Primary Health Care

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Wanted: hearts, minds and hands to give primary care

In the French-speaking countries of Africa the application of the health-for-all strategy has been inconsistent because of economic difficulties and management problems. The latter require a change in outlook and a heightened sense of responsibility among service providers and programme managers. In order to obtain suitable personnel, the authorities should match training to needs and devise sound policies for health manpower development.

The health policy of Africa’s French-speaking countries was conceived prior to Alma-Ata. Priority was given to organizing a hospital system and health centres for essentially curative medicine, together with a network of hygiene and health education services. This clearly favoured the urban areas even though the rural areas were the backbone of the national economies and home to the majority of the people.

Intercountry health bodies were set up to reduce mortality from endemic diseases and epidemics. Pasteur Institutes were established in Abidjan, Algiers, Antananarivo, Bangui, Brazzaville, Dakar, Tunis, Yaoundé and elsewhere. National medical and paramedical schools were founded in which the teachers were mostly French overseas development experts working alongside indigenous teachers, whose numbers gradually increased.

In many countries the health policy proved inadequate or, more precisely, irrelevant in its design and field activities. Following Alma-Ata the countries signed the health development charter for the African region. Subsequently, similar documents drafted by Africa’s highest authorities were adopted, demonstrating the will of political leaders to find the best possible solutions to health problems in keeping with the need to integrate the economic and social aspects of

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development. For example, they signed the plan of action and final declaration of Lagos in 1980, the structural adjustment programme and the priority programme for the economic recovery of Africa (1986–1990), and the United Nations action programme for the economic recovery and development of Africa (1986–1990). These

were all basic strategies laying emphasis on the main social issues, the full utilization of human resources and the needs of specific groups such as women and children. In 1987 came the declaration on health as a basis for development, adopted in Addis Ababa by the heads of state and government of the Organization of African Unity.

The efforts to achieve health for all by the year 2000 through primary health care have taken the form of five-year plans and national government plans relating to:

- establishment of better living conditions through improvement of the environment, housing, and drinking-water supplies;
- immunization against communicable diseases;
- protection of vulnerable groups, especially women and children;
- integration of all health programmes within a framework of primary health care.

A changed approach to primary care

By 1985 it was clear that a fundamental change in the implementation of primary health care was necessary because regional programmes and long-term health development projects based on pilot experiments did not permit its rational and integrated application in the field and were responsible for slow overall progress in the development of a national health system. A new approach was therefore adopted based on three levels of implementation: local or district, intermediate or provincial, and central or national. Institutions and other organized structures manage and carry out operational support activities at the local level, technical support activities at the intermediate level, and strategic support activities at the central level. In theory it should take three years to implement these various activities.

This scenario should improve the development of health programmes, especially those given priority, namely:

- maternal and child health care and family planning;
- control of diseases, especially AIDS and other communicable diseases;
- drinking-water supply and sanitation.
The economic and financial constraints are obvious. Few countries are able to spend more than 5% of their gross national product, which is generally very low anyway, on health care. The economic crisis and the deteriorating terms of trade, the burden of external debt, structural adjustment and its social consequences, natural disasters and civil wars are among the obstacles to health development. To these must be added the population explosion and the widely scattered nature of rural communities. Consequently there are shortages of drugs, equipment and logistical resources, and road networks deteriorate, so that some communities become more isolated than ever.

The human constraints are also considerable. They are characterized by loss of motivation in deprived communities and an absence of community participation, which is clearly related to the shortage of drugs and transport, inadequate supervision, epidemiological surveillance, training and organization of local populations, and the inadequate quantity and quality of human resources. A further and very important human constraint is resistance to change by political, administrative and, above all, university leaders, who have not fully understood the concept of primary health care. They often view it in terms of experiments with rural health which were carried out long before the countries of Africa achieved independence. Awareness sessions have been conducted in order to correct this misconception and give these people a clearer grasp of the concept.

**Human resources**

Primary health care involves two categories of personnel: community health workers, i.e., the health workers who are in the front line of the health system in villages, hamlets and so on, and conventional health workers, such as nurses, midwives, physicians, pharmacists, biologists, sanitary engineers and health administrators.

Community health workers present problems related to training, recruitment, numbers, territorial distribution and service delivery. There are doubts about the manner of their recruitment, their training is inappropriate, supervision of their work is inadequate, their facilities for referral are poor, and their drug stocks are not replenished with sufficient regularity. Furthermore, there is a high drop-out rate. The community health worker programme therefore needs to be reviewed. In most French-speaking countries of Africa these workers are trained at district health units. However, they lack refresher training and supervision by the competent national authorities for reasons connected with motivation, logistical resources and so on. Changes are needed in the way they are recruited, trained and supervised, and in their duties at local level. Their skills should be regularly evaluated. Their numbers are clearly insufficient: in 1983 and 1984 there were only between 1.1 and 2.2 community health workers per 10,000 inhabitants, which meant that very few rural communities could benefit from their services.

Training should be fundamentally reviewed because most newly qualified health workers are not ready to confront field conditions.

For physicians, nurses, midwives and other personnel in the conventional category, numbers are again distinctly inadequate in relation to health needs.
Most training establishments experience problems concerning: the relevance of their programmes; educational methods; the quality and quantity of teaching staff; the planning and production of personnel according to needs; continuous training; mechanisms for evaluating professional work; and poor distribution of personnel. There is a striking concentration of health personnel in major cities. Because of the attractions of the cities and a lack of motivation it is not always possible to distribute personnel according to requirements. It is necessary to introduce a personnel planning policy, career prospects, in-service training, financial incentives and good working conditions outside the big cities in order to serve the rural areas properly. In a number of countries, staff graduating from training colleges are obliged to serve in rural areas for two to four years before they can apply for posts in urban areas. In some countries, medical students must undertake part or all of their final clinical practice in a rural health service.

The recruitment of trained personnel is encountering difficulties related to the current economic situation. Unemployment among doctors and nurses, which is increasing in some countries, is due entirely to the financial constraints preventing governments and private employers from paying salaries.

Training should be fundamentally reviewed because most newly qualified health workers are not ready to confront field conditions. Matters are made worse by the lack of properly organized continuous training.

Training must be redirected and refocused so that health workers at all levels are better prepared to take up their duties in national health systems on the basis of primary care.

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**Not alone**

Community health workers should always bear in mind that they are not working in isolation. Rather, they function within a health system and should be guided and supported by skilled supervisors. They should know where and when to seek guidance, and refer or seek help for patients who are seriously ill or whose treatment is beyond their competence. Community health workers cannot and should not try to do everything alone.