My Student Elective

Zimbabwe three years on

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The ambition to provide "Health For All by the Year 2000" cannot be realised in the developing countries unless they seek an alternative to conventional medical structures. The government and some of the medical profession in Zimbabwe have appreciated this fact and are committed to promoting primary health care as the most pragmatic means of tackling the major diseases which are seen there. Primary health care promoted by the World Health Organisation is not a new campaign but its adoption by governments is more recent, its impact readily being seen by those who examine the statistics. What is happening in Zimbabwe, and in various other countries, may well come to be seen as a revolution in the history of medical practice. Since independence in 1980 there has been the opportunity to restructure, and in some places create, the health care system.

I was fortunate to be able to go to Zimbabwe for a seven week elective at the end of 1983, when I was introduced to the concepts of primary health care by Dr R O Laing, the provincial medical director of Mashonaland Central based at Bindura, and travelled with him learning how it is being implemented in this area.

Practical problems

I was shown the practical problems of establishing, maintaining, and improving primary health care during our travel through north Mashonaland. We drove considerable distances, leaving the metalled road well before our descent over the escarpment, the winding track following the former elephant trails down into the communal lands of the Zambezi Valley. The quality of the land here was poor, the roads unpredictable, and a second year of drought has served to highlight the shortcomings in the distribution of food and land. The large numbers of refugees from Mozambique are proving an additional strain on the scant resources of the indigenous population. We attended the establishment of two district health committees composed of representatives from the whole range of medical and paramedical personnel. These committees aimed at motivating and mobilising the local community to institute simple but effective health measures—for example, teaching builders to construct sanitation facilities. They are constrained by their annual budget of only some £5000 for about 50 000 people, and ultimately all their projects must be self financing.

During the lively discussion of the committees certain themes emerged time and again, illustrating some of the principal concerns of primary health care—namely, maternal and child health, including family planning and an expanded pro-

gramme of immunisation; water and sanitation; nutrition and health education. It was also made clear that to be successful a service must be acceptable, accessible, appropriate, and affordable.

Acceptability

Acceptable policies were those which respected traditional structures, encouraging through education those practices which were beneficial and countering those that were detrimental. The people saw scientific medicine as emphasising only physical health and hygiene and the traditional health system as emphasising moral health and hygiene of the soul. Minor illnesses such as colds, fevers, and diarrhoea were thought to be due to "bad air" arising in the physical surroundings, and (as Western medicine was generally successful in dealing with these) the people were quite willing to come to clinic for treatment of such ailments. Nevertheless, they believed that more serious disease resulted from a lowering of resistance due to immoral practice within a social or spiritual context combined with offending the spirits of the maternal or paternal elders (elders are a central tenet of the culture, which has also incorporated Christianity in many areas, particularly in the townships). Such diseases included tuberculosis, various malignancies, and epilepsy, and they thought that, though Western medicine offered palliation, cure could be secured only by attending to the spiritual cause of the disease, following the recommendations of the traditional healers—the powerful n'angas. Hence patients tended to present with advanced disease having first been to traditional healers. Compliance with treatment regimens was low as the patients were uncertain of the rationale behind them. One example of satisfactory compromise between traditional and scientific practice involved a religious sect, the Apostolics, who were persuaded to hold a mass gathering at which all the children were immunised on condition that they were then "cleansed" at a ceremony performed by their priests.

Accessibility

Health care must be accessible to those who most need it. Although part of the constraint on provision was political and economic, major improvements could still be made within existing facilities. So far as the rural clinics were concerned this meant providing comprehensive curative and preventive services in a single visit to each person.

Such a "supermarket approach" was a departure from specialist clinics, which had been run primarily for the convenience of the clinic staff. Thus a pregnant woman attending the clinic with a small child in tow should be offered antenatal care and advice on birth spacing for herself together with growth assessment and an update of immunisation for her child, as well as any necessary curative treatment—all this in a

single attendance. To insist on each service being provided at separate clinics on different days is to lose the opportunity to manage these patients.

Appropriateness

Appropriate education has made use of drama to put across points with greater impact than lectures could achieve, particularly for people who may never have experienced classroom learning. Revolutionary songs from the days of the struggle for independence had been rewritten to advocate improvements in hygiene, nutrition, and health, even being sung in school assemblies.

Appropriate technology did not exclude high technology. In Bindura the staff hoped to acquire a computer system for analysing epidemiological data in an attempt to determine the most effective allocation of resources. Further examples of appropriate measures included the provision of simple "cord packs" to women coming for antenatal care, to try to reduce the incidence of neonatal sepsis and tetanus. Again, the promotion of suckling immediately after birth, which stimulates release of maternal oxytocin, would reduce the incidence of primary postpartum haemorrhage.

Affordability

So that primary health care should be affordable available resources were concentrated on "high risk" groups within the population. This maximised the impact of medical intervention for a given budget. Screening populations by simple check lists to identify those "at risk" and their referral to the next level in the service was done by the community based village health worker. Other measures included the use of recycled paper for all hospital records, and the national policy of generic drug prescription.

One of the major concerns of medical workers was the health of mothers and children. A crude perspective on the scale of the problem was that the provincial perinatal mortality rate was 130/1000 births and the maternal mortality rate 127/100 000 births (current figures in England and Wales are 13 and 11.9, respectively). Furthermore, about 90% of the clinics' workload is with this group.

Zimbabwe has been in the forefront in implementing programmes to reduce perinatal and maternal mortality and morbidity. These included conferences for medical and paramedical staff, and I attended two held at Karanda and Bindura hospitals.

Representatives from each clinic gave an account of what they had achieved and noted any shortcomings of provision. The aims of the maternal and child health programme in the context of primary health care were re-enforced, talks being given on obstetric and paediatric risk factors, child spacing, and sexually transmitted diseases. We divided into groups to discuss the merits, drawbacks, and implementation of the suggestions.

Traditional birth attendants

I particularly enjoyed a talk on traditional birth attendants, respected elderly women usually from the mother's village who conducted most of the deliveries. Some practices were harmful and were tactfully discouraged—for example, forbidding breast feeding until all the colostrum had been expressed, feeding the newborn with thin gruel, and applying home made pastes to the umbilical stump. The traditional birth attendants were gradually to be incorporated into the programme, since excluding them from their traditional role would have been culturally unacceptable.

That such cooperation between traditional and Western medical care was possible was illustrated in Manicaland, where the traditional birth attendants had agreed not to deliver any woman who had had a previous caesarean section unless she had had at least one antenatal check during her pregnancy. We were told about preschool groups in Rushinga district, where a daily midday high energy meal had virtually eliminated malnutrition. Such groups were also a valuable target for educational intervention, with the opportunity to reach mothers who might not otherwise come to the clinics.

Return to Bindura

My base at Bindura General Hospital was the provincial referral centre for the outlying district hospitals and clinics. More complicated medical problems went from Bindura to the teaching hospital in Harare. There were only eight hospital doctors in the province, serving an estimated 0.75 million people. At Bindura I was an active member of the medical team sharing general duties with the other three doctors. I soon found that much more was expected of every clinical grade than of their equivalents elsewhere. Thus medical assistants gave anaesthetics and doctors of only a few years' experience had to assume full medical and surgical responsibilities. In addition to attending ward rounds on all units, I saw outpatients at midday and worked in casualty theatre through the afternoons dealing with the patients myself and taking advice as necessary. During this time I gained invaluable experience of practical procedures, which I would not have had in Britain. More important, my time in Bindura proved to be a discipline in clinical technique. Only simpler investigations were available at short notice, others taking too long to come back from Harare to influence the management of the patient.

The profile of diseases I saw in the hospital was a compelling re-enforcement to what I had been told of in my earlier travels—particularly the virtual absence of the "diseases of civilisation" in this rural population. Having seen the beginnings of success from the primary health care approach, in the face of what had first appeared to be hopeless difficulties, I wonder whether some major diseases of the Western world might not be prevented by adopting similar methods.

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How much is known about the effect of climate on mood and illness?

It is universally acknowledged that the seasons, as a facet of climate, can exert a considerable effect on mood. Poets, with their innate and penetrating insight into the emotional life of men, make repeated references to these influences. Shakespeare talks of the "winter of our discontent" and, in one of his most exquisite sonnets asks his lover, "Shall I compare thee to a Summer's day?" As to the effect of climate itself there is little published. Kraepelin journeyed to Java at the turn of the century and published a rose tinted account of the Javanese who, he alleged, rarely suffered from depression and among whom suicide is uncommon.¹ This is a subjective impression, and there is little to support the belief that tropical or subtropical climates protect against mental illness. Indeed, my experience over many years of a small, sunbaked Caribbean island would indicate that the same mental disorders, with about the same prevalence, occur as in less exotic climates. However, Myers and Davies suggest that in mania, for instance, there is a seasonality with a peak in summer and a trough in winter.²—H ROLLIN, consultant psychiatrist, Epsom.

¹ Kraepelin E. Vergleichende psychiatrie. *Zentralblatt Nervenerkrankungen* 1904;15: 433-790.

² Myers DH, Davies P. The seasonal incidence of mania and its relationship to climatic variables. *Psychol Med* 1978;8:433-40.