GOBI VERSUS PHC? SOME DANGERS OF SELECTIVE PRIMARY HEALTH CARE

HENRY WISNER

UNICEF presented in its 1982–83 report on ‘The state of the world’s children’ the outlines of a ‘Child survival revolution’. This ‘revolution’ was to be based on widespread adoption of a small number of cheap, assessible and simple technologies. These technologies were aimed at conditions that are responsible for a large proportion of present infant and child mortality in the third world, while leaving other conditions and the wider conditions determining access to food, shelter and sanitation untouched. UNICEF’s ‘revolution’ thus had much in common with other forms in the wider conditions determining access to food, referred to as a ‘GOBI’. The acronym ‘GOBI’ is made up of the first letters of the phrase describing each of four elements in a package of interventions on behalf of children: Growth monitoring, Oral rehydration therapy in case of diarrhea, Breast feeding (as opposed to early weaning and/or bottle feeding), and Immunization.

In its simplest form, UNICEF’s argument for GOBI is compelling and has a lot in common with arguments heard in favor of PHC. The argument runs as follows: (1) Financial and human resources for primary health care in poor countries are scarce and growing scarcer due to the recent decade of international financial crisis. (2) Simple, low cost, widely accessible technologies for saving children’s lives exist. (3) Means for popularizing these technologies at low cost also exist. (4) Therefore GOBI should be implemented as a priority now. The hidden premise, sometimes discussed explicitly, is that PHC as envisioned only as recently as 1978 at the Alma Ata Conference [5] is too costly and taking too long to implement. In particular, the emphasis on people’s access to means of acquiring basic needs such as food and shelter and the emphasis on local control of health programs are criticized as being unrealistic goals.

This line of reasoning can be questioned on a number of grounds, but even without an elaborate critique it is apparent that two possible relations between GOBI and PHC can be inferred. In more general terms, it is possible to think of any form of PHC relating to PHC in either of these two ways.

First, GOBI could be interpreted as an attempt to speed up the process of establishing PHC. Thus GOBI would be seen to be complementary to PHC, providing some of its more important technical ‘content’. GOBI’s success in saving lives would provide satisfaction in communities and commitment to wider change that would make it easier for them to support the grassroots structures of PHC financially and otherwise. GOBI would be seen, in this view, as the ‘leading edge’ of PHC [6, p. 6].

A second interpretation is that GOBI constitutes the negation of the participatory and community-based ideals of PHC, not their complement or precursor. This view recognizes two opposing forms of ‘basic needs approach’ (BNA) [7]. The ‘strong’ BNA encourages people to define their own needs, to organize themselves to demand access to the means to satisfy these needs, and to struggle to overcome political and other obstacles to satisfying these locally-defined needs. The ‘weak’ BNA imposes an external, expert definition of need on the community.
Local organization is encouraged only insofar as it is necessary to make 'delivery' of the good or service possible. Conflict and struggle are neither encouraged nor understandable within the universe of the 'weak' BNA. According to this second interpretation, SPHC in general and GOBI in particular belong to the 'weak' BNA. They are delivery approaches that negate more participatory and conflictual approaches to people getting what they think they and their children need.

For instance, in theory groups of parents can monitor the growth of their children, produce oral rehydration mixtures (salt, sugar, water) in their own homes, speak to one another about the importance of breast feeding. In fact, the national-scale campaigns launched so far in support of GOBI actually preempt these local potentials. Television and other coordinated media blitzes extoll prepackaged oral rehydration salts. In most cases these are prepackaged in distant capital cities. Breast feeding is 'sold' via radio and television with slogans coined outside the affected communities, possibly by the same foreign advertising agencies that had previously sold infant formula and bottle feeding. Immunization, dependent still on a 'cold chain' and considerable logistical preparation, continues to come from 'the top down' but now in massive and possibly unrepeatable campaigns. Little is done to build confidence in people's ability to do positive things about health together, where they live, rather attention is systematically turned toward the 'center' from which wisdom about the breast, magic salts and vaccine issue.

UNICEF BEFORE GOBI

In order to judge these opposing interpretations of GOBI, it is helpful to review UNICEF writings on PHC before GOBI came on the scene. UNICEF was one of the first international agencies to shift from sectoral health concerns to a comprehensive approach which was called "planning for the needs of children" [8, 9]. Throughout the 1970s UNICEF emphasized the importance of 'participation' [10]. In fact, just before GOBI was unveiled, UNICEF was still distinguishing between a 'narrow definition' of PHC and a broader interpretation in very much the same terms used to distinguish the 'weak' and 'strong' BNAs above. Thus PHC would recognize "certain values and principles as requisites of good health care" including the following [11, p. 37]:

1. Equity and justice. The basic right of every individual to health implies the reduction of gaps between those who have access and those who do not to health and other resources necessary for maintaining health—such as income, food, employment, education.

2. An overall development strategy that gives high priority to social goals in addition to economic ones.

3. People imbued with a strong sense of self-reliance and control over their own lives exercising responsibility over their own health. The role of governments and agencies is not to act in the people's behalf to 'deliver' health, but rather to support their efforts and take joint responsibility for health.

4. The emergence of a new international economic

order coupled with a new international development strategy.

In its report on the world's children for 1980–81, UNICEF highlighted three lessons it claimed are to be learned by reassessing several decades of development work [12, p. 5]:

1. Economic growth is a necessary but not sufficient condition for the elimination of poverty.

2. Policies aimed at directly meeting the needs of the poor are a more promising way forward than reliance on the trickle-down of growth.

3. The redistribution of resources and incomes implied by such policies need not detract from, and may even enhance, the prospects for economic growth itself.

Suddenly, however, these lessons seem to have been discarded.

CHILDREN IN DARK TIMES

UNICEF's report for 1981–82 is entitled 'Children in dark times' and catalogs a "slowing down of progress" in child welfare despite agreements on PHC [13]. Whereas infant mortality had been falling steadily:

"for the past five years, it has barely flickered. Average live expectancy, which increased by seven or eight months a year in the 1960s and early 1970s, is now increasing by only two or three months a year. School enrollment rates, which again rose by a regular four or five per cent a year up to the mid-1970s, now seems to have reached a plateau" [13, p. 2].

"In short", UNICEF summarizes, "the optimism of the 1960s which gave ground to the realism of the 1970s has now receded even further to make room for the doubt and pessimism which seems to be settling into the 1980s."

Africa is singled out as a prime example [13, p. 12]: The tenth successive year of declining food production per capita, food shortages, massive refugee movements.

This was the year before GOBI emerged, the year after UNICEF had reported hopefully that 'lessons' had been learned from the critique of growth-oriented development strategies, and that as a result infant mortality could be brought down to below 50 per thousand in all countries by the year 2000. Thus 'Dark times' is a transitional statement and can be read for early signs of three major lines of thought. These include, first and most destructively, the assertion of a belief dating from earlier decades that poverty is 'natural'. Second, the new line of thought develops an ahistorical and idealistic notion of a 'safety net' as the answer to the 'natural' growth of poverty, ordinary parents' helplessness in its face, and the framework with which GOBI will be seen to function. Finally, technology emerges as the linch pin of or substitute for a minimal safety net. Analysis of these characteristics explains why GOBI and other SPHC strategies are not compatible with broader social goals embodied in PCH and why, in practice, implementation of the one blocks development of the other.

The 'naturalization' of poverty [14]

UNICEF invokes world economic crisis as a fact of life, something that has 'happened' to poor nations
and to poor people. An 'adverse external environment' is likely to raise the number of the absolutely poor to one billion by 1990, we are told [13, p. 2], with no suggestion that what is 'external' to some is the comfortable 'internal' (domestic) economic environment to others experiencing financial boom. Economic crisis is assumed to 'strike' from somewhere 'out there' such as 'natural disasters' (e.g. drought, flood, earthquake) are thought to 'occur'. The only concession to the existence of a complex interaction between society and nature seems to be the commonly projected image of 'too many poor people' pressing nature too hard. The only hint that nations or classes like landlords or workers might be conscious agents in conflict are the common platitudes that poor nations have 'mismanaged' industrialization, debt, marketing, etc. and that workers and peasants in Africa and elsewhere have ceased to produce the way they used to.

Subsequently UNICEF added some 'Fs' to GOBI, including 'family spacing' and 'female education' in a way that considerably strengthened the naturalization of poverty [15, 16]. Population growth is seen as a cause, not a symptom of poverty. This is a 'natural' cause. Addressing this 'cause' with female education (the woman's 'ignorance' being yet another 'natural' cause of poverty from within this point of view), the more difficult social causes can be bypassed.

PHC was crystallized as an approach at a time when there was wide agreement that the causes of poverty were nonnatural and that social justice was a requisite for health. By naturalizing poverty once again by its emphasis on external, uncontrollable economic forces, population growth, and female ignorance, UNICEF locates health action wholly outside the realm of socio-economic rights and responsibilities.

A safety net or 'a floor under poverty'

In the 'dark times' described by UNICEF, parents have been deprived of power to protect their children. Rather than question why this is so and whether it is a tolerable state of affairs, UNICEF observes that in such situations 'the community' has to take up the responsibility for children [13, p.2-3]. And if the local community is unable to meet the needs of children, 'then the responsibility extends to the national and international community'. While this reasoning sounds sensible and humane, taken together with the 'external' and 'natural' interpretation of poverty just discussed, what is implied is a dangerous acceptance of increasing powerlessness of the poor parent in the national scheme of things and of the poor nation state in the global order.

In the 1970s, the emphasis had shifted to at least the rhetorical acceptance of 'empowerment' of the poor as the way forward. Parents, peasant farmers, workers, women were encouraged to organize themselves and to demand the power they needed to achieve a decent standard of living. Various international meetings such as ILO's World Employment Conference in 1976 and FAO's World Conference on Agrarian Reform and Rural Development in 1979 had clearly asserted the right of poor people to organize. At that point, the historical initiative was on the side of the 'strong' BNA. Ten years later, discussion of a minimal 'safety net' leaves little doubt that the initiative has been lost to resurgent technocracy and the 'weakest' possible interpretation of 'basic needs'. It is simply accepted that the "local community is unable to meet the needs of its children". UNICEF no longer seeks to aid the process of empowerment of that local community but merely to put "a floor under poverty" [17, pp. 39-51].

**Building on 'social breakthroughs' or blocking them?**

UNICEF's 1982-83 report, 'New hope in dark times', beings by asserting the necessity of 'streamlining' UNICEF practice 'against the headwind' of world recession [6, p. 2]. This refers not only to the necessity of reorganizing UNICEF and rationalizing its 'basic services strategy' in order to bring "more benefits to children for every available dollar" [6, p. 12]. The application of the lessons learned from inefficient and failed projects was discussed in the prior report and was presumably underway.

The year GOBI was announced seems to have been one of ideological streamlining as well as UNICEF. The 'Children's revolution' is a minimal package in the face of the failure of parents to achieve a revolution in the power relations determining health and a failure of poor nations to win a New International Economic Order.

It is not at all that UNICEF ignores grassroots organizations. Quite the contrary, it terms "social breakthroughs" the growth of "community organizations, paraprofessional development workers, primary schools and the primary health networks, the peoples' movements ..." [6, pp. 6-7]. Despite the
rapid growth of such grassroots institution, parents have lost the power to protect their children against the "headwinds of world recession". So UNICEF proposes to use this newly achieved level of mass organization differently: "These social breakthroughs are the missing link between the know-how of science and the needs of people" [6].

A key question is how grassroots organizations are understood by an agency backing GOBI or any other form of SPHC that formulates its limited package of interventions outside of the local situation and mobilizes resources to diffuse that package campaign-style at national scale. One clue is UNICEF's frequent reference to the 'success' of Asian campaigns to introduce high yielding varieties of rice and wheat and family planning campaigns [19]. The model implied is of local organizations as conduits or delivery points. The kind of 'participation' involved has been called "instrumental" rather than "transformative" [20]. People's participation is invoked as acceptance of the package, as recipients of the 'message' but not as transformers of their own situation.

How can the grassroots be encouraged to transform the conditions of poverty when these national campaigns depend entirely on the goodwill and infrastructure controlled by a national elite whose interests are at stake in preserving the status quo? In both symbolic and practical ways the power of national structures are reinforced in these campaigns. Thus when airforce helicopter gunships that have been known to terrorize peasants appear ferrying vaccines, a message is communicated about power. In practical ways, the GOBI approach reinforces centralized urban hierarchies that have been shown to block rural development.

In Honduras, for instance, UNICEF decided to 'package' its oral rehydration campaign in sophisticated ways and to advertise them with television because "mothers were very strongly predisposed towards treatments with sophisticated urban image" [18, p. 54]. Thus foil-wrapped sachets of oral rehydration salts rather than the use of home-made salt and sugar solution was adopted for the campaign. But is this consistent with long-term alternatives to an urban-elite image of development? Such urban cultural bias has been argued to be part of the problem, not part of the solution [21]. It is partly responsible for disastrous shifts in diet and child-care style such as the shift from locally-produced staple grains to imported wheat for bread [22], greatly increased cigarette consumption [23], and the popularity of bottle feeding [24]—all recognized health problems.

In much of the third world dependency on internal markets has grown dramatically in the last 20 years. Now, at a time when the World Bank and the IMF are insisting that governments remove subsidies on consumption and cut back on public expenditure, the poor are highly vulnerable because of their dependency on the market. UNICEF itself has documented the fact that these 'economic adjustments' fall heaviest on women and children [25], and food riots in Mexico, Brazil, Sudan, Zambia and Ghana suggest that the poor have done supporting research. In this light, it is clearly damaging in the long run to introduce even a useful life-saving technology like oral rehydration therapy in a way that reinforces market dependency, urban bias, and an urban-elite image of development through centralized packaging of the salt/sugar mix.

By 1985, only six UNICEF-sponsored national and rehydration therapy programs used the 'cottage industry' approach to decentralized packaging and distribution. Another 33 were urban-based [18, p. 3].

Social-marketing

It is media-technology and the manipulative social psychology developed while 'selling' the Green Revolution in the 1960s that receive most attention from UNICEF as social breakthroughs rather than the self-organization of the poor. "... [In a world where information technology has become the new wonder of our age," writes UNICEF's Executive Director [19, p. 3], "shamefully little is known about how to communicate information whose principal value is to the poor." Such a statement makes a series of assumptions that would require justification but do not receive it in UNICEF texts.

First, it is assumed that the most useful thing about which to communicate is technical information, 'messages' distilling the useful, simple technologies of which people have been ignorant. Others, however, still seem to believe that it is most useful to communicate about relationships such as those governing access to land and income for promoting health [26-28].

Second, there is the assumption that communication to ignorant people from people with 'knowledge' is what is required. This overlooks the cardinal importance of groups of people sharing knowledge and discovering the usefulness of knowledge that had been denigrated by the colonial encounter [29-31].

Third, it is assumed that 'information technology' is the missing key to communication. However, it has become a commonplace of pedagogy that the best communication takes place between two people of similar backgrounds, status, etc. in face-to-face encounters [32]. One of the lessons of the Green Revolution, but apparently not one recognized by the proponents of GOBI, is that useful information spreads with extraordinary speed by word of mouth. UNICEF's chosen information technology is referred to as "social marketing" [19, 33]. Social marketing focusses on products, not on processes. The product can be immunization, use of oral rehydration salts, family planning. The 'product' to be sold in the social market place via mass media may be a complex package of products. Nonetheless, the product exists quite independently of the day to day process of problem solving in households and communities. What are the limitations of such an approach?

First, communication is 'one way'. The chance that the product or package of products is modified though 'feedback' through the communication process is very small. Where there is such feedback, it must come through precisely the decentralized, participatory programs that are in danger of being cut back by ministries infatuated with the 'quick fix' social marketing seems to offer.
Second, the ability to tap local knowledge and skill is virtually zero. At a time when more and more authors are discussing the reservoirs of 'ethnoscience' still untapped in villages and squatter settlements all over the world, it is ironic that a method of 'communicating' with the masses that cuts the state or development agency off from such knowledge should be named a 'new imperative' by one UNICEF consultant [33].

Third, and even more troubling, the social marketing message is 'targeted' at individuals. 'Mothers' are sold oral rehydration salts or IUDs. 'Farmers' are sold new varieties of seed. At a time when there are many other social and economic forces tending to fragment extended families, neighborhoods, and 'self help groups', it is alarming that the force of electronic media should also fragment. A 'process' orientation works against fragmentation, situating possible 'solutions' to 'problems' in the growing understanding of wider social relations by homogeneous groups. For instance, small 'homogeneous self help groups' of divorcees and widows in Lesotho grow to understand their socio-economic marginality and find viable income generating activities in this context [34]. Health improvements for children in these woman-headed households come as secondary effects of increased income. Broadly speaking, PHC as defined in Alma Ata can be interpreted in this way. Ministries that cut back expenditures on such participatory, empowering work because social marketing appears 'faster' or more 'cost effective' cut the tap root of the newly sprouting 'community' at the increasingly fragmented and class-polarized grassroots.

CONCLUSION

Dangers of selective primary health care

Elsewhere SPHC has been criticized for claiming too much for a handful of technologies [35, 36], for evaluating the costs and benefits of health and disease in too narrow an economic framework [37, 38], and for thinly disguising and justifying reductions in public finance for health care in countries feeling the pressure for IMF mandated 'adjustments' [7, Chap. 4; 39].

This brief paper has called attention to another criticism. Despite claims that UNICEF's GOBI can be seen as the 'leading edge' of PCH, it has been argued that implementation of GOBI and other SPHC packages acts, in fact, to undermine the process of local definition of needs, local organization to share knowledge and to struggle for health rights. GOBI does this in several ways.

1. Indigenous, local organizations are distorted and limited in their potential for channeling protest and health demands by their conversion to mere conduits for the delivery of the GOBI package.

2. The effectiveness of local organization is further undermined by the individualizing orientation of GOBI elements and their implied model of disease causation focusing not on social causes but on ignorance and faults in individuals.

3. Both these effects are compounded by the tendency for GOBI implementation to reinforce the status symbolically and importance practically of the central state, the urban hierarchy and the structures of dominance, often including national police and military authorities that are drafted in for logistical help during national immunization campaigns.

4. Reliance on a limited concept of 'social marketing' and on electronic media for campaigns further compounds the previously mentioned effects.

5. Finally, GOBI gives the state and international agencies an excuse for accepting the necessity of cut backs in social expenditure, and accepting the way in which the lack of justice in the international economic system is causing parents to lose control over the conditions that determine the health of their children. The excuse is that this is all the product of an 'adverse external environment', and that GOBI amounts to the best available realistic measure under such circumstances.

6. The ideology of acceptance and resignation in the face of the 'adverse external environment' can only serve to discourage parents and grassroots workers who would otherwise demand more and organize politically to take more.

Is GOBI useful at all?

There is no doubt that UNICEF's emphasis on immunization and oral rehydration therapy have saved many children's lives over the last few years. Were those children subsequently killed by another disease of poverty not targeted by GOBI's selective approach? If they are still alive, what future do they face? If GOBI's implementation actually undermines the radical grassroots organizing that alone can direct demands and struggles for the power to control health, would it be better not to have GOBI?

The alternative to answering 'yes' is to conceptualize a 'social' GOBI that would be the technical content of a locally determined initial process, truly the 'leading edge' of PCH. However, careful note should be taken of the word 'initial'. Appropriate phasing is essential to the long-term construction of popular support for the more comprehensive, more empowering form of PHC launched by the Alma Ata conference. If GOBI-like starting points were chosen flexibly with groups of parents to whom the results of regionally-specific epidemiological surveys were presented for discussion, one would be building long-term foundations for PHC while also moving dramatically against the five or six conditions that account for 80% of child death in the third world [40].

Care would also have to be taken that whatever the form of the initial GOBI-like interventions, they reinforce the social character of the struggle for child survival. Rather than reinforcing individualistic behavior and dependency on the central state, GOBI-like interventions could be implemented by groups of parents and in such a way that the status and role of local community health workers and traditional birth attendants are reinforced.

There should be no illusion about the acceptability of such an alternative to agencies as tightly united in defence of established economic privilege as are most states and most of the international development apparatus. In the 1980s the conditions of profitability leave less room for officially sanctioned populist agitation for the right to food and to health. As the
screw of 'economic adjustment' is turned in dozens of third world countries, it is better from the point of view of the international agencies to be able to say "we tried PCH, complete with its encouragement of grassroots struggle for rights, and it was too slow, too costly, and inefficient". The truth may be that however efficient that earlier PHC approach may have been, any major development approach that emphasizes local articulation of political demands such as the demand for health will be officially rejected in the climate of the 1980s.

One should also guard against idealizing comprehensive PHC. Much of the criticism directed against it is valid. What this paper questions is whether the 'cure' (e.g. selective PHC) is worse than the 'problem'. Comprehensive PHC has, in fact, been slow in taking shape after Alma Ata, and there have been numerous distortions and misuses of institutions dedicated in name to popular control of health [39, 41]. The ideal of community participation has seldom been achieved [7, Chap. 2; 42, 43]. In fact, Barker and Turshen find that "many proponents of comprehensive primary health care ... routinely reduce PHC itself to a depoliticized and technocratic strategy" in any of the following ways [39, p. 84].

1. Thinking PHC is equivalent to provision of basic health service, being really the sum of a list of technical measures which might add up to a second-rate service provision in areas inhabited by the poor, but which leave ignored, and therefore intact, the curative services available to a privileged few;
2. Ignoring the consideration that good health is probably more contingent on overall development than upon the health sector, and choosing to ignore PHC's emphasis on community participation, with its underlying threat of mass struggle;
3. Looking to traditional medicine or intermediate technologies as ways of letting the state off the hook, by providing a shabby alternative to the equitable redistribution of health care resources;
4. Enthusiastically propounding community participation and self-help alone as the path to PHC, thereby necessarily failing to address the question of the role of the state, and by implication failing to recognize the issue of equity.

Nonetheless, the goal of 'health for all' is unlikely without the kind grassroots organization envisioned in earlier notions of comprehensive PHC, whatever fate these visions may have had in practice. It is hard to imagine growing nearer the goal of 'health for all' without such relatively self-reliant local organizations whose demands become more militant even as the privileged in all countries refuse to accede to changes in the distribution of resources and insist on more of the same.

The chief danger of SPHC is that it helps to slow or to divert the growth of local organizations capable of articulating these demands for change at an historical turning point that can only lead to change or to disaster.

REFERENCES
40. Cole-King S. GOBI-FF and PHC. Unpublished paper. UNICEF, New York, 1983. Compare Segall’s insistence that building political support for PHC requires one to “popularize social epidemiological findings” and to “mount a sustained campaign of popular education” in [41, p. 34].