Comprehensive Rural Health Project, Jamkhed, India

Inter-Sectoral Co-ordination for Primary Health Care

Dr. Raj S. Arole

1. Introduction

Health is intrinsically related to development. However, the inter-linkages between health and development were brought to the limelight at the Alma Ata conference on Primary Health Care (PHC) in 1978. The Alma Ata conference not only gave a new impetus to the inter- linkages between health and development but also restated the fact that `Health for All' could not be achieved without inter-sectoral co-ordination. This restatement gave a new direction not only to those involved in promoting health but also to those participating in the process of community development.

The scholars, the policy makers and the development functionaries promoting an inter-sectoral approach to health tend to consider seriously three major sectors that are crucial for health and development. They are:

Agriculture
Education
Environment

While we attempt to discuss how closely health is related to these three sectors, we shall focus our attention on some of the key factors that are to be considered for promoting health through inter-sectoral approach.

2. Guiding Principles

Before we begin to understand the inter-linkages between health and other sectors, we must know the following principles, which are important to the understanding of inter-sectoral co-ordination.

2.1. Development is basic to health

Health is closely related to development. Therefore, any action taken to promote health must be necessarily linked to the process of development. This leads us to understand the concept of development. Defining the concept of development has led to an unending debate as there are different views expressed in many fora. However, there are two critical variables which most of the participants of development debate tend to consider important. They are growth, or production, and distribution.

There are many theories and approaches on how to achieve faster economic growth. The latest and the dominant approach seems to be the market-led economic growth (free market). Similarly there are many views on distribution. While some argue in favour of equitable distribution, the others emphasise distribution in proportion to one's contribution to growth. However, what is most important for us to know is that health care is considered, by and large, part of the degree or level of distribution of the

benefits of growth or production. In order to have a deeper understanding of the concept of production and distribution, we may consider a set of guidelines -- one for the micro (local) and the other for macro (national) analysis -- that are given in annexure 1.

2.2. Equity

The principle of equity essentially follows from the previous principle. However, it must not be considered as having a relationship with only the `distribution' aspect of development. Equity must also be considered in terms of production. For example, agricultural production involves ownership and use of land, technology and labour. Therefore, when we discuss the principle of equity in the context of health of the people particularly the poor, who form the majority of the labour force, it is also necessary to ask the following question:

> *Do or can the poor have the right (at least some if not equal) to ownership of land, technology and labour?*

The most common understanding of equity in terms of health is that "every man, woman and child, no matter where he or she lives, has the right to enjoy good health and deserves to have access to health care services." This definition then implies the following. Firstly, there must be enough health care services - *availability*. Secondly, whatever is available must be *accessible* to the poor, forgotten and the marginalised. However, the meaning of ‘accessibility’ assumes greater importance because there are many factors that determine access. Help rendered by an organisation to the community to use the existing health care services is one factor; an example is providing transport facilities to reach the clinic or the hospital. Another factor can be organising the community to demand from the State that they must also be given a share in the existing health care services.

There are many other factors determining accessibility. However, the most important determining factor is the capacity or the power of the people, and the immediate factor to be considered for building the capacity of the poor is their economic status. Therefore, the next principle of inter-sectoral co-ordination for health is the economic capacity of people (poor).

2.3. Promoting economic capacity of the people (poor)

Economy plays an important role in the health status of the people. It not only enables the people to undertake preventive and curative health care measures, but it also promotes sustainability of their health status. There are many country or community specific strategies or programmes involved to build people's economic capacity. Some of the key strategies are enabling the poor to have:

1. asset creation and development
2. capital formation
3. employment opportunities in the private or public sector
4. access to market avenues

2.4. We shall learn more about these strategies later, when we discuss or share the experience of organisations like CRHP. Please note that these three principles are not independent of each other and therefore they form the guiding principles of inter-

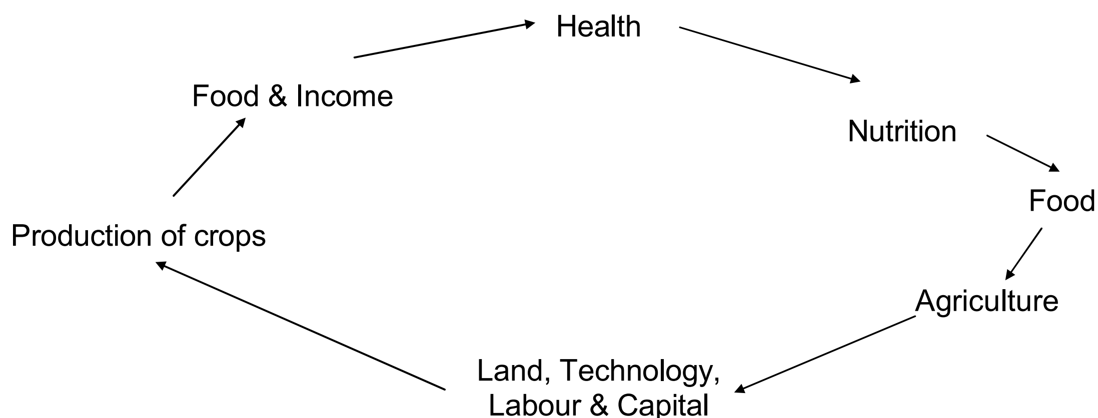
sectoral co-ordination.

3. Health and Agriculture

More than two thirds of the people in developing countries depend entirely on agriculture for their livelihood. Some of the major factors that determine people's health are agricultural policies and products. Most of the poor spend more time in agriculture. Most of their income is spent on food, which basically comes from the agricultural sector. Some of the factors of agriculture that have direct influence on the health of the people are:

1. adequate farm income
2. income from agricultural labour
3. enough food (energy) for agricultural work
4. nutritional value of the food eaten
5. health hazards of agricultural technology

The following figure explains the close relationship between health and agriculture.



NOTE: *While trying to understand this figure, also try to find out the relevance of the principles of Inter-sectoral co-ordination.*

3.1. Impact of Agriculture on Health

The following factors of agriculture affect health of the people, both positively and negatively. While some factors affect people’s health directly, the others have an indirect impact.

1. Policies:
   - 1.1. Food crop vs cash crops
   - 1.2. Shift in consumption (locally grown food vs meal processed in cities)
   - 1.3. Investment (productive regions vs poor regions)
2. Land fertility
3. Crops with harmful effects (dangerous to health) – e.g. health of farm labourers
4. Food with direct health hazards (toxic substances)
5. Agricultural products with major health hazards (tobacco and narcotics)
6. Equity in accessibility to food

4. Health and Environment

The debate on health and environment centres around both the direct and indirect impact of environment on health. The indirect effect can be assessed from the nexus (intersection) between i) poverty and environment and ii) population and environment. The nexus between the major components of environment -- i.e. land, air and water -- and health reveals the direct impact on health.

4.1. Poverty and Environment

There are two views on the nexus between poverty and environment. According to the first view, the excruciating poverty of the rural people forces them to encroach the forest reserves for their livelihood. As a result there is deforestation, which further leads to fall in total rain fall and soil erosion, which adversely affect farm production. A faster rate of decrease in farm production further accelerates poverty, thus leading to poor health status. Therefore preservation of forest resources is advocated strongly for the better health, particularly in the rural areas. You may see this situation in your local area.

On the contrary, according to the second view, the declining environmental resources such as forests are mainly the result of uncontrolled rate of growth and disparity in the consumption of resources between the rich and the poor. It has been estimated that every thousand babies born in the developed industrialised world consume three to four times of most of the earth's resources as 9000 born in the developing world (Luis Indian, "Brundtland Commission Urges New Global Partnership," *Perspective* No.8, Spring, 1992, p. 16. Also refer the statistics on the nutrition intake among the children of rich and poor countries.) Though variations in consumption patterns are evident between developed and developing countries, such variations are more sharp and obvious in our own countries and communities. **Therefore when we begin to promote Primary Health Care in a rural/urban poor community, we must recognise our own situation first before we talk of country variations.**

The faster rate of growth and the increasing tendency for profit induced by market-led economies have forced the developed countries to demand raw materials, with an increasing reliance on imports from the developing countries. **This is also true of urban and rural situations within a country, as well as among developing countries.**

Also imported from the developing world and rural communities is preferential food and food products. This is more visible in the case of the fishing sector, where the fishermen are compelled to harvest commercial species of fish using fishing technologies that effect the ocean environment and causing considerable decline in the production of food species. As a result nutritional and health status of fishing communities is greatly harmed. Similar trends are also seen in the agricultural food and products characterised by the induced preference for cash crops over food crops.

Yet another cause perpetuating deforestation is the major power (hydel) projects financed by multi-national Corporations (MNC), World Bank and the International Monetary Fund (IMF). It is estimated that the Grande Carajas Project in Brazil will cost $62 billion and entail deforestation of an area equal to France and Great Britain together. (Mukherjee, 1993.) Such projects will have harmful effects on the environment and the health of the people.

However, please note for us these issues are not immediate when we want to initiate the process of primary health care in small communities. This

being our immediate situation, let us try to assess the local environmental concerns as perceived by the community.

4.2. Population and Environment

It is true that the faster rate of population growth in the developing countries is the major cause of depletion of natural resources. However, this is not the only reason. Besides the reasons mentioned in the previous section on the nexus between poverty and environment, the other factor used to counter this view is the extremely skewed distribution of resources. In the developing countries, the landless agricultural labourers form the majority population. Lacking access to productive resources such as land, they tend to depend on the forest resources for their existence.

4.3. Water, Air, Land and Health

It has been argued that the health of the poor is affected by dirty water, inadequate sanitation, air pollution, and land degradation. It is estimated that in poor countries:

a. Diarrhoeal diseases resulting from contaminated water kill over 3 million children per annum and cause about 900 million cases of illness each year.

b. Indoor air pollution from burning wood, charcoal or animal dung endangers the health of 400--700 million people world wide.

c. Dust and soot in city air causes 300,000--700,000 premature deaths per annum.

d. Soil erosion can cause annual economic losses ranging from 0.5 % to 1.5 % of GNP.

e. Twenty-five per cent of all irrigated land suffers from salination.

f. Tropical forests, the primary source of livelihood for about 140 million people are being lost at the rate of 0.9 % per year. (Mukherjee, 1993.)

While you look at this data, can you try to find out the rate of prevalence of air and water-borne diseases in your local community? Can you find out the people's understanding of such diseases?

Mining of the earth, nuclear testing, mismanagement of radio-active wastes, dismantling of nuclear weapons, tragedies such as Bhopal caused by Union Carbide (killing in one night 2000 people and permanently disabling 200,000 women, men and children), and wars are some of the environmental hazards which directly lead to dangerous health problems.

The following statement may further help us to understand the nexus between environment and health. **"If any man is rich and does give help to one who stands in need, he gives the poor man what was already his. The earth was made for all, not just for the rich".** Pope Paul IV

5. Education and Health

The inter-linkages between education and health are well established. It has been proved that growth in literacy rates, particularly among women, has produced a positive impact on health. In some countries, states (Kerala in India) and communities, the fall in mortality, morbidity and birth rates is mostly due to the level of education and literacy than to mere economic growth. The positive impact of education on health is the result of improvement in personal and public hygiene, life style, environmental sanitation, appropriate nutrition, and better understanding and positive attitudes towards preventive, curative and promotive care.

However, it has been argued that the nexus between health and education is "to be understood in the wider context of local culture, with its structures of knowledge concerning health." (WHO, 1986.) This concern necessitates a deeper understanding of the inter-linkages between education, knowledge and health. It has been said that "to know (knowledge) is to transform reality." In this context it is important to ask, "What is knowledge, and who has the access to information and knowledge?"

In development terms knowledge is considered the best power that people can have. Therefore, enabling the poor to understand the factors harmful to their well-being is very important. They must be enabled to participate freely in the process of under-standing their situation, and they must be given the right to own and use the knowledge. Often, superstitious beliefs and traditional practices, which form an integral part of culture, are used to explain the very bad health status of rural masses. It is also often argued that the poor do not enjoy good health because they are not open to change.

These arguments do not always find merit. As has been demonstrated by CRHP, the rural people are open to change, and they are open to new knowledge and information that is not used to continue their subordination to the medical profession and the local power structure. What is important for us to know is that there must be an interface between scientific knowledge (this is not to say that traditional knowledge is not scientific) and some of the cultural practices and values of the rural people. This assumes more importance in the field of Primary Health Care, which condemns the superiority and domination of medicine over the health culture of rural communities.

Certainly education and literacy can play a major role to make health care simple and effective. Raising the literacy and educational levels of children and adults, mainly the women, has proved to be more effective at decreasing morbidity and mortality rates than building hospitals for specialised curative care, mostly for the rich.

The impact of education on health should not be understood only within the ambit of 'Health Education', which is normally used to communicate health messages. Health education is different from education, and education promotes not only literacy but also understanding of socio-cultural, economic and political factors that shape the development of people. Since health forms an integral part of development, the positive impact of education on health can be seen only when education becomes a force for enabling people to understand the causes of under-development and to develop appropriate actions to improve their well being. For this the people do not need university degrees and diplomas, but they require conscientisation.

Conscientisation is an awareness-building, learning process through which people perceive, interpret, criticise, and finally transform their own environment. This process can take place through adult education, literacy campaigns, health education, participatory action research (PAR), participatory rural appraisal (PRA), etc. Any form of education, be it health education, adult education or formal education, becomes a liberating force only when it produces the desired results in Primary Health Care (in this context). Therefore, when we use health education or adult education to promote Primary Health Care in our own communities, we must consider seriously how far the content/curriculum and the methods we use become a liberating force.

6. Action for Co-ordination

As mentioned earlier, there are many strategies developed to follow an integrated and holistic view of Primary Health Care. Though the strategies envisaged are at two levels, i.e. macro (government interventions) and micro (community) levels, we shall discuss only the latter since they are community-based and are quite effective in producing the desired results.

The micro level strategies are broadly categorised into four, they are:

1. asset creation
2. providing needed capital
3. employment generation
4. establishing marketing linkages

6.1. Asset Creation and Development

One of the major causes of poverty and its resulting impact on health is the lack of productive assets or resources, such as land, technology and labour. There are people who do not own land, and there are those who own land but do not have the needed technology or the labour to cultivate the land. In such cases, it is imperative that the poor are enabled to have access to productive assets and resources. If land distribution is not possible, the landless can be given other assets such as milk animals, machines and forest, etc. depending on the viability. Similarly people may have land but may not have the capital to work on the land or there may not any irrigation facility. In such cases there is a need to develop the land.

[CRHP has been successful in following the strategy of asset creation, e.g., watershed development in Khandvi village.]

6.2. Capital Formation

Often we come across people who have productive assets but lack capital to use their assets, (land and irrigation). Some people have the skill but do not have the capital to start an economic activity. In such situations, they can be enabled to have access to capital in the following way.

1. bank loans
2. credits and savings
3. matching grant

4. free or subsidised loans

[CRHP has experience with the members of Women's groups and Farmers' clubs and other individuals.]

6.3. Employment

Every effort must be made to encourage self-employment, seasonal employment, and employment for the educated and the retired personnel in the community.

6.4. Marketing Linkages

In the trail of free market, the products produced in the traditional sector may not always find a market. Efforts must be taken either to make the traditional sector competitive or to find suitable market avenues. This is best done in the form of co-operatives. Some of the examples are AMUL in Gujarat and Fishermen Federation in Kanyakumari district.

7. Conclusions

This topic is vast and wide ranging. While we understand the key sectors that are of strategic importance for health, what is important for us is to have the conviction that only an inter-sectoral approach can lead to improvements in health status. With this conviction, whatever we do in this regard must be community-based, and the target must fully participate in this process.

References

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Annexure 1

A Guide for Local Analysis
Class Analysis and Methods of Exploitation

1. Who are the landlords?
2. What do they produce?
3. What are the sizes of their land holdings?
4. What is the extent of their economic power?
5. Status of the landlords, rich, middle, absentee etc.
6. How do the landlords exploit the poor peasants and the farm workers?
7. To what extent do the landlords engage in exploitation?

Problems for a Thorough Land Reform

1. Is land distribution necessary? No. Yes. Why?
2. Is the reduction of rent possible? No. Yes. Why?
3. Are the farm managers and the landlords themselves cruel and oppressive to the workers? No. Yes. How?
4. Can a co-operative without landlords and rich peasants be created? Yes. No. Why?
5. Is the local government in any position to extend credit, extension service and others to the local peasant despite its heavy commitment elsewhere? No. Yes. Why?
6. What can the poor peasants and farmers do to protect their economic and political gains?
7. Is Land Reform being applied? If yes, how? If no, why?
8. To what extent can it be used to alleviate the plight of the poor?
9. To what extend are the landlords free from the Land Reform regulations?
10. Is there a code or law about the land reform? Does it favour the landlords themselves?

Problems of the Workers

1. Are the wages of the workers sufficient for their decent maintenance?
2. Are the wages in step with the profits of the company or plantation?
3. If there is a union, what must be done to strengthen or transform it to a good one?
4. If there is none, what must be done to create one?
5. If the company or plantation repressive or oppressive against the workers? If yes, how?
6. How inefficient or ineffective are any legal provisions to protect workers?
7. What are the present violations of these provisions that the people may work at?

A Guide for Macro-Analysis
The Economic System

1. Production

a. How does society awes itself for material subsistence?

b. What is produced? Agricultural or industrial?
For local consumption or export crops?

c. Where are the centres of production?
Who owns the means of production? Are they owned in the urban or in the rural sector?

e. What kind of economic system is involved? Clan based, feudal, capitalist?

2. Distribution

a. Is there a surplus? Is it real or artificial?

b. How is the surplus distributed? Where are the points of distribution?

c. What are the roles of these points of distribution?
Do they allocate supplies, fix prices, etc.?

d. Who controls the distribution points?

3. Consumption

a. Is it a subsistence or a surplus economy?

b. Who consumes the surplus and where are they located?

4. Other Questions

a. Where does the economic activity take place? Urban or rural?

b. Does the economic initiative come from outside the area or from within the area?
Is the stimulus exterior and foreign or is it interior and national?

d. Are there a dominant sector and a dependent sector within the economy?
How is the rural dependent on the urban sector?

Source: Asian Christian Conference, *Guidelines for Development, pp 58-61*.