MEDICAL AUXILLIARIES IN FAMILY HEALTH

SOME IDEAS AND EXAMPLES

1. WHAT WENT WRONG IN OUR HEALTH CARE SYSTEM?

The Sudan, like many other developing countries, has spent large amounts of money to build and operate curative institutions, but the growth of these services has failed to imporve substantially the material health of the general population especially in rural areas. The basic reason for this lack of adequate return for the relatively big investment in money is that allocation of resources available has been based on a series of faulty assumptions.

1.1 That disease and hospital-oriented medical care systems are the most appropriate means of solving the public health problems of the community.

1.2 That duplicating the traditional Western model which provides advanced medical Technologies and specialised services in prestigious curative institutions will assure improved general health standards.

1.3 That only highly trained medical manpower can deliver good medical care

1.4 That curative and preventive srevices can be run independently in a health care system.

1.5 That what the people demand is synonymous with what they need.

1.6 That the best way to deliver medical care (Bryant, 1969) "is like offering food in a self-service cafeteria; here it is – whoever wants it, come and get it".

2. REASONS FOR FAILURE:

Our medical care systems based on these faulty assumptions have failed by and large to alleviate the problems. The dominant reasons for their deficeincies in providing adequate and equable services are neither the gaps in our medical knowledge nor the lack of resources. The real underlying causes for this failure are:

2.1 That we have failed to work out methods of analysing and evaluating health programmes. One result of this lack of evaluation was that money was spent on expansion of new programmes without looking into what might or might not be achieved by building a hospital, or launching a mass campaign. There is a need for health planners to adequately apply the principles of economic planning not only for the purpose of supporting their claim for resources but also because this will permit them to make allocations within the health sector more effectively.

2.2 That the limited resources we have are not well used. The most limiting resource in our health care system is money. With our per Capita health expenditure not exceeding 70 piasters (US £2) our planning, priorities and

programmes should be realistic. While our official quoted ratio of population to physician is 13,000 (Sudan, 1973) this ratio together with other ratios for other categries of health personnal are more misleading than helpful because our failure to distribute resources more evenly and our inadequate understanding of how to organise and use the limited manpower we have.

2.3 That our health care system does not respond to the real health care needs of our communities. Our traditional approach of curing individual diseases that come to our notice is proving ineffective because it only scrapes the tip of the ice-berg of high morbidity and mortality. Ideally we should be responsible for those who seek our aid and those who don't .In general the population expresses a desire for curative serives. Such an explicit desire can be labelled a felt need. But there also exist real needs which are not expressed simply because the people have never learnt about them. The issue at stake then is to look for more efficient and effective ways of diagnosing community health syndromes and initiating community health action programmes to deal with them. This is the only logical way of eliminating the dichotomy of felt versus Explicit needs.

2.4 That our health personnel are inadequately trained to respond to the needs of the community. It is abundatly clear that there is a discrepancy between the task the medical personnel is able to do and the actual health needs of the community.

In meeting the health needs of the community our top priority should be to train health workers who understand and know how to do what needs to be done (Brtant, 1969). Perhaps the most critical issue refers to the doctor as a leader and teacher of the health team and the question is we wltether want to produce a community oriented Physician capable of guiding comprehensive health care or a bed-side Clinician involved only in a very small part of a very large multifactorial issue.

It looks quite obvious that we need to broaden our traditional and narrow concept of office and bedside medicince to the wider concept of community medicine.

2.5 That while we have very few manpower with whom undertake the enormous task of coping with the health needs of the community, our faulty concept of training and employing highly skilled workers will increase the shortage and widen the gap of staff/population ratio. Two issues stand out very clearly in this respect: (a) that our health care system is not fully utilizing the concept of the health team and; (b) that the attitudes of our professional personnel towards leading and delegating responsibility to auxilliary staff are not definite and clear cut. The only direction in which these considerations lead us is

toward the adoption of an intermediate technology approach (Gish, 1971) which means emphasizing the health centre and health team concepts and the greater use of auxilliary personnel.

3. How to Approach the Problim?

These vital issues may alternatively be approached another way by confronting health planners with three crucial questions and then drawing from these some inescapable conclusions:

3.1 Who are receive health care services? All the population or special sectors in it?the Inescapable conclusion is to provide all the people with reasona ble health care system.

3.2 What kind of services are to be provided? Shall we concentrate on a disease oriented system and continue to be beseiged in our curative towers by ever-increasing numbers of ill people? Or shall we try to modify our system to be more health-oriented and responsive to the needs of the community?

The inescapable conclusion is for us to develop some new thoughts and look for more efficient and effective approaches of re-modelling our system to suit the needs of the community.

3.3 How shall we deliver these services? By what type of personnel? Shall we continue to concentrate on training expensive and highly qualified personnel? Or shall we place more emphasis on developing the type of training and personnel compatible with our resources and relevant to our needs? The inescapable conclusion is for us to adopt an intermediate technology approach suitable for our large supplies of labour and scarce pool of capital.

4. What is to be done?

From the bove sequence of arguments, we have enough information which gives clear pointers for future development. We need not wait to act on the information that is clearly known.

4.1 Limitations of resources is the major obstacle to providing comprehensive medical care. Scarcity of manpower, money and material is felt throughout our health spendings are unavoidable, then the best way to match needs to available resources is to consider priorities even though priority decisions are unavoidably complex.

4.2 The fundemental unit in a community is the family and the majority of families live in scattered rural areas. If the policy of attempting to provide optimal and equable health care services is to be successful our priority target should be to provide these services to families near their homes.

4.3 Curative services are very costy and usually absorb a large fraction of the total of a health service to be available only for the few. For a better cost

effectiveness and cost efficiency performance, there is a vital need for the wider effectiveness and cost efficiency performance, there is a vital need for the wider application of the principles of community health through a simple and cheap delivery system.

4.4 The establishment of integrated primary health centres on a nation-wide scale should receive an increasing share of attention and resources. Such a centre is now considered as the most ideal institution for providing community health care at the periphery of a health service and is defined as (King, 1966) a unit which provides a family with the health services it requires other than those which can only be provided in a hospital. Each health centre would be expected to serve a defined and registered population of 20–50,000 in a defined geographical area of an average of 10 miles radius. Ideally the whole country should be covered by a health centre network with the dual function of providiing satellite units around district hospitals and nuclei for mobile mass campaigns in extended and especial effort areas.

4.5 The function of a comprehensive health centre would be to provide the full spectrus of integrated basic health services:

(1) Curative meducal care; (2) maternal and child health; (3) community nursing or health visiting; (4) communicable disease control; (5) environental sanitation; (6) health education; and (7) record keeping and vital statistices.

4.6 If this type of simple and comprehensive health care is accepted as a model for the periphery, then it can only be run by the type of personnel compatible with the intermediate technology solution; the medical auxiliary who according to king (1966) is "a substitute, an alternative, rather than a complement to the professional. In an integrated primary health centre the medical auxiliary team will consist of: the medical assistant, the auxiliary midwife, the assistant health visitor (community nurse), the sanitarian, the enrolled nurse, the demographic scout and the statistical clerk.

4.7 In the training of these auxiliaries two important concepts are worth observing: (a) the economic concept of mass production which lowers their training cost; and (b) the operational concept of the health team which will increase both the efficiency of their training and their performance. The combination of these two pricinples will ensure a wide population coverage with a better cost /efficiency ratio.

One more crucial question remains to be considered. To assure the effectiveness of an auxiliary health team in achieving an imporvement in general health standards their training and that of their future leaders the medical sudents must stress the following basic principles:

(a) They must know how to make a community diagnosis for which they

must be able to collect, analyse and interpret the relevant data.

(b) They must be able to draw a list of priorities in the light of the community diagnosis and plan a health programme with which these priorities can be achieved.

(c) They must be able to carry out the community health action necessary to imporve the health of the community.

(d) They must be able to mobilise the full participation of the community in the programme.

5. THE ROLE PROFESSIONALS:

One of the very important links in this chain of new endeavours is for the professionals to play the role as the leaders, the innovators, the motivators and the administrators.

5.1 They must endeavour to establish pilot projects on the effective delivery of health care systems which would be able to interact in a meaningful and creative way with the communities they serve. As Roomer (1972) formulates the issue: the main objective is to evaluate primary health centres as a means of protecting and promoting in the developing world through research inquiries into:

(a) practicable methods of delivering basic health services to rural areas;

(b) the staffing and policies of operation; and (c) the measurement of the improvment in health.

5.2 It is gratifying to observe that some African Medical schools have already embarked upon ambitious educational designs based on the community approach in an attempt to solve the inadequacies in their learning models. Prominent among these is the kasangati model of Makerere Medical school (Matovu et al., 1971), the Danfa model of the Ghana Medical school (Sai, 1972) and the Machakos model of Nairobi Medical school. These models have produced rich experiences and a wealth of information on how to deliver effective health services to rural communities.

5.3 It is indeed a sign of mature and health thinking and a stream of change in the right direction that the Department of Peadiatrics and child Health of the University of Khartoum has taken the initiative of replicating the experience and testing the hypothesis on a rural community in the vicinity of Khartoum at Tayba El Hassanab (Omer, 1975).

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