

*** PRIMARY HEALTH CARE AND THE EMPOWER

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*** PRIMARY HEALTH CARE AND THE EMPOWERMENT OF WOMEN

by Ethel G. Martens

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"The happiness of mankind will be realized when men and women coordinate and advance equally, for each is the complement and helpmeet of the other."

`Abdu'l-Baha

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The task of saving the lives of millions of women and female children throughout the world, who die every year from easily prevented illnesses, is daunting. The outrage provoked by so many needless deaths, however, can now be tempered by hope because demands for better health care and improved quality of life for all females are being voiced by communities, health personnel, researchers and policy makers.

In all societies economic policies, such as those that enslave women in low-wage jobs under dangerous conditions, and development strategies, like those that take land out of subsistence farming and put it into cash crops, have a profound effect on the health status of women and their families. Mothers, many of whom are single heads of households, are burdened not only with economic problems but also with the consequences of civil conflict and environmental degradation. They are often ignored by male-dominated health and social services delivery systems or denied equal access to services.

Even within the family disparities exist because of social and cultural bias. For example, preference for the son can lead to the daughter's being given less food. The girl child is also expected to do more work and has less access to education and medical care than the boy. Consequently girls are often ill-prepared to marry and bear children, which they do before they are physically, psychologically and financially equipped to take on the responsibility. Often premature marriage begins a vicious cycle of malnutrition, where underweight mothers have underweight babies who are at risk of suffering from nutritional and educational deprivations. The problems facing women and girl children need, then, to be tackled at all levels: in the family, in the community, and in society at large.

** WORLD HEALTH ORGANIZATION (WHO)

The United Nations agency responsible for international health is the World Health Organization (WHO), which was founded in 1948 and now has more than 170 member countries. The WHO constitution defines health as "a state of physical,

mental and social well being and not merely the absence of disease or infirmity." Many organizations are now adding to this definition a fourth dimension of health -- spiritual well being. The next challenge for WHO is to recognize that a major obstacle to enjoying the right to health is being born female. The WHO constitution states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic and social condition." Gender needs to be added to this list.

Improving health throughout the world is a gigantic task requiring global cooperation. To facilitate this cooperation, WHO established an annual two-week meeting in Geneva. During this World Health Assembly, representatives of member countries meet to exchange information, share experiences, consult about health issues, and devise global strategies. Due in part to these yearly consultations, WHO's understanding of how best to promote health throughout the world has continued to evolve.

During the first three decades, WHO made little progress toward its goal of a healthier world. In 1977 the Director General of WHO called for a new strategy, acknowledging that although the health care strategies of the industrialized world -- that of big hospitals, drugs and curative medicine -- had been exported to the developing countries for thirty years, the health of the world had not improved. In fact, it had worsened.

That year the World Health Assembly resolved that by the end of this century people everywhere should have access to health services enabling them to lead socially and economically productive lives. This goal is known as "Health for all by the year 2000" (HFA/2000).

** PRIMARY HEALTH CARE (PHC)

The strategy for achieving the goal of "Health for All" emerged in 1978 at an historic conference in Alma-Ata in the former Soviet Union. The conference was sponsored by the United Nation Children's Fund (UNICEF) and WHO. Prior to the Alma-Ata Conference, WHO had identified eight components common to nine successful health programs. The code words "Primary Health Care" (PHC) were selected to describe the following eight components in combination:

- education about common health problems and what can be done to prevent and control them; - maternal and child health care, including family planning; - promotion of proper nutrition; - immunization against major infectious diseases; - an adequate supply of safe water; - basic sanitation; - prevention and control of locally endemic diseases; and - appropriate treatment for common diseases and injuries.

Primary health care (PHC) stresses prevention rather than cure. It relies on home self-help, community participation, and technology that the people find acceptable, appropriate, and affordable. It combines modern, scientific knowledge and feasible health technology with acceptable, effective traditional

healing practices. Of special importance for women is that the effectiveness of PHC depends very much upon community acceptance of the primary health care workers, most of whom are women and who, in most cases, are recruited from and selected with the participation of the community.

Other basic concepts drawn from the study were summarized as follows:

- Primary health care should be shaped around the life patterns of the population.
- It should both meet the needs of the local community and be an integral part of the national health care system.
- Preventive, promotional, and rehabilitative services for the individual, family and community need to be integrated.
- The majority of health interventions should be undertaken as close to the community as possible by suitably trained workers.
- The balance among these services should vary according to the community needs and may well change over time.
- The local population should be involved in the formulation and implementation of health care activities.
- Decisions about the community's needs and solutions to its problems should be based on a continuing dialogue between the people and the health professionals who serve them.

These concepts were not new, but it was not until 1977 that they were put together as a comprehensive strategy. Furthermore, based on qualitative results from countries where the principles had been applied and found effective, primary health care was put forward at Alma-Ata not as one alternative but as possibly the only alternative, and the world's top health authorities agreed. They adopted primary health care (PHC) as the strategy most likely to meet the health needs of the majority of the world's population.

Thus at Alma-Ata previously accepted approaches to medicine were figuratively turned on their head. Curative medicine would in the future take second place to prevention. Representatives from all countries in attendance signed the "Declaration of Alma-Ata" and pledged to return home to start channeling funds to primary health care and to shift from central control toward regional and district control. These were drastic changes that, if implemented, would begin to empower people to take charge of their own health care. Such a dramatic shift in thinking and action, however, would require something that was not always forthcoming: political will.

An evaluation conducted in 1983 demonstrated that, even where the political will was present, those responsible for a nation's physical, mental and social well-being did not have sufficient spending power to make significant improvements without assistance. Therefore, in 1985 WHO invited non-governmental organizations (NGOs) to help governments achieve the goals of Alma-Ata. Many responded, primarily, by cooperating with national governments in the training of primary health care workers selected from their communities.

In 1989 in partnership with many NGOs, Facts for Life, a booklet published by UNICEF, WHO, United Nations Educational, Scientific and Cultural Organization (UNESCO) and the United Nations Fund for Population Assistance (UNFPA), brought together vital information on child and family health that they determined

every family in the world had a right to know. It was thoroughly revised in 1993 in light of the most recent research, and now 8 million copies in over 175 languages are being used in more than 100 countries. Facts for Life has become the basis for health education efforts by national health services, for NGO programs in PHC, and for adult literacy classes.

Facts for Life states that the multiple burdens of womanhood are too great. However, male and female roles in many cultures are deeply rooted in tradition and are often perpetuated by the attitudes of both women and men. If these roles are to change, women and men must both agree that change is desirable, and then they must decide together how responsibilities can be redistributed. The importance of consultation on this topic was highlighted by several male health professionals who were interviewed after a medical conference in Tanzania, where the need for men to be more involved in protecting the health of their children was emphasized. "When we try to do this," they said, "our wives think we want to interfere with their work."

Since Alma-Ata, PHC has both enjoyed solid progress and suffered serious setbacks, but where it has been implemented it has brought important benefits to women. Because primary health care relies heavily on the contributions of women, particularly in the area of health education, it raises their self-esteem and empowers them to serve their communities in a number of ways:

- by improving women's health and the health of their families; - by training women both as care givers and as health educators; - by placing them in positions of responsibility; and - by encouraging individual initiative.

The following examples, drawn from experiences with PHC in Africa and India, illustrate how women are being empowered to participate more confidently in shaping the lives of their communities.

* PRIMARY HEALTH CARE EXAMPLES IN AFRICA

Primary health care relies heavily on the contributions of women. It has been said that the real village health workers are the traditional birth attendants (TBAs). "We do it simple," said a seasoned TBA. "We deliver, we wash the woman and baby, we make our joy cries and we go home." Both trained and untrained TBAs agree that ignorance is dangerous. For every mother or infant who dies during child birth, many more who survive are maimed physically and mentally. "These tragedies are largely preventable," says WHO. By providing TBAs with access to primary health care facilities and training, by providing mothers with prenatal care, and by promoting simple hygiene measures, PHC programs have helped reduce high rates of maternal and child mortality and birth-related diseases.

It may take time for someone who has never taken an active role in community work to begin to take on responsibility, but the results can be well worth the wait. The story was told of one woman who was a slow starter. It was six months after her return from training before she began to reach out to the community.

Later at a meeting in her community, government officials (from the agriculture and education sectors) sang her praises, saying how much they had learned from her and wondering aloud why women had not been trained to be agricultural or educational workers, as these were also needed to help the community progress.

Small investments in health education for women pay big dividends. A woman health worker attending a refresher course brought a bag of carrots to the coordinator. She said, "You suggested that we all have kitchen gardens to help feed our families. After training I obtained seeds from the department of agriculture and planted a kitchen garden. I also had a separate plot of carrots and sold them in the market to pay for my son's school fees." (It is hoped that when her daughter reaches school age she will do the same for her.)

Health workers are highly valued members of their communities. "Before I was trained as a health worker," one woman said, "nobody paid any attention to me, but now they listen when I tell them what I learned. We all work together. Now I am a somebody!"

** PRIMARY HEALTH CARE EXAMPLES IN INDIA

For many village women, PHC offers their first opportunity ever to be educated. A facilitator held a ten-day program on PHC for women from nearby villages. Although it was harvest time, approximately 30 women attended every day. Most were illiterate. One woman said, "I wouldn't miss one day of this. When I was a young girl my mother couldn't afford to send me to school. Now, I am receiving an education!"

Primary health care discussions bring women into the process of both making and implementing decisions that affect the community. In a mountain village a PHC worker facilitated an evening meeting on community development. On a raised platform in a house shared by oxen, the discussion took place, with men on one side of the room and women on the other. At first the discussion was dominated by men. Then one old woman asked, "Do we have to wait another fourteen years to get a cover on our well"? Evidently, fourteen years earlier some agency had given money for piping the water down the mountain to a holding tank, but the money ran out before the tank was covered. The women pointed out that dirt from birds flying over was getting into the water and babies were getting sick. After a fruitful discussion in which both the men and the women participated, the community decided to raise money for the cover during a religious celebration. The women said they would help, but asked what would happen if they couldn't raise enough money. They were told of a service club in the nearby town that wanted to help any village making an effort in development. A year later the village had a completely new water system in place.

Alcohol abuse is a major health problem in communities all over the world. These same women took bold collective action to stop liquor vendors coming to the village. The chief had closed the roads to the vendors, but the men were meeting them in the early morning in a corn field. One morning as the vendors approached, the women hiding in the fields rose up with a cry, brandishing

their harvesting knives. The vendors fled in terror.

** CONCLUSION

Primary health care is not only making a difference on the local level, it is having an impact on health planning at the national and international levels. In 1986, a crucial step was taken toward raising the profile and the importance of national health planning. During the 39th World Health Assembly in Geneva, three days of technical discussions on the role of intersectoral cooperation in national strategies for Health for All were held. Among the more than five hundred people participating were thirty-six government ministers and high-level decision makers from areas of critical importance to health, including equity and health; agriculture, food and nutrition; education, culture, information and life patterns; and environment -- water and sanitation, habitat and industry. Broadening participation in discussions of national health policy was a major breakthrough.

The signs of change are building up, global in scope, extending across all sectors and levels. Many of these changes are directly linked to health, while others have powerful potential effects on both health and health care. Primary health care needs to be adapted to varying circumstances at local and national levels. Any country that establishes a solid basis for PHC both provides for the needs of its most vulnerable and needy populations and, at the same time, empowers its most neglected resource -- women.

Ethel G. Martens has been involved in the field of Primary Health Care for nearly forty years. She received her M.P.H. in education in 1957 from the University of California, Berkeley and her Ph.D. in social preventative medicine in 1973 from the University of Saskatchewan. She has worked in the past with the Canadian International Development Agency, US/AID, the World Health Organization, Health and Welfare Canada, and is presently the President of the Board of Directors of IntraDelta Management Consultant International. Dr. Martens has published numerous papers in national and international journals on health education, primary health care, communications and community development. Dr. Martens helped establish the Baha'i International Health Agency and has served as a consultant in primary health care to the Baha'i International Community.

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