Health, Development And Primary Health Care

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Abstract: The peoples and countries of the Third World are struggling to overcome the effects of centuries of colonial dependency and unequal world relationships. These effects can be seen clearly in the area of human health. For example, of the 1978 world total of 17 million early childhood deaths (i.e., those under five years of age) around 97% took place in the Third World (1). If all the countries of the world had the same early childhood mortality rates as those of Northern Europe there would have been only 2 million such deaths. The relationship between such appalling health conditions health conditions and wider social structures is highlighted in the Six World Health Situation Report (1973-1977), prepared by the World Health Organization (2).
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1- Introduction

The most important social trends during the period of this report are reflected in the still low, and in some areas worsening nutritional level of the bulk of the population. The employment situation, including access to land has not improved in many countries and is partly, but not primarily, affected by continuing high rates of population growth, although there are signs of slowing-down of such growth in many ports of the world. The decline of rural life in many countries has led to unacceptable rates of urbanization and social and health problems on a mass scale in the world's cities and larger towns. Although some progress has been made in reducing illiteracy, a significant proportion of children in developing countries still do not attend primary school. The needs of women are being discussed to a greater extent than every before but there has been little practical achievement in this domain.

The policy implications for the health sector which should arise out of the situation described above are considerable. Perhaps the most important of all is the explicit recognition now being given to the view that health development is a reflection of political, social and economic policy and planning and not merely an outcome of the application of health technologies. This recognition can be perceived as being at the heart of the intensive discussions now taking place, both among and within countries, about the political, social and economic links between health and development on the one hand, and the consequent health policies to be followed by government, on the other. It is worth nothing that it is the changing definition of development itself that is, something considerably more than the mere growth of national product - which is critical to the view that an increase in technological and economic capacities alone will not automatically produce health. A brief, health related historical exploration of the experiences of both industrialized and Third World countries is particularly important to an understanding of the present situation of health and disease in poor countries. The two basic points to be made are: one the countries of the Third World - the so-called developing nations - have not always been poor, or at least not in the sense that us implied by the terms "developing" or "underdeveloped" and, two, analysis of the historical experience of today's industralized countries in relation to improvements in the health status of their population leads to the conclusion that these were not especially dependent upon improvements in medical technology.

2-HISTORICAL EXPERIENCE

2-1-Third World

As background to the discussion it should be borne in mind that at the time of Europe an expansion in to the rest of the world there was relatively little to choose between the technological capacities and standards of life of the life of the mass of the population of Europe and the countries to which Europeans were going. This point is fairly well understood in relation to countries such as India or China, or much of the Middle East. It is less appreciated with regard to Black Africa. Latin America is in a rather different situation in that in almost all of those countries the precolonial societies have been almost totally destroyed.

Rather than citing a greeting deal of materials from many different countries with regard to the first issue raised above - that is, what has been called the development of under development (3) - it might be more useful to draw upon the example of one particularly poor, particularly dependent African country. [At the same time, for subsequent issues of the Journal, we would like to invite in-depth studies and analyses based on Ethiopia and other African countries. For the present purpose of general observations, we hope that the example from Lesotho will sufflce.] Lesotho, a small country with a population of somewhat over 1 million, is completely surrounded by South Africa. Formerly a British territory, having the name Basutoland, the country came to independence in 1966. Lesotho is largely rural and even its capital city has a population of only about 50,000. Life expectancy at birth is put at 52 years and infant mortality is probably underestimated at 106 per thousand. The pattern of disease is similar to most other third World countries in that it is shaped primarily by low incomes, in adequate diets, limited access to clean water, and a generally low standard of hygiene for the mass of the population. As in most countries the past emphasis on hospital medicine has been accompanied by neglect of preventive programmes and services (4). What is of interest here is not so much the distressing disease picture of Lesotho, but rather how Lesotho came to be this way.

The Basutoland Kingdom was founded under Moshoeshoe in the early part of the nineteenth century. Its prosperity was such that "by the end of the 1830s the Basotho had stored reserve supplies of millet sufficient for between four and eight years, while in the mid-1840s white farmers 'flocked' to them to buy wheat" (5). This prosperity was based upon Mosheshoe's control of the land and cattle resources if the Caledon Valley. In 1869 Lesotho was forced to cede a large part of its territory to the white-ruled Orange Free State. The loss of this territory coincided with the opening of the Kimberly diamond mines, and these events become a major stimulus for migration of the neighboring white-ruled southern African colonies of the Orange Free State and Cape Colony. At the same time Lestho continued to be a major supplier of grain to the diamond mines at Kimberly and the goldfields of the Rand. Lesotho was engaged in vigorous trade relations with her neighbours based upon the export of labour and grain and the import of manufactured goods. By the late 1880s the tide began to turn against the Basotho people. The Afrikaners of the Orange Free State increased their production of agricultural goods and placed restrictive tariffs on Lesotho grain imports passing through their territory en route to the mines, the railways began to bring in cheap Australian grain, and the coming of rinderpest cattle disease decimated the Basotho herds. By 1903, with the collapse of the trade boom and the onset of drought, Lesotho was obliged to import North American wheat in order to feed herself.

Increasing land pressure arising from the events described, plus growing population and soil erosion, coupled with the need for cash income for imports and colonially imposed hut taxes and school fees and by the early part of this century created a powerful stream of migratory labour from Basutoland to the mines and farms of South Africa. Furthermore, this movement was fostered by the policies of the colonial government, as indicated in the report of the (Basutoland) Resident Commissioner, Colonial Office Report No. 177, 1898/99 as follows:

Though for its size and population Basitoland produced a comparatively enormous amount of grain, it has an industry of great economic value to South Africa, viz., the output of native labour. It supplies the sinews of agriculture in the Orange Free State; to a large extent in keeps going railway works, coal mining, the diamond mines at Jagesfontein and Kimberly, the gold mines of the Tansvaal and furnishes, in addition, a large amount of domestic services in surrounding territories. The number of men who received passes for labour during the year under review amounted to 37,371 These factors are the best rejoinder to those who argue that Basuto land is a useless native reserve. To others, who urge higher education of the natives, it may be pointed out that to educate themabove labour would be a great mistake.

Primarily the native labour industry supplies a dominion want, and secondly it tends to fertilise native territories with cash which is at once diffused for English goods. From the 38,000 Lesotho nationals employed in South Africa at the turn of the century, it was estimated that around 150,000 were so employed by the late 19708 a total equivalent to about half the overall male labour force of the country.In addition, perhaps 100 of the female labor force was also outside the country.

The outmigration of the country's young men has contributed to the rapid decline in the output 0£ agricultural crops. Between 1950 and 1970 the production of all grains fell by 41%. During the.same time period the country's population grew by about 45%, putting additional pressure on available land. Increasing land pressure and soil deterioration encouraged further outmigration which, in turn, deprived Lesotho of manpower resources that could have been employed to reverse the pattern of diminishing agricultural outputs. Thus Lesotho, a "comparatively enormous" producer of grain in 1898,

had net imports amounting to one-fifth of its total consumption of cereals in 1970 (6). Food production is below requirements and this gap is growing while average food consumption is declining (7).

The continuing poverty and dependence of Lesotho can be seen clearly from the results of a 1970 study of the deployment of the labour force (8). It found that of a total population of over 1 million, only 216,000 were "adequately employed" (defined as earning U.S..9175 per annum). There were 640,000 dependents and almost 300,000 either inadequately employed or under employed; Of the 216,000 "adequately employed", 700/0 were engaged outside the country.The same study also makes apparent the gross overall poverty of the people of Lesotho. Of almost 5,200 families in Maseru (the capital city) in 1972/73, about one-fifth had a per annum income of less than U.S. $230; about three-fiths between U.S. 230 and U.S,,;$1,150; and only one-fifth more than U.S..Bl,150. of all rural households 90% had a per annum income of 1f-SS than U.S. $00 and only 2% more than U.S. $ 575 (the overall average was U.S. $250). The case of Lesotho isinstructive not because it is absolutely typical, but because it illustrates some of the most basic structural underpinnings of the development of underdevelopment, and con-sequent health problems of much of the Third World. Lesotho is today one of the poorest countries in the world, one of the most dependent, and one of the most completely integrated into the imperialist market system. It is one classic example of the development of under development.

2-2-Industrialized Countries

Until relatively recently the overall health status of the populations of the industrialized countries was not dissimilar to that of the poorest parts of today's Third World. For example, in the 1840s in Preston, Lancashire, northeastern England, Reverend Clay in his Report of the Commission for Inquiry into the State of Large Towns and Populous Districts found that the lowest social class grouping, "factory operatives", had an infant mortality rate of 312 per thousand, more than three times that of the highest social class grouping, the "gentry which had a rate of 92 per thousand (9). Clay also calculated that of every 1,000 children born to the families of operatives only 112 survived to age 60, in contrast to 451 children of the gentry.It is important to note that such disparities could not have been based upon differences in access to medical care, because at this time there was relatively little that medicine could positively accomplish, but rather upon the differing social and economic conditions of the classes concerned.

More recent historical experiences are reflected in changes in infant mortality rates in New York City over the first three decades of this century (10). From 1900 to 1930 these rates fell from 140 per thousandto around 55 per thousand, an overall fall of about 60%. Of that fall two-thirds occurred in the so-called "diarrhea-pneumonia" complex of childhood diseases. The most striking aspect of this rapid fall of infant mortality in New York City is that it occurred before there were any antimicrobial drugs, or vaccines with which to treat this particular disease complex. The sharp decrease in mortality resulting from control of the diarrhea-pneumonia disease complex in New York City took place in keeping with major social and political changes, particularly those leading to higher incomes for the poor, that were occurring in a society which had already reached a relatively advanced state of technological development. In addition, a number of more specifically public health related developments were taking place in areas such as nutrition, sanitation, education, visiting nurse services and well-baby clinics, etc. In the years since 1930 infant mortality has fallen in New York City from 55 per thousand to below 20. Studies of the effects of modern medical care (the last 50 years or so) on death rates indicate that despite the availability of powerful new drugs and more scientific medical procedures, improved socio-economic conditions still provide the basic preconditions for further significant and relatively rapid declines in infant (and more general) death rates (11). In any event, most scholars agree (12) that medicine per se had contributed little to the major improvements in health status which occurred prior to the 1930s. Rather, it was positive economic, social and political developments which led to improved diets, a cleaner environment, a better educated population etc., and thus more healthy people. In more recent years the experiences of countries such as China and Cuba have borne out the validity of this historical finding.

3- SOCIAL-POLITICAL BASES OF ILL HEALTH

In low income countries the major cause to the degree there is one major cause of early childhood death is malnutrition, which contributes to most other disease problems. A careful study of early childhood mortality in the Americas, where nutritional status is on average better than in Africa or Asia, showed that 57% of the children who died before reaching the fifth year of life had malnourishment as an underlying or associated cause of death (13). The dominant role of birth weight has been firmly established, with biological variables such as age of mother, parity and pregnancy interval playing

relatively minor roles (14). Not surprisingly, in poorer countries anyway, birth weight is primarily determined by the socio economic position of families. As many as 400/0 to 50% of the infants born to poor families in the Third World have low birth weights, as compared to only 5% to 100/0 of those born to richer families.

It is well known that many Third World countries, especially since their political independence, have experienced a fairly rapid fall in infant and child mortality rates, which in turn is linked to a significant growth of population. Although specific reasons for this fall are not precisely known, it is commonly thought to be primarily due to public health measures such as the international smallpox and malaria campaigns and possibly to increasing availability of supplies of clean water and improved nutritional status. Although death rates may have been affected by the smallpox, malaria, and other campaigns, the large fall that actually took place does not appear to be adequately explained by these alone. With regard to clean water, waste disposal and other aspects of sanitation, little has changed for the bulk of the population of the Third World which remains primarily rural; those who have migrated to the towns may have improved their position in this respect. With regard to the nutrition factor, it may be that its important contribution to falling especially) infant mortality rates has come about primarily through the more rapid availability of at least minimum quantities of foodstuffs at times of extreme food shortage and examine. Of course, famine still occurs in the Third World but no longer so regularly as during the colonial era -although recent African experience begins to call this observation into question. There is little evidence that average nutritional standards within much of the Third World are rising, within the context of relatively wide variations, but the very availability of national and international food stocks and the transport systems to move them quickly make it less possible under conditions of independent sovereignty to allow starvation to the point of immediate death. However, although fewer people may die outright from starvation many survive only at lowered nutritional and energy levels; thus undernutrition becomes a chronic process rather than an acute event.

The importance of malnutrition as the primary cause of early childhood mortality, as well as the essentially socio-political basis of malnutrition, can be clearly demonstrated in the context of the experience of oneparticularly poor country, Bangladesh. Per capita income in Bangladesh is around US $ 25 and is badly distributed. Approximately 80Jo of the labour force is engaged in agriculture. The potential capacity of the land and its people to produce food is very great, although only part of that potential is being realized. A major constraint to increased production is limited effective economic demand for foodstuffs. A very substantial proportion of Bangladeshi families either do not own enough land, or in the case of tenants are not allowed to retain for themselves enough of their harvest, or else do not earn enough wage income so as to be able to keep themselves alive. The very large volume of food imports and external contributions coming into the country helps to avoid many immediate deaths from starvation, although it cannot prevent a permanent condition of malnourishment for millions; It has been estimated that only half the population enjoys an adequate caloric intake and even less sufficent protien consumption. Some 1976 data from a fairly typical thana (district) in Bangladesh, Companiganj, illustrate then prevailing situation (5). Almost certainly the situation has worsened during more recent years (6).

Twenty-three percent of families have no land and no salaried income of any kind. Forty-eight percent have less than half an acre of land and less than US $3.60 per month salaried income. Thus, nearly half of the families of this thana do not have the resources within the family to support the family and are dependent upon income from casual labour, usually available only at the time of harvest. Fifty percent of families live off four percent of the land.

Not surprisingly the health-related effects of the situation described are very serious. Given the prevailing nutritional picture even in "no.nnal " years any economic shock will immediately cause grevious damage to the weakest parts of the population. Thus, the economic and political crises experienced by Bangladesh in 1975 increased the crude death rate to around 26 per thousand from an earlier 14 per thousand. As would be expected the increase in mortality was felt most keenly by the children. Infant mortality rose from 128 to 142 per thousand live births and mortality in the one to four years age group from 23 to 55 per thousand. Of all deaths in 1975 in Companiganj thana, 50% were of children under the age of four. Of these deaths 30% were ascribed to "primary malnutrition ", 27% to chronic or acute diarrhoea or dysentery, and close to 20% to other preventable illnesses. The study goes on to report that those in the "low economic group ", had mortality rates three times those in the "high economic group ". In absolute terms high income group experienced a death rate of 9.7 per thousand, the middle income group 16.6 per thousand, and the low incomegroup 31.3 per thousand.

Inequalities of power, influence, opportunity, and the ownership and distribution of assets and income

lie at the root of the much discussed "Bangladesh crisis" In this the country is not unlike many others in the Third World, only more so. Of course, sufficient inequality can kill children in any national environment, but in low income countries the margin of safety is much narrower. Beyond that, in the international area, the wasteful affluence of the industrialized countries is linked not only in a lufntitative sense to the poverty of Third World nations, but also in more subtle relationships which encourage both internal inequality and continuing external dependency on the part of these nations.

The socio-political bases of ill health in Bangladesh as in so many other countries are rooted in centuries of colonial exploitation, economic dependence and external control. The basic global inequaities created during those centuries continue despite political independence having been achieved by virtually all the people of the world. However, the particular patterns of development being followed by many of the newly independent countries, and in the case of the Americas by countries that have long been independent, have reproduced key areas of inequality which had been either initially created or encouraged during the colonial period. Land ownership is being concentrated in fewer hands with agricultural production oriented increasingly to market production, especially the global market for foodstuffs. Coupled with the loss of land by small holders is the breakdown of traditional family support systems which leave the weakest part of the family, the women and children, in the most vulnerable position. There are worsening life conditions for the mass of the population in many countries at the same time as a relative few appropriate the wealth of the nation to themselves. This process goes forward in the context of the general impoverishment of subsistence and other small peasants and farmers, rapidly growing and increasingly filthy urban environments, unemployment and underemployment of unprecedented proportions coupled with the importation of inappropriate capital intensive technologies, rates of illiteracy which often remain virtually constant together with growing university enrollments even in the face of graduate unemployment, and rapid population growth flowing out of continuing poverty and inequality.All of the above has led, inevitably, to increasingly militant and revolutionary reactions and, just as inevitably, in many countries to more and more unrepresentative and repressive regimes as the privileged struggle to protect their perceived interests.

4- FROM GROWTHMANSHIP TO BASIC NEEDS

The conditions described above have led to a re-examination on the part of many development theorists and some governments of the very definition of development. From the end of World War II until the late 1960s the prescription to the economic problems of the Third World advanced by the dominant circles in the advanced capitalist countries was what some have called "growthmanship" (17). The solution to underdevelopment was seen to lie in a relatively rapid growth of national product coupled with some sort of modernization which would lead to gradual amelioration of the situation of the mass of the population. The approach implied, at least in the short and medium term, curtailment of investment in sectors considered as "non productive " -health, education, etc. -until the economy was strong enough to support such "costs ". Even a more equitable spread of income was suspect on the same grounds.

By the late 19608 there was general dis illusionment in bourgeois economic circles with the appropriateness of pure growth models for developing as well as developed countries. Doubts about growthmanship as an appropriate model had been raised by the increasing volume of evidence pointing to the impossibility of repeating nineteenth century experiences in the conditions of twentieth century underdevelopment. Ithad also been perceived that, contrary to expectations and despite a certain amount of economic growth, the previous several decades had witnessed increasing impoverishment for a significant proportion of thepopulation of the Third World. In addition, and in sharp contrast, the experience of developing socialist countries, China in particular, in significantly reducing poverty and its effects was beginning to become more widely known in the non-socialist world.

The decade of the 1970s saw a move away from growth of national product as the unique development indicator. This in turn, opened the way for the needs of the poor, especially as seen in terms of income redistribution, employment creation and the provision of "basic needs ", to emerge as the immediate goal of an increasing number of development programmes. In addition, the need for genuine community participation for the achievement of these goals came increasingly to be part of the common development perspective. All of this, in conjunction with the New Inter national Economic order (NIEO), has come to dominate contemporary development discussion.

5-The New International Economic Order (Wealth) and Health.

As part of the current debate about political, social and economic relations between the developed capitalist countries and the underdeveloped countries little looms larger than the demand of the latter for the New International.economic Order (18). Its name makes clear what it is about. The leadership of the Third World is demanding a greater share of the benefits accruing from international economic relationships; in practice, an international redistribution of income among countries. The developed capitalist countries have responded with calls for a "new international development strategy, which while incorporating some (usually marginal) elements of the NIEO within it, concentrates primarily upon intra-national issues, especially the meeting of people's basic needs, including that of health care by the governments of the developing countries.

The nations which persistently demand the establishment of the New International Economic Order have also committed themselves, formally at least, to basic changes in their own countries in the approach to health development. At the First International Conference on Primary Health Care they joined with all the other countries of the world in stating that "existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries (19). And further that "economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace " (19). Within their organization the Group of 77 has stated that the "central element of the international development strategy of the Third United Nations Development Decade (the 1980s) should be the implementation of the New International Economic Order and in this context action needs to be taken to enhance the share of the developing countries in the international decision making for management of the world economy (20). Also, that within. the new strategy adequate attention should be paid to the eradication of mass poverty and to raising the living standards of people in the developing countries" (20).

The major industrialized capitalist countries however, continue to oppose the basic concept of the NIEO in favour of a separate basic needs strategy which would be independent of any significant changes in the overall world order. In any event, it should be clear that achievement of the NIEO would not by itself guarantee either development in any real sense or improved health conditions for the world's poor. This flows from the fact that more material resources are not the unique basis of improved national health indices.

It is true that, historically, improved levels of income have led to improved health status, at least in the sense that morbidity and mortality experience has shifted from the more acute to the more chronic diseases. As discussed above, this change is not especially related to specific health care (preventive or curative) programmes as such, but rather to overall improvement in living standards. It is also true that dependent capitalist "development" in the neocolonial states has led to a deterioration of the health status of the majority. Thus to be really effective, the NIEO would have to correspond with changes in the internal order of most of the developing countries.

Primary Health Care

Primary health care is a concept based on a redefinition of health, expressing national political committments to a "new health order" and its goal of "health for all by the year 2000". PHC is not some special activity separate from the overall socioeconomic or health care system, nor it is some perfect solution to all health problems arid the sole creator of "health for all ". At the very least, though, it offers the health sector an instrument for the organization of more relevant and effective health care systems. Thus, a reorientation of the health care system, away from its typical hospital bias in favour of a widespread network of fully utilized basic health services, is a minimum goal for any health ministry. An adequate primary health care strategy would be broader than only an extension of the services offered by the conventional Ministry of Health, or even the development of new types of community health activities. The intrinsic philosophy of PHC would find application in terms of overall economic and social policy, specific ministerial and programme activity in all sectors influencing health, and all aspects of the work of the Ministry of Health itself. Planning for health requires a conscious review of the effects on the health of the entire population, and especially on its more vulnerable groups, of all governmental and governmentally influenced decisions and activities. Thisimplies a democratic, interrelated and generally decentralized approach to health related planning and decision making, programme management and implementation, and administration.

The PHC strategy in its more carefully elaborated form relates overall social change to such innovations as the use of village level workers or indigenous health practitioners in health

development. But many of these types of activities appear only as projects; that is, isolated activities carried out apart from conventional national health and other systems which continue to absorb virtually the whole of ministerial budgets. In the absence of changes in the whole of national health planning and delivery systems such projects cannot be expected to be successful. In fact, even apparently quite radical proposals directed toward the training of "bare-foot doctors " or other types of village workers, or concentrated activity directed towards scattered populations, avoid the more central question: the present unsatisfactory pattern of allocation of resources and resulting absence of care even for those who already have reasonably adequate physical access to, say, health or educational facilities. In some ways it appears that answers to long standing problems are being sought outside existing health, education and other systems thus reflecting either cynicism or disillusionment about the possibility of changing the way these structures now function. But such attitudes cannot be allowed to become the basis of two-tier systems, one for the minority with access to an expensive high technology system and one for the rest of the population. While village workers may well be potentially important instruments of change, they can only be so in the context of extensive political, social and economic adjustment at national and international level. At this moment there is at least as much possibility of the PHC strategy becoming in many countries nothing more than a dodge to avoid change, as of its becoming a positive instrument in the creation of change.

It is important to note that despite the almost universal rhetorical support being given to the PHC concept (although different definitions of PHC are being offered), many/most governments and agencies remain tied to more traditional views of the causes of disease and the best ways of organizing scarce resource for disease control activities. These' more traditional views are often expressed in the context of continuing support for categorical disease control programmes, and opposition to the integration of such programmes into more generalized PHC: activities. (Sometimes, however, certain of the apparent intellectual struggle between "verticalists" an integrationists " seem to be based more on empire protection and building than anything else. A particularly pernicious defense of traditional categorical disease control programmes goes under the name, or concept, of "selective primary health care ". Such programmes are vertical in character and are distinguished from, say, unipurpose malaria or family planning programmes only by the fact that they combine several activities within structures which remain essentially vertical in character. Such programmes make a mockery of the integrated PHC approach to health development (21).

Another important point in the PHC approach is community participation. Community control over local PHC activities offers, at least potentialy, the best bruarantee of their successful development. To besuccessflJI PHC will have to make use of technologies which result in services that are affordable to low income populations. It is precisely the fact of community development and control over limited resources,both those contributed directly by the local community itself and by higher levels of government, which offers the best assurance that appropriate technological choices will be made so as to assure the equitable and efficient use of those limited resources. There are many ways in which the community can participate in the different stages of PHC development and implementation, from the definition of problems and the setting of priorities through the planning and implementation of the entire range of locally based PHC activities. It is in the course of such participation that precise judgements could be made which would determine the nature, cost and utilization of PHC activities: judgements concerned with such activities as labour contributions to construction, the training of village health workers, collaboration with traditional healers and birth attendants, the creation of local social insurance funds, and so on. As already implied, it is the net results of such decisions which would determine the basic costs of PHC.

Technical supervision of community level health services in PHC comes from the more specialized levels of the health system, primarily through guidance, education and that supply of appropriate information. Managerial control of PHC activities comes primarily from the community itself; for example, with reward to staff discipline, the supply and safekeeping of drugs, and community links with traditional healers andbirth attendants. In addition to its contribution to the management of PHC, the community can contribute financial resources in a large number of different ways, or its labour for the construction of clinics, pit latrines, and the development of sources of clean water. Labour and time can also be contributed to the control of mosquitoes, snails and other disease carriers. Another important form of labour contribution by the community is the community health worker. If these health workers come from the community in which they live and are truly chosen by it they are likely to have its support.

6- CONCLUSION

Deeper understanding of the bases of good health coupled with changed ideas about economic and

social development are inherent to the primary health care approach to "Health for All by the Year 200". The slogan of Health For All necessarily provides sufficient ambiguity of definition to allow governments to pursue their preferred course of action in reaching their chosen health goals. Of course, many variations of interpretation reflecting different levels of development could properly be expected, but other differences are based primarily upon the degree of willingness to genuinely pursue the PHC approach. Perhaps the most obvious distinction is between, integrated national approaches to health development of the type to be found, typically, in countries maintaining socialist perspectives and the piecemeal, project type activities which characterize most such efforts in capitalist countries within the Third World. In this latter approach, PHC is usually equated with community health workers and isolated low cost community programmes which are distinct from the overall health system of the country.This approach has contributed to the view that PHC is a type of second class medicine reserved for the poor. It need hardly be said that this approach is completely at variance with the expressed purposes of the Declaration of Alma Ata. It is not surprising that in countries in which decisions are taken by and in the interest of only a small part of the population, little progress has been made in implementing the primary health care approach to health development although this has not stopped many such countries from waving the banner of Health for All. It should be clearly stated that primary health care is not, in the first place, about medical care; rather, it is about overcoming under development and thereby achieving health for all. Obviously health for all cannot be achieved in any country in the absence of an end to underdevelopment.

World Bank and other data indicate that in the absence of basic changes 600 to 1,000 million people will still be living in "absolute poverty "in the year 2000 and hundreds of millions of other will continue to live below the "poverty line". The contradiction between these figures and the goal of health for all offers a stark and incompatible contrast. Of course, the fact that such predictions are offered does not mean either that they must come to pass or that they will necessarily encompass the population of any particular country.The first task in each country is to fight against the forces of inequality and oppression which are opposed to a successful outcome of the struggle for Health for All. In fact, throughout the Third World millions already engaged in that struggle, supported by progressive forces and individuals all over that world. As always -the struggle continues.

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