

REACTION TO "PRIMARY HEALTH CARE IN A MULTILEVEL PERSPECTIVE":
A POSITION PAPER FOR THE INTERNATIONAL SEMINAR ON PRIMARY HEALTH
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In this paper I will respond to the questions posed by the Dutch research group as requested in the invitation sent to the participants in this seminar.

The answers I will give are based on a literature study I did concerning Primary Health Care (PHC) and on my own research data which were collected in Somoketro, a rural village in Central Java, Indonesia (September, 1986-January, 1987).

In this paper, I have particularly tried, to elaborate critical remarks on the subject. First at all for a selfish reason: I feel that a discussion about these remarks can help me elucidate some of the problems I have encountered in trying to use the multilevel perspective as a theoretical framework for my Ph.D. research. Second, I believe that (sound!) criticisms are more relevant for further conceptualization of this perspective at this stage than mere expressions of agreement and appreciation. With this warning in mind, I hope that the brevity of my positive comments concerning the multilevel perspective will not surprise the reader.

1. How do you perceive the way in which the political, economic and socio-cultural implications of PHC are described in the position paper?

I can only agree with the assumptions of the position paper regarding the political and economic implications of PHC. Too often PHC is described only in idealistic terms without paying

too much attention to the economic and political considerations which underly this strategy. These considerations have clear consequences for the implementation of the various programs which can be found under the broad 'umbrella' of PHC. A critical evaluation of the aims and results of PHC in political and economic terms (as the multilevel perspective intends to do) is, in my opinion, necessary.

I also feel that attention should be given to the, often conflicting, political and economic interests of the different groups involved at the different levels of the 'transmission' line, which goes from the international organizations via national governments and regional bureaucracies to the target populations.

Nevertheless, this should not mean that scarcely any attention is paid to the socio-cultural implications of PHC. It seems to me that this aspect has received much less recognition in the position paper. For example, themes such as the implications which PHC can have (and has) for the transformation of patients' ideas about illness and health and/or for the introduction of 'Western' concepts in developing countries could be emphasized more.

I would also like to make a more general observation. While reading the position paper I received the impression that despite the many critical remarks about PHC, the research group clerally advocates it and aims to make concrete recommendations for the improvement of basic health care via PHC. The reader is for example warned about the danger the WHO and UNICEF may drop PHC programs altogether in the near future. Nowhere in the paper, however, can one read the reasons why the research group chooses to support PHC. In my way of thinking this is also a political choice and this should therefore be stated explicitly.

2. Do you find the multilevel perspective useful in understanding the functioning of PHC?

I do indeed find the multilevel perspective very useful. As already mentioned, I am in fact now using this perspective as a theoretical framework and analytical tool for my Ph.D. research. Nevertheless, I feel that certain aspects need further definition.

The multilevel perspective offers new insights in the study of PHC by paying attention to the different organizational levels of the health-care system and to the connections (linkages) between these levels. Yet one must be aware of the hidden dangers in this approach. In Hüsken's words: "'linkage' tends to obscure the fact that quite often communication is not established, that efforts to link local processes to national development targets can backfire..." (Hüsken 1988: 12). In addition to searching for links and connections, we must also study failing connections in order to gain insights into the interaction of the different levels.

Another theoretical problem which I encountered during my preparatory research concerned the kinds of relationships which can be analysed using the multilevel perspective: do interpersonal, intersectoral and/or interorganizational relationships all fall under the term 'linkage'? If so, is this concept then not being stretched too far?

For example, the relationship between the private and public sectors of the health-care system is of a different nature than the relationship between the doctor and his patients. Can these different kinds of linkages be studied using the same multilevel perspective without their losing their specific natures? If so, what is the best way to undertake such research?

The study of hierarchical relationships inside the same organizational level also seems problematic to me if one is using

the multilevel perspective; this is because this perspective stresses the connections between the different vertical levels. Yet also hierarchical (vertical) relationships at the same level are very important and cannot be left out of the picture. For example, at district level, in my research there were many relationships at the health center (the Puskesmas) which deserved attention; to name a few: doctor-nurse; doctor-patient; doctor-community health workers; nurse-community health workers. In these cases, different and conflicting interests could be at stake and this would have clear consequences for the implementation of health programs.

This point is particularly important to me since my Ph.D. research will focus on nursing personnel in PHC. To study this subject it is necessary to discern the problems specific to each kind of health personnel and the relationships between them. Therefore, I can't be content neither with the general term 'doctors and other medical personnel' nor with the focus on 'doctors' as the embodiments of different societal levels. Specially in a situation such as that in rural Java where doctors are often unavailable for the people and where the largest share of curative help lies in the hands of nursing personnel (mantri and perawat), I question whether the central question should be "the conflict between the availability of a doctor and the self-dependence principle in PHC" (position paper: 11).

On reading the position paper I also became confused about the meaning of 'horizontal' linkages. It seems to me that this term is used to indicate the relationship between different sectors in society at large: religion, economy, health etc.

In my research proposal, I interpreted this term somewhat differently and gave it a narrower meaning. In fact, I used the concept 'horizontal linkages' to point to the relationships between the formal and informal health circuits, the private and public health sectors, the 'traditional' and 'modern' health spheres. In other words, I referred to different parallel sectors

at the same organizational level inside the selected configuration (in my case: the health-care system). Although these different interpretations are not really antithetical, elucidations on this point would be welcome.

I also have some doubts about a number of assumptions made in the position paper. Such a great emphasis on difficulties created by encouragement of self-reliance (p. 9) gives the impression that the population cannot live without doctors and that they run to the health-center and ask for help for every little complaint. This was not the case in my research area (how to stimulate use of the health center was precisely one of the major problems!). People managed the largest share (50 to 70%) of all illness episodes with self-medication ('traditional' herbs and/or 'modern' pharmaceutical products). Only if the illness was taking a long time to heal and if the cluster of symptoms was defined as a dangerous illness did the family in question look for professional help ('traditional' healers or 'biomedical' doctors according to the illness defined). Their self-reliance was therefore really quite high. This is not, for that matter, a unique situation. In Kleinman's words: "Self-treatment by the individual and family is the first therapeutic intervention resorted to by most people across a wide range of cultures" (Kleinman 1980: 51).

I can, further, rise two questions regarding the way 'traditional' medicine is treated in the paper:

1) I doubt whether "the recommendation to have more faith in traditional medical knowledge and skills does not ring true to the villagers" (p. 9).

First, I think that many governments are still far from making such a recommendation. Second, I wonder why such a recommendation should sound fake to people. It adds or subtracts nothing to or from the villagers' faith. In fact, at least in Java, the people already have a strong faith in 'traditional' healers, a faith which does not need any encouragement. Perhaps

the opposite recommendation - 'to have faith in 'modern' medicine' - would be more appropriate for the circumstances!

2) It is too easily assumed that the "villagers have come to the conclusion that the results of...the curative means of modern medicine are quicker and more effective" (p. 9) and that they are ready to give up the 'old' means "increasingly regarded as inferior" (p. 12).

It is indeed true that 'modern' pharmaceutical products are increasingly being appreciated due to their quick results. Nevertheless, I do not know whether it is true that these products are also seen as being more effective. The quality of 'traditional' herbs and remedies (kerokan, massage...) was never questioned during my interviews. It was even often said that 'traditional' medicine was better. With the latter, said my informants, the disease is permanently cured and the total balance of the body is restored, while 'modern' medicine cures only symptoms with the result that the disease is only temporarily suppressed.

Also, I do not think that the acceptance of 'modern' medicine endangers the use of 'traditional' remedies. Each kind of medical aid was used by my informants for a special purpose: to cure a distinct kind of illness. It was not a question of 'or this or that'. It was 'this and that'. 'Modern' medicine was just added to the already existing medical supplies. It became just one more possible choice in a pluralistic medical system.

Summing up: I think that the multilevel perspective is a very promising theoretical framework. Also, since this perspective is still in a growing phase, it provides an attractive challenge: to try to conceptualize those aspects which still need further discussion and elaboration.

3. Give a short description of the functioning of PHC in the country where you do research (if possibly using the

multilevel perspective).

It is quite difficult to sum up in such a short paper all the available information about PHC in Indonesia. Moreover, the great variety of economic, political, social and cultural conditions found in the various regions of this country make it almost impossible to present general statements on the subject. Nevertheless, I will attempt to give a brief but complete description of PHC, with the warning that when I talk about local situations, I am referring especially to rural Java.

The development of the Indonesian health policy in the past decades has resulted in a number of five-year governmental plans. It was not until the second half of the first five-year plan (Pelita I: 1969-1974) that primary health care began to receive attention. The growing awareness that the urban-oriented network of facilities would not automatically spread to the countryside (as was first assumed) led to the creation of the Puskesmas (Pusat Kesehatan Masyarakat) or rural health centers. The previously established mini clinics for child and maternal health (BKIA: Balai Kesejahteraan Ibu dan Anak) were integrated into the health centers with related activities, namely outpatient treatment, communicable disease control, dental care, laboratory work, family planning, community health education, sanitation. In the long run, each center was supposed to be staffed by one physician, one dentist, one obstetrician, and a number of nurses and assistants.

During the second five-year plan (Pelita II: 1974-1979) the aim to establish a health center in each subdistrict was achieved. However, not every center was provided with the necessary personnel: in 1978 approximately 50% of the centers in Java and about 60% of those outside Java did not yet have a doctor (Rienks & Iskander 1985).

By monitoring the utilization of the health centers, the Ministry of Health soon discovered that only 20% of the target populations were being served by the centers. In particular,

people with a low socio-economic status were not being reached. In an initial effort to reach the rural community stress was laid on mobile treatment: health center nurses were encouraged to operate as field-workers, visiting the villagers at home in order to cure simple diseases and to promote preventive health measures.

The relative scarcity of paramedical personnel proved to be a handicap in this context. Therefore, in a second phase, during the third five-year plan (Pelita III: 1979-1984), emphasis was laid on the planning, education and training of volunteers (kader or village health workers) and on development of Village Primary Health Care Unit (PKMD). The objective of these programs was "to raise the state of health of the community through the efforts of the community members themselves" (Ministry of Health, Republic of Indonesia 1978: 24). It was hoped that, in this way, use of the health centers and coverage of the local population would be maximized. This last development in Indonesian health policy was a result of both the worldwide trend towards involving village health workers in health programs and the (perceived) success of an experiment which in the early 1970's was undertaken by some physicians supported by voluntary agencies in the Banjarnegara regency (Williams & Satoto 1981).

Initial optimism in Indonesian (and international) medical circles regarding the value of village health workers has recently diminished. Often, the local population does not even know that the kader exists; the villagers who do know do not really understand his/her essential tasks.

Further, more and more doubts are arising with regard to the official claims of community participation in the execution of the program. It appears that most of the 'volunteer' health workers are in fact appointed by village officials.

The implementation of this program has also not resulted in the expected maximization of coverage by the health centers. Under-utilization is a major problem.

The picture which results from the description above shows a

strongly centralized health system. Decisions are made at the national level and then transmitted downwards. The vertical line of responsibility starts at the top with the Ministry of Health in Jakarta. At the other end, the local level, is the village health worker. In between there are three levels: provincial (Provincial Health Service: IKES), district (District Health Service) and subdistrict (Puskesmas) level. The health system is furthermore tied horizontally to the government administration at each level.

Decisions made at the international level also influence the policy of this system. The Indonesian government must in fact also take into consideration the wishes of the donor countries and/or organizations regarding his plans (e.g. World Bank, IGGI). Thus international trends affect local development.

It is clear that in the Indonesian health-care system configuration 'linkages' extend from 'the top' to 'the bottom'. The question is whether the contrary also proves to be true. As already noted, we cannot really talk of community participation. At the national level it was decided that community participation would be good to raise health standards. Willing and unwilling villagers were expected to participate in the health programs.

Even the aims of participation were a priori chosen. Even though in the experimental phase village health workers were involved in agriculture, fisheries, road construction etc. (a concept of health in a broad sense), with formal recognition of this in the later Indonesian government's plans, it became clear that priority was to be given to support of the health center's curative health operations (a concept of health in a narrow sense).

Is it therefore not idealistic to talk about self-reliance and community participation when the necessary space is absent in the health system in question? Can local experiments also be successful on a national basis? Do they lose their strength if they are integrated into a strong hierarchical system?

At the district level, each health center runs different

programs. These are: curative and preventive health care; family planning; improvement of the subdistrict's hygiene and sanitation (with priority being given to rural water supplies and human waste disposal); control of communicable diseases (particularly malaria, pulmonary tuberculosis, and gastro enterites); improvement of nutritional status (particularly of pregnant women and children under 5 years of age); and health education. These programs are all parts of a package handed down from the top, a package called 'basic health strategy'.

One could ask in this context whether it is not pretentious and unrealistic to burden a relatively poorly-staffed health center with all these activities. (In my research area the health center had 1 doctor, 2 nurses, 1 obstetrician and about 10 assistants - pembantu imunisasi, pembantu umum, pembantu bidan etc. - for a population of 36,695 inhabitants.)

Is it not to be expected that in these conditions the quality of the health service will leave much to be desired? It seems that attempts to improve quantity are somehow seen as being more important than attempts to improve quality; raising the number of patient appears to give the health centers more prestige than 'invisible' improvements in the quality of care. After all the facade of successful developments must be kept up by showing the higher organizational levels tangible, quantifiable aspects of each program.

Would it not be better to opt for a narrower health program, which is adapted more to the limited possibilities of the health-center staff, than to run after a utopian dream? And would it not be better to value qualitative evaluation rather than to strive for quantifiable results? Even if on paper the success of the family planning program (Keluarga Berencana) seems to be confirmed by figures showing that 100 contraceptive have been distributed in a village with 100 families, the fact remains that these contraceptive are not being used!

I would like to make one final comment about the role of 'traditional' medical practitioners and remedies in the framework

of PHC in Indonesia.

Only with respect to 'traditional' midwives and 'traditional' medicines are some sound attempts being made to integrate them with Western medicine. A course for 'traditional' midwives (dukun bayi) is being organized at the Puskesmas. In this course elementary hygiene rules are taught with regard to the prevention of tetanus neonatorum. It is assumed that tetanus is often acquired via the navel wound after the dukun bayi cuts off the umbilical cord with an (unsterilized) bamboo knife.

It must be said, however, that not all health-center staff and village administration officials are particularly interested in the dukun bayi and their work. Moreover, the dukun bayi are not always enthusiastic about following a course if they are given a choice. An old dukun bayi said to me during an interview: "I have been helping children to be born for 30 years already, what can the 'young' Puskesmas staff possibly still teach me that I do not already know?"

The Puskesmas is also promoting the cultivation and use of a certain number of healing herbs (Apotik hidup). The government is also increasingly registering traditional remedies: laboratory tests are being intensified to prove their effectiveness and to determine possible side effects (thus "measuring their appreciation of traditional medicine against the biomedical yardstick" (Position paper: 13).

These timid efforts must not give the wrong impression, though. True integration of 'traditional' and 'modern' medicine is still far in the future. The Indonesian government is still trying to ignore and deny the important role which indigenous healers play in providing health care. Numbers which quantify the demand for 'traditional' healers (dukun) are played down in official surveys and statistics. The fact that, especially in rural areas, dukun are often consulted is explained in terms of population's poverty and ignorance.

The same line of reasoning can be found in the messages transmitted via television, radio and newspapers. They describe the dukun in negative terms such as dangerous profiteers, who take advantage of the villagers' credulity. Villagers in their turn are accused of holding superstitious beliefs which inhibit all attempts to improve their health conditions by 'modern' means.

Whether this situation can ever lead to a co-operative enterprise based on equality between 'traditional' healers, on the one hand, and 'modern' practitioners on the other, is a question which presently can only be answered in the negative.

4. What is your opinion of the proposed research themes?

Considering the subject of my Ph.D. research, it is logical that I would be particularly interested in the theme: 'The role of medical personnel in PHC'. This is so notwithstanding the fact that my focus is somewhat different, since I have chosen as my central theme the availability of nursing personnel and the unavailability of doctors instead of the problematic relationship between the availability of doctors and the self-dependence principle in PHC.

The other themes also seems really important and worthwhile studying. I especially think that discussion of the two themes: distribution and use of medicines and integration of vertical and horizontal programs deserves to be stimulated since these subjects are of current interest and quite new (as opposed to the other two themes: traditional medicine and family planning which have already received considerable attention in the past).

It does seem that some of the themes discussed in the position paper, do not emerge in the proposed research themes. Attention for population's expectations and for contradictions between the community's wishes and plans at a higher level is,

for example, such a case. This is surprising because a statement such as: "research into the need of local communities with respect to PHC is scarce.it seems that this subject has always been avoided in PHC research" (Position paper: 7) gives the (wrong?) impression that the Dutch research group wants to fill this hiatus in medical sociology/anthropology.

I wonder also how these five themes were chosen. Which criteria were used: whether or not the theme lends itself to analysis using the multilevel perspective? Or whether or not the theme is problematic for PHC so that proposed solutions could really help improve basic health care? Insight into the relevant criteria could be useful to suggest other themes which would fit with the proposed ones in order to form a good articulated research plan. This lead me to the domain of the next, and last, question.

5. What would you consider the most important fields for research on PHC in the country where you do research? Please give suggestions for a concrete research design.

As stated before, attention should be paid to population's expectations concerning PHC. What do they know about PHC programs? How do they experience the 'requirement' to participate? etc. In this context, patient's choices regarding 'traditional' and 'modern' medicine should also be taken into consideration.

Another theme which interests me is the attitude of 'traditional' healers towards PHC and 'modern' medicine in general. Too often researchers focus only on the attitudes of 'modern' health practitioners towards 'traditional' medicine, without paying attention to the other side of the coin.

Another aspect which has not yet received much attention is

the relationship between the governmental health system and volunteer health organizations. Do they co-operate with each other or hinder one another?

Research could also center on the relationship between the private and public health sectors. This relationship could be examined at various levels. At the lowest levels one could, for example, examine the relationship between private doctors' and nurses' practices and the Puskesmas; at the highest levels studies could focus on the relationship between public and private hospitals which cover entire regions.

For those interested in macroprocesses, it could be appealing to study the influence which development aid given by donor countries and international donor organizations has on the Indonesian government's health policies. A study of the role and aims of Dutch development health policies concerning Indonesia could also be relevant in this context.

Finally, a comparison of urban and rural health services could provide us with some useful insights. It could show us how programs planned at the national level are implemented in different situations, and which consequences this diversity has for the results of the various programs. Especially during recent years stress has been laid on the study of rural health services, based on the assumption that urban health services work better and thus need less attention. It is now time to check whether this assumption is correct.

It is obvious that these are only a few of the relevant themes which could be chosen as fields for research on PHC in addition to the themes already proposed by the Dutch research group. I chose them on the basis of my personal interests and thus in an arbitrary way. It cannot therefore be concluded that these are also the 'most important fields for research on PHC in Indonesia'.

Conclusion

In this paper I have tried to answer in an exhaustive way all five questions posed by the Dutch research group. Despite my limited study and research experience, I have tried to formulate a number of considerations which express my opinions on the subject. In this way I hope that I have contributed to this seminar on the multilevel perspective.

I am sure that my theoretical knowledge will be enriched by the discussions at the seminar. Therefore I am already looking forward to November 13th.

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