

Equity and Access in health – Group Discussions

The second theme for the workshop was understanding the issues of equity and access. Chiara's dramatic presentation about the situation in Kimbau in Democratic Republic of Congo was instrumental in bringing out different issues related to the question of equity and access, especially in relation to health services.

Understanding Community Health:

Health should be seen as capacity to fight against all those factors that disturb the harmony of human life. Health is joy in the body and joy is health for the human spirit. Health is not just a right, in the sense of some thing passive but is the end result of efforts of whole communities and thus requires a sense of co-responsibility. So you can not look at health in terms of health givers and target groups, it has to be seen as joint effort between people and services. People who are excluded from a productive life, like refugees, migrants, unemployed, etc. cannot be expected to be "healthy". Persons who are victims of prejudices, violence, drugs, etc. can not be expected to be "healthy". Persons, who are excluded from basic minimum services of health, education, leisure, transport, etc., cannot be expected to be "healthy".

Health is some thing outside the walls and outside the buildings of hospitals and health centres – it is in the persons, the context of their local communities. Inside the walls of hospitals and health centres, often there is not health but sickness-industry – the industry of drugs and there curative, symptomatic cures dominate over every thing else.

It is important to clarify the meaning of community health services for understanding the issues of equity and access. Community health should be seen from communities' view-point, which is a multi-sectoral concept and also because each community understands "health" in different ways. Communities may understand the causes of diseases in different ways, which do not always coincide with the "official" explanations. For example, Epilepsy may not be seen as a disease in some communities in Africa but is rather seen as a consequence of possession of the body by bad spirits. Another example is that of Schistosomiasis with haematuria, which can be seen by some communities in Africa, as male menstruation and thus it may not be perceived as a disease.

Community based rehabilitation may be proposed with certain ideas, but communities perceive rehabilitation in different ways according to the different contexts.

Even the request and need for health services can be very variable, as the priorities for different communities can be very different. Thus usual approach may be seen very much as a quantitative approach, as health professionals look at health indicators, mortality and sickness from different diseases, etc. This approach determines what medical professionals perceive as priorities, while the communities may see it very differently.

Even the community dynamics need to be considered, for example about the AIDS/HIV problem. Our emphasis on prevention of AIDS may be in conflict with the priorities of families and communities, who look at reproduction and maternity as a priority rather than for limiting the families and having safe sex. The community dynamics may also be linked also to traditional medicine.

Factors Influencing Access to Health Services:

Factors influencing access to community health services geographical factors, climatic factors, lack of health policies, wars and economic wars. Then there are factors related to the suppliers of health services. The health policies are mainly decided on big numbers, aggregates and averages. These may thus exclude the poorest, those who cost too much and who are not perceived as productive. There are different examples of heterogeneity of interventions – in some areas, different districts may be running according to different policies and priorities, and some times different actors work in same areas with contrasting policies and interventions. This means that in such cases community health services are not efficient or effective.

There are also issues related to health workers. Workers are often without proper training and the training is very sectoral, focusing on specific diseases rather than on health. Health workers are not taught to think of excluded groups or poorest. Added to this are problems of corruption, low salaries or lack of salaries. Workers can also belong to different caste and ethnic groups and they may even discriminate among the clients of their services. Human factors have an important role in way health workers can facilitate or create obstacles to access to health services.

The question of costs is also linked. If health services are not a right but services with costs, benefits and pressure for lowering or limiting the costs or for recovering the costs, the poorest and marginalised groups are necessarily going to be excluded from any access to health services.

Another group of factors influencing access to health services is related to target group of beneficiaries in the communities. Some time weak persons are abandoned or discriminated by communities, like in the case of leprosy. Even the concept of the community is some times overplayed or exaggerated and in reality that same idealised concept does not exist every where. There may be poor and marginalised persons without any support from communities living near by or surrounding them.

There are also problems of lack of self-esteem and subordination to the powerful among the poor. The situation of marginalised persons may be culturally justified by generations of oppression and exploitation. The “culture” and the language of the poor may be invisible or missing because majority powerful groups do not acknowledge it or consider it as inferior. In such situations, poor and marginalised may self-exclude themselves from services and their community participation may be very little.

Issues of Access and Equity for Disabled Persons:

Disabled persons are one of the marginalised and excluded groups in societies and communities. On the whole, only a small percent of national budgets is spent for health and education. From that, most of the national budget priorities do not consider disabled persons.

Lack of access to any health services at community level is also a barrier for disabled persons in the communities. Looking at the issue of equity from the point of view of gender, the level of participation available to women at the community level is low.

Considering the infrastructures, like physical environment and roads etc., the barriers are every where. For disabled persons living in mountain and hilly areas, such physical barriers completely exclude them from any access to health and education services.

Community would play an important role in overcoming any barriers. So the community has to be united and involved to improve the quality of life for disabled persons. Higher level political commitment is also needed. There is need to work with the communities, where existing services as well as community volunteers need to be trained and involved for improving access of disabled persons to the health services. To reach the communities, identification of key persons in the communities can be very useful.

On the other hand, disabled persons also need to be facilitated to participate in all decision making so that they can develop their own potentials and capacities, so they can raise their own voice to speak to public and to political authorities for their rights.

While working with the communities, community based programmes must make links with governmental services. A judicious use of mass media is very important to create awareness in the decision-makers.

Strategies for Improving Access:

Very much related to this is the issue of sectoralisation of the services, with vertical programmes. Even if it is known that in spite of more efforts vertical approaches do not give best results and do not have impact on overall health status of persons, they predominate in health services. To improve the access to community health services, the strategies can be many. However, it is important to look at integrated strategies, acting at different levels at the same time. For this reason, it is important to start from the concept of health as a global approach.

Reflection on need of integration of health workers in the communities where they work is needed. Some times health workers and professionals are quite distant from the communities where they work, in terms of their mentality and thinking. There needs to be bi-directional process, where health workers understand that if they have technical knowledge, communities have other kinds of knowledge, which is equally valuable and which needs to be valued and respected. It is important that the poorest and weaker groups are active part of the process of change, which is promoted. If the poor groups are just passive spectators, nothing can be done. This is very important for health education. If people participate and see for themselves the changes, which are possible, their

participation can improve. This means that health workers can not just go from outside and deliver something, unless they are part of this dynamic interaction with the communities. Changes cannot come only from speeches and posters.

It is important to act at the level of health policies. It may be very difficult and slow but it is very important. A lot can be said about this and some thing is being done in this direction, but it is not sufficient and needs to be strengthened.

“Equality” is not “equity”, not all diseases are “equal”, but we have look at the disproportionate burden of the diseases on lives of populations. Individuals can ask for equality, communities and collective groups can ensure equity.

To improve access and equity, community awareness about health as a right needs to be made. This should be done in a way which values health as part and potential of community culture, keeping account of traditional healers, birth assistants, health workers, volunteers, popular educators, artists, etc. The learning can be some thing to give to the community, but should be with the community, seen as a dynamic transformative process and not just service delivery. Interventions focusing on vulnerable groups are useful but must involve those vulnerable groups in defining them. Health is also linked closely to education and culture, you can not look at them in isolation. If you do not know, what the community thinks about some thing, you cannot “treat” it.