Letters

Myths of community-based health care

Editor – I am responding to Adnan Hyder (*1*), who says that "community-based health care has been plagued by principles which have become myths". It should be pointed out that his principles/myths were not part of Alma-Ata's message (*2, 3*) and mostly emerged five years later in the debate which advocated a shift to selective primary health care. An unfortunate polarization between top-down and bottom-up approaches in scaling up programmes to national coverage since then has often stalled health care reform. The dichotomy is false, since we need both. Community-based primary health care brings together multiple approaches to rationalize the balance.

I agree with Hyder in debunking the first myth: there is no "universal model", an idea arising from the common public health preference for a blueprint approach. The second myth of focusing "only on villages" was a claim made in arguing against Alma-Ata but it was never a principle of the Health for All movement. The same applies to the claim that "governments are the problem", since everyone agrees that governments must be a full partner with communities. When he refutes the claim that community-based programmes are "less expensive", with no indication of less expensive than what, I agree with him that rigorous analysis of real but invisible costs may help. However, to resolve the old polarization, studies of both governmental and community-based activities are needed which look for points of synergy and mutual facilitation.

Most of all, I agree with Hyder when he turns from evaluation by costs alone to introduce transparency, equity and need. In the final paragraph he stresses recognition of "the value base upon which the notion of community-based health care stands". He focuses correctly on the values of equity, empowerment and respect, and emphasizes the overriding need for recognition of the plurality of pathways by which these values are put into practice — hopefully in government and village partnerships. A major problem remains: to change the attitudes of international experts who seem to want to prolong the appearance of an argument as part of academic competition. I hope Hyder's letter will help each of us to clarify our own myths. ■

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2. *Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978*. Geneva, World Health Organization, 1978 ("Health for All" Series, No.1).
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Reliability of the clinical surveillance criteria for measles diagnosis

Editor – WHO has estimated that of the approximately 31 million measles cases and 960 000 measles deaths worldwide, 99% have occurred in the least developed or developing countries (*1*). Reported cases were considerably lower, at 702 298, which indicates the need to improve surveillance if measles is to be ultimately eradicated. In the industrialized world where there is a low incidence of measles cases, the problem is one of overreporting.

The WHO case definition of measles requires the presence of fever and rash with one or more of the following symptoms: cough, coryza or conjunctivitis (*2*). However, these clinical presentations can readily be confused with other rash-associated conditions, particularly those due to viruses, such as roseola infantum, human herpesvirus-6 (HHV-6), rubella, dengue and parvovirus. The consequences of misdiagnosis may adversely affect policy decisions. In the first 35 weeks of an enhanced surveillance programme in England and Wales (*3*), it was reported that only 3.7% (126/3442) of notified measles cases were confirmed in the laboratory. This emphasizes the importance of laboratory confirmation of clinically suspected measles cases.

South Africa has implemented strategies to eliminate measles, including mass immunization campaigns during 1996–97 which reached over 90% of the target population, in addition to a national routine coverage rate of 85% for children 12–23 months of age. As part of this policy, it has been recommended that cases suspected to be measles, on WHO criteria, should have a blood specimen taken for laboratory confirmation by measles IgM determination.

To investigate reliability of the criteria and to establish a diagnosis in non-confirmed cases, sera from 220 patients reported clinically as measles cases were submitted to the laboratory for confirmation. The sera were tested for IgM antibodies to measles, rubella, parvovirus B19, EBV and HHV-6. Avidity tests were carried out on HHV-6 IgM positive sera. Of the 220 sera tested only 12 were measles IgM positive (5.5%), emphasizing the importance of laboratory confirmation of clinically suspected measles cases. A high proportion of the cases, 106/220 (48.2%), were positive for rubella, as has been found in several previous reports for clinically suspected measles cases. Parvovirus serology was positive in two cases and EBV in none, suggesting that these viruses may not be a significant differential diagnosis of measles-like rash illness. IgM serology for HHV-6 was positive in 12.7% (28/220) of the sera, however the age group of these patients and the avidity test results suggested that these were not primary infections.

Thus, it would appear that, in South Africa, rash-like illnesses fitting the surveillance criteria for measles were far more likely to be rubella. Nevertheless, the WHO clinical case definition is of value as regards optimizing the sensitivity of the clinical examination, even if there is some loss of specificity. ■

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