

# CHILD HEALTH STRATEGIES IN PRIMARY HEALTH CARE

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## SUMMARY

*Various key aspects needing consideration in primary health care services for children are described. These include the need for basic curative facilities, a dyadic approach, concentration on major issues, use of appropriate technology and cultural appropriateness.*

## INTRODUCTION

The topic of this presentation is, of course, very vast, and much discussion has occurred in recent years. For example, it is widely recognized that the extension of basic health services to underserved rural areas and slums is essential everywhere. Secondly, it is apparent that this can only be done by means of primary health care (PHC) workers which, in turn, implies that the government of the particular country, and the health and medical establishment have to be convinced that this is really important, desirable, feasible, economical and appropriate.

This presentation will, then, touch on a few strategies which are of universal importance.

## CURATIVE NEEDS

Curative activities, albeit basic and simple, have to be part of such services.<sup>1</sup> An assumption that PHC services can be exclusively preventive and promotive almost certainly dooms them to failure.

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## REWARDS AND OPPORTUNITIES

It has to be realized that primary health care workers (PHCW) are like the rest of humankind. They have eyes and they see other people in the health system being rewarded. The altruism and dedication of volunteers rarely can be assumed for prolonged periods. Some system of rewards and possibly promotion has to be thought out which is appropriate for the particular country.

## PRIMARY COMMUNITY IMPROVEMENT

The term "primary health care" is really a misnomer. Its activities cover much more, so that it is really a primary village of community improvement service. Analysis of any programme shows that there are certainly major activities which classically fall under the umbrella of curative or preventive medicine or health services. However, there are also always other elements, such as increasing home food production or village level income generation, which fall under other ministries and other disciplines. This means automatically that any strategy for child health improvement through primary village or community improvement has to be interdisciplinary. As well known, it is easy to talk about such interdisciplinary coordination and very difficult to carry it out. Many are willing to be the coordinators, but few wish to be coordinatees.

## DYADIC NEEDS

One aspect of a child health strategy is that it should not be exclusively a child health strategy. It should be dyadic, that is, concerned with the health of the mothers as well. Even at the present day, this is sometimes not fully appreciated. Perhaps this is related to the separateness of obstetrics and paediatrics in medical schools.

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## MAJOR PROBLEMS

At risk of stressing the obvious, priority needs to be given to major problems. There are, of course, dozens of problems which one would like to be able to deal with. However, with limited resources priority has to be focused on those health problems which are numerically on the top of the list, with the highest morbidity and mortality, with the most significant social impact and with the greatest possibility of rectifying with potentially available PHC services. At the same time, determination of such priorities must also be based on the feelings, anxieties and understandings of the community. For example, an immunization programme in the 1960's in one part of Uganda was made easier because polio vaccine was included. This was, in part, because the son of the traditional chief of this part of the country at that time had been paralyzed by polio. Because of this, community awareness, anxiety and acceptance of immunization was especially high.

## INCORPORATE NEW UNDERSTANDING

Many problems have been well-recognized for years. However, sometimes there may be surprises. For example, recent medical awareness of the commonness of IDD (iodine deficiency disorders) in some areas of the world is a most important development, needing to be incorporated into planning a dyadic PHC programme.<sup>2</sup> For years goitre has been considered to be the main ill-effect of iodine deficiency. Of course, it is a highly visible feature, easily observed in clinical examination. However, recent work, especially in China,<sup>2</sup> has shown that IDD is a public health problem not of cosmetic significance only, but also as far as the foetus is concerned. Children born to mothers who were iodine deficient in pregnancy may show brain damage and mental deficiency, or, indeed, clinically diagnosable cretinism. In some surveys that have been done, for example, in China, IDD may affect about 6% of the newborn babies. In other words, iodine deficiency moves from a problem of cosmetics to a nutritional hazard of significant public health and social impact needing consideration in PHC services.

## APPROPRIATE TECHNOLOGY

Another principle that has to be considered in developing child health strategies is to ensure simplicity and economy. Automatically, this leads to a consideration of using or devising the most appropriate technology. For example, if a lowcost scale of sufficient accuracy is available and already employed in the local culture, plainly its use should be promoted in PHC, as has already happened in Indonesia and the Philippines.

Appropriate technology in PHC services may be indigenous with the scale mentioned, or, alternatively, it may be devised for a particular purpose. A fairly

recent example for the latter is the weight-for-height wall chart.<sup>3</sup>

However, it also needs to be appreciated that sometimes there can be the danger of appropriate technology moving from being very simple to being more useful in the minds of those who are devising it. At the same time, this poses a real risk of moving back from appropriate to inappropriate, as it becomes too complicated for ready understandability.

## CULTURE APPROPRIATENESS

As with all aspects of a health service, cultural appropriateness is a key strategy. Nowadays, there is usually a greater awareness of this than in the past, but it still needs emphasis. For example, in devising a weaning food, whether this be at the village level or for small scale processing, its composition has to be related to cultural food attitudes and beliefs. Of particular significance is the great importance of the cultural superfood.<sup>4</sup> This is the local staple which dominates the whole diet and supplies a high percentage of the calories, protein and many other nutrients. For instance, in Central America, corn or maize would fit this bill, and in much of Asia, rice is obviously the cultural superfood. It follows, therefore, that weaning "multimixes"<sup>5</sup> need to centre on this food, even, as in some cultures, though this may not be nutritionally optimal. This is the case, for example, in parts of East Africa where plantain is the cultural superfood.

An essential approach is that of "cultural relativity". All cultures have adopted wise practices as a result of experience over hundreds of years. At the same time, no culture — whether traditional or so-called Western — has all the answers or a monopoly of wisdom.

It is helpful to consider current knowledge concerning local customs and divide them into four groups: beneficial, neutral, uncertain and harmful.<sup>6</sup> Of course, sometimes such an interpretation can be very wrong. However, this approach gives a basis for action. The beneficial practices should be actively, positively and prominently incorporated into child health strategies. By so doing, more effective rapport may develop, and this may perhaps make it easier when trying to deal with the inevitable harmful practices found in every culture on every continent.

Sometimes, knowledge of beliefs and attitudes can help in a variety of different ways. For instance, in Indonesia it has been noted that the so-called "chicken vision" or "twilight blindness" is recognized.<sup>7</sup> Recent studies have shown that there is a close correlation between mothers' recognition of this visual difficulty and serum retinol (vitamin A) levels.<sup>7</sup> Also, in countries where xerophthalmia is common, Bitot's spots are recognized. For example, in some Indonesian languages,

they are very aptly called "fish scales" because of their appearance.

Cultural details are very important, but information available to health professionals can often be based on casual observation and discussion with those believed to be knowledgeable. This is certainly helpful, but ideally such information can best be sought jointly with anthropologists, who are deeply involved with the community.

## BREASTFEEDING

The term GOBI-FFF has been devised and popularized in recent years by UNICEF. It is an excellent method of focusing on feasible activities for priority problems.

As is well-known, the 'G' is for Growth; the 'O' for Oral Rehydration; the 'B' for Breastfeeding; the 'I' for Immunization; the 'F' for the Feeding of the weaning child and the mother; the second 'F' for Family Planning, and the third 'F' for Female Education.

All of these are important and all, except female education, are related to breastfeeding, which is why the 'B' is placed centrally (Fig. 1).

Breastfeeding is a vital part of any child health strategy anywhere. It is particularly important in circumstances where there is insufficient money and poor hygiene. It is, of course, **not** the only child health strategy needed. Nevertheless, in the earlier part of infancy, it

does encompass much more than nutrition alone. It does have an impact on growth (G), of course. Nowadays, it is part of oral rehydration (O), as it is agreed that the continuation of breastfeeding during ORT is a substantial and important part of the fluid replacement and a supply of nutrients. It also continues the presence of anti-infective substances and ensures the continuation of the breastfeeding process itself.

Immunization (I) can be considered as part of breastfeeding, as it is functionally a form of passive immunization.

With regard to the 'F' (for Feeding), the breastfeeding has no positive impact on the nutrition of the mother, except with the lactation amenorrhoea of prolonged breastfeeding and the consequent conservation of iron stores. But, breastfeeding in a biological fashion, that is, into the second or third year, which has been the norm of humankind until very recently, makes up a part of the weaning diet. Early on, breast milk is the food, but after the earlier part of infancy, breast milk becomes a small, but nutritionally significant, complement, an addition to the other foods the child should be having in the form of weaning "multimixes".<sup>4</sup>

As for family planning (F), it has only recently been appreciated that the term "breastfeeding" covers many variations. For example, it can vary from an occasional feed with other formula also given, to frequent feeds. It is biological breastfeeding with frequent feeds during the day and night that has the most significant child spacing effect, accompanied by prolonged lactation amenorrhoea. Even in the modern world, lactation amenorrhoea is a greater cause of child spacing than achieved by available technological family planning services. This does not mean to say that breastfeeding works equally well everywhere. In fact, it does not it is "dose-related." That is, its effects are proportional to the amount of sucking, the prolactin secreted, and the inhibitory effect on the ovaries and resulting lactation amenorrhoea. Certainly, technological family planning is part of any dyadic child health strategy, but needs to be combined with the natural contraception of breastfeeding. If the child spacing effect of breastfeeding is lost, it becomes exceedingly difficult and expensive to replace. A recent analysis by the World Bank has shown that the amount of child spacing from breastfeeding in traditional societies can be much greater than achieved by technological approaches (Table I).<sup>8</sup> A synthesis of the two is obviously the goal.

## GROWTH MONITORING

This has become a fundamental part of any child health services and the rise of growth charts has become widespread. However, recent work suggests this activity works well when undertaken by highly motivated, enthusiastic people, who are well trained in the procedure.

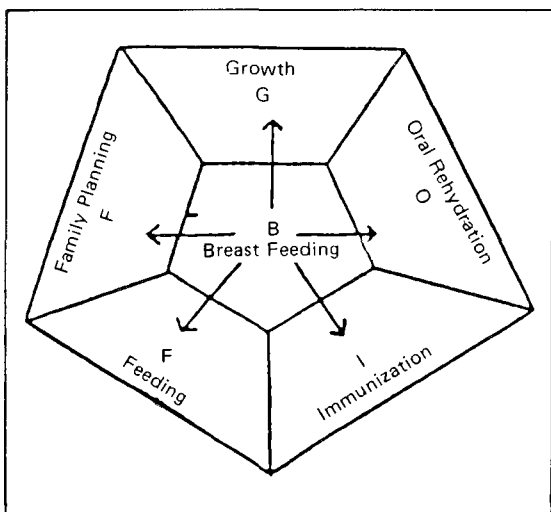


Fig. 1 **GOBI-FF**: Main aspects of UNICEF programs and policy: breastfeeding plays a role in most aspects, (G = Growth and its monitoring; Oral rehydration; Immunization: passive, Feeding weaning: breast with extra supplement in weaning period; Family planning: lactation amenorrhoea).

**TABLE I**  
**SOURCES OF FERTILITY REDUCTION, IN**  
**SELECTED DEVELOPING COUNTRIES**  
**(BIRTHS PER WOMAN)**

Country	Maximum fertility of average woman	Actual fertility	Reduction from maximum fertility due to:			
			Marriage delay	Breast-feeding	Contraception	All others factors
Bangladesh	17	6.0	1.2	6.8	0.8	2.3
Colombia	17	4.3	4.7	1.5	4.2	2.3
Costa Rica	17	3.2	4.7	0.8	6.9	1.5
Ghana	17	6.2	2.2	4.3	0.9	3.4
Indonesia	17	4.5	2.6	5.2	2.5	2.1

Source: Adapted from World Bank, World Development Report 1984.

However, when growth monitoring using whatever type of chart is undertaken routinely by PHC workers, training and supervision are needed to a greater extent than is usually the case at the present moment.<sup>8</sup>

## TRAINING

Training is obviously a key issue in PHC and must include medical students and paediatricians. We must try to get away from the "Marie-Strumple-Winklestein Syndrome" type of training in medical schools. Medical students (and their instructors) need to recognize that there is not only a social urgency in PHC, but also scientific importance and prestige in this type of work.

## ADVOCACY

Lastly, effective child health strategies are not going to come out of the air without advocacy. This is another role which the paediatrician and the health professional need to play.

This implies advocacy in general, not only for those more medical matters related to child health directly, such as immunization programmes or breastfeeding. It also includes other matters which are going to lead to the improvement of community conditions — the water supply, income generation, land reform, etc. The paediatrician who is really concerned has to realize that there is more to paediatrics than the stethoscope, and that advocacy for particular activities is also part of social paediatrics. For example, it can include advocacy for the need for a Code of Marketing of Breast Milk Substitutes and, at the same time, the need to reconsider the attitude of the health professional, particularly the paediatrician, in relation to the infant food industry. Thus, advocacy is needed for the politician and for the administrator. This

needs to be combined with a self-examination of the paediatrician's role in relation to the various social forces, particularly financial support from the infant food industry. The latter is very easy to succumb to, but, like the drug (*dadah*) addict, once you have become accustomed, or even addicted, it is very difficult to throw off this "habit".

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