

# Primary Health Care

Shirley Buzzard

## Look, listen and learn: preparing the ground for primary health care

Questionnaires used in health systems research are often stereotyped rather than being devised with a view to learning certain facts. The replies frequently confirm what is widely known anyway: that people who have poor housing, many children, low incomes, and defective water supplies and sewage disposal systems tend to have poor health. Anthropological methods, on the other hand, can reliably uncover local values and belief systems; they can help to identify and solve potential problems; and, unlike questionnaires, they can provide information on context, individual variation, and causality.

In connection with primary health care programs, data have to be collected in order to identify the most common health problems and obtain accurate pictures of communities. The research methods used for achieving these goals are discussed below.

### Surveys

It has become customary to conduct an all-purpose survey at an early stage, usually on the basis of questionnaires administered to a relatively large sample of a population in order to elicit information on demography, living conditions, health status, sanitary facilities, and socioeconomic attributes, in addition to providing baseline data on the indicators of program success. Designing, administering, and analysing questionnaires are highly technical tasks. Physicians and others who are not trained in social sciences frequently believe they can use questionnaires without any train-

ing in sampling procedures, interviewing techniques, the construction of questions, and coding. Some workers feel that survey research is more scientific than observational research, and medical doctors prefer it. The latter tend to be so committed to the biomedical research model that qualitative information on human behavior is suspect to them (1). Any study on primary health care should include, from the first planning stages, a clear definition of what data need to be collected and of when and how the results will be used. If there are no clear objectives for data collection, the shotgun approach is used—asking a little about everything but not much about anything. Questionnaires tend to be too long and involved, and are often given to an unnecessarily large or improperly chosen sample. They also gloss over individual variation within the community (2).

### Timing

The timing of data collection requires careful planning. If data are not available from existing sources, it may be necessary to conduct a survey for the collection of data on baseline

---

The author is an anthropologist in Washington, DC, USA. This article is based on one that appeared in *Social science and medicine*, 19 (3): 273–277 (1984), published by Pergamon Press Ltd, Headington Hill Hall, Oxford OX3 0BW, England.

indicators at an early stage. Mechanisms should be in place for the collection of comparable data at regular intervals throughout a project.

Surveys usually involve little or no participation by community members, whose expectations may, nevertheless, be raised when a survey is conducted. Yet as much as a year may elapse between a survey and the appearance on the scene of a trained health promoter. Com-

**Anthropological methods were developed because of the need to collect data from individuals and communities with non-Western patterns of thought and little formal schooling.**

munity surveys, if timed correctly, can be a powerful vehicle for education and an excellent mechanism for community involvement. Short, focused questionnaires should be used, and community participation in the collection and analysis of data should be encouraged. Programs should be devised to give an immediate positive response, and interviews should be used as an important educational opportunity. Several short questionnaires covering limited topics, given to relatively few people and administered a few months apart, are likely to elicit much useful data and may be used by health promoters to publicize a new thrust of a program.

#### *Existing sources of data*

Program planners and managers are inclined to overlook existing sources of data, and to want specific studies conducted for their projects by their own staff. They tend to overlook records of hospitals, clinics, health centers, and doctors' offices. Even records of drugs sold by pharmacies may give a picture of morbidity patterns. Records of medical personnel may be more accurate than door-to-door surveys. In some places, childhood diarrhea is so common as to be considered normal; when members of a family are asked if anyone in the

family has been sick, they may not mention the occurrence of diarrhea, even though it is a major cause of infant mortality.

Scores of university students have conducted studies in urban low-income areas near their universities. The United Nations Children's Fund, the World Bank, the United States Agency for International Development and other major funding institutions normally incorporate major research components into their projects and the results of these studies are usually accessible. Data may also be available on other primary health care projects.

Another source of data consists of "unobtrusive measures" (3), among which are data collected on the effects of human behavior. To estimate the incidence of bottle feeding, store owners may be asked how many baby bottles and how much infant formula they sell. Some water projects increase the amount of construction in an area, and this may be documented in terms of sales of cement or nails. One should be imaginative in the quest for sources of information.

#### *Resources needed*

Program planners often underestimate the amount of time and money it takes to carry out a major community survey. After data collection, which may take several weeks if questionnaires are long, analysis and interpretation will require additional time and money. It is possible to make a manual tabulation of the data from up to 50 questionnaires, and this can be a useful educational skill for health promoters to learn. But larger samples will require data processing resources, which may be very expensive in urban areas and not available in rural areas.

A major survey of 1000 families in an urban area will probably take at least 6 months, starting with the design of the questionnaire and finishing with data analysis.

#### *Relevance*

A distinction should be made between facts it would be interesting to know and information that is essential for further programming. Many of the items on questionnaires fall into the former category. In setting up the initial

research plan for a project, attention must be given to explicit applied research objectives. Will the answer to a question affect programming? Does it matter if the average age of women is 26.5 or 33.2, or if 68% of houses have bamboo sides? It is worth evaluating each question in terms of relevance.

### Anthropological Methods

Anthropological methods were developed because of the need to collect data from individuals and communities with non-Western patterns of thought and little formal schooling. These methods provide data, as well as identifying community belief systems that affect behavior, and are therefore particularly appropriate for health systems research.

Planners of primary health care programs may look beyond the questionnaire and conduct smaller, more specific, carefully timed studies of greater validity and utility. Small-scale studies may be part of a consciousness-raising effort in a community, relating to a specific health issue. For program planning, educational programs, and midcourse evaluations, the methods mentioned below may usefully be added to the list of conventional methodologies.

#### *Participant observation*

Choosing five families and spending a few days with each may tell more about the health beliefs and practices in a community than a survey covering 500 families. Observations may be made on diet, access to food, cash flow, relations within the family, water storage and use, the disposal of human and household wastes, and beliefs about health and illness.

Participant observation allows the researcher to quantify observed activities and, more importantly, to see the context in which they occur and the patterns they represent (4). It is also an excellent way of sharpening the observational skill of health promoters. People's behavior is often different from what they state it to be. In participant observation, the researcher has the advantage of recording what people do, not just what they say. For example, asking a woman to describe birth procedures gives far less information than observation.

While she may state that sanitary conditions prevail during delivery, in fact the absence of hand-washing or a failure to achieve complete sterilization of cutting instruments may be observed.

#### *Life histories*

By encouraging people, especially women, to recount their life histories, considerable insight can be gained into what they consider important (5). Such information is critical for maternal and child health programs and for family planning education programs. By studying the life histories of only 20 women, one can determine patterns of reproduction and uncover women's feelings about marriage, childbirth, and contraception and their image of themselves and their roles in society. Furthermore, women are rarely asked to tell their life history and are pleased when someone takes an interest in them. Listening may be one of the most important skills a health promoter can develop.

#### *Interviews*

Interviews, more or less structured, are an easy way to get information on specific topics, such as family planning and folk notions about contraception. Interviews with local doctors, herbalists, midwives or community leaders may provide data, not only on commonly occurring illnesses, but also on people's under-

**Listening may be one of the most important skills a health promoter can develop.**

standing of their causes and treatment. In interviews conducted with small groups of women, the comments of one woman may elicit responses from others, revealing whether a consensus exists on particular issues.

Interviewing and participant observation are complementary, the one allowing the completeness and accuracy of data obtained from the other to be tested (6).

*Mapping*

This old anthropological technique is useful for showing the locations of health resources, sewage disposal sites, latrines, water sources, markets, health posts, and other facilities. A visual representation of a community and its resources and problems may prove enlightening to members of the community. Social groupings, neighborhood boundaries, or socioeconomic variations, when represented on a map, may highlight previously unrecognized relationships (7). I used maps of wells in Indonesia, of health posts in Colombia, and of water distribution systems in Haiti to show the extent to which clients were reached by programs. In water projects, maps of water resources, water systems and proposed extensions are particularly valuable.

*Children*

Secondary-school children, who often adhere strongly to their societies' highest aspirations and values, can, when they write essays on the expectations of their own or the opposite sex, reveal much that is helpful to people who design educational programs for these children and their parents. Essays may indicate the understanding that the children have of conception and childbirth, or their ideas about food and health. In Kenya, such essays yielded a wealth of information on sex role expectations. Similar essays written by younger child-

ren in Ecuador indicated children's beliefs about the relationship of different types of foods to illness and health.

Children should not be overlooked as potential collectors of data. They can be keen observers of the use of certain facilities such as latrines or wells. By involving children in mapping or the collection of demographic data, community participation in a project can be effectively broadened. Older children may be the most literate people in the community and can assist in other research. □

## REFERENCES

1. FOSTER, G. M. *Human organization*, **41**: 189-197 (1982).
2. FOSTER, G. M. *Human organization*, **38**: 179-183 (1979).
3. WEBB, E. J. ET AL. *Unobtrusive measures: nonreactive research in the social sciences*. Chicago, Rand McNally, 1966.
4. BRUYN, S. *Human organization*, **20**: 224-235 (1963).
5. LANGNESS, L. L. *The life history in anthropological science*. New York, Holt, Rinehart & Winston, 1965.
6. BECKER, H. S. & GREER, B. *Human organization*, **16**: 28-32 (1957).
7. RICHARDSON, F. L. W. *Human organization*, **9**: 31-32 (1950).

## ***Sickle-cell disease: should governments promote abortion?***

*Technologies are now at the point where homozygous sickle-cell fetuses can be diagnosed at an early enough stage to offer parents the choice of abortion. How strong a stand a government can take on offering abortion in such circumstances is still open to debate. If the government has a good educational programme on the options, a good health service, and a caring attitude, then its interference in such issues can be justified.*

—Professor Prawase Wasi in *Health policy: ethics and human values*, edited by John H. Bryant & Zbigniew Bankowski. Geneva, CIOMS, 1985.