor does it need political favours to keep quiet. The likely result is that public health care, particularly in the rural areas, finds itself in dire straits and is disliked by the local population. Especially when well-functioning private medical services are available in addition to the inadequate public provisions, public health care will provide negative political publicity for the government. It then proves that the government is not capable of performing its most essential task. Especially in Africa and Latin America, where many private institutions (churches and NGOs) are active in the area of medical care (and education), this development is frequently seen. However, in many Asian countries as well, public health service is often regarded as a second-rate choice by the population. Even in a more prosperous country such as The Netherlands the state does not always guarantee every medical provision. In recent years, the Dutch government has, for example, tried to economize on all kinds of medical costs by withdrawing from some sectors of health care, leaving them in the hands of volunteers and/or commercial organizations.

As we have just mentioned, the failure to distribute health care provisions effectively to all sections of the population was one factor that led to the PHC concept, according to which the ambition to make expensive specialist curative provisions available everywhere should be abandoned. Only the most indispensable (and affordable) services should be provided by the state and apart from those the population should learn to look after itself as best as it can, for instance by means of disease prevention. This 'solution' places national governments in a peculiar quandary. On the one hand, PHC appeals to them because it shows them a way out of the impasse

which health care has reached. On the other hand, achieving one of the PHC's main objectives (greater self-dependence by the people) could constitute a threat to the concept of a unified state [11].

The present estimate is that many governments in developing countries have adopted the PHC concept without giving much substance to the aims of autonomy. By officially including PHC in government policy, by training people, by setting up programmes and providing resources, the state has incorporated PHC into the existing health care system. PHC is not so much an 'antidote' to a maladjusted and overly expensive health care system but rather an extension of it. In most cases it is still organized from the top and carried out by professional workers from the state, with the help of outside finances. In this way PHC becomes a means of subordination which can be used to reach social and political consensus. Werner's [12, p. 47] distinction between 'community-supportive' and 'community-oppressive' PHC still provides an apt description of the state's dilemma:

Community-supportive programmes or functions are those that favourably influence the long-range welfare of the community, that help it stand on its own feet, that genuinely encourage responsibility, initiative, decision-making and self-reliance at the community level, that build upon dignity.

Community-oppressive programmes or functions are those which, while invariably giving lip-service to the above aspects of community input, are fundamentally authoritarian, paternalistic or are structured and carried out in such a way that they effectively encourage greater dependency, servility and unquestioning acceptance of outside regulations and decisions and in the long run cripple the dynamics of the community.

The latter strategy is financially advantageous to the state in two respects. At the level of the local population the state hopes to be able to economize on personnel and material resources and to present this cut-back as a qualitative improvement of health care; after all this is PHC. At the top, at the level of the international organizations, it hopes to acquire more financial aid by using PHC as a banner. In that light it is obvious that the concept of PHC can be overstretched. Summing up, it can perhaps be said that at the level of the national government, PHC has three particular characteristics:

- a. Medical: the objective is to expand the 'coverage' of medical provisions and to push back the mortality and morbidity rates.
- b. Political: the medical improvements brought about by state-initiated PHC must increase the political credibility of the government.
- c. Financial: via PHC the government hopes to reduce its expenditure (for basic health care) and to increase its revenue (with international aid).

Professional health workers

Those who want to gain an impression of what PHC means for health care personnel, should ask themselves what opportunities there are for health workers to become dedicated to PHC and what their interests are in implementing a PHC policy.

There seem to be at least five reasons why doctors, nurses and other health care staff have little interest in PHC.

First, the government offers them insufficient opportunities to perform the preventive and informative tasks expected of them. If the curative services function badly, those who provide them are likely to lose their credibility as health counsellors. They are not able to mobilize the local community for preventive measures, because the people are not prepared to listen to health workers who cannot even offer adequate curative care.

Second, PHC has little financial appeal to health workers. Doctors and nurses in government service often earn an extra income by providing curative care privately (formally or informally). In a well-to-do environment this additional income can rise to a multiple of the official salary. An appointment to a PHC project, however, is likely to deprive doctors and nurses of this opportunity, mainly because they will probably be posted to a poor rural area. An additional disadvantage is that they are supposed to concentrate on preventive services for which the population is unwilling to pay.

Third, doctors and other health workers have usually not been trained to provide preventive health care and have little professional interest in it [13]. Many doctors are not interested in health but in disease. A serious disease presents a challenge, while an improvement in diet or drinking-water has little appeal. Such objectives are regarded as less interesting. The same applies, to a lesser degree, to nurses.

Fourth, conscientious performance of a PHC task is rarely beneficial to the career of a health worker. Those who want to carve out a career for themselves have to steer away from the periphery where PHC is usually found. Higher functions fall to those who have succeeded in finding a position in the administrative centres or who have specialized.

Finally, health workers are often opposed to a PHC function for all sorts of personal reasons such as primitive living conditions in rural areas, attitude of their relatives and limited educational opportunities for their children [14].

To sum up, health workers may assume a negative attitude towards PHC because of the following implications:

- a. Frustration in their work, because they do not get sufficient support from the government and because the population is not interested in their message.
- b. Reduction of income.
- c. Medically the work is uninteresting.
- d. The consequences for their career are negative.
- e. Personal problems within the family.

The population

In the section dealing with PHC policies at the highest level, that is at the level of the WHO, World Bank and UNICEF, it was stated that these organizations tend to determine the needs and wishes of local communities. But what do those concerned have to say?

Research into primary health care needs of local communities is scarce. Although medical anthropol-

ogy has already established a respectable tradition in the study of lay opinions about illness and health, it seems that this subject has been largely avoided in PHC research. One explanation could be that policy-makers anticipated the findings of such research and did not know how to put them into practice. Consequently, the emphasis on prevention and on the greatest possible autonomy in health care should not be seen as an evaluation of the real desires of local population groups but as an indication of what they are supposed to want. Here the concept, already mentioned, of 'descending cultural values' applies. Some 'messages' reaching the periphery are picked up, others are rejected. The effectiveness of modern curative drugs, for example, is widely recognized and ever larger groups of the population are wanting them. Hence the opposition to any government policy which recommends prevention and withholds modern drugs. It illustrates the contradiction pointed out earlier in this paper: the local community *is told* to become more *independent*.

Although only little research has been done into the PHC client's perspective, Bloom's conclusion seem plausible: "Clients' perceived needs may vary widely from planners' epidemiological definition of needs" [15, p. 8]. Justice [16] comes to a similar conclusion. She describes how unaware international organizations were of the problems and cultural conventions of villagers in Nepal and how this lack of knowledge led to PHC initiatives which failed completely to fit in with the culture and needs of the local population. We will confine ourselves to three examples of local opinions which deviate from the PHC objectives that exist at a higher level of social organization.

During her research in Nepal, Stone [17] examined closely the question of what the villagers themselves regarded as their most urgent needs. Apparently they were not at all pleased at the strong emphasis on *prevention* which, in addition, was provided at the *expense of curative aid*:

... it is not only that the PHC 'package' fails to deliver what the people really want by way of modern health 'services', but also that the package itself runs the risk of being perceived as largely unneeded and irrelevant to the majority of people it is intended to serve. During my... household interviews covering the work of village health workers, one woman's comment was typical: "He comes, he writes things down. He tells us to do this and that. What benefit is there to us?" Another man remarked: "It is his job to come here. I do not mind. But when we are sick, there is nothing he can do."

PHC is perhaps forced to ignore local priorities for curative services since it cannot deliver them in good quality on a wide scale [17, p. 296].

In another quotation the villagers' exasperation at not being given curative aid by PHC workers is even more strongly expressed. One of the workers relates:

Sometimes they get angry. One woman when I measured her child's arm... we saw the child was too thin. She got angry and said: "Then why don't you do something? You come to show me my child is not good like this and then you do nothing!" [16, p. 297].

A PHC project in South Cameroon which at first was primarily oriented towards prevention and

education-cum-awareness 'developed' after some time into an almost purely curative service, not differing very much from a pharmacy on wheels where people could buy their medicine. Ironically, both parties, the medical staff and the villagers, appeared to be reasonably satisfied with this procedure [18].

A second contradiction between a population's needs and PHC objectives, which Stone also discusses, lies in the assumption made by PHC officials that people consider *health to be their greatest concern*. It is quite possible the people in question beg to differ and regard their deplorable living circumstances as problem number one because they rightly believe that poverty is the principal cause of all kinds of disease. Indeed, this opinion is in agreement with the official formulation of PHC in the Alma Ata document. The "Intersectoral Action for Health" report [19] gives a most detailed description of this point of view and has translated it into 19 recommendations. The sixth recommendation, for example, reads as follows:

Governments should:

formulate comprehensive agriculture and health policies, covering all aspects of development of human and natural resources and actively supported by coherent strategies including:

- joint diagnosis of the food and nutrition situation from agricultural and health points of view;
- explicit statement of health goals in agricultural development plans and programmes, particularly when there is likely to be a conflict between health and production objectives;
- systematic analysis and assessment of the nutritional and health impact of agricultural policies and projects and of the process of resource allocation [18, p. 131].

How these broad statements should be translated into concrete action in a PHC project is, however, not at all clear. Village health workers usually have no other choice than to 'stick to their guns' and try to solve immediate health problems. At this point the PHC supply no longer meets the demands of the villagers. The fact of the matter is that the villagers often know exactly what they want: instant financial aid, not improvements in agriculture in 5 years' time or more. They are faced with so many immediate problems that they cannot afford the long term view. For the same reasons they are relatively uninterested in improvements for the whole community but first want help for themselves and their close relatives. Rather than 'preventive' help for their financial problems they require an immediate 'solution', however narrow-minded that may appear to a 'rational' outsider.

Huyts [20], in her study of two community health projects in South Cameroon, writes that the population cooperated with her because it expected personal benefits (gifts, work, free medicine and 'connections') in return. Sanitary improvements for the village interested these people much less. It does not seem an exaggeration to claim that the villagers, in having such expectations (direct advantages), actually react in exactly the same way to PHC as do those involved in it at other levels: the experts in the international organizations earn a comfortable living from PHC; national governments try to acquire more develop-

ment funds via PHC (which would also bring private gains to state officials); health workers adopt a reserved attitude because there is little money in PHC for them; and villagers hope to become 'better off' with it.

The third example of conflicting expectations is closely linked with the two mentioned earlier. The stimulation of *greater self-reliance* may be no more than the concern of a foreign project staff hailing the Western ideal of individual independence. Or it can be a strategy by which a government tries to rid itself of certain burdens in a decent and internationally accepted manner. Such self-reliance is not always liked by the villagers. They may rightly gain the impression that highlighting self-reliance is a euphemism for leaving them to fend for themselves. In particular, the recommendation that they should have more faith in traditional medical knowledge and skills does not ring true to the villagers, who for years have been told that those traditional methods are useless or even dangerous. The same villagers have meanwhile come to the conclusion that the curative methods of modern medicine have quicker and more effective results than their own traditional methods. If they are forced to take up the 'old' methods again they feel they are being fobbed off with inferior quality health care. That is not the way they want to become 'self-reliant'. They are demanding their share of the national facilities and will not accept that the right to have doctors, hospitals and proper medicines is reserved to the urban population.

That same contradiction within PHC can be found in The Netherlands. Bensing [20], for instance, has pointed out that only healthy people are willing to assume greater responsibility for their own health. The sick and the weak, on the other hand, will ask for more care from professional medical workers. The enthusiasm for 'volunteer aid' is also greatest among those who do not have anyone in need in their immediate vicinity. And patients' associations do not appear to be pressing for more autonomy in their campaigns but rather to be aiming for greater medical dependence and for more advanced diagnostic and therapeutic techniques. Those who worry about their health and welfare see more self-reliance not as an improvement but as a threat to their situation.

In summary it can be said that the population often expects something quite different from PHC than has been planned for it at higher levels. The three principal conflicts are probably:

- a. People ask for curative instead of preventative aid.
- b. People expect material advantages.
- c. People do not want self-reliance if it means they will be left to fend for themselves.

A broad and hypothetical sketch has thus been given of the changes which the concept of PHC may undergo at the various levels of social organization. Research will have to prove whether and how these conflicting views occur in specific PHC settings. A multi-level approach seems to be a suitable strategy for revealing the more hidden problems of present PHC policies via the analysis of the divergent—and sometimes conflicting—views and interests at the different levels of social organization.

RESEARCH THEMES

Research into problems of PHC from a multi-level perspective will mostly not focus on PHC in general nor on all levels at which PHC is planned and implemented. It is more likely that research will be limited to a few levels or that a choice is made for a certain aspect of PHC. In the next section five such aspects will be outlined as possible themes of research. The key question will be to what extent greater understanding can be gained of processes of conceptualization and implementation of PHC by studying the theme at different levels of social organization. In all five themes to be presented here questions about the local community's perception of and participation in PHC, as opposed to perceptions and involvements at other levels, seem particularly relevant.

Vertical organization and horizontal integration

Since the Second World War, programmes combating infectious diseases such as malaria, small pox and tuberculosis have always been well-known variants of specific organizational modes of international and national health programmes. The objectives and the means regarded as necessary to realize them are determined at the top of the organization pyramid and further specified and translated into quantitative targets at lower levels of decision-making. In general the programmes are rigid, with clear-cut divisions of tasks and authority between levels of organization and leave little room for regional variations.

In other fields of health care, such as immunization, family planning and provision of drinking-water, large-scale vertical programmes have also been drawn up. Such programmes are internationally oriented. Multilateral organizations such as the World Bank and UNICEF were, and still are, responsible for taking the initiative, for financing and implementation, for providing training material and stimulating the necessary research. Vertical programmes can be very attractive to planners and top managers. However, in practice, the coexistence of a number of such specific programmes and of the regular national health programme can easily lead to practical problems. Thus a vertical programme can be successful on a narrow front but at the same time—for example by monopolizing the best trained and most dedicated personnel—prevent progress on a broader front.

In the 1970s it gradually became clear that a broad, horizontal, integrated approach offered better perspectives for a lasting improvement in public health than a conglomerate of various vertical programmes. From 1978—and before that in a few countries like China and India—the so-called PHC programmes were created on a large scale. In these programmes the principle of horizontal integration of health care covering a variety of activities occupied an important place. In recent years, however, many donor organizations and policy-makers have become somewhat impatient with the slow progress within PHC and seem to want to go back to a vertical approach [22]. Research from a multi-level perspective can shed a new light on this issue. Important questions are:

What criteria are used to measure the effects of PHC at various levels of health planning and how are these criteria regarded by a population directly involved in PHC activities? Other crucial questions are: To what extent have international donor organizations dropped 'self-reliance' as a cultural ideal and the final goal of development? What are the political and economic interests of the organizations behind the present shift of emphasis toward selective PHC? How is this new emphasis translated from the supra-national level to the national governments? And finally, what PHC approach should be recommended as the most 'effective', viewed from a multi-level perspective? It may be advisable for this type of research to concentrate on selected parts of health policy, such as immunization or diarrhoeal disease control.

The role of medical personnel in PHC

Various researchers have drawn attention to the 'trained incapacity' of medical personnel in PHC and in rural health care in general. The 'incapacity' of doctors in particular seems to be due to insufficient medical training and to the difference in educational level between doctors and villagers. In an exploratory study on this issue in Somalia, Buschkens [14] draws attention to differences in life style between doctors and villagers and emphasizes differences in upbringing, religion and social aspirations.

The unwillingness and 'incapacity' of doctors and other medical personnel to serve in PHC is not the only problem. A more serious issue seems to be that their activities can pose a direct threat to one of the basic principles of PHC, the stimulation of self-dependence in the field of health care. Doctors in particular are viewed by the local community as representatives of a higher level of social organization. They embody, as it were, the links between different societal levels. By providing professional curative help, they can deprive the villagers of a serious motivation to seek self-dependence. The conflict between the availability of a doctor and the self-dependence principle in PHC stems from a lack of insight into the problematic relations between the different levels of organization in health care.

Lower-skilled health workers may feel caught between two levels of health care organization. They do not receive the support and material resources from above to carry out their work and, partly as a result, are not accepted by the local population [23, 24]. Curiously this fundamental conflict within PHC has as yet hardly been brought up from this angle in the numerous publications and reports about PHC.

Distribution and use of medicines

The role of medicines in PHC is problematic and controversial. The popularity of Western medicines is bound up with cultural perceptions of effectiveness and with technological dependence. The effective functioning of pharmaceutical distribution channels depends mainly on the smoothness of operation of the linkages between the various levels of organization. The kind of medicines obtainable or used in local communities depends on a complicated procedure based on such factors as commercial interests of

pharmaceutical companies, the economic situation of the importing country, the medical opinions and personal interests of national policy-makers, the quality of the distribution system, the attitudes of doctors and other health staff with regard to the prescription of medicines and the cultural conceptions and financial resources of villagers.

As a result of the relations between the various levels of organization, the knowledge of Western medicines is widespread but their distribution is not always so. Even in peripheral communities people are familiar with the efficacy of these products and ask for them. Their own curative methods are increasingly regarded as inferior and therefore discarded. However, the medicines themselves penetrate insufficiently into the periphery. Their distribution breaks down at higher levels where interested parties receive a disproportionate share at the expense of the rural areas. The great faith in Western medicines and their limited availability often makes the demand for them even greater. Efforts to set up a PHC programme with a 'low supply of medicines' and with a strong emphasis on prevention therefore meet with a great deal of distrust, the result of which can be a complete rejection of PHC programmes.

Finally, like doctors and other health workers, medicines produced externally introduce a form of dependence into local communities which can conflict with the basic aims of PHC. Pharmaceuticals are themselves linkages. They move from one level to another, bringing with them not only the medically defined therapeutic substances they contain, but also crucial social and cultural aspects such as money-value (price), information about use (or lack of such information), political and economic dependence and meaning. These aspects (price, information, meaning) are likely to change considerably during a medicine's 'journey' from level to level. Prices may, for example, rise sharply at the local level and a doctor's or salesman's ideas about pharmaceuticals may differ considerably from those of an ordinary patient. The individuals involved in the transaction and transportation of medicines are also 'linkages'; they are like agents acting between different levels of social organization. The most relevant 'actor-linkages' are pharmaceutical representatives, government health personnel, health workers, shopkeepers (including pharmacists) and patients. By following the drugs themselves and the individuals involved in their transaction we hope to gain a better understanding of how dependency, or self-reliance, is created in the context of PHC.

Traditional medicine

In the Alma Ata document [5, p. 33] collaboration with traditional medical practitioners is recommended in the following terms:

Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well

worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly.

In addition, the WHO [24] has devoted a report to the integration of Western and traditional medicine. Optimism about possible cooperation between representatives of different medical cultures also predominates in a collection of articles [25], published under the auspices of the WHO.

Although some scepticism about traditional medicine still exists, the idea seems to prevail internationally that additional training and involvement of traditional practitioners can make up the great shortage of personnel in PHC or at least ease it. Another advantage is that traditional practitioners will be less inclined to leave their community than specially trained health workers who are likely to seek further career opportunities elsewhere after they have completed their training. Their close relationship with their fellow-villagers is yet another advantage.

At the national level lip service is quite often paid to this passage in the WHO document. Promotion of traditional medicine frequently serves the purpose of national and cultural self-awareness. In practice there is hardly any question of real collaboration and exchange between modern and traditional medicine in the framework of PHC [26]. Health workers within the biomedical system are generally opposed to the idea of collaboration, whereas traditional practitioners are often more responsive. They expect an increase in prestige and income through their association with the official health care system.

As yet, little is known about the reaction of local population groups to the incorporation of traditional medicine into PHC. While they have long been accustomed to Western and traditional medicine being used side by side, they are likely to see themselves fobbed off with second rate provisions when traditional practitioners are mobilized as village health workers.

Critical observers have shown divisions of opinion on the plea for reassessment of traditional medicine. Some have criticized it as being romantic and unscientific [27] and a questionable method of economizing. Others are of the opinion that the WHO's guidelines are only a beginning and are still characterized by ethnocentrism and scientism. They take the view that policy-makers still make too extensive use of the biomedical yardstick when evaluating traditional medicine. Research into opinions and practices concerning traditional medicine and PHC at different levels of integration will doubtlessly lead to more policy-relevant conclusions.

Family planning

Although family planning is mentioned only once in the Alma Ata document as a component of PHC, it is definitely regarded as an essential item in most PHC programmes [28]. Family planning is thought about very differently at the various levels of social organization. At the level of the international organizations anti-natal and neo-Malthusian opinions predominate. National governments have often adopted this view—sometimes voluntarily, sometimes under pressure—but are not very successful in selling it to the population.

The interests of the peasants and urban poor with regard to children differ fundamentally from the views of government leaders, which are tuned towards the national economy and political stability. The views of representatives of international organizations are again directed towards other 'dangers' such as ecological disaster and international stability. A study of the views on and interests in family planning at the various levels will provide insight into the successes and failures, as well as the future possibilities of family planning as a part of PHC.

CONCLUSION

Reports and articles on PHC clearly show that PHC has no fixed meaning. At different levels of social organization people appear to have different interests in PHC and, consequently also have different ideas about it. There is no such thing as a world-wide PHC concept. We will have to be satisfied with a non-definition. PHC is what people say it is. Research into problems in the functioning of PHC should not overlook this semantic confusion.

In this article we have proposed to take this confusion as a point of departure for research. Exposing the absence of a common definition of 'PHC' and tracing back this absence to a lack of common interests in it, is the main contribution a multi-level research approach can make towards a better understanding of how 'PHC' works and why it so often does not work.

Is it possible, however, to formulate a critique of PHC if we do not agree on a definition? The confusion surrounding the concept of PHC at various levels of social organization also affects this paper. If international institutions, national governments, health workers and local communities have their own definition of PHC, why not social researchers? Are they not cultural beings with their own ideas and interests?

The somewhat schizophrenic position we have taken is indeed that PHC has no fixed meaning. At the same time, however, we have measured its functioning against the Alma Ata definition, not because we accept that definition is the only true one, but because it is the one to which participants have pledged their allegiance.

But we also have our own ideas on PHC, shaped by our cultural background. These have prompted the questions raised in this paper. We cannot anticipate the results of a multi-level study, but one conclusion seems almost certain: PHC cannot be separated from its political meanings. If we agree on a programmatic definition of PHC as "democratization of health care" [29], it will be clear that the ideal cannot be achieved as long as the political reality allows people so little room to pursue their own views and interests.

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Philippines, Somalia and Zimbabwe) and from the The Netherlands commented on the text through reaction papers which were discussed at the seminar. We would like to thank all the participants, in particular M. Colpa, who contributed to the present text with their criticisms and suggestions. We are also grateful to an anonymous reviewer who sent us some useful comments and to W. de Rijke and M. J. Collins who helped prepare this English version.

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