

Primary health care in the Eastern Mediterranean Region before and after Alma-Ata

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Introduction

Addressing the issue of primary health care (PHC) in the Eastern Mediterranean Region before and after the Alma-Ata Declaration is a demanding task. It is, in essence, writing a history of the national health system of 22 countries over the past two decades. This task is also constrained by the fact that not all the data and information on the health situation twenty years ago can be easily accessed.

The aim here is to review, analyse and present a concise resumé of two eventful decades in which PHC has made all the difference in the health systems of Member States in the Region. To facilitate this review the PHC situation before and after Alma-Ata has been grouped into three main categories of functions.

The first category relates to creating an environment conducive to health, the second to learning the art of well-being and the third to the delivery of preventive and curative services. These three main areas are valid for the assessment of PHC as well as for future action. Each of the three functions overlap and interact. They are detailed here beginning with a very brief review of the situation before Alma-Ata followed by what has been achieved to date. Further discussion includes the different elements of successes, failures, challenges and possible future strategic

solutions. This article looks briefly at the history of PHC in the Region and how to build on the experience gained so far to reform and upgrade PHC.

Primary health care—definition, scope and range

The Alma-Ata Declaration states that:

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 of 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.

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This definition describes the different features of PHC. It is clear that the scope of PHC focuses on the whole system and processes of curative, preventive, promotive and rehabilitative care concerned with the improvement of people's health. It also focuses on the means and activities that bring improvement to health care. As a multifaceted concept, it includes elements that are determined by the level of socioeconomic development rather than a fixed package of programmes. The components (elements) of PHC vary from one country to another. In the Alma-Ata Declaration mention was made of at least eight elements of which the PHC programme should comprise. These elements were examples rather than a fixed menu, chosen for their importance and to respond to the priorities and needs of developing countries. In fact, these elements show the global consensus on priorities and the global thinking on addressing priorities as well as the solidarity of the world towards addressing major health needs.

However, although priorities, and the means to handle them, change with time, PHC always remains the essential means and strategies to address priorities identified in partnership with the community to achieve health for all.

Another feature of the PHC concept is the level it works at, which is determined by the prevailing health system. The number of levels of health care varies from one country to another. A usual pattern in the Region is that levels of care coincide with the administrative levels.

The first formal level will be a health unit (Egypt, Islamic Republic of Iran, Morocco, Pakistan, Sudan) or a health centre (Iraq and Saudi Arabia). The bigger the country the smaller the first level of care. This is to allow for higher accessibility in a cost-effective way. The staffing of the first level of care also varies as does the range of

functions. Some countries have auxiliary health workers (Djibouti, Islamic Republic of Iran, Somalia, Sudan, Republic of Yemen) whereas most countries deploy physicians in the first level of care (Egypt, Iraq, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Syrian Arab Republic and Tunisia). The first level of care or the local level of care is a useful indicator to show the extent and principles of the service to community. Budgetary allocations, by level of care, are also important indicators of the commitment and translation into action of PHC policies. They indicate the priority setting in planning at the different PHC levels and the PHC activities (promotive, curative, preventive) in each level.

Primary health care as a term was introduced to the Region in the Regional Director's Report of 1975. Before that, the term basic health services (BHS) was used. In some countries (Egypt and Pakistan) the term basic health services is still used in the ministry of health structure to mean local level services. In addition to its dimension of care provision, PHC has a social justice dimension which affects continuity, reorientation and readjustment of the health system.

Irrespective of how PHC is formally labelled in a country, this review will focus on how far the three main functions of PHC are performed in the Region. These interrelated functions are grouped under three main headings; the ability of the PHC approach to create an environment (climate) conducive to health; the development of the health system towards a better quality of life and not merely the absence of disease, i.e. the art of well-being, socially, spiritually and physically; and PHC's most common function, the delivery of preventive or curative services.

Creating an environment conducive to health

By creating an environment conducive to health we refer to the efforts made to create a climate which helps the health system achieve health for all by inputs and activities outside its formal (ministry of health) hierarchy. Such an environment must have the prevailing vision and policies regarding sustainability, adequacy, integration, equity and quality of the following essential health system features: managerial processes, organization set up, resources (human and material), norms and knowledge, public and private health economies, and delivery of health care at first level, referral level, secondary level and tertiary level. By addressing these parameters as a national, macro-level responsibility, the national health system is geared towards the principles and targets of health for all.

Social and spiritual dimensions are also important factors contributing to health behaviour and to the different stages of policy formulation, programming, planning and assessment. These dimensions will be discussed later when we look at the art of well-being function, where their impact is more pronounced on the citizenship of individuals.

An environment conducive to health needs political commitment, organized financing and planning based on political commitment, intersectoral action and partnership with the community. Each one of these will be briefly discussed.

Political commitment

Political commitment for PHC shapes the health care system, its functions, organization, economics, delivery and management style. It is an interactive process between the stakeholders (politicians, planners, economists, and pressure groups) and the

ministry of health. Before Alma-Ata, the main preoccupation of the ministry of health was the clinical care system and its curative institutions. The image of health was seen in hospitals; the main investment was in building hospitals and the main parameters were the number of beds and physicians per population. The focus and scope were mostly the curative care infrastructure. Health was, in a way, translated as being "not ill" or "cured", and health policies were restricted to yearly national plans for civil work, logistics, training, equipment and salaries. This was a simple exercise usually done by planners with little involvement by health program managers. Involvement of grassroots in the planning process was minimal and the community role was negligible. Planning was a normative function limited to the central ministry of health.

After Alma-Ata, explicit policy statements supported grassroots infrastructure development and equity in the Region. The trend was also in support of promotive services, decentralization and equitable distribution of health services. All countries of the Eastern Mediterranean Region are signatories to Alma-Ata and committed themselves to the principles of the PHC approach.

After Alma-Ata and by 1979, WHO introduced the concept of "country health programming" where criteria for prioritization, feasibility, relevance, role of other sectors, etc. were important parameters for the planning process. Almost all countries in one way or another underwent this exercise which later on was upgraded into a new planning exercise called Managerial Processes for National Health Development. Both of these exercises contributed to a new way of thinking, first in ministries of health and through them in the planning process for health in the country as a whole.

At this stage, countries were requested to develop their own strategies to implement PHC. This step greatly influenced national development plans to cater for PHC programmes. In fact, today many countries resort in their health planning to these principles introduced by WHO in the 1980s and early 1990s. Successful stories in such planning processes are seen in Islamic Republic of Iran, Oman and Saudi Arabia.

Primary health care financing

Financing of health care determines the scope of care whether promotive, preventive, curative or rehabilitative, and the sustainability of its provision. Before Alma-Ata there was a mixture of public and private financing as well as traditional practice. The main thrust of health care financing was for clinical care which gave the private sector a relatively prominent role. Financing was mainly out-of-pocket and health expenditure as a percentage of GNP was very low in the 1970s. As the structure of health care was limited to curative services, financing was accordingly planned basically per hospital bed. Hospitals are costly venues for treating simple ailments. Data on the cost-effectiveness of the health care financing before Alma-Ata is limited, but assuredly hospitals were treating diarrhoeal cases, acute respiratory infections, malaria and other endemic diseases, all of which were highly prevalent in most countries at the time. As there were no cost-effective alternatives such as health units, one can assume that essential care (PHC) provided by hospitals was costly.

Another feature of health care financing before Alma-Ata was that it served only a small section of the population, namely those who were in the vicinity of hospitals. The high incidence and prevalence of diseases and mortality rates in the 1960s and 1970s clearly reveal a burden of diseases

which hospitals could not cope with. There were, however, several efforts by some Member States, such as Egypt with its integrated health complex in the 1960s, the Islamic Republic of Iran with its *behvarz* in the 1970s, and Sudan in the 1960s with its medical health assistants, to find a more cost-effective way of running health care services and thus widening the scope of care.

With Alma-Ata, the shift of emphasis was made towards the community, spreading out health care, albeit thinly, and opting away from costly hospital care in order to address priority prevalent health problems. Alma-Ata also sought for partners to shoulder the cost of health care, such as communities, health related sectors and traditional healers. It became evident that, with Alma-Ata, we were looking for a more cost effective strategy to achieve health for all.

Comparing 1980–1985 with 1990–95, more countries are allocating a higher percentage of their GNP to health care. Seven countries in the Region spent more than 5% of their GNP on health care. It is encouraging to see that the expenditure devoted to local health care has increased during the past decade and that for several countries of the Region more than 50% of their health care expenditure is spent on local health care. This increase in resource allocation shows a shift in commitment to PHC. Commensurate with increased allocations for health there has been a quantitative increase in the number of people served and functions provided including promotive, preventive and rehabilitative health care. Such investment in health care has produced a favourable climate for health services to thrive in.

Since Alma-Ata, health systems evolved three main ways of financing PHC in the Region. Each way affects the health environment differently. The first group

consists of countries whose health care is entirely funded by the government; the second group has an emerging private sector while the government remains the main source of health care provision; and the third group has a strong private sector. It is increasingly being recognized that health care is becoming an expensive service warranting serious consideration. Similarly, there is growing evidence of increased per capita expenditure on health, especially with the increasing proportion of the ageing population and increased urbanization, with a corresponding rise in the incidence of chronic, degenerative and sociological diseases. Despite a more rational orientation of public health care systems and cost-effective measures taken by countries it is felt that many health care systems are characterized by inefficiencies and uncertainties of economic scenarios. The challenge is to design and develop sustainable mechanisms of health care financing strategies and procedures aimed at encouraging other government bodies, the private sector and communities to jointly shoulder the ever-increasing cost of health care in order that individuals lead a healthy lifestyle.

There is a growing need to look for alternative mechanisms for health care financing. Options being explored include national insurance schemes, employer/employee sickness funds, the private sector, fee-for-service and community financing schemes. The use of financial data for decision making, the evaluation of health care systems and development of scenarios for projecting health costs in the future are some of the new initiatives under taken by some countries as part of the health care reform strategy to improve the quality of PHC service delivery systems.

The role of the private sector in PHC services

The private sector, before and after Alma-Ata, has played an important role in many countries, particularly in the delivery of urban health care, including PHC services. However, information is scarce about the details and size of this role.

The role of the state in regulating the private health sector has been weak in most countries. Professional self-regulatory rules were either not observed or inadequate to control the mushrooming private sector activities in consultation clinics, private health institutions and the pharmaceutical trade in some countries prior to Alma-Ata. The influence of private services varies among countries but is substantial in a few (Egypt, Lebanon, Yemen).

In general, the private sector in the Region has been characterized by inconsistent standards, overprescribing, no mechanisms for monitoring the quality and costs for clients and emphasis on curative services. In some countries public sector personnel have been permitted to have part-time private practices, thus undermining the principle of equitable access to public sector services.

After Alma-Ata, the limitations of the private sector continued, the need to regulate and coordinate their activities were not motivated by attempts to abolish or undermine their role, but rather to make this role achieve national health goals. In many instances, regulations, directives and laws for regulating private health activities were already there, but the problem was in their enforcement. Standards of services in the private sector could be improved further by adopting optimum licensing and relicensing requirements, encouraging group practices as opposed to individual clinics and by supporting professional syndicates to monitor their members and make participa-

tion in continuing education activities mandatory in order to continue holding a licence to practice, (as applied in the Islamic Republic of Iran).

Health insurance schemes in the financing of PHC

Health insurance schemes introduced after Alma-Ata were among the possible options for financing PHC services which have attracted attention. There are many types of insurance schemes, including national insurance schemes, providing universal coverage; employees insurance schemes limited to employees in government, private sectors or both; and private insurance policies bought by individuals. The second type of scheme, which covers employees, has been adopted in some countries (Egypt, Islamic Republic of Iran and Jordan), while Cyprus has considered developing a national insurance scheme. In Egypt, the government employees' insurance scheme is being expanded and has already provided coverage to all students in the country.

Health insurance schemes, particularly for employees, require a tangible clientele to justify establishing such schemes. This explains why health insurance is not yet so widespread in the Region. However, the increasing tendency for privatization and market economy should hasten the need for designing new approaches to finance health services and, no doubt, health insurance will feature prominently among these new approaches.

User charges

User charges were introduced before Alma Ata for curative services and to raise funds in the face of dwindling public health budgets. However, many cautioned against their use in PHC services as there was mounting evidence of the tendency to exclude those in greatest need of services,

thus threatening the equity principle. However, user charges are easy to institute and sometimes seem the only available option for some non-supported PHC facilities or services. In some countries nominal user charges have been used to curtail excessive consultations in an otherwise free service but not levied on preventive services or those targeted at higher-risk groups, (i.e. mothers and children).

Intersectoral action

The notion of intersectoral action before Alma-Ata could have been practised in some countries on an ad hoc basis but not necessarily as a policy issue from the ministry of health. This is mainly because the ministries of health have been institutions for curing, focusing more on hospitals. They were not recognized as development institutions nor was there the necessary vision to shoulder such responsibility. It is true that ministry of health officials were not equipped nor trained in such development issues as intersectoral action or community involvement. The structure of the ministries did not cater for such a responsibility and their administration did not reflect intersectoral action as a function.

Another factor contributing to the failure of leadership in ministries of health to promote intersectoral action was the lack of decentralized set-ups at the provincial and lower levels. It is at this lower level that intersectoral action is more feasible and relevant. In brief, intersectoral action was ad hoc and not institutionalized.

With the advent of the PHC approach, a new vision has been introduced to ministries of health. Health, as defined by the WHO Constitution, is not limited to absence of disease, but includes physical, mental and spiritual well-being. In order to achieve well-being, other partners must be included. Health for all again re-empha-

sized this definition and the PHC minimum list of at least eight components made it very clear that to achieve most of them intersectoral action is needed. Water, sanitation, nutrition and mass education are all dependent on sectors other than the ministry of health. This new way of thinking has changed the vision of health ministries and their hierarchical set-up to focus more on promotive and preventive health as well as to develop decentralized structures at provincial and district managerial levels. A classical example of intersectoral coordination is the school health programmes which were launched to combat communicable diseases, malnutrition among school children, and improve dental care and eye care. Intersectoral action was crucial to fortification programmes in many countries such as iodization of salt, vitamin A in cooking oil and ferrous sulfate supplements in wheat flour. Anti-smoking policies were formulated banning smoking in public places and transportation. Breast-milk substitutes or formulas were also addressed to a certain degree. Mass education by the mass media in support of health campaigns, promoting healthy lifestyles and controlling endemic diseases were all launched after Alma-Ata as manifestations of intersectoral action.

Developing appropriate environmental conditions such as increasing access to safe drinking water and adequate excreta disposal can dramatically improve the health conditions of a community. There has been an increase in the percentage of the population with safe drinking water from 56% in 1983 to 65% in 1993. Although for urban dwellers the access has not increased significantly (from 89% in 1983 to 90% in 1993) improvement has been made in rural areas from 36% in 1983 to 48% in 1993. There is a similar trend with adequate excreta disposal facilities. In 1983, 37% of the population had access to adequate dis-

posal and this increased to 48% in 1990. For rural dwellers the increase has almost doubled from 12% to 23% during the same period. However, Afghanistan and Somalia do not follow this positive trend due to civil strife.

These different scenarios for intersectoral action are more effective at lower levels. An environment conducive to health entails better coordination by all partners. Intersectoral and intrasectoral coordination are essential prerequisites for sustainability of health care. With changing demographic, social and epidemiological patterns the agenda in front of intersectoral action is even greater. More concerted efforts and policies in support of intersectoral action are needed.

Community partnership

Community partnership is deep rooted in the history of the countries of the Eastern Mediterranean Region. It is related to social, cultural and religious heritage. During the initial period of PHC implementation, governments assumed full responsibility for nationwide health delivery and the community remained a passive receiver. However, communities are now more demanding of transparency and accountability by health providers. The need, therefore, for active community involvement is necessary to meet these demands and to increase both the coverage and efficiency of the programme. In addition, since the indicators of health have witnessed a shift from disability, morbidity and mortality measurement towards measuring quality of life, then community mobilization and involvement are vital to achieving quality of life.

Community involvement is at the heart of the health-for-all movement. It is about the *all* of health for all. Some claim that the outstanding evolution in the thinking of public health with the advent of Alma-Ata

was the notion of community involvement. Primary health care is directly affected by the political and socioeconomic circumstances which may support community involvement or limit it.

The Region can enhance the implementation of community involvement further through different approaches such as the basic development needs (BDN) approach and similar in-built social and historical developmental community approaches, such as El-Touiza in Morocco and El-Taawin in Yemen. Other approaches are those which focus on spiritual and social dimensions, or use techniques and methods of quality health care. The extension of health workers into the community such as, the friends of health centres in Saudi Arabia, community support groups in Oman, health volunteers in the Islamic Republic of Iran, community health workers in Pakistan and health guides in Yemen, are some feasible strategies to enhance the implementation of community involvement.

The ubiquitous school network and nongovernmental organizations are important community assets which can be used more as entry points to launch community involvement. Tapping potentials in the Region such as the *shura* system is a worthy effort, which needs to be studied and adopted. The spirit of *shura* is the essence of community involvement (as experienced in Afghanistan).

Literacy and the role of academic institutions

Education and health have been the twins of social services. In the 1960s, formal education was confined to urban settings. Literacy rates in the Region were low. Advancement in literacy in most of the countries of the Region must have contributed to creating a better environment for health. Research worldwide has shown the

impact of literacy, especially among mothers, on health conditions and infant and maternal mortality rates. In reviewing the percentage of the population with accessibility to health care with literacy rates, a higher correlation is noticed with literacy rates (0.83 for total literacy rates, 0.78 for male literacy rate and 0.81 for female literacy rate). When we compare the correlation of human resources and GNP to access to health care in our Region the correlation is lower than with literacy. In other words, it can be said that literacy contributes more to improving the health environment than other factors such as GNP and resources.

Another factor contributing to a conducive environment to health is the production of human health resources responsible for important achievements regarding the expansion and creation of new schools and institutions which were limited before Alma-Ata. The number of schools of medicine and health institutes has increased recently to reach more than sixty schools of medicine and twice that number of health institutes for allied sciences. However, despite this fact, there is still no universal solution to the delicate equation of production, need and distribution of health workers. Overproduction with maldistribution and discrepancy between nurses and physicians is a hinderance to the development of human health resources. The Iranian experience in combining medical education and health services within one ministry represents a radical approach to solve the problems of coordination between the health ministry and medical schools.

Universities and academic institutions after Alma-Ata have taken certain steps in support of PHC through:

- reviewing the basic undergraduate training curricula and integrating the case management of certain diseases

such as diarrhoea, ARI and malaria according to WHO recommendations;

- gearing postgraduate training courses, particularly PHC and family health courses, to local urban health needs and adapting the latter to the prevailing health centre model (e.g. in Iraq and Oman);
- participating actively in the urban PHC service delivery, particularly in centres that are used for training and committing themselves to issues of service development (Jordan, Pakistan, Republic of Yemen);
- making PHC problems part of their essential research activities (Pakistan, Sudan, Yemen);
- making family practitioners a speciality in the Arab Board in many Arab countries, especially the member countries of the Gulf Cooperation Council.

After Alma-Ata there was considerable experience of the positive roles played by the medical institutions in support of national PHC goals and development of working relationships between ministries of health and academic institutions. The initiative of the community-based universities, the Aga Khan (Pakistan), Suez Canal (Egypt), Gezira (Sudan) and others in the Region, were launched to support the PHC approach.

Reviewing the five different issues discussed above namely: political commitment, PHC financing, intersectoral and intrasectoral collaboration, community partnership, and literacy and the role of academic institutions, shows that these issues before Alma-Ata were not systematically addressed in relation to health simply because the health vision itself was not always geared to health for all. The health vision was distorted and focused on clinical (hospitals and curative) care. After Alma-

Ata a movement in support of the above five issues started, however it has yet to fully achieve the desired orientation and change of national health care systems.

Learning the art of well-being

Health is not merely the absence of disease, it is also the status of physical, mental and spiritual well-being. In order to achieve this status the individual has to share responsibility for protecting and promoting their health. Their role could be substantial, especially when it comes to the style of living the individual is opting for. This is the role of individuals, synergistic and complimentary, enabling the creation of a conducive environment for health, as reviewed earlier. It is also an enforcing and corrective factor for providing care when needed, which will be reviewed later. We are speaking of a continuum; of a macro system of providing quality of life primary health care. In such a PHC system, the individual is living in an atmosphere where health is valued in social, economical, physical, educational and political terms. Well-being is a combination of improved quality of life, extended longevity and reduced illness. In all these, the individual is entrusted with the responsibility of facing challenges and overcoming them. Before Alma-Ata, the role of individuals and the community was passive. The role of the individual is more important at present where there is a shift of disease patterns from infectious diseases to behaviour-induced diseases such as obesity, diabetes, hypertension and stress. In assessing the performance of PHC in the Region, this function of PHC (and the art of well-being) needs to be analysed and assessed at the individual, family and community levels. The regional experiences of basic development needs (BDN) and urban PHC, healthy cities

and the Action-oriented School Health Curriculum provide the main interventions that have created awareness of well-being in individuals and communities since Alma-Ata. All of these interventions targeted the individual, creating a sense of responsibility and active involvement in health.

Basic development needs approach

Basic development needs focuses on developing individual and collective responsibility, in promoting quality human behaviour and community interaction with local challenges. It emphasizes dignity and accountability. It does not only ensure solidarity with social and cultural events but also addresses alleviating poverty thus achieving a balance between social and economic development. This is what is sometimes called development with a human face. It is based on organizing the community, capacity building and developing self-management and self-reliance.

Urban PHC and healthy cities and healthy villages

Before 1978, urbanization was not considered a major concern. The needs of the urban population were stereotyped and determined without taking into consideration people's own point of view or perspective. This was due to the absence of community organizations in support of health development; lack of rapport between services and the community; and the absence of inclusion in health plans of the mechanisms by which people could be involved. Recently, megacities such as Cairo, Karachi and Tehran have emerged. The pace, causes and patterns of urbanization have differed between countries and possibly within the same country. Three patterns of urbanization evolved after Alma-Ata. The first pattern is where urbanization occurred at a fast pace and where most of the

population is now urban, (most member countries of the Gulf Cooperation Council, Cyprus and Libyan Arab Jamahiriya). The second pattern is where urbanization was substantive (40%–60%), but not dramatic (Egypt, Islamic Republic of Iran, Morocco, Pakistan and Tunisia). Finally countries where the urbanization process has been modest or slow (Afghanistan, Sudan, Somalia and Republic of Yemen).

After 1978 urbanization and population ageing yielded different health patterns, which are:

- *Poverty-linked*: resulting in poor housing, poor nutrition, overcrowding, absence of safe water and sanitation.
- *Environmental*: mainly related to air, soil and noise pollution, waste and industrial hazards.
- *Medical problems related to urban lifestyles*: including noninfectious chronic diseases of metabolic, degenerative or neoplastic origin; smoking; and road traffic problems. Presently these problems represent the major cause for morbidity and mortality in many countries in the Region.
- *Psychosocial problems*: represented by increased incidence of mental stress and neurotic disorders, adolescent delinquency, alcohol and drug addiction, sexually transmitted diseases and violence. The special at-risk groups for these problems are poor or unemployed youth and street children.

These patterns of diseases show what to focus on at present in order to create an environment conducive to urban health care. In many cities, there has been an absence of a unified administrative or managerial body responsible for overall city health. Municipalities, governorates, ministries of health, the private sector and nongovernmental agencies, in many instances, operated inde-

pendently. The absence of a unified urban health authority impeded the development of comprehensive health plans for cities, and at the operational level, hindered coordination efforts. This set-up meant different policies and values of health. It may be argued that different providers should be encouraged but that the health policies should be consistent. The role of the ministry of health as the responsible authority for health policy is being promoted and acknowledged for PHC.

With proper approaches to community organization and community sensitization, many tasks could be achieved in urban PHC, and there are a number of experiences in the Region of building local capacities of citizens to contribute to health through partnership and ensuring responsibility in health development. They include urban health volunteers (Islamic Republic of Iran), Friends of Health centres (Saudi Arabia), and Red Crescent volunteers (Qatar), together with many other examples from nongovernmental organization projects, BDN initiatives and university projects. The Aga Khan University model of community health workers in Karachi city and PHC teams of nongovernmental organizations in slum areas around Khartoum are good examples of alternative approaches under pressing circumstances.

The healthy villages and healthy city initiatives were launched in the 1990s. The basic concept of the project was to put health as a priority agenda for citizens and city authorities and to mobilize intersectoral and community resources in the city. The project used political lobbying, communication and community organization as its main strategies. The experience pointed to the great potential of the healthy city approach in achieving PHC goals in the urban setting.

Examples of healthy villages from the Region emphasized solidarity of villagers in health and willingness to participate in projects for the improvement of their environment. Projects for laying water pipes, connecting to sewage disposal networks, solid waste collection and disposal were entry points to organize and mobilize communities in many countries. Health clubs in Tunisia, Social Fund activities in Egypt, engineering input by the University in the Orangi pilot project for sanitation in Karachi and female volunteers in urban health centres in Islamic Republic of Iran are all examples of initiatives taken to ensure well-being.

Health protection and promotion

Health protection and promotion have a synergistic effect, creating an environment conducive to health through change in the knowledge, attitudes, behaviour and practice of individuals. With the advent of the PHC movement, health promotion became an integral part of all preventive programmes. It has been researched through several knowledge, attitudes and practices surveys and health promotion has become a cross-cutting activity in the work of many departments and institutions. Health education departments at present exist in all ministries of health. Training in health promotion forms a substantial part of training programmes for health personnel. However, these are only part of the health promotion spectrum. After Alma-Ata, countries in the Region have also launched several initiatives and policies in support of health promotion such as the Action-oriented School Health Curriculum (AOSHC) and the policies on spiritual and social heritage prevailing in the Region. The aim of AOSHC is for children to acquire life-long healthy lifestyles and skills. Children are trained at school in home health, communi-

ty health and campaigns against smoking and drugs. These children then become agents for change in their homes and the community.

Other initiatives introduced in the Region with the advent of PHC were the Tobacco or Health Initiative, the Milk Formula Code, Baby-Friendly Hospitals, Care of the Elderly, the Safe Motherhood Initiative, followed by the reproductive health movement, and the fortification of micronutrients in the staple foods of children and adults, especially mothers. All these were triggered or enhanced by the PHC movement. These policy issues enhance individuals' active involvement in healthy living.

The Region is rich in spiritual teachings in support of healthy living. The responsibility of individuals, as shown in religious teachings, is very clear regarding many aspects of daily life. The teachings of holy books go into details of personal hygiene, caring for the environment, responsibility for family health, caring for the elderly and young, support to the poor and destitute and rewarding all good deeds to neighbours and community. Such potential has been with us for centuries. Alma-Ata encouraged reference to these teachings, however, the potential has not yet been fully explored or used to ensure the individual's compliance to such teachings. A start has been made through conferences such as the Amman Declaration for Health Promotion which tackled several issues regarding healthy lifestyles according to Islamic teachings.

Delivery of preventive and curative services

In the early 1970s a few countries tried demystifying medical care, for example, by using auxiliaries to treat common, simple ailments.

Though still in the domain of medical care the treatment was nearer to the people. Research in poorer communities, mainly outside the Region showed the relationship of other developmental interventions to health, such as agriculture to nutrition and infection; water to diarrhoeal diseases. But before Alma-Ata, public health (which is the basis for PHC and health for all) was given a second rank and usually was the responsibility of the municipality and not the ministry of health. Preventive programmes such as malaria control and smallpox eradication, the two most prominent preventive programmes, were vertical and isolated from the mainstream of health thinking and vision. In fact, smallpox eradication was made possible, in addition to its epidemiological feasibility, when community mobilization, surveillance and logistics were integrated into the health system. Before PHC and health-for-all concepts had been in operation globally the delivery of health services was characterized by being centralized, not integrated intrasectorally nor intersectorally, and of a vertical, isolated nature, confined to the medical profession and technology.

The PHC system and health infrastructure

Substantial quantitative infrastructure development has been witnessed since Alma-Ata. Health technology, health functions, logistics and networks all expanded dramatically in comparison to the era prior to Alma-Ata. At the same time initiatives were launched for developing human resources for health and the building of training institutions. These varied from training of community health workers to the training of paramedics and higher levels of health professionals.

Accessibility to health care is relatively high in several countries of the Region: 80% of the population in 18 countries have access to local services. However, in a few

countries, such as Afghanistan, Somalia and Republic of Yemen, accessibility is low (39%, 20% and 45% respectively). The urban/rural difference is also revealing as a majority of the countries report figures that show that more than 80% of the urban population has access to health care, (with Republic of Yemen being the exception at 68%). However, this accessibility rate is not seen in many rural populations. For example, in Republic of Yemen and Morocco only one-third (35% and 38% respectively) of the rural population has access to health care.

The ratio of health personnel to population is quite high in the majority of the countries. Twelve countries have at least 10 physicians per 10 000 population in the Region; Lebanon has a high of 28 and Afghanistan a low of 0.3 physicians per 10 000 population. Fifteen countries have at least one dentist per 10 000 population, with Lebanon again having the highest, 11.7 per 10 000 population and Afghanistan the lowest at 0.03. There is at least one pharmacist per 10 000 population in 15 countries with Lebanon having the highest ratio, 8.7 and Somalia the lowest, 0.01. On average there are 21 nurses/midwives per 10 000 in the Region (Libyan Arab Jamahiriya has a high of 36.6 and Afghanistan a low of 0.7 per 10 000 population). A ratio of at least 10 hospital beds per 10 000 population is found in 16 countries; Libyan Arab Jamahiriya also has the highest number with 36.9 but the regional average is only 18.42. Nine countries have at least one PHC centre per 10 000 population; Palestine has the highest ratio of 3.7 per 10 000 and Afghanistan the lowest of 0.1.

Overall the increase of health facilities, training institutes and human resources is one of the main achievements of PHC. The quality of services provided has also im-

proved in many countries with the adoption of the PHC approach since Alma-Ata.

Provision of care

The provision of care has improved significantly over the past 15 years. The percentage of women attended by trained personnel during pregnancy has tripled from 15% in 1983–85 to 49% in 1991–93, and the number of women immunized with tetanus toxoid during pregnancy has jumped from 8% to 50% in the same period. The percentage of women of childbearing age using contraceptives has doubled from 16% in 1988 to 33% in 1991–93. The number of infants immunized against diphtheria, pertussis and tetanus has increased from 40% in 1983–85 to 76% in 1991–93. At present it is above 80%.

Such preventive measures have contributed to a drop in infant mortality in the Region of more than 20 points from 101 per 1000 live births to 77 between 1983 and 1993. The Islamic Republic of Iran and Egypt have had the greatest decrease in infant mortality, down 57 and 64 points respectively between 1980 and 1995. During the 1990s, the infant mortality rate was 25 or less in nine countries in the Region. The under-five mortality rate dropped from 129 per 1000 in 1990 to 106 in 1991–93 and currently ranges from a high of 248 in Afghanistan to nine in Cyprus. The under-five mortality rate was 25 or less in five countries in 1995. In addition, the maternal mortality rate has dropped from 474 per 10 000 live births in 1990 to 312 in 1991–93.

At present with the ageing of the population, the overall life expectancy for the Region is 62 years, whereas eight years ago it was 55 years. However, there is great variation between countries. For example, life expectancy ranges from under 50 in Afghanistan and Somalia to over 75 in Cyprus and Kuwait. With increasing life expectan-

cy in most countries for both men and women, more and more elderly populations are seen. The Region had also witnessed a shift in epidemiological patterns; countries are reporting more and more chronic diseases and there is a shift from childhood and communicable disease to behavioural, chronic and adulthood patterns of disease. For example, in Oman, hospital deaths from cardiovascular disease, cancer and injuries (the three leading causes of death in 1996) have increased dramatically from slightly more than one quarter (28%) of all hospital deaths in 1984 to more than half (52%) in 1996. Many countries are witnessing a double burden of diseases (chronic and acute) which are challenging their PHC systems.

Chronic physical illness, such as arthritis, diabetes, hypertension and cardiovascular diseases are common problems that require long-term costly care and follow-up among the older age groups of the population, as are psychological and mental disorders, and malnutrition. While the number of elderly is increasing the fertility rate in most countries of the Region remains high with the net result that a large number of infants and children that also require care. Rapid urbanization over the past decades has resulted in approximately 50% of the population in the Region living in urban areas. Different health outlets provide a range of clinical and preventive activities. However, for essential care, the health centre has remained the main prototype for the delivery of urban PHC services, particularly within the city proper setting. Most health facilities limit themselves to the delivery of clinical care and some preventive services within their facilities. They undertake little, if any, promotional and community-based delivery activities. The relationship with the community has usually been weak and, in contrast with the situation in rural PHC,

the facilities have not usually applied the principles of the catchment area in defining the area and population that they served.

Little coordination has existed between health centres and environmental health officers, the private sector and nongovernmental organizations delivering health or officials in other sectors relevant to health. There has been concern that many urban health centres were not offered adequate resources to enable the delivery of credible services to the relatively sophisticated urban public seeking good quality care.

After Alma-Ata, improved and expanded care was provided but still more efforts are needed. Urban health centres need to be reoriented to the PHC principle of delivering a comprehensive range of services, intersectoral coordination and community participation in PHC services. The orientation task should be linked to building up managerial and technical capacities within health centres, including the development of a management health team which would oversee community-related activities.

The countries of the Region can be divided into three groups, those Member States with values above all three health-for-all targets, countries with values below all three targets and a middle group which have achieved one or two of the targets. In those countries doing well, life expectancy is generally over 70 with Oman having seen the most dramatic improvement of an increase of 12 years for women between 1980 and 1995. For those countries that are doing poorly, they have only had comparatively slight increase in this area. Again, for those countries doing well, many have also seen a dramatic annual decrease in the under-five mortality rate ranging from 3%–8% annually with an average of 5% for males and 6.2% for females. However, for some countries the decrease in the under-five mortality rate has been very slow, (av-

eraging 1.6% annually) and the rates continue to remain quite high, ranging from 112 to 248. Immunization coverage for infants under the age of one reached nearly 100% in some countries, yet for other countries the coverage is considerably lower.

Thus, the diversity in the adequacy of health care systems and the support offered to them by governments is evident. While there are countries which still struggle to reach all members of their population with basic services, others are addressing the challenges of demographic transition, changing morbidity patterns and the population's demands for improved quality and cost-efficiency of services.

Referral

The performance of a health system can be viewed from three perspectives, namely the provider (technical), the user (benefit-risk) and management (cost-benefit), which do not necessarily coincide all the time. In fact, their concerns and expectations may sometimes be contradictory. A referral system should be a bidirectional process, include a strong component of information exchange, and referral should only be justified when the required services are not available at a lower level. To this extent health system infrastructures prior to Alma-Ata were limited and referral care was not clear cut.

People often seek inappropriately high levels of service because of the many constraints of their system, such as a shortage of resources, inadequate services at the PHC units, scarcity of drugs and ineffectiveness of the organizational managerial system.

Health systems after Alma-Ata developed several levels of care and referral rates vary from one country to another. For example, Pakistan has six hierarchical levels starting with the village health worker

followed in ascending order by basic health units (BHU), rural health centres, *tehsil/taluka* hospitals, district hospitals and tertiary hospitals. However, the coordinating mechanisms and routes of communication for referrals between such different levels are weak. The results of a study revealed that 50% of those attending BHUs were ultimately referred elsewhere (33% treated and referred while 17% were referred outright). Consultants thought the complaints of 44%–77% of those attending could have been dealt with adequately at lower levels.

Health centres after Alma-Ata have to provide a substantial care service to ever increasing number of users (customers) which was, prior to Alma-Ata, provided by hospitals. Health centres are not supported enough by the secondary level facilities. Most hospitals in the urban setting seem to lack the orientation, capacity and willingness to offer logistic and technical support to first level PHC facilities. This is further compounded by a commonly encountered problem of patients bypassing PHC facilities and crowding the outpatient departments of hospitals. Some countries have taken the initiative of developing polyclinics (Libyan Arab Jamahirya) and referral health centres (Tunisia) to help resolve these problems; however, these initiatives remain limited and motivated by the desire to stem the flow of patients to tertiary facilities, rather than tackling the primary problem of lack of support to PHC facilities logistically, technically and managerially.

Nongovernmental organizations and other providers

Nongovernmental organizations, especially charitable ones, were found in the Region before Alma-Ata. However, their function and number have expanded since. For example, in Egypt there are more than 13 000 registered nongovernmental organizations.

Recent regional experiences have pointed to an expanding role played by nongovernmental organizations, particularly in the delivery of PHC services to the urban poor and periurban dwellers. The ideals and philosophy of these organizations have also changed to be in line with PHC principles.

Partnership with nongovernmental organizations was introduced after Alma-Ata and is expected to flourish in the future by contracting with them to deliver PHC services in which they have proved more effective and able to comply with national PHC policies. An example of this is the Egyptian government decision to allocate 40% of its social fund activities to nongovernmental organizations.

Other partners in PHC delivery are the community health workers. The relation between the health system and the different types of community health workers has been variable. In some experiences the community health worker will be an integral part of the health services where they are supported, supervised and trained by the health administration (the Islamic Republic of Iran and Sudan). Elsewhere they are partners or "friends" of the health facilities where they contribute to or are consulted on health functions (Oman and Saudi Arabia). Depending on the training, their job description, their support by the health system and community as well as by their location community health workers perform a wide range of activities. Traditional birth attendants perform mainly natal and postnatal care plus some educational and social activities. Trained community health workers perform preventive, promotive and limited curative care in their locality. Volunteers as in the Islamic Republic of Iran focus on promotional and environmental issues as well as educational messages.

Quality of PHC

Quality improvement (QI) is a new discipline introduced after Alma-Ata in many countries. Hospitals were the first health facilities to introduce quality health care. There is a growing interest nowadays among countries in the Region in introducing quality assurance. Some countries introduced in the 1990s tools for QI by developing guidelines, criteria and standards for carrying out training of trainers and setting up systems for supervision and evaluation as well as extensive training of health personnel in quality of PHC (Bahrain, Kuwait, Oman, Saudi Arabia and United Arab Emirates).

The recently improved standards of living in most countries of the Region, the availability of trained health workers and improved accessibility to health care have contributed to the increased awareness of governments for the need for QI of primary health care services. Also, consumer awareness and the demand for better quality services combined with competition between the private and government sectors to provide quality health care services has further added to the search for improved delivery in some countries.

Different models of QI are found in the Region and the structure of quality improvement systems varies from one country to another. Though these models are as yet implemented in limited cases, they reveal the conceptual model on which QI is based. While QI may be found in one level of service provision it may be yet to exist at another for instance, QI may be part of the PHC department at the central level yet no representation of QI is found at lower levels. Some countries show extensive reorganization of the central ministry of health prominently featuring QI. Recently with support from international agencies, model projects were launched in several coun-

tries, especially in hospitals, propagating the new trend in understanding QI as a leadership tool to continuously improve performance.

There are many health care providers in addition to the ministry of health. Examples of these are municipalities, traditional healers, private practitioners, and NGOs. Some sectors have their own health care system. It is necessary to provide for an integrated health care system whereby the role of each should be clearly identified and agreed upon. Within this, it is expected that the role of the ministry of health would be mainly in policy formation, assessing health status, monitoring the quality of services, providing advice and mastering national health planning. The ministry of health should also be entrusted with strategic and future thinking in anticipation of forthcoming changes and challenges.

Despite the expansion of health networks in almost all countries, it is clear that to achieve harmony between the different levels of health services will need more effort, particularly in relation to the referral system. Much investment after Alma-Ata was made by Member States on the infrastructure, health facilities were built, human resources produced and logistical support developed, especially in relation to drugs. Recently, high-cost technology and drugs, coupled with increased expectation and demand by the public are creating a major challenge to the financing and maintenance of early achievements. Quality of health services within the PHC context is linked to the PHC principles of equity, efficiency, effectiveness, relevance and accessibility. Quality assurance of health care has been introduced to the Region in 1995 as an initiative based on the previous experience of Member States as well as the prevailing thinking globally.

Concluding remarks

Before Alma-Ata, health care delivery was limited to a small proportion of the population and concerned mainly with clinical care. The environment conducive to health was mainly limited to the health authority, mainly the ministry of health plus sporadic efforts by other sectors. Health authorities paid little attention to the art of well-being. Populations were mainly rural and environmental health in the cities was strained. Gradually emigration to urban areas and the phenomenon of slums arose in the 1970s bringing along new challenges to health systems.

After Alma-Ata, PHC as an approach has become a movement with clear principles of community involvement, intersectoral action, equity and health in development. Such a movement has dominated the vision of health care systems in all countries. Overall, progress in health care delivery through the PHC infrastructure has been witnessed during the last two decades (1979–98), especially in infrastructure development, coverage and accessibility. Accessibility has increased from less than 40% before Alma-Ata to above 80%. Presently, Member States, based on the catchment area principle, are fostering their efforts on the quantitative and qualitative aspects, through various measures and creative, innovative approaches such as BDN, family practice concept, healthy villages/healthy cities, eradication/elimination of diseases and promotion and protection of health.

The World Health Report, 1997, suggested three major health-for-all indicators, namely life expectancy at birth, infant mortality rate (IMR) and under five mortality rate, to be used to put countries into three categories. The three categories are:

- *EMR Member States above all three health-for-all targets:* those countries which have achieved the targets of life expectancy at birth above 60 years, IMR less than 50 per 1000 live births and under-five mortality rate less than 70 per 1000 live births. In our Region, twelve countries in 1997 had achieved these targets. They are: Bahrain, Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia and United Arab Emirates.
- *EMR Member States below all three health-for-all targets:* this is the least developed countries group which is comprised of Afghanistan, Djibouti, Somalia, Sudan and Republic of Yemen. In this group none of the three targets were met.
- *Other EMR Member States:* this category contains those countries that have achieved one or two of the targets. This category contains five countries: Egypt, Iraq, Libyan Arab Jamahiriya, Morocco and Pakistan.

The varying degrees of achievements among countries and sometimes within countries can be attributed to new changes and challenges, which have faced countries of the Region during the last two decades. A major factor has been economic recession, which coupled with demographic changes, especially urbanisation and population ageing, has slowed progress in achieving health-for-all targets. New epidemiological trends with chronic diseases have topped the list of morbidity and mortality causes. These, together with the recent global market economy dominance, to which many

health care systems in the Region were not ready to cope with, constrained the health systems even further.

Where PHC has led our Region is an intriguing notion. For individuals, health workers and communities in the last two decades, it has been a period full of challenges and contradictions. The health landscape has been redrawn, the domination of the hospital and the bio-medicine paradigm has faded. Primary, public health care led, health systems are envisioned and welcomed by governments in the Region. Now we have a remarkable strategy for health at the heart of our national health systems. A paradigmatic shift in values and goals has really taken place in the 1980s and 1990s that is trying to deliver the promises of better health for all, centred on the values of social justice, quality of life, ecological sanity and sustainable health development.

Primary health care principles found a good, fertile basis in the Eastern Mediterranean Region where the value systems in the societies have always been in support of such human values. The communities in the Region have yet more potential to be discovered and more initiatives to present in order to achieve health for all. PHC is an evolution of health thinking. It is built on cumulative development and experience from previous decades and probably centuries. With such roots in history, it is an everlasting, sustainable strategy achieving health for all. The cumulative experience of the countries of the Region in the development of PHC systems should enable strategic, proactive thinking in dealing with new challenges as well as epidemiological, economical, environmental and social changes.

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