Accessibility 40 years after Alma-Ata

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Abstract

In September 1978, a conference, jointly organized by UNICEF and WHO was held in Alma-Ata (former USSR) to find ways to respond to the "catastrophic state" of African health systems (Brisset 1978). Following this conference, the World Assembly of the World Health Organization adopted the strategy of "primary health care"[1]. Accessibility was one of the five core principles of primary health care. The overall objective to achieve was "Health for all in the year 2000".

The primary health care initiative has been the subject of many comments and critics especially targeting the organization of health systems, the roles of health providers and communities, traditional medicine, the cost of care, the quality of care, etc. However, it is worthy notice that literature barely consider the physical space and buildings that "clothes" (Kellert & Heerwagen 2013) health care practices. My paper deal with the issue of accessibility in the context of Alma-Ata and after, by focusing on the buildings and layout of spaces of care. I will pay special attention to infrastructure (roads) and architectural features considered as direct factors of accessibility: doors and gates.

I will start by discussing the concept of accessibility. Then, using data from ethnographic fieldwork in Cameroon and Morocco, I will show how the selected architectural features, beside functional purposes, reveal through the ways they are used, rich insights about structural violence (roads), social inequalities (doors, gates and roads), agency (doors), that should be taken into account during the design process. Considering the design of doors and their uses in particular, I can argue that in the contexts studied, they transform the privacy of the doctor-patient interaction into a projected form of interaction that will remain a difficult ideal to achieve (Tantchou, 2018). By doing this, my purpose is to highlight how the built environment configure interactions in hospital settings, thus care practices, reinforce social, professional structures/status and power relations.

Keywords: accessibility, doors, gates, ethnography

1. Introduction

Accessibility was one of the five core principles of the primary health care initiative defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination"[2]. The World Assembly of the World Health Organization adopted the strategy in 1978 with the overall objective of achieving "Health for all in the year 2000". This initiative has been the subject of many comments highlighting its weaknesses since the beginning of the 80s. The comments especially target the organization of health systems (vertical vs horizontal approach), the roles of health providers and communities, traditional medicine, the cost of care, the quality of care, etc. (Van der Geest 1982, Vaughan and Walt 1984, Ridde 2004). However, it is worthy notice that literature barely considers the physical space and buildings that "clothes" (Kellert & Heerwagen 2013) health care practices.

My paper will deal with the issue of accessibility in the context of Alma-Ata and after, by focusing on the buildings and layout of spaces of care. I will pay special attention to infrastructure and architectural features considered as direct factors of accessibility: roads, doors and gates. I will start by discussing the concept of accessibility. Then, using data from ethnographic fieldwork in sub-Saharan Africa and Morocco, I will show how the selected architectural features, beside functional purposes, reveal through the ways they are used, rich insights about structural violence (roads), social inequalities (doors, gates and roads), agency (doors), that should be taken into account during the design process. Considering the design of doors and their uses in particular, I want to argue that in the contexts studied, they transform the privacy of the doctor-

1 See the Alma Ata declaration: http://www.who.int/publications/almaata_declaration_en.pdf.

2 See the Alma Ata declaration: http://www.who.int/publications/almaata_declaration_en.pdf.

patient interaction into a projected form of interaction that will remain a difficult ideal to achieve (Tantchou, 2018). By doing this, my purpose is to highlight how the built environment configures interactions in hospital settings, thus care practices, reinforces professional, social structures/status and power relations.

This paper is based on research conducted in Cameroon, where I did fieldwork from 1997-2014 and Morocco, where I did fieldwork from 2014 to 2017 in primary care facilities, university hospitals and private practitioners. I also had the opportunity to have discussions with patients with chronic diseases, pregnant women, and HIV-positive individuals, and had organised focus group discussions with women to learn about their perception of the space of hospital settings. In what follows, I will start by defining what I understand by accessibility. Then, using data from my fieldwork, I will focus on two features associated with access: doors and gates.

Figure 1: Access to a health care facilities – What about disabled people?

2. ACCESSIBILITY

Access to health care is about enabling a patient in need to receive the right care, from the right provider, at the right time, in the right place, dependent on the context (Saurman 2016). Penchansky and Thomas (1981) define access as the degree of fit between the clients and the system. They identified five factors that affect access. 1) Availability: adequacy of the supply for the clients' volume and types of needs. 2) Accessibility: relationship between the location of supply and the location of clients, taking into account transportation, travel time and cost. 3)Accommodation: the relationship between the manner in which supply resources are organised to accept clients (including appointment systems, hours of operation, walk-in facilities...) and the client's ability to accommodate to these factors and their perception of their appropriateness. 4) Affordability: the relationship of prices to the client's ability to pay and existing health insurance. 5) Acceptability: which relates to the nature of the relationship between users and providers (Penchansky and Thomas 1981). To these five dimensions, Saurman added the concept of awareness. A service that is aware of the local context and population needs could provide more appropriate and effective care, and patients could better access and use such services if they were simply aware of them in the first place (Saurman, 2016). Roads, gates and doors allow for access.

2.1 Access(ability) in Morocco: missing connections between the locations of supplies and clients

As mentioned, accessibility is the relationship between the location of supply and the location of clients, taking into account clients' transportation, travel time, distance and cost. According to the ministry of health, in Morocco the mean distance to reach a health facility is 219 km. There is a huge difference according to location: 13.8 km in urban areas and 38.5 km in rural areas. On average, it takes 35 minutes for those living in urban areas to reach a health-care facility, and 77 minutes for those living in rural areas. Overall, 41.1% of patients are over an hour away from the nearest health care facility. This is a serious issue when considering hospital care. Rural dwellers spend at least 90 minutes to reach a hospital; urban residents

take 53 minutes (Ministère de la Santé 2007: 97). Lack of transportation is one of the major reasons why pregnant women in rural areas don't usually deliver in a medical facility (only 46.2% do) (Gruénais 2011). It seems logical that patients travelling a long distance should be received first to allow them to have a chance to find transport to go back home, but that is not the case. Sometimes, patients coming from long distances will wait the longest because they are rural dwellers, because they lack connections in hospital and because they are poor, they don't have the language skills and they are unable to corrupt health workers to benefit from differential treatment, meaning, being treated according to one's ability to pay or connections inside the hospital or health care facilities (Andersen 2004). A study in Morocco reveals that 88% of the patients who had to travel more than an hour waited for at least another hour before seeing the doctor. On the other hand, patients living next to the health facility waited a couple of minutes (Conseil santé 2009: 22-23).

When the issue of mobility from one's house to the health centre or the hospital is solved. The issue of fees is solved, then patients can reach the gates of the hospitals or the primary health care facilities. Before entering the gates, let mention that when thinking about the layout of the space, it is important to consider the connection between places. This is perhaps beyond the reach of architects, but they should have sufficient knowledge of the matter to be able to raise these issues when involved in the design of hospitals in Africa, because constructing a building that will be underused or closed after a couple of years is a waste of resources. According to a report from the ministry of health, in 2012, 143 primary health facilities were built and closed in Morocco (Minsanté 2012).

3. TWO FEATURES ASSOCIATED WITH ACCESSIBILITY: DOORS AND GATES

3.1 Gates: violence

Gates are not neutral features. They are places of physical and symbolic violence according to status. Differential treatment (Andersen, Idem.) is common in hospital settings, where people are treated according to their connections or the amount of money they are able to spend on care. One colleague commenting about one university hospital said that in Morocco, it was easier to get inside the hospital by car than by walking. Gates are a place of symbolic violence or what a doctor calls "poorly oriented psychology" because of the succession of iron bars and the presence of a security agent, for the theoretical purpose of security, but in reality only renders patients aggressive because of the feeling of being excluded from what should be a right.

Those coming from rural areas without any connections, lacking language skills, or what Michel Lussault calls elementary spatial skills appropriate to hospital settings (Lussault 2010, Lussault and Stock 2010), may be treated roughly because they don't know how to reach the location where their appointment is, and they lack the language skills to answer questions concerning why they are there or where they are going. On the other side of the gates, what we call "rabatteurs" pay special attention to these poor patients for the theoretical purpose of helping them. "Rabatteurs" are people working in connection with doctors to divert patients from the official free of charge circuit where waiting is a common feature. When you go to the hospital, a doctor said, be prepared to spend at least the first part of the day. But with the help of a "rabatteur", the poor people having their transportation issues in mind, will be brought to specific doctors or nurses and asked to pay for their treatment. The privatisation of public service is common in Africa where users pay fees for what should be actually provided to them free of charge (Van der Geest 1985, Van der Geest 1985 , McPake, Mwesigye et al. 1999, McCoy, Bennet et al. 2008, Tantchou 2019). Sometime they will pay fees higher than what they would have paid in a private facility because of being moved from one place to another by the "rabatteurs", and not spend time waiting. So, be sure of going back home as scheduled. One of the "rabatteurs" told me: "if you want to do everything as prescribed, it is Ok. But if you want parallel circuits, because you are in a hurry, you have to pay. But I will be kind to you, it will be for next time, you will give me a cup of tea".

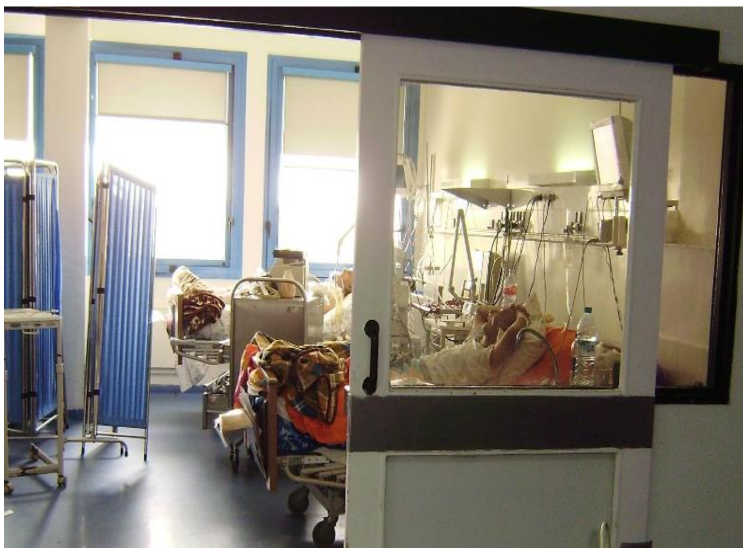
Wealthier and literate patients or urban dwellers with language skills and/or elementary spatial skills (Lussault, Idem.) appropriate to hospital settings will answer as expected; their communication skills will reveal their status, they will give the name of a doctor or a nurse, or a family member working in the hospital and this will enable them to benefit from differential treatment.

Gates are also places of economic activity. Gates are thus places of financial transactions. Health workers are not provided with a cafeteria inside the hospitals studied. The wealthier can take an hour to go back home for lunch. Other will go to the vendors at the gate to buy a snack, a sandwich and a drink. One nurse complains about this, saying: "we can't enforce good eating habits when we are not provided with help to eat well". In the studied hospitals, you can't pay with a credit card. You need cash or a check. Sometimes, because they spend the day receiving a giving back money, devises lack at the level of the cashiers. So users will need to obtain exact change to pay for services. The vendors around the hospital help with that. Consequently, there are frequent communications between the inside and the outside of the hospital. The gate doesn't enclose and doesn't mark the frontiers of the hospital, maybe the physical frontier, but if we refer to functionality and the roles needed for the working of the hospital, the gate will stretch. Gates lead to doors. The doors of an elevator. Those of an office, a room or a lab. In the following I will not deal with elevators, a subject of its own in hospital settings.

3.2: Doors

Like gates, doors are not neutral. Walking through doors to enter the hospital setting can be traumatising; doors can open onto gloomy and dirty corridors or they can lead to the surprise of entering a luminous, wide and clean space. Sometimes, that's how you recognise spaces where the wealthier patients are hospitalised: natural light, windows; plenty of space. Doors reveal status and functionality, they clarify who is authorised and not authorised, they help to manage privacy, enable a retreat from people, exert control over information and the regulation of interactions (Kupritz 2000), and create one's own space. Yet, creating space in hospital wards means establishing boundaries: developing connections, electing those who are authorised to cross the boundaries and those who are not, having the opportunity to close one's door. In one of the services studied where hospitalisation is free of charge, doors are always open. Yet, when staying at a hospital for a long period of time, you may need privacy, the possibility of being alone, of feeling your body, of refusing to be disturbed, or refusing to communicate.

Figure 2: Any place for privacy?



This is only possible for those who can afford private rooms. People in those rooms are not treated like people in free of charge rooms. An example of this is a conversation between a nurse and a doctor before the beginning of ward rounds. The doctor was asking about a specific patient. The nurse answered that she went to his private room and knock at the door. Nobody answers. So she thought he was taking his shower or he was still sleeping. The patient, a wealthier man, closed his door and nurses were not allowed to enter without his permission. If this shouldn't be allowed in hospitals for security purpose, the nurses and the doctor never raised the issue. This might be because of what Blundo and Olivier de Sardan call "*investissement corruptif*" (Blundo and Olivier De Sardan 2007), that is by treating wealthier patients in a certain way, you expect them to give you a recompense.

Doors here are rarely sliding. You use your hands and water spots and disinfectant are not common, doors open inside or out. They are noisy. In the context studied, doctors are rarely alone with their patients in a consultation room; even in that case, the door of the doctor's office will open quite frequently. So as he is interviewing a patient, you will hear a knock, then the twist of the door handle, the creaking of the door opening, a question, an answer then the twist, the creaking and sometimes the snap of the lock. The privacy of the doctor-patient interactions is an ideal that remains difficult to achieve (Tantchou, 2019). Noisy spaces drain mental and emotional resources, undermining patient-provider relations.

Figure: hands to open the doors, water spots/disinfectant not common, keep hands' "clean"?

Centre Hospitalier Universitaire, Rabat, 2016

Hôpital régional de Maroua, 2014

Sometimes, these waiting rooms are in front of the doors of doctors' offices. The noisy doors and noisy waiting spaces lead some of the patients to complain about their blood pressure rising while they wait inside some of the health-care facilities' waiting rooms. One doctor even hypothesised the idea of waiting-room-related increases in blood pressure or stress.

Doors are also reassuring, because behind the doors lies the possibility of a diagnosis, treatment, and thus a solution to one's health problem. But, between the first symptoms and entrance into the doctor's office, there is a long way, a long process. 40 years after Alma Ata, accessibility is still a huge problem mainly for the poor.

4. Conclusion

Accessibility is still a problem, and so is the adaptability of health services to the context and trust in health providers, which I didn't discuss. Mechanic (1996) emphasized the "affective" dimension in health-seeking behavior. Perceptions of and trust in the provider are an essential aspect of access (Acharya and Cleland 2000, Wachara, Komatra et al. 2005). Negative attitudes of health personnel towards patients are barriers to the use of available care. Many studies have highlighted the tensions characterising patient-practitioner relations in Africa. Andersen raised the idea of an "attitude problem" (Andersen 2004), with differential treatment common. Insufficient human resources for health care, high workload and low incomes have been put forward to explain health providers' negative attitudes. The architecture of health facilities should be considered. If architecture can configure behavior, then architects have something to do to change patient-providers relations through their design and the layout of space of care. 40 years after Alma-Ata, the poor are cured, not care for.

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