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REVITALISATION OF PRIMARY HEALTH CARE

Background Document for 20th Anniversary

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1. THE ALMA ATA DECLARATION : BACKGROUND, FOCUS AND IMPLICATIONS

The concept of Primary Health Care (PHC) evolved during the 1970's, influenced by and influencing the **basic needs approach** to social development. Informed on the one hand by the disappointments experienced in implementing the basic health services approach, (Gish 1979, cited in Werner & Sanders 1997, p 15) and on the other by the remarkable progress in improving health in China, as well as by the achievements of many small, mostly NGO-inspired, community-based health care initiatives in developing countries, (Newell 1975), WHO and UNICEF elaborated the strategy of Primary Health Care as the means to achieve Health for All by the Year 2000.

The concept of PHC had strong sociopolitical implications. It explicitly outlined a strategy which would respond more equitably, appropriately and effectively to basic health care needs and also address the underlying social, economic and political causes of poor health. Certain principles were to underpin the PHC Approach (PHCA), namely, universal accessibility and coverage on the basis of need; comprehensive care with the emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action for health; and appropriate technology and cost-effectiveness in relation to the available resources (Adapted from Tarimo & Webster 1994, p 3).

Primary health care is 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. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care:

1) reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2) addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3) includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4) involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5) requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6) should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those almost in need;

7) relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Source: WHO and UNICEF, Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6-12 September 1978.

The implications of the PHCA were recognised, even at the time of the Alma Ata Declaration, to be far-reaching if the strategy were to be properly applied: the principles would have to be translated into changes not merely in the health sector but also in other social and economic sectors as well as in community structures and processes.

Some of the changes required would include the redistribution of existing resources (financial, material and human) for health; a reorientation and a broadening of the skills of health personnel to enable them to respond to the challenges of implementing PHC and to work in teams as well as with other sector professionals and communities; and improved design, planning and management of the health system to facilitate greater community involvement, intersectoral collaboration and decentralisation (Adapted from Tarimo & Webster 1994, pp 8-9).

2. TAKING STOCK: A BALANCE SHEET OF P.H.C. IMPLEMENTATION

Twenty years after the Alma Ata Declaration the experience of many countries in implementing PHC has led to elaboration of the concept, raised new issues and challenges and resulted in differences in interpretation.

A major fault line was introduced in the Alma Ata document wherein PHC was defined as both a "level of care" and an "approach": these two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some developed countries and sectors PHC became synonymous with primary medical care provided by general doctors, with the result that PHC has been viewed by many as a cheap, low technology option for poor people in developing countries (Tarimo & Webster 1994, p 88).

From Primary Medical to Primary Health Care

	Focus	
From		To
Illness		Health
Cure		Prevention and Care
	Contents	
From		To
Treatment		Health Promotion
Episodic Care		Continuous Care
Specific Problems		Comprehensive Care
	Organisation	
From		To
Specialists		General Practitioners
Physicians		Other Personnel Groups
Singlehanded Practice		Team
	Responsibility	
From		To
Health Sector Alone		Intersectoral Collaboration
Professional Dominance		Community Participation
Passive Reception		Self-responsibility

Source: Vuori, H. (1984). Primary health care in Europe – problems and solutions. *Community Medicine*, 6, p 221-231.

Even in countries which embraced PHC as the key to Health For All (HFA), unforeseen changes in the 1980s in the **political and economic situation** bedeviled its implementation, leading to a conclusion that: "It was adopted several years too late for the political and social movements that could have provided support and served as a springboard for development" (WHO 1998A, p 145).

There have, however, been significant successes in implementing PHC, although mainly in the development of peripheral health services, rather than in the facilitation of social development though the promotion of an intersectoral approach and community participation, which might lead to improvements in living environments and provision of job opportunities. (WHO 1998A, p 145).

Perhaps the most important achievement of the HFA movement has been its widespread acceptance among governments, non-governmental and international organisations where it has influenced planning for more equitable distribution of health resources, reorientation of services and the development of new types of health personnel (Tarimo & Webster 1994, p 61). Such planning frameworks and charters, as well as national plans which call for coordinated sectoral action for health, have often, however, been undermined in their implementation by inauspicious sociopolitical environments, insufficient knowledge and commitment from other sectors and a lack of enabling legislation and financial and human resources.

While government **expenditure** on the health sector as a percentage of the GNP has increased in most countries (UNDP 1993, cited in Tarimo & Webster 1994, p 28), the percentage devoted to local health services has been increasing in developed countries, been stagnant in developing countries and has decreased in the least developed countries (WHO 1993, cited in Tarimo & Webster 1994, p 28), with the resultant recent deterioration of services in the latter group.

2.1   Progress in Implementing the Programme Elements

Since the early 1980's there has been considerable progress in the **coverage** of populations with the essential elements of health care.

Figure 1. **Access to selected elements of primary health care, developing countries, 1983-1985 and 1991-1993**

¹ Percentage of population.
² Percentage of children under one year.
³ Percentage of pregnant women.
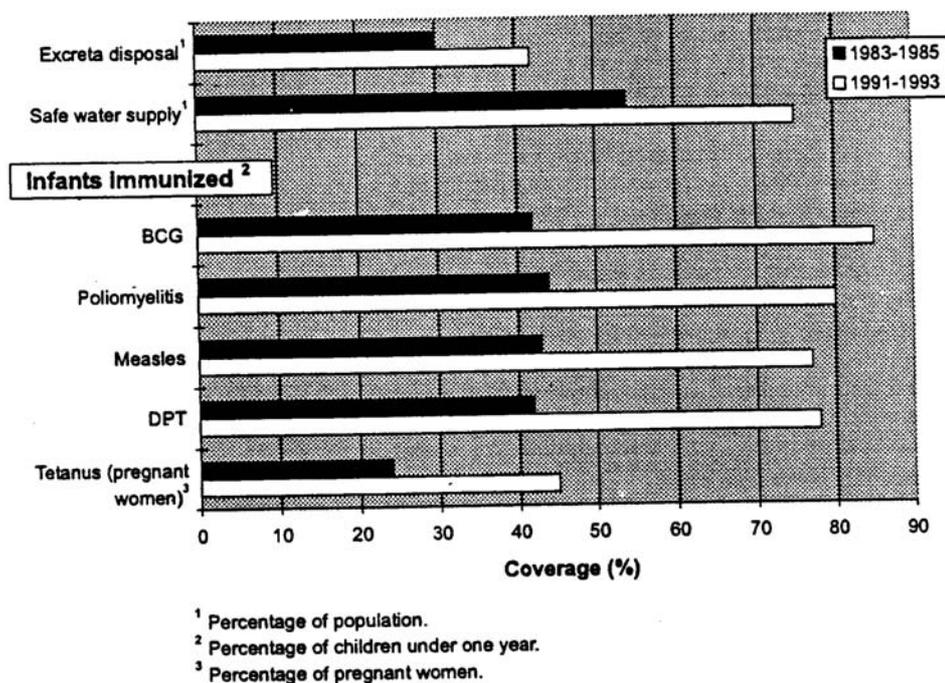
(Source: WHO 1998B, p 4)

The world's percentage of the population covered has increased markedly but millions of people remain without access to the basic elements of care, with the gap between availability in the developed and least developed countries widening as is that between the rich and poor within countries (WHO 1998A, p 153).

There has been some progress in improving access to **water supply and sanitation**, although great differences continue to exist between and within countries and social groups. A welcome development is the shift in focus from water quality alone towards a more integrated approach to environmental improvement. The advantages of this approach are evidenced in the dramatic progress in controlling dracunculiasis.

The **nutrition situation** in developing countries remains serious with almost 200 million young children being malnourished and almost a billion people receiving less than their basic daily requirements of energy and protein. Clearly, progress in this area demands not only health sector

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interventions (e.g. treatment of infectious disease, supplementary feeding, nutrition education etc.) but also effective intersectoral actions to improve living conditions and household food security.

Perhaps the most spectacular achievements have been in **maternal and child health care and family planning**, although maternal health has received far less attention than child health, with levels of **maternal mortality and morbidity** from largely preventable causes in developing (particularly the least developed) countries remaining unacceptably high.

Table: Maternal Mortality Rate.

Country groupings	Maternal mortality per 100 000 Live births, 1991	Number of Member States Included, 1991
Developing countries	421	113
of which least developed	*727*	*37*
Eastern Europe	41	8
Developed market economics	34	25
Total	**370**	**146**

(Source: Tarimo & Webster 1994, p 39)

Child health care provision has increased greatly over the past two decades with the vigorous promotion of certain selected "Child Survival" technologies: growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunisation (GOBI). Of these, **immunisation** has shown the most dramatic improvement, with global coverage of children under one year increasing from 20% (WHO 1992, cited in Tarimo & Webster 1994, p 43) in 1980 to 80% by 1990. This impressive progress notwithstanding, there remain areas for concern. These include apparent stagnation in immunisation coverage since 1990, with the most difficult-to-reach population being the group experiencing a disproportionate burden of vaccine-preventable disease; the reappearance of diphtheria in th Newly Independent States as a result of vaccine shortage and poor programme management (WHO 1995, cited in Tarimo & Webster, 1994, p 44); and less than 50% coverage of pregnant women with tetanus toxoid vaccine.
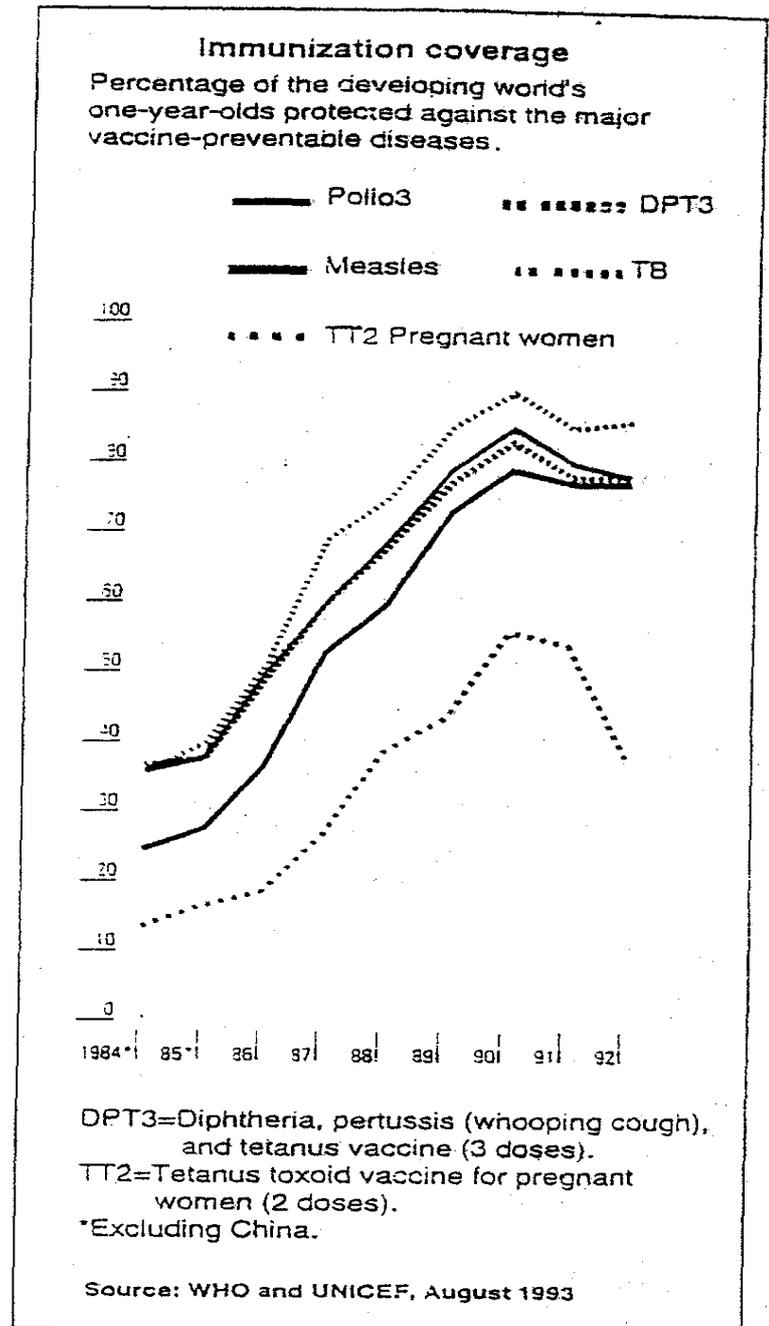
(Source: UNICEF 1994, p 3.)

Fig. 1-1 Global immunization coverage.

Acute respiratory infection (ARI) and **diarrhoeal diseases** are the two leading causes of death in children under 5 globally. Since the early (in the case of diarrhoea) and late 1980s (in the case of ARI) standardised case management guidelines have been developed with rewarding results: however, particularly in the case of diarrhoea, the impact has been less than anticipated due to interrupted and inaccessible supplies of oral rehydration solution, improper usage and an unabated high incidence of diarrhoea as a result of minimally improved environmental hygiene and persisting malnutrition (Werner & Sanders 1997, pp 36-40). More recently, given that 70% of young child deaths can be attributed to diarrhoea, pneumonia, measles, malaria and malnutrition, clinical guidelines for the **integrated management of childhood illness** (IMCI) have been developed.

Control of the three most common and serious **communicable diseases**, tuberculosis (TB), HIV/AIDS and malaria has proved elusive. TB is now responsible for over 25% of avoidable adult deaths worldwide (WHO 1993, cited in Tarimo & Webster 1994, p 46) with 95% of cases occurring in developing countries; its prevalence has risen sharply over the past decade-and-a-half as a result of HIV infection, deteriorating socio-economic conditions and poor quality control programmes, together with the emergence of multi-drug resistant organisms. The HIV epidemic has spread rapidly to affect over 30 million individuals, mostly in developing countries, especially Sub-Saharan Africa (SSA), and involves predominantly young adults and children born to HIV-infected women. In some SSA countries gains in survival achieved over the past few decades are being reversed by the effects of HIV infection. By the year 2000 Zimbabwe, for example, will have experienced a 10-year reduction in the life expectancy of a child born in 1990 (WHO 1998A, p 93). In developing countries it is transmitted mainly through heterosexual intercourse, particularly in the presence of untreated sexually-transmitted diseases (STDs), while in developed sectors, and increasingly in a number of Eastern European countries, through intravenous drug injection. As with TB, underlying factors such as socio-economic decline and unemployment, ignorance, complacency and stigmatisation of sufferers, and in the case of HIV the subordinate social and economic status of women, have fuelled the epidemic (Sanders & Sambo 1991, p 162). The malaria situation remains serious, particularly in SSA where it imposes

high mortality and morbidity levels and a major economic burden from lost productivity and escalating treatment costs as antimalarial drug resistance spreads.

Current strategies for control of these diseases are multifaceted and remarkably similar. TB control programmes plan to rely heavily on directly observed short course chemotherapy (DOTS); HIV control has focused on the prevention of sexual transmission by targeted educational activities and early treatment of STDs; and malaria control on early diagnosis and treatment, the implementation of selected preventive measures and containment of epidemics. While the technologies employed in all three cases have evolved considerably in the past decade e.g. improved short course anti-TB drug regimes, guidelines and drugs to effectively treat STD "syndromes", and geographic information systems to assist in targeting malaria vector control, sustained success in combating these diseases is unlikely without well-developed health systems, improved living and working environments secured through anti-poverty measures and coordination with health-related economic and social sectors, and active participation by communities in such control campaigns. Indeed, a recent review has pointed out the lack of evidence for effectiveness of DOTS in the absence of a well functioning health service and community engagement (Volmink & Garner 1997).

The major **non-communicable diseases** such as cardiovascular disease, cancers, diabetes and mental illness together with violence and injuries contribute significantly to the burden of disease in developed, and, increasingly, in developing countries. Reflecting increasing contamination of the food chain and the environment by chemical, hormonal and radioactive pollution, most cancers are on the increase in developed and developing countries, an exception being lung cancer which is declining amongst men and the younger generations in developed countries as a result of reduced tobacco consumption : the reverse is generally true for women everywhere as well as for developing countries where smoking is on the increase. Diabetes too has become much more common globally, reflecting inappropriate dietary patterns and exercise habits. Cardiovascular disease is now becoming more common in developing countries but has declined dramatically in most developed countries : here smoking reduction, particularly amongst men has been a major factor. The high prevalence of mental illness and the increasing incidence of violence and injury reflect marked changes in living and working environments which are characterised by rapid, squalid and stressful urbanisation, structural unemployment and increasingly visible disparities within most societies (WHO 1998A, p 56 - 57).

The complex epidemiology of non-communicable diseases reveals starkly the inadequacy of control measures based on a narrow medical-technical approach which in the past has relied heavily on a combination of medical measures and individually-directed health education. It is clear that a wide-ranging set of actions, involving a range of sectors and tied to more fundamental measures, is necessary for sustainable impact. For example, it is unlikely that the burden of ill-health imposed by cardiovascular disease and diabetes will be substantially reduced in all groups in the population unless, in addition to more effective treatment, sustained changes in smoking, dietary and exercise habits and their determinants (tobacco and food prices and marketing, wage levels, access and attitudes to recreational facilities etc.) occur : such changes are predicated on more fundamental social and economic reforms and community actions. Similarly, a sustained reduction in violence, injuries and mental-illness will require improved and more equitable living and working opportunities, more supportive social structures and more effective controls on weapons and drug and alcohol abuse : the attainment of these has far-reaching implications for the way societies and their economies are organised.

Thus it is that the understanding and application of **health education**, one of the elements of PHC, has evolved significantly from a preoccupation with individual behaviour change towards a broader set of activities termed "health promotion" whose scope has been elaborated at international conferences in Ottawa, Adelaide, Sundsvall and Jakarta and which incorporates individual as well as social action.

The health promotion initiative is based on five interrelated components:

- The integration of policy on all social issues, recognizing that education, housing, and finance policies are as important to health as are health care policies themselves;
- The creation of supportive environments;
- The strengthening of community action;
- The development of individuals' skills in applying health knowledge and undertaking advocacy; and
- The reorientation of services towards the promotion of well-being and prevention of disease (Ashton & Seymour 1988).

The implementation of this approach or "the new public health", has major implications for the HFA initiative. While still in its infancy it has shown some exciting promise : some of its applications are reviewed in Section 5.

- The final programme element to consider is **Essential Drugs**. Since 1978 when the Action Programme on Essential Drugs was established, great progress has been made. By 1990 64 countries had installed operational essential drugs programmes, 28 were developing such programmes, and at least 68 had formulated national drug policies. Despite this, however, approximately two billion people still do not have access to the most important drugs and vaccines (Tarimo & Webster 1994, p 52). At the same time the drugs bills for most countries and their health services remain massive, and wastage and irrational drug use in public and especially private sectors remain problems. There is thus still a great need for comprehensive national policies and actions covering procurement and quality control, distribution, rational prescribing and dispensing as well as consumer education.

2.2   Progress in Health Systems Development

National level support for the reorientation of existing facilities and personnel has been visible in many countries where large numbers of workshops on PHC have been organised for health workers, and organisational structures developed to facilitate PHC implementation. **Logistic support** for health services in terms of drugs, equipment, vehicles and communications, has frequently been inadequate, often being determined by the overall level of development of the country, except where special (often donor-provided) resources have been allocated, as in the case of immunisation and diarrhoeal-disease control programmes (Tarimo & Webster 1994, p 33).

In recognition of the fact that, almost a decade after Alma Ata, the activities of various programmes and institutions largely continued to be piece-meal and poorly coordinated, and that health services often remained concentrated in particular areas, leaving large population groups with little or no access to health care, the concept of the district health system (DHS) was born. The district was identified as "the natural meeting point for 'bottom-up' planning and organisation and 'top-down' planning and support" (Tarimo 1991, p 4): a place where community needs and national priorities could be reconciled.

The DHS, then, has been promoted as the unit within which the implementation of primary health care by the health and health-related sectors (public and private), and communities can be best organised and coordinated. District management structures were envisaged as a focus for decentralisation of political power and resources, increased democracy and equity.

Despite efforts over the past ten years or more, there are few countries where district health systems are functioning fully and effectively (Tarimo & Webster 1994, p 32). Interventions are often externally funded, based on "blue print" models which do not create ownership of systems and lead to a lack of commitment amongst those responsible for implementing the changes.

While the recognition at Alma Ata of the importance of **health services research** and operational studies has stimulated skills development, training materials production and even health systems research studies, investment in and utilisation of findings from these activities remain weak. Often this results from the lack of relevance of this research and/or the non-involvement of decision-making cadres in its planning and conduct and the application of inappropriate methodologies.

Added to this is the confusion caused by **health sector reforms**, which are introducing radical management change into already fragile district systems and often make the situation worse before their "medicine" works. Those in a position to influence international policy appear to shift and redefine their policies frequently, and tend to concentrate on "quick fix" solutions rather than sustainable developments of public health services and improvements of quality of care (Campbell 1998). Furthermore, there is all too often a major separation between policy formulation and implementation, with little focus on the realities of putting policies into practice (Walt 1994).

Fiscal austerity, which has been a feature of the global economic crisis of the past two decades, demands greater value for money. Together with rising unemployment and changes in the labour market, changes in demographic and social trends, and rapid technological advances with major cost implications for health services, it has, over the past two decades, driven a process of health sector reform in developed countries (WHO 1996A, p 4).

In developing countries reform strategies are being directed at inefficient use of scarce public funds on inappropriate and cost-ineffective services with poorly functioning systems; poor

coverage by inadequately planned and managed services; and low quality services rendered by unmotivated, poorly trained staff in poorly equipped facilities (Cassels 1995, p 331).

While there is no consistently applied, universal health care reform package, it potentially includes six component areas. These are: improving the performance of the civil service – through better functioning management systems and reduced but more efficient personnel numbers; decentralisation of management responsibility and/or provision of health care to district-level local government or other local agencies; improving functioning of national ministries of health – through restructuring, improved resource management, better planning and more efficient implementation strategies and monitoring systems; broadening health financing options – through user fees, insurance schemes etc.; introducing managed competition between providers of clinical and support services; and working with the private sector through contracting, regulating and franchising different private providers (Cassels 1995, p 338).

Although the above aims appear rational in their conception, the reform process has evolved at different rates and to different extents in different countries and it is difficult to generalise about the success of its implementation. It appears that in many, especially developing, countries the rhetoric of implementation often masks the truth that fundamental change has not occurred (Mills 1998, p 12). Piecemeal approaches have sometimes aggravated inequities (as with user fees in several countries), (Kutzin 1995, p 9) or led to increased dysfunctionally and a deterioration of local health services as decentralisation of responsibility has occurred, mostly without decentralisation of resources and enhancement of local capacity (WHO 1998A, p 147). Furthermore, the focus on cost-effective and efficient "delivery" of "health care packages" threatens to reinforce the technicist emphasis seen with selective PHC and aggravate the neglect of the process of health development (Baum & Sanders 1995, p 155). Although the rationale is compelling for decentralisation of implementation and management of PHC to a self contained geographical area, the district health system (DHS) is being misappropriated by those concerned with the technical aspects of management (e.g. information systems, management development etc.) rather than with its role in developing comprehensive services within sub-districts (Tarimo & Webster 1994, p 67). The DHS was, after all, conceived as a means to better organise and support integrated and comprehensive PHC (Tarimo 1991).

Most of the financing options proposed as part of health sector reform represent different forms of the "public-private mix". Experience to date indicates that, although privatisation ought to be

an instrument for achieving certain policy objectives, it has frequently become an end in itself. Growth in private health care has often resulted in the shifting of costs to households by increasing cost sharing; through the rationing/priority-setting decisions about which services (or packages of care) will be publicly funded; and the creation of competing private insurance schemes and informal payment mechanisms. Because of differential ability to pay, these new financing approaches undermine equity-oriented health policies (WHO 1998C, pp 3 - 4). This suggests that privatisation is based on ideological commitment rather than sound evidence of its effectiveness.

2.3   Progress with Human Resources for Primary Health Care

The successful functioning of health systems depends crucially on adequate numbers and competence of personnel who account, in most countries, for at least 70% of recurrent expenditure on health services. Consequently, **health personnel/human resource development (HRD)** assumes not only a priority place but is also a primary step in health systems development.

Since 1978 there has been a considerable expansion in health human resources particularly at the "auxiliary" or "paramedical" level in developing countries and, especially in the immediate post-Alma Ata period, in the community health worker cadre. Despite this, many poor countries, especially the least developed, have too few health workers to provide universal coverage and in all countries there continues to be significant maldistribution of, and imbalances between, various types of health workers. For example, the health worker to population ratios between countries and between the public and private sectors within countries, and variation in the ratio of nurses to doctors in different countries is striking.

Teamwork is, on the whole, poorly developed (WHO 1988, cited in Tarimo & Webster, 1994, p 54) and the motivation and competencies of health personnel require considerable strengthening, especially in the non-clinical domains, to implement PHC. Also, greater involvement of traditional practitioners in the health system has been advocated in some countries: achievements in this regard have been limited, with the notable exceptions of China and India where progress largely antedated Alma Ata.

If **education and training** are to serve the development of comprehensive and integrated health systems, then the PHCA, with its clinical and public health components, needs to permeate much more strongly most health professional education. There is, however, in most tertiary health science educational programmes an unfortunate separation between the clinical health care and public health components (White 1991, cited in Zwi et al, 1994). The latter is often marginalized in the formal curriculum and, when present, is usually presented in an abstract and theoretical form. Indeed, the substantial failure of most tertiary education health science institutions to adapt their missions and activities to the challenge posed by HFA has probably been one of the most significant impediments to the successful implementation of PHC, and a major reason for the continued dominance of specialist and hospital-based health care in many countries.

Further, the training of health professionals mainly at the secondary and tertiary levels of care has meant that health workers are ill-equipped to do primary level work. If health workers are to render comprehensive care at all levels, their practical and theoretical training must be relevant to addressing the needs of the population. It is urgent, therefore, that district-based health teams receive such training (Flahault & Roemer 1985, cited in Tarimo & Webster 1994, p 55).

There are also many aspects of the **management** of human resources which are critical to the functioning of the health system and to which insufficient attention has been given. These include incentives and regulations to improve retention as well as issues of ongoing support and supervision of health personnel. Neglect of these has contributed to demoralisation and loss of personnel and inefficient and low quality service provision in the public health sectors of many countries (Bassett, Bijlmakers & Sanders 1997).

2.4   Progress in Securing International Support for PHC

At Alma-Ata agreement was reached and pledges were made concerning technical and financial support for poor countries by international organisations, funding agencies and other donors. While WHO and UNICEF have supported the development of national plans and assisted in regional plans of action, they have had little success in mobilising international resources for PHC. No increase in aid flows has occurred and minimal action has been taken to address the indebtedness of the least developed countries. Similarly, none of the recent global conferences on

issues related to health (population, women, social development, the environment) has been followed by flows of money to implement recommendations.

2.5   Summary

While progress in implementing the PHC strategy in developing countries has been greatest in respect of certain of its more medically-related elements, the narrow and technicist focus characterising what has been termed the selective PHC approach (Walsh & Warren 1979) has at best delayed, and at worst undermined, the implementation of the comprehensive strategy codified at Alma Ata. The adoption in developing countries of certain selected interventions, such as growth monitoring, oral rehydration therapy (ORT), breastfeeding and immunization (GOBI), constituted the centrepiece of UNICEF's Child Survival Revolution, which, it was argued, would be the 'leading edge' of PHC ushering in a more comprehensive approach at a later stage. The relative neglect of the other PHC programme elements and the shift of emphasis away from equitable social and economic development, intersectoral collaboration, community participation and the need to set up sustainable district level structures suited the prevailing conservative winds of the 1980s (Rifkin & Walt 1986). It gave donors and governments a way of avoiding the fuzzier and more radical challenges of tackling inequalities and the causes of ill-health. The result was the enthusiastic initiation of selective interventions often delivered through vertical, centrally organised programmes, that received generous funds to the detriment of the more comprehensive approaches: Child Survival, especially immunisation and diarrhoea case management, has been substantially supported by various donors, notably USAID.

Partly in response to criticism of its structural adjustment programmes the World Bank (World Bank 1993) proposed its own version of health sector reform. This influential policy document had a number of positive aspects : it recognised that poverty and ill-health are causally related and that improved health is likely to result from economic improvement and changes in sectors other than health. It also discouraged further investment in specialised tertiary care. It is recommended that governments should adopt a three pronged policy approach to health reform : foster an enabling environment for households to improve health; improve government spending in health; and facilitate involvement by the private sector. The centrepiece of its policy for improving spending on health is a proposal for a package of public health interventions and a package of essential clinical services. This approach is, in effect, a more elaborate version of the selective PHC approach, virtually neglecting intersectoral work and community involvement.

The content of these "packages" is determined by what are regarded as cost-effective interventions. New activities such as de-worming and vitamin A supplementation were added to the above selected technologies which governments should be aiming to provide.

Proponents of the selective approach point to the impressive increases in immunisation coverage, declines in infant mortality in many countries and the successful eradication of polio from the Americas. However, fifteen years after the adoption of these packages of care, the health experience of many children has not improved (UNICEF 1996; WHO 1996B) immunisation coverage rates have stagnated (UNICEF 1994) and infant mortality rates have risen in many Sub-Saharan countries (Commonwealth Secretariat 1989). In addition, instead of dying young of diarrhoea, for example, survivors are suffering the effects of undernutrition (Chen 1988) and often perishing later in early childhood (Gadomski et al. 1990). Questions have been raised about the sustainability of mass immunisation campaigns (Hall & Cutts 1993), the effectiveness of health facility based growth monitoring (Chopra & Sanders 1997) and the appropriateness of ORT when promoted as expensive and often inaccessible sachets or packets and without a corresponding emphasis on nutrition, water and sanitation (Werner & Sanders 1997). Evaluations at both national and provincial levels have found that it is only when core service activities (such as the child survival technologies, DOTS, use of management guidelines for common diseases) are embedded in a more comprehensive approach (which includes paying attention to health systems, engaging health-related sectors and involving local communities) that real and sustainable improvements in the health status of populations are seen (Gutierrez et al. 1996).

As mentioned earlier, in developed countries there has been an unfortunate misinterpretation of PHC by many in the health sector. The equating of primary medical care with PHC has resulted in a separation of its components, with clinical aspects (mainly curative with limited preventive and rehabilitative functions) becoming the responsibility of medical practitioners, and the promotive and many preventive functions devolving to other personnel (e.g. environmental health workers) employed usually by local authorities. In developing countries health promotion programmes have not received the attention they have in developed countries in the decades since the Ottawa Charter. Particularly in Europe, Canada and Australia a health promotion movement has developed and led to promising initiatives in a number of settings including schools, hospitals, cities, work places etc. (Ashton & Seymour, 1998; Baum, 1998). In the 1990s some of these models are being reproduced in low income countries. The developmental nature of these programmes mean it may take a number of years of their impact is known.

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While much of the clinical care remains with medical practitioners operating alone or in group practices, there have been some successful initiatives in comprehensive primary health care through community health centres in Britain, Canada and Australia. Typically these centres have been managed by community boards which have been a mechanism for moving community participation beyond rhetoric. Their activities have included:

providing services to individuals (including medical, nutrition, counselling, podiatry, physiotherapy, speech pathology); support groups (e.g. stress management, dealing with violent behaviour, parenting skills. illness support groups for chronic diseases such as cancer, diabetes, asthma); community development and social action on issues such as domestic violence and local environmental concerns.

These centres had their heyday in the 1980s, but have suffered from the trends towards privatization, contracting out of government services and a retreat to "core business" which is seen as treating disease rather than preventing it. In South Australia and Victoria, for instance, the network of community health centre with local boards of management have been amalgamated and found it more and more difficult to do the innovative primary health care work they engaged in the 1980s. They have struggled to justify their existence as managerial reforms to the health system have introduced an emphasis on market economics (Baum 1995).

3.   THE CURRENT WORLD HEALTH SITUATION AND ITS CONTEXT : THE IMPLICATIONS FOR HEALTH FOR ALL

3.1   The Global Health Situation

Over the past 50 years and even over the past 20 considerable gains in health status have been achieved. Globally, life expectancy at birth has increased from 46 years in the 1950s to approximately 65 years in 1995 (WHO 1998B) and the total number of young children dying has been restricted to approximately 12.5 million instead of a projected 17.5 million (UNICEF 1996, p 10). Substantial control of certain communicable diseases, notably poliomyelitis, diphtheria, measles, onchocerciasis and dracunculiasis has been achieved through immunisation and specific disease control programmes (Tarimo & Webster 1994, p 61.) and cardiovascular diseases have

decreased in males in developed countries, partly because of a decline in smoking (WHO 1998A, p 56-57).

Despite these gains, however, there have been setbacks. Although in aggregate terms child mortality and life expectancy have improved in all regions of the world. (World Bank 1993, p 2) disaggregation of these data reveals that the gap in mortality rates between rich and poor countries has widened significantly for certain age groups: the relative probability of dying for under-5-year-olds in developing countries compared to Western and Eastern European countries increased from a ratio of 3.4 in 1950 to 8.8 in 1990 (Legge 1993).   Furthermore, in a number of Sub-Saharan African (SSA) countries, infant mortality rates (IMR) actually increased in the 1980s under the impact of economic recession, structural adjustment, drought, wars and civil unrest and HIV/AIDS (Commonwealth Secretariat 1989).

Significant reversals in health status have been experienced in the newly independent states of Eastern Europe, with male life expectancy in particular being sharply eroded, with poverty and unemployment, increased alcohol consumption, violence and declines in health service provision being the main contributory factors (WHO 1998A, pp 180 - 181).   In a number of Western industrialised countries mortality differentials have increased over the past two decades, paralleling widening disparities in socio economic status (Davey-Smith & Egger 1993). There is now increasing evidence that in developed countries mortality is affected more by relative than absolute living standards (Wilkinson 1997).   Several studies show that lack of control in the working environment, solitude, stress, unemployment and a sense of lack of control over one's life are associated with higher mortality and morbidity rates (Marmot & Shipley 1996, cited in WHO 1997, p 3; Wilkinson 1997). Increasing inequities between rich and poor in developed and developing countries threaten social cohesion and contribute to violence and psychosocial stress (Kawachi & Kennedy 1997).

This is nowhere seen more starkly than in those developed countries with indigenous populations, in whom the burden of ill-health remains unacceptably high. In Australia, for example, the Aboriginal population, rural and urban, continues to experience higher mortality rates and much higher morbidity than white Australians. While some successes have been achieved in reducing infant and young child mortality (although these rates remain at 3-4 times the levels in white Australians), infectious disease morbidity remains extremely high, impairing intellectual and physical development in many children. In addition almost all non-communicable diseases (so-

called "diseases of lifestyle") manifest earlier and progress more rapidly in the adult population, resulting in considerably lower life expectancy than in the general population (Torzillo & Kerr 1992).

The past two decades have also witnessed the alarming resurgence and spread of "old" communicable diseases once thought to be well controlled e.g. cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue etc. while "new" epidemics, notably AIDS, threaten this century's health gains in many, mostly developing, countries. Many developing countries are also experiencing an epidemiological transition, with cardiovascular diseases, cancers, diabetes, other chronic conditions and violent trauma replacing communicable diseases in some social groups, but in others, co-existing with them. Some, therefore, term this process an epidemiological polarisation, with poorer sectors of the population experiencing both high child mortality and morbidity as well as a high burden of non-communicable disease. (Frenk et al 1989)

3.2   The Global Context

The social, economic and political factors influencing the above mixed progress in health are varied and complex. The most important include wealth and income distribution **between** and **within** countries. The chasm between rich and poor has been widening to record extremes. In its 1993 Human Development Report, the UNDP disclosed that the richest 20% of the world's people own and control 83% of the earth's resources. The poorest 20% own and control less than 1.5 percent of resources. This disparity is rapidly growing: the share held by the richest fifth of humanity rose from 70.2% in 1960 to 82.7% in 1989, and to 84.7% in 1991. So 4 billion people must share the remaining 15% of global income, surviving on an average monthly income of US$70. According to UNDP Administrator J.G. Speth:

> The gap between the rich and the poor has not narrowed over the past 30 years, but has in fact widened greatly. In 1962 the richest 20 percent of the world's population had 30 times the income of the poorest 20 percent. Today the gap has doubled to 60 fold. (Speth 1995, cited in Werner & Sanders 1997, p 87)

By the same token, today the world's 358 billionaires have a combined net worth of $760 billion – equal to the total assets of the poorest 45 percent of the world's population: about 2.5 billion people. Many of the world's richest are owners/proprietors of the world's biggest businesses and

transnational corporations (TNCs). As a group, TNCs control 70% of world trade and 80% of all land growing export crops. Yet the TNCs employ only 3% of the world's paid labor (Godrej 1995, cited in Werner & Sanders 1997). Their huge profits go mainly to a handful of owners. Thus with their emphasis on large-scale industry, nonrenewable energy, and labor-saving technology, TNCs significantly contribute to jobless growth which has increased global unemployment to a crisis level (Werner & Sanders 1997).

In a situation where one-quarter of the world's population, or more than 1.3 billion men, women and children, live in absolute poverty with an income of less than one dollar per day (UNDP 1997) access to the most basic needs for health is inevitably seriously undermined in many developing countries.

Access to Basic Needs in Developing Countries

Food Availability
Daily calorie supply per capita in 1992 (100 is normal)

	1965	1992
all developing countries	72	82
sub-Saharan Africa	75	67

Water and Sanitation
In developing countries:
- nearly 1.2 billion people in the developing world lack access to a safe water supply 2.5 billion people in developing countries have no access to proper sanitation
- from 1990-1996, an average of 40% of rural people did not have access to water, compared to 13% of urban people
- from 1990-1996, an average of 80% of rural people did not have proper sanitation, compared to 18% of urban people

Housing
In developing countries:
- more than 1 billion people in developing countries live without adequate shelter or in unacceptable housing
- at least 600 million people live in dwellings that threaten their health and lives worldwide, 100 million people are homeless

Source: UNDP. Human Development Report, 1997

In developed countries demographic changes have resulted in a large and rapidly growing aging population. Eighteen out of 20 countries in the world with the highest percentage of older people are in the European region of WHO : between 13,2% and 17,9% of their populations are over 65

years old. Within the next 20 years this age group will grow rapidly and in the next 30 years the proportion of people aged over 80 will grow especially fast (WHO 1998E, p 36)**.** This, together with rapidly widening disparities in socio-economic status, structural unemployment, increasing pollution of the environment, social disruption and its exploitation by the drug, alcohol and tobacco trade explains the widening inequalities in health experience and the features of the non-communicable disease pattern which is dominated by cardiovascular disease, cancers, tobacco-related lung disease, drug abuse, mental ill-health and trauma (WHO 1998B, p 9 – 13).

Untrammeled economic growth has spawned global environmental hazards which include ozone depletion, global warming, air pollution, loss of biodiversity and the virtually unrestricted movement across borders of hazardous products and wastes, which are having negative impacts on health in both developed and developing countries (WHO 1998B, p 14). These hazards affect especially poorer and more vulnerable communities. In some parts of the CCEE and NIS extensive industrial and radioactive pollution pose serious short and long-term health hazards, and in South Eastern Europe and central Asia over 100 million people are without access to safe drinking water **(WHO, 1998E p.7).** In some countries in these areas, physical and mental trauma and damage to infrastructure as a result of continuing civil and military unrest have aggravated the already high disease burden.

The above global situation is a result of a complex history of uneven economic and social development extending over centuries, but progressing much more rapidly over the past 100 years or so. The past two decades, however, have seen an unprecedented acceleration of this process, with the 1970s oil crisis and the worldwide economic recession ending the long post-World War II boom. This recession was precipitated by the stringent financial policies adopted by the Northern countries (particularly the US and the UK) from the early 1980s, involving tight credit, high interest rates and reductions in government spending. The resulting economic slowdown was passed on to the developing countries through reduced demand for their exports and cuts in foreign aid (Raghavan 1991, p 10). This, together with deteriorating terms of trade, led to a reversal in the flow of capital with developing countries becoming net exporters of capital and acquiring huge debts.

Developing country indebtedness, recession and neoliberal economic policies in the industrialised countries, and the political and economic collapse of the former Soviet bloc countries and their integration into the global market economy have accelerated preexisting

economic, political and social interdependence and led to what is now termed **globalisation**. A former chief economist of the OECD commented that "the primary agent of globalization is the transnational enterprise" (Ostrey 1990, quoted in Raghavan 1996, p 13). Others have suggested that "globalization is really about the expansion of TNC activities to the developing world and on TNC terms" (Raghavan 1996, p 13) and that "globalisation is proceeding largely for the benefit of the dynamic and powerful countries." (UNDP 1997)

Restructuring of developing country economies has been promoted by the International Monetary Fund (IMF) and World Bank through Structural Adjustment Programmes (SAPs) and by the agreements of the World Trade Organization, including that concerning Trade-related Intellectual Property Rights (TRIPS). The introduction of SAPs has been shown in a number of developing countries to be associated with accelerated development of economic stratification and inequities and significant reversals in the health and welfare of vulnerable groups (Cornia, Jolly & Stewart 1998; Bijlmakers, Bassett & Sanders 1995). The WTO agreements, and specifically TRIPS, threaten the economic sovereignty of poorer nations and are likely to undermine their already fragile food security situation, as well as their ability to undertake indigenous technological development, including in the area of essential pharmaceuticals (Khor 1996).

3.3   The Capacity of Health Systems to Respond

As noted earlier, substantial support for PHC and significant improvements in coverage with (some of) its programme elements have occurred in the past two decades. However, an unfavourable political and economic climate has significantly undermined its full implementation. The major constraining factors have been the general absence both of a facilitatory social environment and political support for community-based comprehensive development efforts, as well as significant withdrawal by the state from provision of public services, including health care. Lack of investment in public health infrastructure to protect the quality of food and water and to effect proper waste disposal is leading to additional health threats (WHO 1998C, p 1).

Technological innovation and globalisation have created unprecedented potential for improved interventions in health care, communications and information in all countries. However, with

widening inequities worldwide and near-collapse of peripheral services in many developing countries, such advances in many situations benefit only the few.

Although still in its early stages and usually only partially implemented, health sector reform shows little evidence as yet of a positive impact on health system functioning, particularly in developing countries where many local health services are seriously underresourced and have often become dysfunctional as a result of personnel losses and demoralisation, inadequate drugs, equipment and support. Community-level care and programmes have also suffered from a decline in support for community health worker schemes, occasioned by a complex of factors which have included observed limitations of such programmes (Walt 1990), perceived threats by the medical establishment to their hegemony, and financial problems besetting developing country governments and communities.

With less and less money the ministries of health have resorted to donor agencies, which now determine to a large extent the main lines of action of health projects. Also, with less and less money, services in government facilities are poor. Communities are increasingly losing confidence in these services and are turning to traditional and private practitioners. Corruption has become institutionalized in many health facilities. Ministries of health need to restore confidence, first and foremost in themselves. Ministries of health have to earn respect, not from assertions and statements, but by demonstrating their ability to develop policies, strategies, and plans that provide direction for the national effort in health development, mobilizing its implementation and revising the plans regularly (Tarimo & Webster 1994, p 70).

Many of the former Soviet bloc countries have experienced a sharp deterioration, and some a collapse, of their public health services. This has affected control of communicable and non-communicable diseases – which are generally more prevalent as a result of economic deterioration and social distress – as well as personal health care services. With more general economic decline there has been a sharp fall in health expenditure in many of these countries (Feachem in WHO 1996A, p 59). Together with a decline in the availability of private resources for significant sections of these countries' populations, there is here too truly a pressing need to reinstate a community-based and intersectoral approach to health.

4. <u>THE REVITALISATION OF PRIMARY HEALTH CARE</u>

In advocating Primary Health Care, the Alma Ata Declaration affirms that health is determined mainly by factors lying outside the medical or public health services. Countries which have achieved the greatest and most durable improvements in health tend to be those with a commitment to equitable development that is broad-based and multisectoral. Good empirical evidence for this comes from a number of countries, including some poor developing countries – the "Good Health at Low Cost" examples of Sri Lanka, China, Costa Rica and Kerala State in India. These countries demonstrate that investment in the social sectors, and particularly in women's education, health and welfare, has a significant positive impact on the health and social indicators of the whole

population (Halstead et al 1985). WHO has a critical role to play in demonstrating to governments the value of **investments in the health and social sectors**. This is particularly important and urgent given the withdrawal of the state and the dynamic towards increasing privatisation of health and social services impelled by currently dominant neoliberal policies.

To realise the equity essential for a healthy society, evidence suggests that a strong, organised demand for government responsiveness and accountability to social needs is crucial. Tacit recognition of this important dynamic informed the Alma Ata call for strong community participation. To achieve and sustain the political will to meet all people's basic needs, and to regulate the activities of the private sector, a process of participatory democracy – or at least a well-informed movement of civil society – is essential : analysts have noted that such political commitment was achieved in Costa Rica through a long history of egalitarian principles and democracy, in Kerala through agitation by disadvantaged political groups, and through social revolution in China (Mosley 1985, cited in Halstead et al. 1985, p 242). "Strong" community participation is important not only in securing greater government responsiveness to social needs but also in providing an active, conscious and organised population so critical to the design, implementation and sustainability of comprehensive health systems.

Given that the current global socio political environment is markedly different from that of the late 1970s and is not generally supportive of a basic needs approach to social development, a number of strategies need to be employed – in different combinations depending on the particular situation – to revitalise PHC and drive forward the HFA initiative. Reflecting the dialectical relationship between strong, organised community demand and government responsiveness and

accountability, these strategies are complementary and are bottom-up (e.g. **community-based programme development**) as well as top-down (e.g. **policy development and planning**).

4.1 Strategies for Health Development

The PHC approach is based on the understanding that health improvement results from a reduction in both the **effects** of disease (morbidity and mortality) and its **incidence** as well as from a general increase in **social well-being.** The effects of disease may be modified by successful treatment and rehabilitation and its incidence may be reduced by preventive measures. Well-being may be promoted by improved social environments created by the harnessing of popular and political will and effective intersectoral action.

Of particular relevance to the development of comprehensive health systems is the clause in the Alma Ata declaration stating that PHC "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly".

Comprehensive health systems include, therefore, **curative** and **rehabilitative** components to address the effects of health problems, a **preventive** component to address the immediate and underlying causative factors which operate at the level of the individual, and a **promotive** component which addresses the more basic causes which operate usually at the level of society.

The table below illustrates, using some common health problems, the complementary role of the different components in holistically tackling them. Such a matrix, which starts from a disease focus, is useful for health professionals in providing them with an understanding of the broader, developmental interventions required to comprehensively address them.

Comprehensive Primary Health Care for some common diseases : a summary framework of priority interventions

DISEASE	INTERVENTION			
	Rehabilitative	Curative	Preventive	Promotive
Diarrhoea	Nutrition rehabilitation	Oral rehydration Nutrition support	Education for personal and food hygiene Breastfeeding Measles immunisation	Water Sanitation Household Food Security Improved child Care
Pneumonia	Nutrition rehabilitation	Chemotherapy	Immunisation	Nutrition Housing Clean Air
Measles	Nutrition rehabilitation	Chemotherapy Nutrition Support	Immunisation	Nutrition Housing
Tuberculosis	Nutrition rehabilitation	Chemotherapy Nutrition support	Immunization Contacts (tracing)	Nutrition Housing Ventilation
Cardiovascular Disease	Weight loss Graded exercise Stress control	Drug treatment Supportive therapy	Nutrition education Increased exercise Treat hypertension Smoking cessation	Nutrition policy Tobacco control Recreational facilities

Strategies for comprehensively tackling such health problems can be grouped essentially under two complementary headings: **promoting healthy policies and plans** and **implementing comprehensive and decentralised health systems**. Success of these strategies depends upon the

creation of a facilitatory environment through such actions as **advocacy, community mobilisation, capacity-building, organisational change, financing** and **legislation.**

4.1.1 <u>Developing and promoting healthy policies and plans</u>

The choice between various policy options must be made on the basis of an ethical framework or a clear set of values and principles: these are essentially those enunciated in the Alma Ata Declaration with emphasis on **equity** in health and **participation** in decision-making about matters that affect both individual and societal health.

Governments and international organisations have a responsibility to ensure the conditions and opportunities to enable present and future generations to exercise these rights. (WHO, 1998E p.12)

WHO's Role

Public health problems and therefore necessary responses are increasingly becoming global. Consequently, the need for strong global **leadership** is crucial. (Baum 1998, p 57) WHO should assume a strong **advocacy** role. It should take the lead in analysing and publicising the negative impact globalisation and neoliberal policies are having on vulnerable groups. It should spearhead moves to limit health hazards aggravated by globalisation, including trade in dangerous substances such as tobacco and narcotics. At the same time WHO should demonstrate and promote the benefits of equitable development in the realisation of HFA – which includes strong investment in the social sectors. It should vigorously promote health as a human right and give support to governments in building their capacities in policy, planning and advocacy.

Roles and Functions of WHO in the 21st Century

- Serve as the world's health advocate, by providing leadership for HFA.
- Develop global ethical and scientific norms and standards.
- Develop international instruments that promote global health.
- Engage in technical cooperation with all countries.
- Strengthen countries' capabilities to build sustainable health systems and improve the performance of essential public health functions.
- Protect the health of vulnerable and poor communities and countries.
- Foster the use of, and innovation in, science and technology for health.
- Provide leadership for the eradication, elimination or control of selected diseases.
- Provide technical support to prevention of public health emergencies and post-emergency rehabilitation.
- Build partnerships for health.

Cited in: WHO. (1998). Health for all in the twenty-first century. Document A51/5

Role of Governments

In developing health policies and plans governments should give serious consideration to employing a process which engages as partners those sectors, agencies and social groups critical to the achievement of better health. The first step is **creating awareness** of the need to make health objectives part of socio-economic development. Since "health" and "medicine" have become virtually synonymous in the popular consciousness, it is important to convey the understanding that ill-health results from unhealthy living and working conditions, from the failure of society to equitably provide health promoting conditions. It then becomes obvious that health problems are the result of multisectoral failure and that their solution cannot lie in health care alone, but requires comprehensive and intersectoral actions. Such **advocacy** needs to be illustrated by a demonstration of health inequities and their social determinants, and needs to be directed in a user-friendly fashion at all prospective partners, especially underprivileged communities and their political representatives. Here the media have an important role to play.

The **policy development process** must be as transparent and inclusive as possible to secure broader understanding and greater ownership of the policies. Ideally, structures involving the different partners need to be created at different levels from local to national, or within such settings as schools or workplaces. The priority should be to focus on geographical areas with the

greatest health needs. Subgroups with responsibility for health, within local, provincial or national government (e.g. health committees of local government councils) should be promoted and should have links to the above structures.

Health Facilitators – Ostergotland Invests in Local Health Work

The health facilitator project was implemented in four socially and economically disadvantaged areas of Ostergotland between 1994 and 1996. The health facilitator was a link between people living in the area and those responsible for health policy-making. The intention behind the project was to build on the internal power of people living in the area, to identify health concerns specific to the local community, and to ensure the long-term survival of activities to promote health.

What distinguished health facilitators from other health workers was that they move out from the primary health center, where health services are normally located, and established offices within the local community. The facilitators, in a sense, "cohabited" with existing programmes, for example programmes targeted at vulnerable groups such as unemployed or immigrant mothers. Their way of working was quite different to the other health workers. By walking around the local community, talking to people, and participating as far as possible in community life, they were able to gain important insights on what people living in the area felt to be the main health concerns.

Health facilitators were able to provide qualitative information about the local community, which could only be gathered by working in the way described. As well as meeting and talking with people, facilitators wrote to key people within the community, for example asking voluntary organisations and people in the private and business community such as shopkeepers to describe what they saw as the main health issues for the community. This type of qualitative information was unique and later supplemented the official statistics and survey data, which until then were the usual basis for health policy analysis.

(Source: Regions for Health Network – Leading Edge Series No. 3
Cited In: WHO 1998E, p.24)

Developing consensus by initiating a dialogue with the public and enlisting their support can contribute to the continuity and sustainability of policies for health. The setting of **goals** and indicators (for different levels) can be valuable in defining policy objectives more specifically, allowing progress to be monitored by partners: the way goals are communicated can assist in popularizing public health issues. They can help focus partners on the scope and rationale for the policy, their roles in implementation and become a rallying-point around which civil society can mobilize and demand accountability. Goals need not always be quantifiable since the process of health promotion is dynamic and imposing measurement may be restrictive. There is a need to have goals related to process/capacity building as well as to broad disease/well-being outcomes.

A transparent consultation process is important to legitimize the policies which then need formal approval, preferably at the highest level of government.

The formulation and implementation of health policies requires **new alliances** with different sectors, voluntary organisations and public and private bodies. The health sector needs to take leadership in prioritising health in other sectors : here the establishment of functional intersectoral structures is desirable.

Intersectoral Action to Reduce Traffic Accidents

In the early 1970's, Denmark had the highest rate of child mortality from traffic accidents in Western Europe. A pilot was started in Odense, with an ongoing budget of approximately US$ 150, 000 a year. 45 schools participated in an exercise carried out with accident specialists, planning officials, the police, hospitals and road authorities, to identify the specific road dangers that needed to be addressed. A network of traffic-free foot and cycle paths were created as well as a parallel policy of traffic speed reduction, road narrowing and traffic islands. Following the success of the pilot study, the Danish Safe Routes to Schools Programme has been implemented in 65 out of 185 proposed localities and the number of accidents have fallen by 85%. Accidents can, and must, be avoided. It is the responsibility of each one of us, but many initiatives can come from local authorities.

Source: Walking and Cycling in the City. WHO, 1998E, p. 64

The implementation of policies may require different actions at different levels. These include **laws** or **financial** and **management** instruments, and, importantly, on mechanisms to involve networks within civil society (WHO 1998E, pp. 123-148)**. Financing** should be equity-based to ensure that underprivileged groups are not excluded from health care for economic reasons. Resources should be allocated according to need rather than for services actually delivered. Prepaid health plans, including national health insurance may make services more accessible to the underprivileged (Tarimo & Webster 1994, p 70).

The **monitoring** and **evaluation** of progress in policy implementation is important to ensure accountability. Markers of success are when indicators of progress towards goals are referred to by elected bodies or displayed in the mass media.

HFA Policy Development in Finland – A Continuous Process of Implementation, Evaluation, and Revision.

In 1985, the Finnish Government submitted to parliament for discussion, a national HFA document with 32 policy statements. This was the first of its kind in Europe and was quickly followed by a strategy for its implementation. At the time there was a high degree of political support for the HFA approach and a blossoming economy.

The first reactions to the policy and strategy were quite mixed. The media questioned the feasibility of "promising" health for all within 14 years. The health sector was somewhat disappointed with what they felt to be the small attention given to health care. The document was used, however, to argue for true intersectoral work and was introduced in the training of health professionals. The implementation process did not run as smoothly as had been anticipated. Despite broad political consensus on the main policy directions, little attempt had been made to define priorities or assign responsibility for action. By 1990, it was decided to revise the policy and to combine this with a review of the whole process by WHO. The review process raised considerable interest, since in the meantime, the policy environment had changed; the economy was showing signs of depression; and a major reform of planning and financing was underway which entailed transferring responsibility for financing health services to the 455 municipalities.

The WHO review group suggested the following: the policy process had been largely expert-led and confined to the health sector; early involvement of other sectors and wider consultation processes might have helped with the implementation of the policy; the policy did not receive high enough visibility in mass media or on the grassroots level; more specific objectives and targets for vulnerable groups might have increased the potential for promoting equity in health; and more human and financial resources should have been used for implementation and monitoring of the policy.

A revised strategy following wide ranging consultations was approved in late 1992. The revised policy was more selective, specified the roles and tasks of all partners, and established a defined time-frame. Much more emphasis was given to publicity, training and teaching materials. At the beginning of 1998, a new process of evaluation and revision was initiated. The new policy will have a 2-year preparatory period which will involve widespread consultations with other groups and sectors. Particular attention is to be given to future health challenges, the life-span concept, and equity issues. As the case of Finland clearly demonstrates, HFA is not a once-off measure but a continuous process of implementation, evaluation, and revision.

(Source: WHO 1998E, p 143.)

4.1.2 Implementing Comprehensive and Decentralised Health Systems

The implementation of PHC has too often focused on the (often facility-based) curative and preventive components of comprehensive care, while the health promotion initiative has stressed the broader social components. *This gap needs urgently to be bridged since they are clearly indivisible in the process of health development.*

4.1.2.1 Health Promotion in Practice

The implementation of healthy public policies, which emphasize the role of intersectoral activity, has been significantly enhanced since the late 1980s by the growth of the health promotion movement. The Healthy Cities initiative, and subsequently a focus on other settings such as schools, markets, work places and hospitals, demonstrate an approach which takes forward the policy development activities described above. These initiatives can garner political support and encourage local agencies and sectors to reassess their policies and practices in influencing health.

Facilitating **organisational change** and encouraging (particularly government) staff to be more flexible, innovative and responsive to local communities are key actions in achieving success. (Baum 1998, pp 445-6) In the past many of the initiatives to promote **community participation** in health have concentrated on inviting community people to participate in activities established (and largely controlled) by the health services. A recent WHO study uncovered a wide range of community groups or organisations – which have been termed 'health development structures' (HDSs) – that play some role in promoting health. A report noted that "the majority of HDSs owe their origins to age-old community traditions of mutual support and cooperation and have a long history of community action" (WHO 1994). They include, in addition to representative health councils, women's groups, youth groups, social clubs, cooperative societies, mutual aid societies and sporting clubs. There are many roles, often invisible, played by such groups, that contribute to improving health. This could be achieved more systematically in partnership with the health sector, but has hitherto been largely unexploited. Settings-based health promotion initiatives offer a perspective and mechanism for this kind of relationship. The concept of **health promoting districts** holds much promise and should be developed as a means of extending health services towards a more intersectoral and developmental role.

By 1997 there were over 1000 communities participating worldwide in the Healthy Cities initiative. WHO has identified twenty steps for establishing a Healthy Cities project.

WHO: Twenty Steps to develop a Healthy Cities Project

Getting Started

1. Build a support group that includes people with an understanding of the new public health and who have leadership and determination.
2. Understand and explore the concepts behind healthy cities, especially the links between health and the environment. Ensure all the support groups are involved.
3. Know the city by conducting some kind of community needs assessment.
4. Identify potential project partners and if possible obtain some seed monies.
5. Decide on where the project will be located (options include local government, community organisations, or independently).
6. Prepare a sound proposal, which is concise, clear, convincing and pragmatic.
7. Get approval from the relevant authorities, which normally involves seeking the support of powerful political and community groups.

Getting Organised

8. Appoint a steering committee with clear responsibilities to plan, lead and co-ordinate the project. Sub-committees for fundraising, personnel and specific projects can be established if necessary.
9. Review, rework and research the project environment to ensure it is feasible and is being implemented in an appropriate way. Check that communication between the relevant organisations is happening effectively.
10. Define project work with a detailed plan, which includes innovative but workable strategies.
11. Set up a project office.
12. Plan strategy and develop a city health plan that provides for the short- and long-term vision of the project.
13. Build capacity in terms of resources and personnel.
14. Establish accountability by putting monitoring and evaluating systems in place. Regular response should be made available to key people in the city or community.

Taking Action

15. Increase health awareness among politicians, community members and bureaucrats.
16. Advocate strategic planning to ensure that all opportunities are used and plans put into practice.
17. Mobilise intersectoral action so that it is collaborative, not competitive.
18. Encourage community participation from all sections of society. Support local action programs and initiatives for health development.

Source: Baum, F. (1998). The New Public Health: An Australian Perspective. Melbourne: Oxford University Press.

4.1.2.2   The Development of Comprehensive, Community-based Programmes

Whereas health promotion activities, recognising the fundamental contribution to health of equitable social and economic development, commence with a multisectoral focus, programmes originating around diseases or health problems start from a health care or service response. While curative, preventive and caring actions are very important and still constitute the core of medical care, comprehensive PHC demands that they be accompanied by rehabilitative and promotive actions. By addressing priority health problems comprehensively as indicated in the table in Section 5.1, a set of activities common to a number of health programmes will be developed as well as a horizontalised infrastructure. The promotive activities will necessarily involve other sectors and, if successful and widespread, create pressure for supportive policy responses.

The principles of **programme development** apply to all health problems, whether specific communicable (e.g. diarrhoea) or non-communicable diseases (e.g. ischaemic heart disease) or health-related problems (e.g. domestic violence).

Long-term Changes in Behaviour from Comprehensive Community Based Health Promotion Programmes

The North Karelia Project is a well known community-wide health promotion project which sought to change the cardiovascular risk factor profile of the inhabitants of a community in Finland. Rather than targeting individuals at 'high risk' for health messages and behaviour change - the approach taken by most health systems - it sought to change the norms of the whole community.

It sought to do this by bringing together different sectors (education, health, welfare etc.) to work towards a common goal. Through a mixture of health promotion messages delivered in a variety of different settings and media (i.e. schools, offices, factories), improvement in the clinical care and management of cardiovascular diseases, the development of social infrastructure which facilitated healthier lifestyles (i.e. provision of leisure facilities and cycle lanes) and the implementation of local legislation it managed to bring about a significant reduction in risk factors and mortality from cardiovascular disease.

Furthermore, recent evaluations have found that the reduction cardiovascular mortality and high risk behaviours, such as smoking, is still significantly lower than control areas more than ten years after the intervention (P. Puska 1995; E.Vartiainen 1998)

Source: P. Puska et al (1995)
        E. Vartiainen et al (1998)

Much experience has been gained internationally in the development of comprehensive and integrated programmes to combat undernutrition: these experiences can provide useful lessons for other programmes (Sanders 1997).

After the priority health problems in a district have been identified, the first step in programme development is the conducting of a situation analysis. This should identify the prevalence and distribution of the problem, its causes, and potential resources, including community capacities and strengths, which can be mobilized and actions which can be undertaken to address the problem. The more effective programmes have taken the above approach, involving health workers, other sectors' workers and the community in the three phases of programme development, namely, assessment of the nature and extent of the problem, analysis of its multilevel causation and action to address the linked causes.

Bangladesh Rural Advancement Committee (BRAC)

The initial health project of the Bangladesh Rural Advancement Committee BRAC) was initiated in 1972, as a component of a 'community development programme' at Sulla Thana.

Based on their initial health programme experiences at Sulla , and the focus on child health marked by the International Year of the Child in 1979, BRAC embarked on a nation-wide ORT programme: The programme was launched in early 1980 with a goal of teaching oral rehydration therapy to every one of 13million village households in the country. Teams of trained female workers went house-to-house to teach village women how to make the solution and to teach them a "short, seven-point message about diarrhoea prevention and treatment". (Lovell & Abed 1993, cited in Rohde 1993, p 217). A decade after initiating the ORT programme BRAC completed its goal.

Following a review of their experiences of delivering a largely curative service, and their recognition "…that most such services [curative] do not reach those most in need – the poorer sections" and that "…such curative services need a constant supply line, which an NGO like BRAC cannot ensure in the long run", the BRAC programme reversed its emphasis and "…evolved into an educational programme" that attempted to "…empower the people to manage their own health, either by themselves or with help from the government" (Chowdhury 1990, cited in Streefland & Chabot 1990, p 117).

In discussing the lessons learnt by BRAC over two decades, Lovell and Abed (1993) suggest that:

 "BRAC continues to search for the right combination of health interventions that can move both villages and the government health system toward higher levels of prevention and care on a sustained basis…By developing strong, better-educated and empowered village groups, capable of utilizing and making demands on government health services, a higher quality of preventative health measures will be practised in the community" (p.225)

MacDonald (1993) suggests that the more recent involvement of BRAC in the formation of village health committees and mother's clubs is an indication that the programme has returned to an educational approach that is more aligned to the principles of comprehensive PHC, and is reflective of the participatory research aspects of BRAC's initial work which involved "…a collective building-up of understanding and confidence, aiming, in the vocabulary of Hope and Timmel, at social transformation" (Hope & Timmel 1984, quoted in MacDonald 1993, p 151).

Source:
Chowdhury, A.M.R. (1990). 'Empowerment through health education: the approach of an NGO in Bangladesh'. (Chapter 9). Cited in: Streefland, P. & Chabot, J. (Eds). (1990). *Implementing Primary Health Care. Experiences since Alma-Ata*. Amsterdam: Royal Tropical Institute, p 117.

Hope, A & Timmel, S. (1984). *Training for Transformation. A Handbook for Community Workers*, Gweru: Mambo Press, quoted in MacDonald, J. J. (1993). *Primary Health Care: Medicine in its place*. London: Earthscan, p 151.

Lovell, C. & Abed, F.H. (1993). 'Scaling-up in Health: Two Decades of Learning in Bangladesh'. (Chapter 10). Cited in: Rohde, J., Chatterjee, M. & Morley, M. (Eds) (1993). *Reaching Health for All*. Delhi: Oxford University Press, p 217.

MacDonald, J. J (1993). *Primary Health Care: Medicine in its place.* London: Earthscan.

Clearly, the specific combination of actions making up a comprehensive programme will vary from situation to situation. However, there are certain principles which should inform programme design, one of which is the deliberate linking of actions which address causative factors operating at different levels. So, for example, in a nutrition programme any intervention around dietary inadequacy (immediate level of causation) should also address household food insecurity (underlying level of causation). Thus the choice of food supplement should be based both on its nutrient value but also on its availability, cost and cultivability and/or purchasability. The careful choice of an appropriate food supplement should be reinforced as an educational action to positively influence food habits and feeding practices. Clearly this principle of linking curative or rehabilitative (feeding), preventive (nutrition education), and promotive actions (improved household food security) could and should be applied to health programmes other than nutrition.

In addition a nutrition programme will include a minimum of core health service activities (mostly facility based) including effective growth monitoring and promotion, the integrated management of childhood illness, the promotion of breastfeeding, the promotion of energy and nutrient dense weaning diets based on commonly available local foods.

Similar minimum or core service components can also be identified for other health programmes e.g. activities in the Safe Motherhood Initiative, the Integrated Management of Childhood Illness, DOTS, technical guidelines for the management of common non-communicable diseases etc. There is an advantage in standardizing and replicating these core activities in health facilities at different levels, thus reinforcing their practice throughout the health system.

A comprehensive approach to undernutrition in Zimbabwe : the Children's Supplementary Feeding Programme

The existing community-based popular infrastructure that had developed during the war permitted a more rapid and better-organized implementation of the nutrition program than would otherwise have been possible. Mothers evaluated the children's nutritional status by measuring and recording their upper arm circumferences. Those with mid-upper-arm circumferences less than 13 cms were included in the program. The reasons for this cut-off point were explained to all parents, both those of children admitted to the program, as well as those considered not at risk. Then they established locations for supplementary feeding (which the mothers preferred to be located close to their homes and fields), and themselves cooked the food and fed the underweight children.

The design of the programme was informed on the one hand by an understanding of the most important factors underlying rural child undernutrition in Zimbabwe and on the other by knowledge of rational dietary measures and identification of locally used and cultivable food sources (analysis). By deliberately selecting for use in the programme foods which were highly nutritious, traditionally used in weaning and commonly cultivated, and by reinforcing their value with a very specific message in the form of a widely distributed poster asserting the importance of groundnuts and beans in addition to
the staple, it was possible to shift the focus of the intervention from supplementary feeding towards small-scale agricultural production. This was aimed at resuscitating the cultivation of groundnuts - culturally a "women's crop" - which had been largely displaced as a food crop in Zimbabwe by the commercialization of maize. The provision by local and national government of communal land, agricultural inputs and extension assistance, together with the policy of collective production on these groundnut plots, contributed to improving poor households' food security. The joint involvement of Health and Agriculture in this project led to the development of intersectoral Food and Nutrition Committees at ward (sub-district), district and provincial levels.

The programme design therefore allowed the linking of a rehabilitative measure (supplementary feeding) to preventive and promotive interventions (nutrition education and food production), thereby displaying the features of a comprehensive primary health care programme. This comprehensive approach to child undernutrition, widely displayed through the CSFP's operation, greatly influenced the management of this problem within the health sector. It resulted in a changed approach within health facilities to the dietary management of the sick child and to nutritional rehabilitation. It also created a community-level infrastructure of feeding points and (later) food production plots/child care centres to which recuperating undernourished children could be discharged. Thus the sequenced addressing of immediate (dietary) and underlying causes (household food insecurity, inadequate young child care and inaccessible health services) by the feeding and the communal plots and preschool centres respectively, was made possible by both careful design based on a prior analysis and by the presence of a well-organized and motivated population. Intersectoral action and structures for nutrition and food security developed around the project, from bottom-up and were supported at higher levels of government.

Source: Sanders in Werner, D & Sanders, D. (1997). Questioning the Solution: The politics of Primary Health Care and Child Survival. Palo Alto: HealthWrights.

4.1.2.3 The District Health System, Sub-Districts and Health Centres

As mentioned earlier, there are at local level in most countries a number of programmes, often vertically organised and centrally administered, with specialised staff who perform only programme functions. The development of comprehensive programmes which are integrated into a decentralised district service inevitably requires transformation of both management systems and practice. Making the transition from a centralised bureaucratic system to a decentralised, client-oriented organisational culture calls for a significant investment in developing both management systems and structures and the management capacity of health personnel. District

level staff must be able to support decentralised development of comprehensive programmes with clear roles, goals and procedures.

To properly undertake the challenge of health development health personnel need to be able to gather and use appropriate **health information** for planning programmes as well as monitoring and evaluating their implementation.

Interventions in this field are seen as a very cost-effective technical and financial investment (World Bank 1993). However there has not been adequate effort to develop, implement and use locally relevant health and management information systems and there is still transmission of raw data to national level without informing district management. District level staff therefore have to make major decisions based on "estimates – sometimes frank guesses" (Vaughan & Morrow 1989 p.132) – and very often they lack the skills needed to make these good guesses.

Even when routinely collected information is available and relevant, sub-district and district managers have difficulty in getting access to it due to resource constraints, unintelligibility of technical jargon, and general lack of empowerment which mean that these personnel have limited opportunity to learn from new ideas about their work.

There have been a number of attempts to set up appropriate information systems and these have met with interesting results. For example:

- In Indonesia better information facilitated priority identification and planning and empowered staff to bargain better for resources; (Bossert et al 1991)
- In the Gambia staff allocation was considerably influenced by improved information from the periphery; (Conn et al 1993)
- In Ghana improved data collection led to increased self-sufficiency, improved relevance of information and improved supervision. (Heywood & Campbell 1997)

However these are all small-scale projects which have not been replicated on a larger scale. There needs to be increased support for taking these small projects to scale and developing "bottom-up" models of information systems that are relevant for the service provider, support the management decisions of the district manager and yet feed into the overall information needs of higher levels.

Where information for planning and programme or system development or improvement is lacking, **health systems research** is an important tool to assist decision-making (Taylor 1984, cited in Tarimo & Webster 1994, p 34). The challenge is to develop practical methods for dealing with the problems of decision-makers, many of which are to do with the operation of the health system. The creation of capacity and activity in operational research is therefore an important step in management improvement. There is now significant experience in using the "district problem-solving" approach, where health personnel identify priority health system problems and are guided in the development of research approaches to identify their causes and fashion appropriate solutions (Varkevisser et al, 1991).

Here there is an important opportunity for academic departments of public health to develop productive working relationships with the health sector and at the same time strengthen the relevance of their educational efforts (Smith & Bryant 1988

Some district managers and district level personnel will be based at the district centre or hospital, but in most situations the majority will be located in **health centres** (HCs) in sub-districts. HCs are or should be the focal point within the DHS for comprehensive PHC : they should provide quality care as well as facilitate the promotion of the community's health. This implies that, apart from their clinical skills, the health centre team should have the ability to identify and forge alliances with other health workers (e.g. general practitioners, traditional healers), other sectors, non-governmental development organisations and HDSs. For this sub-district and district-level staff need skills in advocacy, negotiation and compromise (WHO 1997A, p 24).

To be able to successfully reach out to communities and households, health centre staff need to be able to work with and through **community health workers** (CHWs). In the 1970's and 80's an important role was given to these community-based workers in the implementation of PHC (Frankel 1992). One of the strongest features of CHWs is that they are predominantly women who can often identify and gain access to those households and individuals with the greatest health needs. Indeed, many of the "model" PHC initiatives relied extensively on CHWs for their successful operation. Further, the role of CHWs was seen not merely as a technical one of extending basic health care to peripheral communities and households: it was also, importantly, frequently an advocacy and social mobilising role, enrolling the conscious involvement of communities and other sectors in health development. As a result of a number of factors which have been noted earlier, many of these programmes have proved difficult to sustain. This has

contributed to diminished advocacy by policy-makers for the retention of this cadre. Given their potential major contribution to HFA it is urgent that this issue be revisited and policy clarified.

The importance of health centres in the DHS must be reflected in the resources allocated to them and also by allowing them to generate and retain local resources. A minimum package of materials and supplies must be agreed upon and enforced. Adequate human resources for health centres are critical and stable staffing levels need to be maintained since these facilities are often the first point of contact for the public with the health system.

Just as health centres should be the locus of district-based comprehensive PHC in developing countries so should primary care facilities such as group practices, polyclinics and health centres increasingly assume a similar role in more developed sectors and countries. They can ensure continuity of care in the health care system and in other settings such as workplaces, schools and homes by serving a specified population or geographical area, and through having as part of their team professionals responsible for home visits and for particular functions e.g. mental health, occupational health, physical rehabilitation etc. (WHO 1998E, pp. 104/5).

Such community health centres should ideally, be managed locally by Boards with a majority of local residents. This would allow them to identify, analyse and take action in partnership with their communities on local public health issues. Such actions could include the formation of patients' groups on particular health issues (e.g. diabetes, hypertension), establishing health education groups, and working with other sectors such as housing, education, welfare and transport to assess the potential for changing their operations so that they are more likely to promote health. Staff would need skills in multi-disciplinary work, have skills in primary health care and public health and a strong commitment to community participation.

4.1.3   <u>Monitoring equity in health and health care</u>

Equity is core to the policy of Health for All. Socio-economic inequalities are growing everywhere, possibly at a more rapid rate than ever before. Together with reductions in public health and social services in many countries, this is leading to growing inequities in health. In order to be able to more successfully advocate for equity in health and health care amongst international organisations, governments, donors and professional organisations, Ministries of health need to be able to demonstrate any social differentials in access to health resources or in

health outcomes. Their capacity to routinely monitor equity in health and health care needs to be strengthened through the use of simple yet valid approaches, using where possible existing data sources from all relevant sectors (WHO 1998D).

Table: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
1: Health determinants indicators:	Prevalence and level of poverty Educational levels **Adequate sanitation and safe water coverage**
2: Health status indicators:	Under 5-year child mortality rate Prevalence of child stunting *Recommended additional indicators*: Maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1-4 year old mortality rate expressed separately.
3: Health care resource allocation indicators:	Per capita distribution of qualified personnel in selected categories. Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels. Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
4: Health care utilization indicators:	Immunisation coverage Antenatal coverage % of births attended by a qualified attendant Current use of contraception.

Source: World Health Organisation (1998). *Final report of meeting on policy-orientated monitoring of equity in health and health care. 29 September – 3 October 1997*. Geneva: WHO, page ii.

4.1.4 <u>Human Resource Development for Primary Health Care</u>

Sufficient numbers and effective performance of health personnel in all phases of health systems development – policy development and advocacy, planning/design, implementation, management and evaluation – is fundamental to, almost a prerequisite for, the realization of HFA.

In H.R. **planning**, the dominant approach of employing "norms" to calculate numbers of health personnel required needs to be supplanted by one which considers not only their numbers, but more importantly, the competencies of personnel required to implement PHC (Green 1992).

With regard to **education** and **training** of health personnel, the PHCA needs to inform both the curriculum content as well as the process and the choice of venues of learning. The aim should be to equip learners with competencies spanning a broader range than has traditionally been the case. There is accumulating evidence that problem-oriented and practice-based approaches result in more relevant learning, and in the acquisition of problem-solving skills, both necessary attributes for the successful development of systems based on the PHCA (Engel 1997). If health workers are to contribute to a health system which enables people to assume more responsibility for their own health through an emphasis on preventive and promotive measures integrated with curative and rehabilitative measures, then their training must expose them to good practice at district level and to the social issues at community level.

There is also an urgent need for teaching staff in the health sciences to upgrade their skills to give effect to such reorientation of the curricula (WHO 1996C). This will require substantial staff development programmes. Health care professionals involved in teaching should have contractual service positions with the health department and the responsibility to render care at the relevant level of the system (specialists at higher level hospitals and generalists within districts).

The above suggestions for education reform apply equally to all categories of health personnel as well as to undergraduate and post-graduate training. It has long been acknowledged that nurses play a pivotal role in the PHC team, and in addition constitute the largest category of health

personnel in most countries. Endorsement of such educational reforms and their fuller elaboration and promotion by countries' nursing leadership is critically important for progress towards HFA (WHO 1997B).

In most countries health science educational institutions have not effected curriculum reform along the lines described above. Although there are indications that some have embarked or will embark on such a course, there will probably still be a significant delay before sufficient "new" graduates are available to work in and transform the health system. Clearly, if the implementation of comprehensive PHC is to be achieved during the next decades, the process of curriculum reform in the educational institutions needs to be accelerated and accompanied by a massive programme of capacity development of personnel *already working* in the health system. In short, the current HFA imperative demands the rapid expansion of **continuing education** activities in most countries.

Continuing education and training in three (related) areas is necessary. Firstly, many health (and health-related) personnel who have been working in the health system for a long time and were trained in the distant past, may require to undertake general course(s) to orient them in comprehensive PHC. The second type of educational exposure should be in specific programme-related areas, given the advances that have occurred in understanding and applying technical and social factors. The third type of training should focus on strengthening management, including of resources (human and material, including pharmaceuticals), finances and information. Much of the above education and training is best conducted in the appropriate work setting, mainly in districts, around the real problems encountered by health workers.

A Short Course Programme: Public Health Education, in South Africa.

The University of the Western Cape Public Health Programme, Bellville, South Africa has been presenting short courses in a series of Summer and Winter schools since 1992. The programme is held under the auspices of the Committee on Public Health Education, which brings together all the major health training institutes in the Western Cape Province of South Africa.

The courses expose health and health-related workers to the latest thinking in public health and enable them to discuss and exchange ideas on improving planning and implementation of primary health care in the changing environment of South Africa. To date, some 3 000 participants – mainly nurses and mid-level managers – have attended these courses. Participants come from all over South Africa and from other African countries, such as Mozambique, Zimbabwe, Zambia and Botswana. Many of these courses are used as the teaching blocks for the Masters in Public Health Programme, which is offered by the University.

Most courses offered are one week long to enable busy health workers to receive continuing education with minimal disruption to their work environments. Health teams from specific districts or institutions often attend a course together - this facilitates and enhances the team's ability to problem solve and manage. Selection of subjects reflect the main public health priorities as expressed in the country's Reconstruction and Development Programme and the Health Ministry's 1997 '*White Paper for the Transformation of the Health System in South Africa*'. For example, courses include: Primary Health Care and Restructuring the Health Sector; Nutrition in Development – a Course for Programme Implementers; An Introduction to the Essential Drugs Programme for Districts; Rural and Farm Health; Management of Primary Health Care for Health Promotion; Integrated Environmental Management Approach to Community Water Supply and Sanitation, and Mental Health Within the Context of Primary Health Care.

Many of the courses are co-facilitated by visiting international lecturers. Courses include field visits to district health care centers, and make use of interactive, problem-based learning methodology.

At present, distance learning materials are being developed for the modules of the Masters Programme – these materials will in the future be incorporated for use in the short course programmes.

Source: WHO, 1995B

Clearly, the level and range of training will be different for different categories and levels of personnel. Some (e.g. district managers) may require continuing education in all of the above areas whereas others may only need exposure in some areas (e.g. programme managers). Policy-makers and planners operating at higher levels of the service may require composite courses which blend a "reorientation" thrust with applications in the programme and management areas. They will also need to acquire substantive advocacy, policy-development and planning skills.

Undertaking some of the above in-service learning in multi-disciplinary teams is important and valuable in promoting better teamwork.

Similarly, education in PHC needs to involve personnel from other health-related sectors as well as community members: capacity development for these constituencies has generally been neglected and has weakened the growth of both community participation and inter-sectoral involvement in health development.

Human resource management problems referred to earlier cannot be solved within the health sector alone, but will require more fundamental interventions in the economy and in the public sector. However, some important intra-sectoral measures should be promoted: these can broadly be grouped into incentives and regulations. Amongst the possible incentives are: continuing education, including the possibility of formal certification and qualification for promotion; additional pay and accelerated promotion as well as allowances for children's schooling for serving in remote and under-served areas; honorary academic appointments carrying both financial and other privileges, etc. Possible regulations include: limitations on the licensing of private medical facilities; control over public sector workers' involvement in private practice, and compulsory service in under-served areas for specified periods after graduation, etc. (Tarimo & Webster 1994, 55)

Day to day management of human resources involving support, supervision, labour issues etc. is acknowledged to be critically important for the effective functioning of district health systems. This area of management also requires considerable strengthening and should be a priority training issue.

5. <u>CONCLUSIONS</u>

- It is clear that progress towards Health for All has been uneven. Gains already achieved are under threat from a complex and accelerating process of globalization and neoliberal economic policies which are impacting negatively on the livelihoods and health of an increasing percentage of the world's population and the large majority in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes that have reduced substantially the impact of certain (mostly infectious) diseases, its intersectoral focus and social mobilizing roles – which are the keys to its sustainability – have been neglected, not only in the discourse but also in implementation.

- Government health ministries need to enthusiastically enter into partnerships with other sectors, agencies and communities to develop intersectoral policies which address the determinants of inequities and ill-health. The policy development process needs to be inclusive, dynamic and transparent and supported by legislation and financial commitments.

- In terms of implementation, the challenge is to revitalize Primary Health Care by drawing together the best of the PHC experience and the best of the HP initiative as well as important associated activities such as those around Local Agenda 21. Here the lessons learned in implementing Healthy Cities projects need to be applied more widely.

- The time is long overdue for energetically translating policies into actions. The main actions should centre around the development of well managed and comprehensive programmes involving the health sector, other sectors and communities. The process needs to be structured into well-functioning district systems which require, in most countries, to be considerably strengthened, particularly at the household, community and primary levels. Here comprehensive health centres and their personnel should be a focus of effort and investment and the reinstatement of community health worker schemes should be seriously considered.

- The successful development of decentralised health systems will require targeted investment in infrastructure, personnel and management and information systems. A key primary step is capacity development of district personnel through training and guided health systems

research. Such human resource development must be practice-based and problem-oriented and draw upon, and simultaneously reorientate, educational institutions and professional bodies.

- Clearly, the implementation and sustenance of comprehensive PHC requires inputs and skills that demand resources, expertise and experience not sufficiently present in the health sector in many countries. Here partnerships with NGOs and expertise in various aspects of community development is crucial. The engagement of communities in health development needs to be pursued with much more commitment and focus. Here the identification of well-functioning organs of civil society, whether or not they presently are active in the health sector, needs to be urgently pursued.

- In promoting the above move from policy to action, WHO has to play a much bolder role in: advocating for equity and legislation to facilitate its achievement; pointing out the dangers to health of globalization and liberalisation; stressing the importance of partnerships between the health sector and other sectors; integrating its own internal structures and activities to ensure that comprehensive PHC programmes are developed; entering into partnerships with and influencing other multilateral and bilateral agencies and donors as well as non-governmental organisations and professional bodies towards a common vision of PHC; and arguing for major investment in health, especially in human resource development, without which HFA will remain a mere statement of intent.

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